General Comments on 1st Quarter 2021 Data

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

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

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

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

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

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

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PROVIDER: Texas Center for Infectious Disease
THCIC ID: 000108
QUARTER: 1
YEAR: 2021

Certified With Comments

2021 data entered for Texas Center for Infectious Disease - discharged patients for this 1st qtr are only seven the amount is correct.

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PROVIDER: Baptist St Anthonys Hospital
THCIC ID: 001000
QUARTER: 1

YEAR: 2021

Certified With Comments

The data is correct to the best of my knowledge as of this date of certification

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PROVIDER: Matagorda Regional Medical Center
THCIC ID: 006000
QUARTER: 1
YEAR: 2021

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: CHRISTUS Good Shepherd Medical Center-Marshall
THCIC ID: 020000
QUARTER: 1
YEAR: 2021

Certified With Comments

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

==========
PROVIDER: Yoakum Community Hospital
THCIC ID: 023000
QUARTER: 1
YEAR: 2021

Certified With Comments

All claims were processed through THA's STAR program, any corrections made in THCIC's system 13.

==========
PROVIDER: CHRISTUS Good Shepherd Medical Center-Longview
THCIC ID: 029000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

==========
PROVIDER: United Memorial Medical Center
THCIC ID: 030000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

(Removed by THCIC)

*Potential confidential information removed by THCIC.
==========
PROVIDER: St Davids Hospital
THCIC ID: 035000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

E- 617 - Other Prodcedure Date earlier than 3 days before Admit Date or after Statement Thru Date: Error must remain due to specific coding and mock billing practices
E- 618 - Principal Prodcedure Date earlier than 3 days before Admit Date or after Statement Thru Date: Error must remain due to specific coding and billing practices
E- 690 - Invalid Physician 2 (ED Attending) Identifier for ED claim: All claims reviewed, NPI# for ER physicians group correct as entered, patient left before physician evaluation
W-650, W-616, & W-653 Date of Birth: newborns transferred from other hospital, date of birth, principal diagnosis, admission date, and admission type correct as entered

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

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PROVIDER: Baylor Scott & White Medical Center Taylor
THCIC ID: 044000
QUARTER: 1
YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Taylor
THCIC ID 044000
1st Qtr 2021 – Inpatient
Accuracy rate – 100%
No comments needed.

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PROVIDER: Texas Health Huguley Hospital
THCIC ID: 047000
QUARTER: 1
YEAR: 2021

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of October 14, 2021. If any errors are discovered in our data after this point, we will be unable to communicate these due to THCIC rules. This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgments about patient care.
Submission Timing
To meet the States submission deadline, approximately 30 days following the close of the calendar year quarter, we submit a snapshot of billed claims, extracted from our database. Any discharged patient encounters no billed by this cut-off date will not be included in the quarterly submission file sent in.
Diagnosis and Procedures
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed which can alter the true picture of a patient's hospitalization, sometimes significantly.
Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a ICD-10-CM effective 10-1-2015. This is mandated by the federal government and all hospitals must comply.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25

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

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PROVIDER: Baylor Scott & White Hospital-Brenham
THCIC ID: 066000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White Hospital-Brenham
THCIC ID 066000
1st Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

==========
PROVIDER: CHI St Lukes Health Memorial San Augustine
THCIC ID: 072000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Certifier is I.T. and not Local Facility.

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PROVIDER: HCA Houston Healthcare Tomball
THCIC ID: 076000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Corrected to the best of our ability at the time of certification.

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PROVIDER: Mission Trail Baptist Hospital
THCIC ID: 081001
 QUARTER: 1
    YEAR: 2021

Certified With Comments

I hereby certify on behalf of CFO (Removed by THCIC)
Thank you,
(Removed by THCIC)

*Potential confidential information removed by THCIC.
==========
PROVIDER: Wilbarger General Hospital
THCIC ID: 084000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

I have reviewed the reports

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PROVIDER: TMC Bonham Hospital
THCIC ID: 106001
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Certified as accurate.

==========
PROVIDER: Baptist Medical Center
THCIC ID: 114001
 QUARTER: 1
    YEAR: 2021

Certified With Comments

I certify for Baptist Medical Center on Behalf of (Removed by THCIC) (CFO). (Removed by THCIC)

*Potential confidential information removed by THCIC.
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PROVIDER: CHI St Lukes Health Memorial Lufkin
THCIC ID: 129000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

==========
PROVIDER: The Hospitals of Providence Memorial Campus
THCIC ID: 130000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Discrepancy between Birth Date and diagnosis not resolved.

==========
PROVIDER: Northeast Baptist Hospital
THCIC ID: 134001
 QUARTER: 1
    YEAR: 2021

Certified With Comments

I hereby certify 2021 1st Quarter Inpatient 2524 Encounters. On behalf of (Removed by THCIC), CFO at Northeast Baptist Hospital. (Removed by THCIC), Director Revenue Analysis at Northeast Baptist Hospital.

