General Comments on 4th 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.

4q2021 Inpatient Certification Comments

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PROVIDER: United Memorial Medical Center

THCIC ID: 030000

Certification

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PROVIDER: United Memorial Medical Center North Hospital

THCIC ID: 975402

Certified

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PROVIDER: United Memorial Medical Center Sugar Land Hospital

THCIC ID: 975780

Certified

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PROVIDER: Palestine Regional Medical Center

THCIC ID: 629001

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PROVIDER: TMC Bonham Hospital

THCIC ID: 106001

Certified as accurate

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PROVIDER: Texas Surgical Hospital

THCIC ID: 975785

inpatient

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PROVIDER: Hamilton General Hospital

THCIC ID: 640000

All data viewed for accuracy as of 6/30/22.

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PROVIDER: Baptist St Anthonys Hospital

THCIC ID: 001000

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

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PROVIDER: Highlands Rehabilitation Hospital

THCIC ID: 718002

Vibra Healthcare is certifying October and November 2021. HCA purchased Highlands Rehab Hospital on December 1, 2021 therefore we will not be submitting any further claims for this entity.

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PROVIDER: Christus Mother Frances Hospital Sulphur Springs

THCIC ID: 975159

2 claims with invalid POA codes

==

PROVIDER: Kindred Hospital-San Antonio

THCIC ID: 645000

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 144 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.
==
PROVIDER: Kindred Hospital Houston NW
THCIC ID: 706000

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 140 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.
==
PROVIDER: Kindred Hospital-Houston Medical Center
THCIC ID: 676000

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 221 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.
===
PROVIDER: Kindred Hospital-Tarrant County
THCIC ID: 690000

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 110 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.
===
PROVIDER: Northwest Hills Surgical Hospital
THCIC ID: 794000

96 claims, 0 errors.

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PROVIDER: Kindred Hospital Tarrant County Fort Worth SW

THCIC ID: 800000

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 145 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.
==
PROVIDER: Kindred Hospital San Antonio Central
THCIC ID: 975155

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 120 records are correctly reported. (Removed by THCIC)

*Potential confidential information removed by THCIC.
==
PROVIDER: Kindred Hospital El Paso

THCIC ID: 727100

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 138 records are correctly reported as Elective. (Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.
==
PROVIDER: Kindred Hospital Dallas Central
THCIC ID: 914000

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 128 records are correctly reported. (Removed by THCIC)

*Potential confidential information removed by THCIC.
==
PROVIDER: Kindred Hospital Sugar Land

THCIC ID: 792700

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 187 records are correctly reported.
(Removed by THCIC)

*Potential confidential information removed by THCIC.
==
PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000

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: Texas Health Harris Methodist Hospital Cleburne

THCIC ID: 323000

Data Content

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

Administrative data may not accurately represent the clinical details of an

encounter.

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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.

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and procedures to the first 25 diagnoses codes and the first 25 procedure codes.
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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
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not anticipated that this limitation will affect this data.

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birth, or information not available. The best way to focus on severity of
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discharge, not the admitting source code. Many hospital information systems and
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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: Kindred Hospital Clear Lake
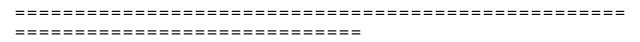
THCIC ID: 720402

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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 151 records are correctly reported as Elective.

(Removed by THCIC) Kindred Healthcare

*Potential confidential information removed by THCIC.

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PROVIDER: Methodist Rehab Hospital

THCIC ID: 862000

Unable to correct gender as related to diagnosis

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PROVIDER: Northeast Methodist Hospital

THCIC ID: 154002

E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after Statement Thru Date: Error must remain due to specific coding and billing practices. 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

E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after Statement Thru Date: Error must remain due to specific coding and billing practices. All errors have been reviewed and corrected to the best of the facilities ability.

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PROVIDER: Methodist Texsan Hospital

THCIC ID: 154003

E- 617 - Other Procedure 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 Procedure Date earlier than 3 days before Admit

Date or after Statement Thru Date: Error must remain due to specific coding and

billing practices. All errors have been reviewed and corrected to the best of

the facilities ability.

