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General Comments on 2nd Quarter 2001 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 is administrative data, collected for billing purposes, not clinical data.

- Data is submitted in a standard government format, the UB-92 (or HCFA 1450). State specifications require the submission of additional data elements. These data elements include race, ethnicity and non-standard source of payment. 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 is generally not provided by the patient, rather, it is collected subjectively and may not be accurate.

- Hospitals are required to submit data within 90 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 also 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.

- Hospitals record as many as twenty-five diagnosis codes and twenty-five procedure codes for each patient for billing purposes. Data submitted to THCIC is limited to nine diagnosis codes and six procedure codes. Therefore, the data submitted may not fully represent all diagnoses treated by the hospital or all procedures performed. A consequence may be that sicker patients with more than nine diagnoses or undergoing more than six procedures are not accurately reflected. This may also result in total volume and percentage calculations for diagnoses and procedures not being complete.

- THCIC assigns the Risk of Mortality and Severity of Illness scores using the APR-DRG methodology designed by 3M Corporation. These scores may be affected by the limited number of diagnosis and procedure codes collected by THCIC and may be understated.

- Length of Stay is limited to three characters in length and therefore cannot exceed 999 days. A few patients are discharged from some hospitals after stays of more than 999 days and the length of stay for these patients, presented as 999 days, is not correct.

- Several data elements are suppressed and will be released after corrections to data submission processes have been made. These data elements will be released beginning with data for 3rd quarter 2000. They include:
  - Standard source of secondary payment
  - Non-standard source of secondary payment
  - All charges

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

newborns is suppressed indefinitely.

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

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PROVIDER: Austin State Hospital
THCIC ID: 000100
QUARTER: 2
YEAR: 2001

Certified with comments

Due to the system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admissions sources on the encounter records, are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment = Because of system constraints, all payment sources on the encounter records are, reported as charity. The sources of payment, by percent, are:

Table with 2 columns: Source of Payment and Total Percentage (%). Rows include Self-Pay, Worker's Comp, Medicare, Other Federal Program, Commercial, Blue Cross, Champus, Other, Missing/Invalid, Non-Standard Source of Payment, State/Local Government, Commercial, Medicare Managed Care, Medicaid Managed Care, Commercial HMO, Charity, and Missing/Invalid.

Severity Index = All patients admitted have been determined to be danger to self or others and the severity of illness is determined by an acuity

assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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PROVIDER: Big Spring State Hospital  
 THCIC ID: 000101  
 QUARTER: 2  
 YEAR: 2001

Certified with comments

Due to the system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admissions sources on the encounter records, are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Due to system entry there is a slight variance between actual demographic data and what is reported.

Standard Source of Payment = Because of system constraints, all payment sources on the encounter records are, reported as charity. The sources of payment, by percent, are:

Standard Source of Payment	Total Percentage (%)
Self-Pay	2%
Worker's Comp	n/a
Medicare	4.91%
Medicaid	9.49%
Other Federal Program	n/a
Commercial	1.49%
Blue Cross	n/a
Champus	1.06%
Other	n/a
Missing/Invalid	n/a

Non-Standard Source of Payment Total Percentage (%)

State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.00%
Commercial HMO	n/a
Charity	81%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be danger to self or others and the severity of illness is determined by an acuity

assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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PROVIDER: University of Texas Medical Branch Hospital  
 THCIC ID: 000102  
 QUARTER: 2  
 YEAR: 2001

Certified with comments

\*No comments received by THCIC.

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PROVIDER: Rio Grande State Center  
 THCIC ID: 000104  
 QUARTER: 2  
 YEAR: 2001

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraint, all admissions sources on the encounter records, are reported as court/law enforcement. The data reported also includes voluntary admissions. The Local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the Local Mental Health Authority.

Standard Source of Payment = Because of system constraints, all payment sources on the encounter records are, reported as charity. The sources of payment, by percent, are:

Standard Source of Payment	Total Percentage (%)
Self-Pay	0.55%
Worker's Comp	n/a
Medicare	5.92%
Medicaid	7.32%
Other Federal Program	n/a
Commercial	0.87%
Blue Cross	n/a
Champus	0.32%
Other	n/a
Missing/Invalid	n/a
 Non-Standard Source of Payment	 Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.00%

Commercial HMO	n/a
Charity	85%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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PROVIDER: University of Texas M.D. Anderson Cancer Center  
THCIC ID: 000105  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### THCIC Intro

The University of Texas M.D. Anderson Cancer Center is one of the nation's first three comprehensive Cancer Centers designated by the National Cancer Act and remains one of only 36 such centers today that meet the rigorous criteria for NCI designation. Dedicated solely cancer patient care, research, education and prevention, M.DAnderson also was named the best cancer center in the United States by the U.S. News & World Report's "America's Best Hospitals" survey in July 2000. As such, it was the only hospital in Texas to be ranked number one in any of the 17 medical specialties surveyed.