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

QUARTER: 1
YEAR: 2021

Certified With Comments

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

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PROVIDER: Methodist Hospital
THCIC ID: 154000
QUARTER: 1
YEAR: 2021

Certified With Comments

E-617 & E-618 Principal and other procedure dates: all principal procedure date errors are due to mock billing procedures and are correct as entered
E-637 SSN: unable to identify based off patient admission, patient did not provide or chose not to provide information
W-650 & W-653 Date of Birth: newborns transferred from other hospital, correct as entered
E-652 Admission Type: correct as is after review of medical record
E-690 E-693 W-695 W-696 Practitioner identifier/Practitioner Name Match: NPI/Provider name match correct as entered. Corrected names with double or hyphenated name.
All errors have been reviewed and corrected to the best of the facilities ability

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PROVIDER: Methodist Specialty & Transplant Hospital
THCIC ID: 154001
QUARTER: 1
YEAR: 2021

Certified With Comments

E-618 Principal procedure dates: all principal procedure date errors are due to mock billing procedures and are correct as entered
E-637 Invalid SSN: SSN found to be correct as entered after review
E-768 Manifest diagnosis code verified as correct in hospital docuemtation
All errors have been reviewed and corrected to the best of the facilities ability

==========

PROVIDER: Northeast Methodist Hospital

THCIC ID: 154002
 QUARTER: 1
    YEAR: 2021

Certified With Comments

E-637 (3) SSN correct as entered; unable to retrieve correct SSN from patient after review of patient EHR and demographic data.
E-768 (7) Manifest diagnosis code verified in hospital system as stated on coding summary.

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PROVIDER: Methodist Texsan Hospital
THCIC ID: 154003
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Diagnosis & Procedures: all principal procedure/other procedure date errors are due to mock billing procedures and are correct as is

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PROVIDER: Las Palmas Medical Center
THCIC ID: 180000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

This data i submitted in an effort to meet regulatory requirements.  It is administrative data not clinical data and is utilized for billing and financial decision directives.  Conclusions drawn could be erroneous due to reporting constraints, subjectivity in assignment of codes, system mapping and normal clinical error. Diagnostic and procedural data may be incomplete due to data field limitations.  The State data file may not fully represent all diagnoses treated or procedures performed.  It should also be noted that charges are not equal to actual payments received by the facility or facility costs for providing services.  Errors occurring in this data and not corrected were 1 invalid condition code, 3 admission type versus principal diagnosis code, 6 invalid revenue procedure codes and 1 manifest diagnosis code.  All other corrections were completed to the best of my ability and resources available at the time.

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PROVIDER: Medical Center Hospital
THCIC ID: 181000

QUARTER: 1
YEAR: 2021

Certified With Comments

Two rejections due to manifest diagnosis

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PROVIDER: Texas Health Harris Methodist HEB
THCIC ID: 182000
QUARTER: 1
YEAR: 2021

Certified With Comments

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both ‘HMO, and PPO’ are categorized as ‘Commercial PPO’. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to “home” as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

==========
PROVIDER: Baylor Scott & White Hospital College Station
THCIC ID: 206100
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White Hospital College Station
THCIC ID 206100
1st Qtr 2021 Inpatient
Accuracy rate – 99.91%
Errors from the 1st Quarter FER reflect the following error codes E-617.
Procedure date verified in hospital system , reported as posted
Errors will stand as reported.

==========
PROVIDER: Laredo Medical Center
THCIC ID: 207001
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Some claims are incomplete due to not having all information to code completely.

Some providers have not changed their information in the NPI Registry therefore the claims cannot be corrected. Providers have been notified will be fixed.

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PROVIDER: Baylor Scott & White The Heart Hospital Denton
THCIC ID: 208100
QUARTER: 1
YEAR: 2021

Certified With Comments

Baylor Scott & White The Heart Hospital Denton
THCIC ID 208100
1st Qtr 2021 Inpatient
Accuracy rate – 99.52%
Errors from the 1st Quarter FER reflect the following error codes E-617.
Procedure date verified in hospital system , reported as posted
Errors will stand as reported.

==========

PROVIDER: CHRISTUS Spohn Hospital-Kleberg
THCIC ID: 216001
QUARTER: 1
YEAR: 2021

Certified With Comments

Done

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PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth
THCIC ID: 235000
QUARTER: 1
YEAR: 2021

Certified With Comments

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

but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

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PROVIDER: Wise Health System-Medical Center

THCIC ID: 254001
 QUARTER: 1
    YEAR: 2021

Certified With Comments

The claims in this file are up to date as of the time of submission.  Errors or missing data equal the data in the billing system.

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PROVIDER: Texas Health Harris Methodist Hospital-Stephenville
THCIC ID: 256000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

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

ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both 'HMO, and PPO' are categorized as 'Commercial PPO'. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

==========
PROVIDER: University Medical Center of El Paso-Alameda
THCIC ID: 263000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

==========
PROVIDER: The Hospitals of Providence Sierra Campus
THCIC ID: 266000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

E-code discrepancy

==========
PROVIDER: Metropolitan Methodist Hospital
THCIC ID: 283000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

W-650 & W-653 Date of Birth: newborns transferred from other hospital, date of birth, principal diagnosis, and admission type correct as entered
E-652 Admission Type: newborn and principal diagnosis correct as is after review of medical record
All errors have been reviewed and corrected to the best of the facilities ability

==========
PROVIDER: Baylor Scott & White Medical Center Waxahachie
THCIC ID: 285000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Waxahachie
THCIC ID 285000
1st Qtr 2021 – Inpatient
Accuracy rate –  99.89%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported

==========
PROVIDER: Baylor Scott & White Medical Center-Irving
THCIC ID: 300000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center-Irving
THCIC ID 300000

1st Qtr 2021 Inpatient
Accuracy rate – 99.96%
Errors from the 1st Quarter FER reflect the following error codes E-617.
Procedure date verified in hospital system , reported as posted
Errors will stand as reported.