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PROVIDER: St Davids Rehab Center

THCIC ID: 649000

E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after

Statement Thru Date: Error must remain due to specific coding and billing

practices

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

ability.

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PROVIDER: Methodist Hospital

THCIC ID: 154000

E- 617 - Other Procedure 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 Procedure Date earlier than 3 days before Admit

Date or after Statement Thru Date: Error must remain due to specific coding and

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

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PROVIDER: Metropolitan Methodist Hospital

THCIC ID: 283000

E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after Statement Thru Date: Error must remain due to specific coding and billing practices

E -663 - Invalid Patient Zip: Unable to determine patient zip based on demographics in record, chose not to provide or homeless. E-725 - Missing patient address line 1: unable to identify based off of patient admission, patient did not provide or chose not to provide information. E- 690 - Invalid Physician 2 (ED Attending) Identifier for ED claim: All claims reviewed, NPI# for ER physicians group correct as entered, patient(s) left prior to physician evaluation, or physician unknown. All errors have been reviewed and corrected to the best of the facilities ability.

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PROVIDER: Nacogdoches Medical Center

THCIC ID: 392000

data reviewed and certified

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PROVIDER: St Davids South Austin Hospital

THCIC ID: 602000

E- 618 - Principal Procedure Date earlier than 3 days before Admit Date or after
Statement Thru Date: Error must remain due to specific coding and billing
practices
All errors have been reviewed and corrected to the best of the facilities
ability.

==

PROVIDER: Physicians Surgical Hospital-Panhandle Campus

THCIC ID: 852901

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.
No errors detected on the certification report.

==

PROVIDER: Physicians Surgical Hospital-Quail Creek

THCIC ID: 852900

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.
No errors detected on the certification report.

==

PROVIDER: North Central Baptist Hospital

THCIC ID: 677001

I hereby certify 4th quarter 2021 IP. 5465 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: University Behavioral Health-Denton

THCIC ID: 826800

I am new to this facility as of June 6th. I was unable to do corrections due to time for corrections had lapsed.

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PROVIDER: Mission Trail Baptist Hospital

THCIC ID: 081001

Certified on behalf of CFO (Removed by THCIC) that all information is accurate to the best of our knowledge/information provided.

*Potential confidential information removed by THCIC.

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PROVIDER: Baylor Scott & White Medical Center Hillcrest

THCIC ID: 506001

Baylor Scott & White Medical Center Hillcrest

THCIC ID 506001

4th Qtr 2021 – Inpatient

Accuracy rate – 99.94%

Errors from the 4th Quarter FER reflect the following error codes E-617, E-618.

Procedure date verified in hospital system , reported as posted

Errors will stand as reported

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PROVIDER: Baylor Scott & White Medical Center Lakeway

THCIC ID: 975165

Baylor Scott & White Medical Center Lakeway

THCIC ID 975165

4th Qtr 2021 Inpatient

Accuracy rate – 99.88%

Errors from the 4th Quarter FER reflect the following error code E-617.

Principal procedure date verified in hospital system , reported as posted

Errors will stand as reported

===

PROVIDER: Baylor Scott & White All Saints Medical Center-Fort Worth

THCIC ID: 363000

Baylor Scott & White All Saints Medical Center-Fort Worth

THCIC ID 363000

4th Qtr 2021 Inpatient

Accuracy rate – 99.96%

Errors from the 4th 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: Encompass Health Rehab Hospital Arlington

THCIC ID: 660000

information is complete and accurate to the best of my knowledge.

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PROVIDER: UT Health East Texas Tyler Regional Hospital

THCIC ID: 975299

W-696: Related to ER provider.

E-648: Converted patient type to outpatient. Reason for visit is appropriate.

E-617/618: Procedures are within the date range of the admission. Transfer.

E-655: Admission source is appropriate

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PROVIDER: Knapp Medical Center

THCIC ID: 480000

4Q2021 Inpatient Certification of Data

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PROVIDER: HCA Houston Healthcare Clear Lake

THCIC ID: 212000

Manifest code used as a primary DX was fixed and fatal error corrected

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PROVIDER: Vibra Hospital of Richardson

THCIC ID: 975143

certifying with knowledge of invalid revenue procedure code

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PROVIDER: Covenant Childrens Hospital

THCIC ID: 686000

For the 4q2021 dataset we have different types of uncorrected errors that
related to patient record information. Our facility has changed electronic
medical record systems since these patients were cared for at our facility.
Because of the change in systems we no longer have access to correct the data in
our old EMR system, which is why we cannot correct the errors in this dataset.