Because M.D. Anderson consults with, diagnoses and treats only patients with cancer, it is important in the review of these data that key concepts about cancer and patient population are understood. Such information is vital to the accurate interpretation and comparison of data.

Cancer is not just one disease. Rather, it is a collection of 100 or more diseases that share a similar process. Some forms of the disease are serious and life threatening. A few pose little threat to the patient, while the consequences of most cancers is in between.

No two cancers respond to therapy in exactly the same way. For example, in order to effectively treat a breast cancer, it must be staged according to the size and spread of the tumor. Patients diagnosed with Stage I and Stage IV breast cancer may both receive radiation therapy as treatment, but two distinctive courses of treatment and doses are administered, dependent on the stage of the disease. Even two Stage I breast cancers can respond differently to the treatment.

M.D. Anderson treats only patients with cancer and their related diseases. As such, the population is comparable to a total patient population of a community hospital, which may deliver babies, perform general surgery, operate a trauma center and treat only a small number of cancer patients.

Congress has recognized M.D. Anderson's unique role in providing state of the art cancer care by exempting it from the DRG-based inpatient prospective payment system. Nine other freestanding NCI designated cancer centers are also exempt.

Because M.D. Anderson is a leading center for cancer research, several hundred patients may be placed on clinical trials every year, rather than -- or in addition to -- standard therapies. Highly regulated and monitored, clinical trials serve to improve conventional therapies and provide new options for patients.

Patients often come to M.D. Anderson for consultation only. With M.D. Anderson physicians consulting with their hometown oncologists, patients often choose to get treatment at home rather than in Houston.

More than half of M.D. Anderson's patients has received some form of cancer treatment before coming to the institution for subsequent advice and treatment. This proportion is far higher than in general hospitals, making it difficult to compare M.D. Anderson to community facilities.

As a public institution, M.D. Anderson welcomes inquiries from the general public, advocacy organizations, the news media and others regarding this data. Inquiries may be directed to Julie Penne in the Office of Communications at 713/792-0655.

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PROVIDER: Kerrville State Hospital  
 THCIC ID: 000106  
 QUARTER: 2  
 YEAR: 2001

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admissions sources on the encounter records, are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment = Because of system constraints, all payment sources on the encounter records are, reported as charity. The sources of payment, by percent, are:

Standard Source of Payment	Total Percentage (%)
Self-Pay	4.90%
Worker's Comp	n/a
Medicare	2.92%
Medicaid	12.21%
Other Federal Program	n/a
Commercial	2.95%
Blue Cross	n/a
Champus	0.00%
Other	n/a
Missing/Invalid	n/a
 Non-Standard Source of Payment	 Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.00%
Commerical HMO	n/a

Charity	77%
Missing	n/a

Severity Index = All patients admitted have been determined to be danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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PROVIDER: Rusk State Hospital  
 THCIC ID: 000107  
 QUARTER: 2  
 YEAR: 2001

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admissions sources on the encounter records, are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment	Total Percentage (%)
Self-Pay	1.65%
Worker's Comp	n/a
Medicare	9.15%
Medicaid	5.18%
Other Federal Program	n/a
Commercial	1.99%
Blue Cross	0.00%
Other	n/a
Missing/Invalid	n/a

Non-Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.12%
Commercial HMO	n/a
Charity	82%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the

severity of mental illness due to reporting methodology.

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PROVIDER: San Antonio State Hospital
THCIC ID: 000110
QUARTER: 2
YEAR: 2001

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admissions sources on the encounter records, are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Table with 2 columns: Source of Payment and Total Percentage (%). Rows include Standard Source of Payment (Self-Pay, Worker's Comp, Medicare, Medicaid, etc.) and Non-Standard Source of Payment (State/Local Government, Commercial, etc.).