==========

PROVIDER: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000
QUARTER: 1
YEAR: 2021

Certified With Comments

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both 'HMO, and PPO' are categorized as 'Commercial PPO'. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Del Sol Medical Center
THCIC ID: 319000
QUARTER: 1
YEAR: 2021

Certified With Comments

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

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PROVIDER: Texas Health Harris Methodist Hospital Cleburne

THCIC ID: 323000
QUARTER: 1
YEAR: 2021

Certified With Comments

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

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

==========
PROVIDER: Baylor University Medical Center
THCIC ID: 331000
QUARTER: 1
YEAR: 2021

Certified With Comments

Baylor University Medical Center
THCIC ID 331000
1st Qtr 2021 Inpatient
Accuracy rate – 99.93%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.

==========
PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
QUARTER: 1
YEAR: 2021

Certified With Comments

Cook Children's Medical Center has submitted and certified FIRST QUARTER 2021 inpatient, outpatient surgery and outpatient radiology encounters to the Texas Health Care Information Council with the following possible data concerns based on the required submission method.
Since our data was submitted to the State we have uncovered medical coding errors regarding the following patient conditions in 2005 and 2010 discharges:
Post-operative infections
Accidental puncture and lacerations
Post-operative wound dehiscence
Post-operative hemorrhage and hematoma

Comparative complication reports reflecting the above conditions could misstate the true conditions at Cook Children's Medical Center for the FIRST QUARTER OF 2021.
There may be some encounters will have one of the following issues:
Questionable Revenue Procedure Modifier 1
Questionable Revenue Procedure Modifier 2
These are errors that are very difficult, if not impossible to correct as that is how they are sent to the respective payers. This is especially true for modifier errors related to transport (Rev Codes 0540 & 0545). Per the following website, these modifiers appear to be legitimate:
https://www.findacode.com/code-set.php?set=HCPCSMODA.
Additionally, there may be outpatient encounters where there is an invalid NPI associated with the attending provider. These are most likely to be encounters in the ED where a patient was seen by a nurse in triage and charges were incurred, but left without being seen by a physician or an advanced nurse provider.
However, our overall accuracy rate is very high, so this will be a small proportion of our encounters.
We will continue to work with the Revenue Cycle team to improve the accuracy of the data elements going forward.
This will affect encounters for the FIRST QUARTER OF 2021
Patient charges that were accrued before admit or after discharge were systematically excluded from the database. This can happen when a patient is pre-admitted and incurs charges to their encounter before their admit date or charges are discovered and added to the patient encounter after they are discharged. Therefore, the charges for many patient encounters are under reported.
The data structure allowed by THCIC erroneously assigns surgeons to surgical procedures they did not perform. The data structure provided by THCIC allows for one attending and one operating physician assignment. However, patients frequently undergo multiple surgeries where different physicians perform multiple procedures. Assigning all of those procedures to a single 'operating physician' will frequently attribute surgeries to the wrong physician. THCIC chooses to only assign one surgeon to a patient encounter, not to each procedure.
Furthermore, the data structure established by THCIC allows for a limited number of diagnoses and procedures. Patients with more than the limit for diagnoses or procedures will be missing information from the database. This is especially true in complex cases where a patient has multiple major illnesses and multiple surgeries over an extended stay.

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PROVIDER: HCA Houston Healthcare West
THCIC ID: 337001
QUARTER: 1
YEAR: 2021

Certified With Comments

Certify with one error, which could not be corrected.

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PROVIDER: Medical City Dallas Hospital
THCIC ID: 340000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

INFORMATION IS VALID

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PROVIDER: Nocona General Hospital
THCIC ID: 348000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

ALL DATA IS CORRECT AS SUBMITTED TO MY KNOWLEDGE.

==========
PROVIDER: Baylor Scott & White All Saints Medical Center-Fort Worth
THCIC ID: 363000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White All Saints Medical Center-Fort Worth
THCIC ID 363000
1st Qtr 2021 Inpatient
Accuracy rate – 99.87%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.

==========
PROVIDER: Nacogdoches Medical Center
THCIC ID: 392000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

data certified

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PROVIDER: Adventhealth Central Texas
THCIC ID: 397001
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Errors corrected to the best of my ability.

==========
PROVIDER: CHRISTUS Spohn Hospital Corpus Christi
THCIC ID: 398000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Done

==========
PROVIDER: CHRISTUS Spohn Hospital Corpus Christi-Shoreline
THCIC ID: 398001
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Done

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PROVIDER: CHRISTUS Spohn Hospital Corpus Christi-South
THCIC ID: 398002
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Done

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PROVIDER: Valley Baptist Medical Center

THCIC ID: 400000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

the 3 remaining errors can not be resolved and have been reviewed by the Reg. team several times without resolution. No further updated information is available on these pts.

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PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

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PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to “home” as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

==========
PROVIDER: Ascension Seton Smithville
THCIC ID: 424500
QUARTER: 1
YEAR: 2021

Certified With Comments

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

==========
PROVIDER: CHRISTUS Spohn Hospital-Beeville
THCIC ID: 429001
QUARTER: 1
YEAR: 2021

Certified With Comments

Done

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PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
QUARTER: 1
YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes. Administrative data may not
accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from

a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is ‘over and above’ the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An ‘apples to apples’ comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

Director.