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PROVIDER: St Joseph Medical Center

THCIC ID: 838600

838600 would like to certify 100%.

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PROVIDER: JPS Health Network - Trinity Springs North

THCIC ID: 975121

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.

After review of the required THCIC claim submission data criteria, JPSH has

amended their reporting criteria to include previously omitted closed accounts and align with THCIC requirements. The change will impact reported data starting 4th Quarter 2021 and may change overall reporting volume.

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PROVIDER: Ascension Seton Highland Lakes

THCIC ID: 559000

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.0 errors on inpatient claims were unable to be corrected prior to certification. The primary resources with user permissions that can technically resolve the data errors do not have the expertise to resolve all errors; and in some cases the errors are not resolvable.

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PROVIDER: Ascension Seton Hays

THCIC ID: 921000

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.6
errors on inpatient claims were unable to be corrected prior to certification.
The primary resources with user permissions that can technically resolve the
data errors do not have the expertise to resolve all errors; and in some cases
the errors are not resolvable. x1 error for SSN due to incomplete or inaccurate
information entered, x2 attending first name and x2 attending last name errors
due to inaccurate data entry, x1 admission type error due to incorrect code
mappings.

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PROVIDER: Hardeman County Memorial Hospital

THCIC ID: 102000

Certifying data for the 4th quarter of 2021 without 100% due to the deadline of
recertification regeneration from the help desk.

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PROVIDER: The Hospitals of Providence Spine & Pain Management Center

THCIC ID: 975803

No comments necessitated

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PROVIDER: The Hospitals of Providence East Campus

THCIC ID: 865000

No comments necessitated

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PROVIDER: University Medical Center

THCIC ID: 145000

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: Texas Health Center-Diagnostics & Surgery Plano

THCIC ID: 815300

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.

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PROVIDER: Texas Health Huguley Hospital

THCIC ID: 047000

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of July 7, 2022. 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 has undergone 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: Texas Institute for Surgery-Texas Health Presbyterian-Dallas
THCIC ID: 813100

The Q4 2021 All Data/information in these files contain accurate data in areas such as Coding, Admissions, Diagnostic, & Bill Type Etc. All corrections complete

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PROVIDER: HCA Houston Healthcare Tomball

THCIC ID: 076000

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

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PROVIDER: Texas Health Presbyterian Hospital-Kaufman

THCIC ID: 303000

Data Content

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

Race/Ethnicity

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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 Harris Methodist Hospital-Stephenville

THCIC ID: 256000

Data Content

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

Diagnosis and Procedures

Patient diagnoses and procedures for a particular 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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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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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: DeTar Hospital-North

THCIC ID: 453001

DeTar Hospital North had 1 Inpatient account that did not have a claim filing indicate code populated in System 13 for Q4 2021. All other transmitted data was populated and transmitted accurately.

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PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth

THCIC ID: 627000

Data Content

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PROVIDER: Vibra Specialty Hospital

THCIC ID: 839100

Certifying with knowledge of error in missing indicator code for subscriber.

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PROVIDER: Las Palmas Medical Center

THCIC ID: 180000

This data is submitted in an effort to meet statutory requirements. It is administrative data not clinical data. It is utilized for billing and administrative decisions at a facility level and transparency with state entities. All fatal errors were corrected and warning errors that remained were invalid attending practitioner name match and operating practitioner name match. This occurs when the data does not match in the software field when there is a middle name recorded, or a double last name is recorded or MD is placed erroneously in one of the naming fields at the time the data crosses from one software system to another. The data was corrected to best of my ability with the resources provided at the time of deadline.

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PROVIDER: Texas Health Seay Behavioral Health Hospital
THCIC ID: 720000

Data Content
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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.

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PROVIDER: Millwood Hospital

THCIC ID: 765001

The claims with Revenue code errors were combined to other accounts due to

Medicare billing policies and 1 account was reversed due to patient being

transferred to short term hospital.

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PROVIDER: CHI St Lukes Health Memorial San Augustine

THCIC ID: 072000

Certifying data as National I.T. and not local market.

==

PROVIDER: HCA Houston Healthcare North Cypress

THCIC ID: 975321

complete

==

PROVIDER: Ascension Seton Smithville

THCIC ID: 424500

"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
0 errors on inpatient claims were unable to be corrected prior to certification.
The primary resources with user permissions that can technically resolve the
data errors do not have the expertise to resolve all errors; and in some cases
the errors are not resolvable."

==

PROVIDER: Ascension Seton Medical Center

THCIC ID: 497000

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.14 errors on inpatient claims were unable to be corrected prior to certification. The primary resources with user permissions that can technically resolve the data errors do not have the expertise to resolve all errors; and in some cases the errors are not resolvable. x6 Admission Type errors =Newborn and Principal Diagnosis Not=Newborn were due to incorrect code mapping;x2 admission source were due to

incorrect code mappings , x6 physician identifier missing

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PROVIDER: Texas Health Springwood Behavioral Health Hospital

THCIC ID: 778000

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.

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PROVIDER: CHI St Lukes Health Memorial Lufkin

THCIC ID: 129000

Certifying Data as National I.T. and not as local market.

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PROVIDER: Fort Duncan Regional Medical Center

THCIC ID: 547001

claims corrected to the best of our knowledge

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PROVIDER: Dell Seton Medical Center at The University of Texas

THCIC ID: 975215

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."12 errors on inpatient claims were unable to be corrected prior to certification. The primary resources with user permissions that can technically resolve the data errors do not have the expertise to resolve all errors; and in some cases the errors are not resolvable. x1 patient race error due to incorrect mappings , x1 no attending provider documented, x9 physician missing identifier errors, x1 revenue code unmatched.

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PROVIDER: John Peter Smith Hospital

THCIC ID: 409000

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.

After review of the required THCIC claim submission data criteria, JPSH has amended their reporting criteria to include previously omitted closed accounts and align with THCIC requirements. The change will impact reported data starting 4th Quarter 2021 and may change overall reporting volume.

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PROVIDER: UT Southwestern University Hospital-Zale Lipshy Rehab

THCIC ID: 653003

Procedure dates are correct as reported

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PROVIDER: Texas Health Presbyterian Hospital-Plano

THCIC ID: 664000

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: UT Southwestern University Hospital-Clements Psych

THCIC ID: 448002

No Errors

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PROVIDER: UT Southwestern University Hospital-Zale Lipshy

THCIC ID: 653001

The procedure dates are correct

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PROVIDER: UT Southwestern University Hospital-Clements University

THCIC ID: 448001

Procedure dates are correct

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PROVIDER: Baylor Scott & White Heart & Vascular Hospital Dallas

THCIC ID: 784400

Baylor Scott & White Heart & Vascular Hospital Dallas

THCIC ID 784400

4th Qtr 2021 Inpatient

Accuracy rate – 100%

No comments needed.

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PROVIDER: Glen Rose Medical Center

THCIC ID: 059000

Failed to correct data errors by deadline. Certifying without correction.

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PROVIDER: Medical Arts Hospital

THCIC ID: 341000

Due to the sheer volume of the data and with limited resources within the hospital, I cannot properly analyze the data with 100% accuracy. But at this time, we will elect to certify the data.

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PROVIDER: El Paso LTAC Hospital

THCIC ID: 841300

We are certifying 2021 4th Quarter Inpatient Data with the one error of missing discharge hour.
Thank You!

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PROVIDER: Baylor University Medical Center

THCIC ID: 331000

Baylor University Medical Center

THCIC ID 331000

4th Qtr 2021 Inpatient

Accuracy rate – 99.92%

Errors from the 4th 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: Coryell Memorial Hospital

THCIC ID: 346000

On 2/23/22, System 13 correctly documented Coryell Health had 193 discharges in the fourth quarter of 2021. The Certification Summary now lists only 127 discharges for the fourth quarter.