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PROVIDER: UT Southwestern University Hospital-Clements University
THCIC ID: 448001
 QUARTER: 1
    YEAR: 2021

Certified With Comments

No errors to re[ort

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PROVIDER: UT Southwestern University Hospital-Clements Psych
THCIC ID: 448002
 QUARTER: 1
    YEAR: 2021

Certified With Comments

No errors to report

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PROVIDER: Dallas Medical Center
THCIC ID: 449000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Certify Q1 2021 inpt

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PROVIDER: CHI St Lukes Health - Memorial Livingston
THCIC ID: 466000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

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

QUARTER: 1
YEAR: 2021

Certified With Comments

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

Length of Stay

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Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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Cost/ Revenue Codes

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

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PROVIDER: Knapp Medical Center
THCIC ID: 480000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

1Q2021 Certification of Data

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PROVIDER: Memorial Medical Center
THCIC ID: 487000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

We have corrected these to the best of our ability

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PROVIDER: Driscoll Childrens Hospital
THCIC ID: 488000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

All provider identifying information has been verified and will be updated against a reference file and continues to be reviewed on an ongoing basis.

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PROVIDER: Ascension Seton Medical Center
THCIC ID: 497000

QUARTER: 1
YEAR: 2021

Certified With Comments

Seton Medical Center Austin has a transplant program and Neonatal Intensive Care Unit (NICU). Hospitals with transplant programs generally serve a more seriously ill patient, increasing costs and mortality rates. The NICU serves very seriously ill infants substantially increasing cost, lengths of stay and mortality rates. As a regional referral center and tertiary care hospital for cardiac and critical care services, Seton Medical Center Austin receives numerous transfers from hospitals not able to serve a more complex mix of patients. This increased patient complexity may lead to longer lengths of stay, higher costs and increased mortality.
All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.
These data are submitted by the hospital as their best effort to meet statutory requirements.

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PROVIDER: Medical City Arlington
THCIC ID: 502000
QUARTER: 1
YEAR: 2021

Certified With Comments

INFORMATION IS VALID

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PROVIDER: Baylor Scott & White Medical Center Hillcrest
THCIC ID: 506001
QUARTER: 1
YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Hillcrest
THCIC ID 506001
1st Qtr 2021 – Inpatient
Accuracy rate – 99.83%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported

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PROVIDER: Baylor Scott & White Medical Center-Grapevine
THCIC ID: 513000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center-Grapevine
THCIC ID 513000
1st Qtr 2021 Inpatient
Accuracy rate – 99.83%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.

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PROVIDER: Baylor Scott & White Medical Center Temple
THCIC ID: 537000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Temple
THCIC ID 537000
1st Qtr 2021 – Inpatient
Accuracy rate – 99.66%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported

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PROVIDER: Baylor Scott & White McLane Childrens Medical Center
THCIC ID: 537006
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White McLane Childrens Medical Center
THCIC ID 537006
1st Qtr 2021 – Inpatient
Accuracy rate – 99.40%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted

Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported

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PROVIDER: Ascension Seton Highland Lakes
THCIC ID: 559000
QUARTER: 1
YEAR: 2021

Certified With Comments

Seton Highland Lakes, a member of the Seton Family of Hospitals, is a 25-bed acute care facility located between Burnet and Marble Falls on Highway 281. The hospital offers 24-hour emergency services, plus comprehensive diagnostic and treatment services for residents in the surrounding area. Seton Highland Lakes also offers home health and hospice services. For primary and preventive care, Seton Highland Lakes offers a clinic in Burnet, a clinic in Marble Falls, a clinic in Bertram, a clinic in Lampasas, and a pediatric mobile clinic in the county. This facility is designated by the Center for Medicare & Medicaid Services as a Critical Access Hospital and is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations under its Critical Access designation program.
All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.
These data are submitted by the hospital as their best effort to meet statutory requirements.

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PROVIDER: Ascension Seton Edgar B Davis
THCIC ID: 597000
QUARTER: 1
YEAR: 2021

Certified With Comments

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

remain unidentified in the THCIC Practitioner Reference Files.
These data are submitted by the hospital as their best effort to meet statutory requirements.

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PROVIDER: St Davids South Austin Hospital
THCIC ID: 602000
QUARTER: 1
YEAR: 2021

Certified With Comments

618 - Principal Prodcedure Date earlier than 3 days before Admit Date or after Statement Thru Date: Error must remain due to specific coding and billing practices
768 - Manifest diagnosis codes may not be used as the Admitting Diagnosis Code: Admitting diagnosis that reflect manifest codes are corret as entered after review
All errors have been reviewed and corrected to the best of the facilities ability

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PROVIDER: Round Rock Medical Center
THCIC ID: 608000
QUARTER: 1
YEAR: 2021

Certified With Comments

E-768 (3) Manifest diagnosis code verified as correct in hospital system and coding summary
E-707 (1) Missing operating practitioner identifier correct as entered. NPI/Provider name match; correct as entered. NPI name match unable to correct due to double name, last name listed as first, hyphenated name, or group physician, testing physician order entry.
W-653 (1) W-650 (1) Newborn transfer from other hospital, correct as entered

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PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth
THCIC ID: 627000
QUARTER: 1
YEAR: 2021

Certified With Comments

Data Content
This data is administrative data, which hospitals collect for billing purposes.