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PROVIDER: Baylor Scott & White Medical Center Austin

THCIC ID: 975789

Baylor Scott and White Medical Center Austin

THCIC ID 975789

4th Qtr 2021 Inpatient

Accuracy rate – 100%

No comments needed.

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PROVIDER: Baylor Scott & White Medical Center McKinney

THCIC ID: 971900

Baylor Scott & White Medical Center McKinney

THCIC ID 971900

4th Qtr 2021 Inpatient

Accuracy rate – 99.83%

Errors from the 4th 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 The Heart Hospital McKinney

THCIC ID: 975385

Baylor Scott & White The Heart Hospital McKinney

THCIC ID 975385

4th Qtr 2021 – Inpatient

Accuracy rate – 100%

No comments needed

==

PROVIDER: Baylor Scott & White The Heart Hospital Denton

THCIC ID: 208100

Baylor Scott & White The Heart Hospital Denton

THCIC ID 208100

4th Qtr 2021 Inpatient

Accuracy rate – 99.56%

Errors from the 4th Quarter FER reflect the following error code E-617.

Procedure date verified in hospital system , reported as posted

Errors will stand as reported

==

PROVIDER: Del Sol Medical Center

THCIC ID: 319000

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 Hospital Frisco

THCIC ID: 975783

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.

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PROVIDER: Covenant Hospital-Levelland

THCIC ID: 307000

For the 4q2021 dataset we have different types of uncorrected errors that related to patient records. Our facility has changed electronic medical record systems since these patients were cared for at our facility. Because of the change in systems we no longer have access to correct the data in our old EMR system, which is why we cannot correct the errors in this dataset.

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PROVIDER: Mayhill Hospital

THCIC ID: 831700

I have reviewed and claims have been revised.

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PROVIDER: Hunt Regional Medical Center Greenville

THCIC ID: 085000

Three E-617 errors - In all three cases the patient presented to the ED, entered into Observation (Outpatient) status and then admitted into Inpatient status. The procedures in question in each case took place while the patient was in Observation status.

Two E-618 errors - In both cases the patient presented to the ED, entered into Observation (Outpatient) status, and then admitted into Inpatient status.

==

PROVIDER: El Paso Behavioral Health System

THCIC ID: 858600

6 Medicare accounts with no charges secondary to combined billing due to readmission status.

==

PROVIDER: Ascension Seton Bastrop

THCIC ID: 975418

"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, women's 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

0 errors on inpatient claims were unable to be corrected prior to certification. The primary resources with user permissions that can technically resolve the data errors do not have the expertise to resolve all errors; and in some cases the errors are not resolvable."

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PROVIDER: Baylor Scott & White Medical Center Centennial

THCIC ID: 975285

Baylor Scott & White Medical Center Centennial

THCIC ID 975285

4th Qtr 2021 Inpatient

Accuracy rate – 99.92%

Errors from the 4th Quarter FER reflect the following error code E-617.

Principal procedure date verified in hospital system , reported as posted

Errors will stand as reported

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PROVIDER: ContinueCare Hospital at Hendrick Medical Center

THCIC ID: 973590

Charges and payor errors correct for account

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PROVIDER: CHRISTUS Dubuis Hospital Beaumont

THCIC ID: 975255

Certified as correct.

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PROVIDER: Baylor Scott & White Medical Center-Irving

THCIC ID: 300000

Baylor Scott & White Medical Center-Irving

THCIC ID 300000

4th Qtr 2021 Inpatient

Accuracy rate – 99.90%

Errors from the 4th Quarter FER reflect the following error code E-618.

Principal procedure date verified in hospital system , reported as posted

Errors will stand as reported.

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PROVIDER: HCA Houston Healthcare Kingwood

THCIC ID: 675000

Unable to correct 7 remaining errors for charges and NPI.

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PROVIDER: Baylor Scott & White McLane Childrens Medical Center

THCIC ID: 537006

Baylor Scott & White McLane Childrens Medical Center

THCIC ID 537006

4th Qtr 2021 – Inpatient

Accuracy rate – 99.76

Errors from the 4th Quarter FER reflect the following error codes E-617, E-618.