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

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PROVIDER: Hamilton General Hospital
THCIC ID: 640000
QUARTER: 1
YEAR: 2021

Certified With Comments

Data certified as complete and accurate with all information available at time of reporting.

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PROVIDER: Kindred Hospital-San Antonio
THCIC ID: 645000
QUARTER: 1
YEAR: 2021

Certified With Comments

Kindred Hospital is a long –term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 208 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.

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PROVIDER: St Davids Rehab Center
THCIC ID: 649000
QUARTER: 1
YEAR: 2021

Certified With Comments

E-637 SSN correct as entered; unable to retrieve correct SSN from patient

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PROVIDER: Texas Health Specialty Hospital-Fort Worth
THCIC ID: 652000

QUARTER: 1
YEAR: 2021

Certified With Comments

Data Content
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accurately represent the clinical details of an encounter.
The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is ‘over and above’ the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.
Diagnosis and Procedures
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Length of Stay

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Admit Source data for Normal Newborn

Texas Health Specialty Hospital does not have a newborn population.

Race/Ethnicity

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

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Discharge Disposition

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==========
PROVIDER: UT Southwestern University Hospital-Zale Lipshy
THCIC ID: 653001
 QUARTER: 1
    YEAR: 2021

Certified With Comments

No errors to report

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PROVIDER: UT Southwestern University Hospital-Zale Lipshy Psych
THCIC ID: 653002
 QUARTER: 1
    YEAR: 2021

Certified With Comments

No errors to report

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PROVIDER: UT Southwestern University Hospital-Zale Lipshy Rehab
THCIC ID: 653003
 QUARTER: 1
    YEAR: 2021

Certified With Comments

No errors to report

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PROVIDER: Kindred Hospital-Mansfield
THCIC ID: 657000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long –term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 78 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.
================================================================================
PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

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

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PROVIDER: HCA Houston Healthcare Kingwood
THCIC ID: 675000
QUARTER: 1
YEAR: 2021

Certified With Comments

UNABLE TO CORRECT NPI ISSUES RELATING TO NPI BELONGING TO ORGANIZATION AND NOT INDIVIDUAL

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PROVIDER: Kindred Hospital-Houston Medical Center
THCIC ID: 676000
QUARTER: 1
YEAR: 2021

Certified With Comments

Kindred Hospital is a long –term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 258 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.
==========
PROVIDER: North Central Baptist Hospital

THCIC ID: 677001
 QUARTER: 1
    YEAR: 2021

Certified With Comments

I hereby certify 1st quarter 2021 IP.  4713 encounters.  On behalf of (Removed by THCIC),
CFO at North Central Baptist Hospital.  (Removed by THCIC), Director
Revenue Analysis at North Central Baptist Hospital.

*Potential confidential information removed by THCIC.
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PROVIDER: Kindred Hospital-Tarrant County
THCIC ID: 690000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long –term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 124 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.
==========
PROVIDER: Premier Specialty Hospital of El Paso
THCIC ID: 701000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

certifying data with errors, errors were unable to be corrected prior to certification, Working with Revenue Team to correct the errors from happening. Thank you

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PROVIDER: Kindred Hospital Houston NW
THCIC ID: 706000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long –term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 149 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.

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PROVIDER: Texas Health Seay Behavioral Health Hospital
THCIC ID: 720000
QUARTER: 1
YEAR: 2021

Certified With Comments

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

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

Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.
Standard/Non-Standard Source of Payment
The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both 'HMO, and PPO' are categorized as 'Commercial PPO'. Thus, any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.
Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Kindred Hospital Clear Lake
THCIC ID: 720402
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long –term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 179 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.
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PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to “home” as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Kindred Hospital El Paso
THCIC ID: 727100
QUARTER: 1
YEAR: 2021

Certified With Comments

Kindred Hospital is a long –term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 169 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.
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PROVIDER: Texas Health Heart & Vascular Hospital
THCIC ID: 730001
QUARTER: 1
YEAR: 2021

Certified With Comments

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

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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Cost/ Revenue Codes

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

Discharge Disposition

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

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PROVIDER: Texas Health Springwood Behavioral Health Hospital
THCIC ID: 778000
QUARTER: 1
YEAR: 2021

Certified With Comments

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

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Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.
Discharge Disposition
THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to “home” as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Intracare North Hospital
THCIC ID: 782001
QUARTER: 1
YEAR: 2021

Certified With Comments

One patient with a duplicate diagnosis code

==========
PROVIDER: Baylor Scott & White Heart & Vascular Hospital Dallas
THCIC ID: 784400
QUARTER: 1
YEAR: 2021

Certified With Comments

Baylor Scott & White Heart & Vascular Hospital Dallas
THCIC ID 784400
1st Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

==========
PROVIDER: Harlingen Medical Center
THCIC ID: 788002
QUARTER: 1
YEAR: 2021

Certified With Comments

Our Q1 2021 inpatient data is 100% accurate - no comments

==========
PROVIDER: Kindred Hospital Sugar Land

THCIC ID: 792700
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 227 records are correctly reported.
(Removed by THCIC)

*Potential confidential information removed by THCIC.
==========
PROVIDER: Ascension Seton Southwest
THCIC ID: 797500
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

==========
PROVIDER: Ascension Seton Northwest
THCIC ID: 797600
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

==========
PROVIDER: Kindred Hospital Tarrant County Fort Worth SW
THCIC ID: 800000
 QUARTER: 1

YEAR: 2021

Certified With Comments

Kindred Hospital is a long –term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referral are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 178 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.