Procedure date verified in hospital system , reported as posted

Errors will stand as reported

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PROVIDER: Texas Health Harris Methodist Hospital Southlake

THCIC ID: 812800

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.

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PROVIDER: Baylor Scott & White Medical Center Buda

THCIC ID: 975391

Baylor Scott & White Medical Center Buda

THCIC ID 975391

4th Qtr 2021 Inpatient

Accuracy rate – 98.73%

Errors from the 3rd Quarter FER reflect the following error code E-617

Procedure date verified in hospital system , reported as posted

Errors will stand as reported

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PROVIDER: Winnie Community Hospital

THCIC ID: 781400

Admission diagnosis did not transfer.

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PROVIDER: Doctors Hospital-Laredo

THCIC ID: 301000

99% accuracy due to unavailable data for corrections to obtain 100%.

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PROVIDER: Swisher Memorial Hospital

THCIC ID: 273000

Our 4Q2021 Inpatient claims had 5 claims with errors that were not corrected. These errors included missing claim filing indicators and missing primary payer name. These claims are usually Self Pay or Indigent claims. We missed the deadline for corrections as they just kept getting put off.

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PROVIDER: Texas Rehabilitation Hospital-Fort Worth

THCIC ID: 902200

Software update, incorrect claims were old procedure codes

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PROVIDER: Texas Health Hospital Clearfork

THCIC ID: 975167

Data Content

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

Diagnosis and Procedures

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

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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 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.

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The standard and non-standard source of payment codes are an example of data

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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

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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: South Plains Rehab Hospital

THCIC ID: 975371

Missed correction deadline for 2 claims that had invalid occurrence.

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PROVIDER: Ascension Seton Edgar B Davis

THCIC ID: 597000

"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.

0 errors on inpatient claims were unable to be corrected prior to certification. The primary resources with user permissions that can technically resolve the data errors do not have the expertise to resolve all errors; and in some cases the errors are not resolvable."

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PROVIDER: Texas Health Harris Methodist Hospital Alliance

THCIC ID: 972900

Data Content

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

Diagnosis and Procedures

Patient diagnoses and procedures for a particular 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.

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

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Race/Ethnicity

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Discharge Disposition

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PROVIDER: Texas Health Harris Methodist HEB

THCIC ID: 182000

Data Content

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Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the

hospital using a universal standard called the International Classification of Disease, or ICD-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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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 Allen recommends use of ICD10 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

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Discharge Disposition

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PROVIDER: Baylor Scott & White Continuing Care Hospital

THCIC ID: 850300

Baylor Scott & White Continuing Care Hospital

THCIC ID 850300

4th Qtr 2021 Inpatient

Accuracy rate – 100%

No comments needed

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PROVIDER: Reagan Memorial Hospital

THCIC ID: 343000

Certifying with known errors.

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PROVIDER: Premier Specialty Hospital of El Paso

THCIC ID: 701000

Certify with no comments

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PROVIDER: North Runnels Hospital

THCIC ID: 151000

2021 Q4 is being "Certified with Comments". Due to an EHR conversion going live
December 8, 2021, provider documentation was hindered and delayed. This
impacted the errors for this quarter. Staffing is also still an issue.

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PROVIDER: Texas Health Presbyterian Hospital Flower Mound

THCIC ID: 943000

Data Content

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

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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.

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PROVIDER: Baylor Scott & White Medical Center Round Rock

THCIC ID: 852600

Baylor Scott & White Medical Center Round Rock

THCIC ID 852600

4th Qtr 2021 – Inpatient

Accuracy rate – 99.94%

Errors from the 4th Quarter FER reflect the following error codes E-617, E-618.

Procedure date verified in hospital system , reported as posted

Errors will stand as reported

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PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth

THCIC ID: 235000

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.

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PROVIDER: Baylor Scott & White The Heart Hospital Plano

THCIC ID: 844000

Baylor Scott & White The Heart Hospital Plano

THCIC ID 844000

4th Qtr 2021 Inpatient

Accuracy rate – 99.85%

Errors from the 4th Quarter FER reflect the following error codes E-617, E-618.