==========

PROVIDER: Baylor Medical Center Trophy Club
THCIC ID: 805100
QUARTER: 1
YEAR: 2021

Certified With Comments

No errors were identified in these reports

==========

PROVIDER: Texas Health Harris Methodist Hospital Southlake
THCIC ID: 812800
QUARTER: 1
YEAR: 2021

Certified With Comments

The Q1 2021 All Data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, & Bill Type etc. They may contain duplicates/missing claims but the file was reviewed and all corrections made

==========

PROVIDER: Texas Institute for Surgery-Texas Health Presbyterian-Dallas
THCIC ID: 813100
QUARTER: 1
YEAR: 2021

Certified With Comments

The Q1 2021 All Data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, & Bill Type etc. They may contain duplicates/missing claims but the file was reviewed and all corrections made

==========
PROVIDER: Medical City Las Colinas
THCIC ID: 814000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

INFORMATION IS VALID

==========
PROVIDER: Baylor Scott & White Medical Center-Plano
THCIC ID: 814001
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center-Plano
THCIC ID 814001
1st Qtr 2021 – Inpatient
Accuracy rate –  99.73%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported

==========
PROVIDER: Texas Health Center-Diagnostics & Surgery Plano
THCIC ID: 815300
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

==========

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

YEAR: 2021

Certified With Comments

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

The state requires that hospitals submit revenue information including charges.

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

==========

PROVIDER: Heart Hospital-Austin
THCIC ID: 829000
QUARTER: 1
YEAR: 2021

Certified With Comments

637 - Invalid Patient SSN: SSN found to be correct as entered after review of record and hospital systems
All errors have been reviewed and corrected to the best of the facilities ability

==========

PROVIDER: North Austin Medical Center
THCIC ID: 829900
QUARTER: 1
YEAR: 2021

Certified With Comments

W-650 & W-653 Date of Birth: newborns transferred from other hospital, date of birth, principal diagnosis, admission date, and admission type correct as entered
E-768 - Manifest diagnosis codes may not be used as the Admitting Diagnosis Code: Admitting diagnosis that reflect manifest codes are correct as entered after review
E-652 - Admission Type = Newborn and Principal Diagnosis Not = Newborn: review of coding summary and UB04 show admission type and principal diagnosis correct as entered
All errors have been reviewed and corrected to the best of the facilities ability

==========

PROVIDER: Mayhill Hospital
THCIC ID: 831700

QUARTER: 1
YEAR: 2021

Certified With Comments

All claims have been reviewed and resolved.

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PROVIDER: St Davids Georgetown Hospital
THCIC ID: 835700
QUARTER: 1
YEAR: 2021

Certified With Comments

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

==========

PROVIDER: St Joseph Medical Center
THCIC ID: 838600
QUARTER: 1
YEAR: 2021

Certified With Comments

St. Joseph Medical Center is certify 1st quarter 2021 Inpatient. We have a 98% accuracy rate, due to issues with the vendor files.

==========

PROVIDER: Baylor Scott & White The Heart Hospital Plano
THCIC ID: 844000
QUARTER: 1
YEAR: 2021

Certified With Comments

Baylor Scott & White The Heart Hospital Plano
THCIC ID 844000
1st Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

==========

PROVIDER: Baylor Scott & White Continuing Care Hospital
THCIC ID: 850300

QUARTER: 1
YEAR: 2021

Certified With Comments

Baylor Scott & White Continuing Care Hospital
THCIC ID 850300
1st Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

==========

PROVIDER: Dell Childrens Medical Center
THCIC ID: 852000
QUARTER: 1
YEAR: 2021

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 increase the hospital's costs of care, lengths of stay and mortality rates. In addition, the hospital includes a Neonatal Intensive Care Unit (NICU) which serves very
seriously ill infants, which substantially increases costs of care, lengths of stay and mortality rates.
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: Baylor Scott & White Medical Center Round Rock
THCIC ID: 852600
QUARTER: 1
YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Round Rock
THCIC ID 852600
1st Qtr 2021 – Inpatient
Accuracy rate – 100%
No comments needed.

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PROVIDER: Physicians Surgical Hospital-Quail Creek
THCIC ID: 852900
 QUARTER: 1
    YEAR: 2021

Certified With Comments

certifying with no errors detected

==========
PROVIDER: Physicians Surgical Hospital-Panhandle Campus
THCIC ID: 852901
 QUARTER: 1
    YEAR: 2021

Certified With Comments

certifying with no errors detected

==========
PROVIDER: Central Texas Rehab Hospital
THCIC ID: 854400
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Central Texas Rehabilitation Hospital provides services for patients who
requires rehabilitation services. This data was pulled from the patient
accounting system using the discharge dates criteria. Therefore, all 176 records
are reported accurately.
(Removed by THCIC)
Kindred Healthcare

*Potential confidential information removed by THCIC.
==========
PROVIDER: El Paso Behavioral Health System
THCIC ID: 858600
 QUARTER: 1
    YEAR: 2021