Procedure date verified in hospital system , reported as posted

Errors will stand as reported

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PROVIDER: Covenant Medical Center

THCIC ID: 465000

For the 4q2021 dataset we have different types of uncorrected errors that related to patient records. Our facility has changed electronic medical record systems since these patients were cared for at our facility. Because of the change in systems we no longer have access to correct the data in our old EMR system, which is why we cannot correct the errors in this dataset.

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PROVIDER: Texas Health Specialty Hospital-Fort Worth

THCIC ID: 652000

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

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.

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: Harlingen Medical Center

THCIC ID: 788002

We couldn't correct the errors with error code 668 (total claim charges is not equal to some of service line charges) as system 13 is not allowing to add charges that were missing and we are getting pop up message saying "adding new charges disabled".

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PROVIDER: Ascension Seton Southwest

THCIC ID: 797500

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 requirements0 errors on inpatient claims were unable to be corrected prior to certification. The primary resources with user permissions that can technically resolve the

data errors do not have the expertise to resolve all errors; and in some cases the errors are not resolvable.

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PROVIDER: Texas Health Presbyterian Hospital-Denton

THCIC ID: 820800

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: Baylor Scott & White Medical Center Waxahachie

THCIC ID: 285000

Baylor Scott & White Medical Center Waxahachie

THCIC ID 285000

4th Qtr 2021 – Inpatient

Accuracy rate – 99.82%

Errors from the 4th Quarter FER reflect the following error codes E-617, E-618.

Procedure date verified in hospital system , reported as posted

Errors will stand as reported

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PROVIDER: Glen Oaks Hospital

THCIC ID: 754000

63 rev code missing and 63 charges not present . The rev code for all 63 is 0124 and charges is $2,000. During the correction this data was entered and assumed to be saved. I am not sure why it is showing as still missing. The missing address errors comes from patients that were homeless with no address.

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PROVIDER: Baylor Scott & White Medical Center Temple

THCIC ID: 537000

Baylor Scott & White Medical Center Temple

THCIC ID 537000

4th Qtr 2021 – Inpatient

Accuracy rate – 99.88%

Errors from the 4th Quarter FER reflect the following error codes E-617, E-618.

Procedure date verified in hospital system , reported as posted

Errors will stand as reported

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PROVIDER: Texas Health Presbyterian Hospital Allen

THCIC ID: 724200

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.

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: Resolute Health

THCIC ID: 973850

only 4 errors for zip code, provider did not match and E code qualifier. IT issues

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PROVIDER: Texas NeuroRehab Center-LTAC

THCIC ID: 622001

Error was thought to be corrected through System 13 but when checking with IT from system 13, we should click on "check for corrections" after every error to ensure their system re-checks for errors.

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PROVIDER: The Hospitals of Providence Sierra Campus

THCIC ID: 266000

No comments necessitated

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PROVIDER: Mesa Springs

THCIC ID: 973430

The 4th Qtr. 2021 data for ethnicity is incorrect We are working on our system
to be able to accurately report this statistic.

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PROVIDER: Baptist Medical Center

THCIC ID: 114001

I certify on behalf of (Removed by THCIC) CFO of Baptist Medical Center

*Potential confidential information removed by THCIC.

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PROVIDER: Baylor Scott & White Medical Center Taylor

THCIC ID: 044000

Baylor Scott & White Medical Center Taylor

THCIC ID 044000

4th Qtr 2021 – Inpatient

Accuracy rate – 99.96%

Errors from the 4th Quarter FER reflect the following error code E-617.

Procedure date verified in hospital system , reported as posted

Errors will stand as reported

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PROVIDER: Baylor Scott & White Medical Center Lake Pointe

THCIC ID: 975286

Baylor Scott & White Medical Center Lake Point

THCIC ID 975286

4th Qtr 2021 Inpatient

Accuracy rate – 99.71%

Errors from the 4th 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: Stephens Memorial Hospital

THCIC ID: 430000

Missed the deadline to correct one account with one error with revenue code error.

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PROVIDER: St Lukes Patients Medical Center

THCIC ID: 846100

There are minimal errors that can be corrected, but are a past the correction period for System 13. We have 2 error types that are patient identifiers where data wasn't available for social security and residence. Neither are substantial, and could be corrected to meet System 13 edits for data format when information is not available. The org has undergone personnel changes and some system issues that has delayed the certification. The certification period was extended, and we have also requested for permission to make corrections.

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PROVIDER: Texas Health Arlington Memorial Hospital

THCIC ID: 422000

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

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

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

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

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PROVIDER: HCA Houston Healthcare Pearland

THCIC ID: 974390

For error E-690 - Invalid Attending Practitioner Identifier: operating practitioner is same as attending practitioner.

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PROVIDER: Baylor Scott & White Medical Center-Grapevine

THCIC ID: 513000

Baylor Scott & White Medical Center-Grapevine

THCIC ID 513000

4th Qtr 2021 Inpatient

Accuracy rate – 99.89%

Errors from the 4th 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

Cook Children's Medical Center has submitted and certified FOURTH 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 FOURTH 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 FOURTH 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: Ascension Seton Northwest

THCIC ID: 797600

"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. 1 error on inpatient claims were unable to be corrected prior to certification. The primary resources with user permissions that can technically resolve the data errors do not have the expertise to resolve all errors; and in some cases the errors are not resolvable. x1 Missing Patient ZIP errors were due to incorrect information received"

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PROVIDER: The Hospitals of Providence Transmountain Campus

THCIC ID: 975188

No comments necessitated

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PROVIDER: Baylor Scott & White Medical Center-Plano

THCIC ID: 814001

Baylor Scott & White Medical Center-Plano

THCIC ID 814001

4th Qtr 2021 – Inpatient

Accuracy rate – 99.81%

Errors from the 4th 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 Hospital-Brenham

THCIC ID: 066000

Baylor Scott & White Hospital-Brenham

THCIC ID 066000

4th Qtr 2021 Inpatient

Accuracy rate – 100%

No comments needed.

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PROVIDER: Baylor Scott & White Hospital College Station

THCIC ID: 206100

Baylor Scott & White Hospital College Station

THCIC ID 206100

4th Qtr 2021 Inpatient

Accuracy rate – 99.78%

Errors from the 4th 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: The Hospitals of Providence Memorial Campus

THCIC ID: 130000

No comments necessitated

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PROVIDER: Baylor Scott & White Medical Center Marble Falls

THCIC ID: 974940

Baylor Scott & White Medical Center Marble Falls

THCIC ID 974940

4th Qtr 2021 Inpatient

Accuracy rate – 99.71%

Errors from the 4th Quarter FER reflect the following error code E-618.

Principal procedure date verified in hospital system , reported as posted

Errors will stand as reported

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PROVIDER: Midland Memorial Hospital

THCIC ID: 452000

All claim data errors where corrected - a few were completed after the

correction deadline, but they are all have been corrected for this quarter.

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PROVIDER: Texas Health Heart & Vascular Hospital

THCIC ID: 730001

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.

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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

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.

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PROVIDER: Ascension Seton Williamson

THCIC ID: 861700

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. 0 errors on inpatient claims were unable to be corrected prior to certification.

The primary resources with user permissions that can technically resolve the

data errors do not have the expertise to resolve all errors; and in some cases the errors are not resolvable.

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PROVIDER: CHI St Lukes Health - Memorial Livingston

THCIC ID: 466000

Certifying data as National I.T. and not local market.

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PROVIDER: University Medical Center of El Paso-Alameda

THCIC ID: 263000

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

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

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PROVIDER: Baylor Scott & White Medical Center Pflugerville

THCIC ID: 975340

Baylor Scott & White Medical Center Pflugerville

THCIC ID 975340

4th Qtr 2021 Inpatient

Accuracy rate –100%

No comments needed

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PROVIDER: Texas Health Hospital Rockwall

THCIC ID: 859900

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.

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PROVIDER: Dell Childrens Medical Center

THCIC ID: 852000

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 5State 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.6 errors on inpatient claims were unable to be corrected prior to

certification. The primary resources with user permissions that can technically

resolve the data errors do not have the expertise to resolve all errors; and in

some cases the errors are not resolvable. Admission type errors x6 were source

errors were due to incorrect code mappings

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PROVIDER: Texas Health Presbyterian Hospital Dallas

THCIC ID: 431000

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.

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

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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.

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

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.