Certified With Comments

2 Medicare accounts without charges due to combined billing.l

==========
PROVIDER: Texas Health Hospital Rockwall

THCIC ID: 859900
 QUARTER: 1
    YEAR: 2021

Certified With Comments

The Q1 2021 All Data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, & Bill Type etc. They may contain duplicates/missing claims but the file was reviewed and all corrections made

==========

PROVIDER: Ascension Seton Williamson
THCIC ID: 861700
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

==========

PROVIDER: The Hospitals of Providence East Campus
THCIC ID: 865000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

No comments

==========

PROVIDER: Kindred Hospital Dallas Central
THCIC ID: 914000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referrals are screen by our centralized

admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 142 records are correctly reported.
(Removed by THCIC)

*Potential confidential information removed by THCIC.

==========

PROVIDER: Encompass Health Rehab Hospital Abilene
THCIC ID: 920000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

these uncorrected errors are for SS#'s that we could not get!

==========

PROVIDER: Ascension Seton Hays
THCIC ID: 921000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

==========

PROVIDER: Texas Health Presbyterian Hospital Flower Mound
THCIC ID: 943000
 QUARTER: 1
    YEAR: 2021

Certified With Comments

The Q1 2021 All Data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, & Bill Type etc. They may contain duplicates/missing claims but the file was reviewed and all corrections made

==========

PROVIDER: Carrollton Springs
THCIC ID: 969500
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Social security number was not available in 5 records. Our staff was trained to enter all zeros in case social security number is not available. Now we have trained our staff to enter all 9s.

==========

PROVIDER: Baylor Scott & White Medical Center McKinney
THCIC ID: 971900
QUARTER: 1
YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center McKinney
THCIC ID 971900
1st Qtr 2021 Inpatient
Accuracy rate – 99.88%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.

==========

PROVIDER: Texas Health Harris Methodist Hospital Alliance
THCIC ID: 972900
QUARTER: 1
YEAR: 2021

Certified With Comments

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

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

==========
PROVIDER: Mesa Springs
THCIC ID: 973430
 QUARTER: 1
    YEAR: 2021

Certified With Comments

The 1st Qtr. 2021 data for ethnicity is incorrect.  We are working on our system

to be able to accurately report this statistic.

==========
PROVIDER: Rock Springs
THCIC ID: 973730
 QUARTER: 1
    YEAR: 2021

Certified With Comments

2021Q2

==========
PROVIDER: Resolute Health
THCIC ID: 973850
 QUARTER: 1
    YEAR: 2021

Certified With Comments

There are no claims to correct in the claim correction tab for this quarter

==========
PROVIDER: Baylor Scott & White Medical Center Marble Falls
THCIC ID: 974940
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Marble Falls
THCIC ID 974940
1st Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

==========
PROVIDER: JPS Health Network - Trinity Springs North
THCIC ID: 975121
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Introduction
John Peter Smith Hospital (JPSH) is operated by JPS Health Network

under the auspices of the Tarrant County Hospital District.  The JPS Health Network is accredited by the Joint Commission. In addition, JPSH holds Joint Commission accreditation as a hospital.
JPSH is the only Texas Department of Health certified Level I Trauma Center in Tarrant County and includes the only psychiatric emergency center in the county.  The hospital's services include intensive care for adults and newborns, an AIDS treatment center, a full range of obstetrical and gynecological services, adult inpatient care and an inpatient mental health treatment facility.
JPSH is a major teaching hospital offering, or providing through co-operative arrangements, postdoctoral training in orthopedics, obstetrics and gynecology, psychiatry, surgery, oral and maxillofacial surgery, radiology, sports medicine, podiatry and pharmacy. The family medicine residency is the largest hospital-based family medicine residency program in the nation.
In addition to JPSH, the JPS Health Network operates community health centers located in medically underserved areas of Tarrant County; school-based health clinics; outpatient programs for pregnant women, behavioral health and cancer patients; and a wide range of wellness education programs.
JPSH has confirmed that for errors related to “Other Procedure Date must be on or after the 3rd day before the Admission Date”, patient was in observation status at the time of the procedure. Procedure date and time are accurate based on when the procedure was completed.

==========
PROVIDER: Medical City Frisco
THCIC ID: 975139
 QUARTER: 1
    YEAR: 2021

Certified With Comments

INFORMATION IS VALID

==========
PROVIDER: Methodist Southlake Hospital
THCIC ID: 975153
 QUARTER: 1
    YEAR: 2021

Certified With Comments

No changes.

==========
PROVIDER: Kindred Hospital San Antonio Central
THCIC ID: 975155
 QUARTER: 1

YEAR: 2021

Certified With Comments

Kindred Hospital is a long term care hospital that provides an acute hospital level of care and services to patient requiring a long hospitalization. Kindred hospital admissions are sorely based on referrals from various health care settings; such as: short term acute care; skilled nursing; sub-acute and in some cases direct admits from home. All referrals are screen by our centralized admission department prior to admission and scheduled for admission at least 24 hours in advance. Therefore, all 151 records are correctly reported.
(Removed by THCIC)

*Potential confidential information removed by THCIC.

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PROVIDER: Baylor Scott & White Medical Center Lakeway
THCIC ID: 975165
QUARTER: 1
YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Lakeway
THCIC ID 975165
1st Qtr 2021 Inpatient
Accuracy rate – 99.68%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.

==========

PROVIDER: Texas Health Hospital Clearfork
THCIC ID: 975167
QUARTER: 1
YEAR: 2021

Certified With Comments

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

hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.
If a medical record is unavailable for coding the encounter is not billed and is not included in the data submission. This represents a rare event that is less than 1% of the encounter volume.

Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-10-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An ‘apples to apples’ comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-10-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

not anticipated that this limitation will affect this data.

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

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

==========

PROVIDER: St Davids Surgical Hospital
THCIC ID: 975169
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

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PROVIDER: The Hospitals of Providence Transmountain Campus
THCIC ID: 975188
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Coding was found to be accurate

==========

PROVIDER: Dell Seton Medical Center at The University of Texas
THCIC ID: 975215
 QUARTER: 1
    YEAR: 2021

Certified With Comments

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

==========

PROVIDER: Encompass Health Rehab Hospital Pearland

THCIC ID: 975246
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Certify without comment.

==========
PROVIDER: CHRISTUS Dubuis Hospital Beaumont
THCIC ID: 975255
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Data submitted as correct.

==========
PROVIDER: Baylor Scott & White Medical Center Centennial
THCIC ID: 975285
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Centennial
THCIC ID 975285
1st Qtr 2021 Inpatient
Accuracy rate – 99.63%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.

==========
PROVIDER: Baylor Scott & White Medical Center Lake Pointe
THCIC ID: 975286
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Lake Point
THCIC ID 975286
1st Qtr 2021 Inpatient
Accuracy rate–  99.90%

Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.

==========
PROVIDER: UT Health East Texas Carthage Hospital
THCIC ID: 975294
 QUARTER: 1
    YEAR: 2021

Certified With Comments

No errors on C12 Certification Error type report

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PROVIDER: UT Health East Texas Henderson Hospital
THCIC ID: 975295
 QUARTER: 1
    YEAR: 2021

Certified With Comments

There area  no errors for C12 Cert. Error Type list

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PROVIDER: UT Health East Texas Tyler Regional Hospital
THCIC ID: 975299
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Principal procedure date unknown.

==========
PROVIDER: HCA Houston Healthcare North Cypress
THCIC ID: 975321
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Name match corrections were made to the best of our ability at the time of certification.

==========
PROVIDER: Baylor Scott & White Medical Center Pflugerville
THCIC ID: 975340
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Pflugerville
THCIC ID 975340
1st Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

==========
PROVIDER: Baylor Scott & White The Heart Hospital McKinney
THCIC ID: 975385
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White The Heart Hospital McKinney
THCIC ID 975385
1st Qtr 2021 – Inpatient
Accuracy rate – 100%
No comments needed.

==========
PROVIDER: Baylor Scott & White Medical Center Buda
THCIC ID: 975391
 QUARTER: 1
    YEAR: 2021

Certified With Comments

Baylor Scott & White Medical Center Buda
THCIC ID 975391
1st Qtr 2021 Inpatient
Accuracy rate – 100%
No comments needed.

==========
PROVIDER: Valley Baptist Micro-Hospital Weslaco
THCIC ID: 975415
 QUARTER: 1

YEAR: 2021

Certified With Comments

certified today

==========
PROVIDER: Ascension Seton Bastrop
THCIC ID: 975418
QUARTER: 1
YEAR: 2021

Certified With Comments

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

==========
PROVIDER: United Memorial Medical Center Sugar Land Hospital
THCIC ID: 975780
QUARTER: 1
YEAR: 2021

Certified With Comments

(Removed by THCIC)

*Potential confidential information removed by THCIC.
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PROVIDER: Texas Health Hospital Frisco
THCIC ID: 975783
QUARTER: 1
YEAR: 2021

Certified With Comments

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

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

Length of Stay

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Admit Source data for Normal Newborn

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

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Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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Cost/ Revenue Codes

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

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

==========
PROVIDER: Baylor Scott & White Medical Center Austin
THCIC ID: 975789
QUARTER: 1
YEAR: 2021

Certified With Comments

Baylor Scott and White Medical Center Austin
THCIC ID 975789
1st Qtr 2021 Inpatient
Accuracy rate – 99.18%
Errors from the 1st Quarter FER reflect the following error codes E-617, E-618.
Procedure date verified in hospital system , reported as posted
Principal procedure date verified in hospital system , reported as posted
Errors will stand as reported.

==========
PROVIDER: The Hospitals of Providence Spine & Pain Management Center
THCIC ID: 975803
QUARTER: 1
YEAR: 2021

Certified With Comments

No comments

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PROVIDER: Texas Health Hospital Mansfield
THCIC ID: 975870
QUARTER: 1
YEAR: 2021

Certified With Comments

All errors corrected.

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PROVIDER: Methodist Hospital Stone Oak Rehab Center
THCIC ID: 975881
 QUARTER: 1
    YEAR: 2021

Certified With Comments

2 Errors could not be corrected.  One Invalid Condition Code was corrected but would not save.  Patient SSN was entered but would not save.

==========

PROVIDER: Clearsky Rehab Hospital of Flower Mound
THCIC ID: 975889
 QUARTER: 1
    YEAR: 2021

Certified With Comments

one error identified for total claim charges.
Claim was overlooked and not corrected in error.