Severity Index = All patients admitted have been determined to be danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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PROVIDER: Terrell State Hospital
THCIC ID: 000111
QUARTER: 2
YEAR: 2001

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admissions sources on the encounter records, are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standar Source of Payment	Total Percentage (%)
Self-Pay	1.29%
Worker's Comp	n/a
Medicare	11.18%
Medicaid	3.10%
Other Federal Program	n/a
Commercial	0.36%
Blue Cross	n/a
Champus	0.00%
Other	n/a
Missing/Invalid	n/a
Non-Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.00%
Commercial HMO	n/a
Charity	84%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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PROVIDER: University of Texas Health Center Tyler  
 THCIC ID: 000112  
 QUARTER: 2  
 YEAR: 2001

Certified with comments

Data Content:  
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The State requires us to submit inpatient claims, by quarter/year, gathered from a billing form called a UB92. The State requires us to submit a "snapshot" of billed claims, extracted from our database approximately 20 days following the close of the quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file.

#### Diagnoses and Procedures :

Patient diagnoses and procedures for a particular hospital stay are coded by the Hospital using a universal standard called the International Classification of Disease, or ICD-9-CM. The Hospital complies with the guidelines for assigning these diagnosis codes; however, this is often driven by physicians' subjective criteria for defining a diagnosis.

Another limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine. New codes are added yearly as coding manuals are updated.

The State is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnosis codes and the first six procedure codes. As a result, the data sent by us do meet State requirements but cannot reflect all of 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, that those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format.

#### Race/Ethnicity:

During the Hospital's registration process, the admissions clerk does not routinely inquire as to a patient's race and/or ethnicity. The race and ethnicity data elements are subjectively captured. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The State has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the State's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the Hospital.

#### Standard/Non-Standard Source of Payment:

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

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

#### Certification Process:

Due to the infancy of the State reporting process and the State's computer system development, the certification process is not as complete and as thorough as all parties would like to see in the future. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate.

Physicians:

All physician license numbers and names have been validated as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

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PROVIDER: N TX State Hospital Vernon  
THCIC ID: 000113  
QUARTER: 2  
YEAR: 2001

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admissions sources on the encounter records, are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment	Total Percentage (%)
Self-Pay	1.11%
Worker's Comp	n/a
Medicare	0.30%
Medicaid	15.23%
Other Federal Program	n/a
Commercial	2.16%
Blue Cross	n/a
Champus	0.13%
Other	n/a
Missing/Invalid	n/a
Non-Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.05%
Commercial HMO	n/a
Charity	81%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter

record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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PROVIDER: N TX State Hosp Wichita Falls
THCIC ID: 000114
QUARTER: 2
YEAR: 2001

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admissions sources on the encounter records, are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Standard Source of Payment = Because of system constraints, all payment sources on the encounter records are, reported as charity. The sources of payment, by percent, are:

Table with 2 columns: Standard Source of Payment, Total Percentage (%). Rows include Self-Pay (1.85%), Worker's Comp (n/a), Medicare (5.68%), Medicaid (8.22%), Other Federal Program (n/a), Commercial (2.73%), Blue Cross (n/a), Champus (0.47%), Other (n/a), Missing/Invalid (n/a). Non-Standard Source of Payment section includes State/Local Government (n/a), Commercial (n/a), Medicare Managed Care (n/a), Medicaid Managed Care (0.02%), Commercial HMO (n/a), Charity (81%), Missing/Invalid (n/a).

Severity Index = All patients admitted have been determined to be danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based ont he patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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PROVIDER: Harris County Psychiatric
THCIC ID: 000115
QUARTER: 2
YEAR: 2001

Certified with comments

Patient Age Breakdown-One patient record was updated after submission of the original file.

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PROVIDER: Waco Center for Youth
THCIC ID: 000117
QUARTER: 2
YEAR: 2001

Certified with comments

Due to system limitations, note, that this is just an estimate and relates to identified source of funds, rather than actual collections from the identified source of funds.

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data reported also includes emergency admissions.

Admission Source = Because of system constraints, all admissions sources on the encounter records, are reported as court/law enforcement. The data reported also includes voluntary admissions. The local Mental Health Authority refers the majority of admissions.

Patient Discharge Status = All patients, when discharged, are referred to the local Mental Health Authority.

Table with 2 columns: Standard Source of Payment, Total Percentage (%). Rows include Self-Pay (2.01%), Worker's Comp (n/a), Medicare (n/a), Medicaid (1.06%), Other Federal Program (n/a), Commercial (1.91%), Blue Cross (n/a), Champus (0.47%), Other (n/a), Missing/Invalid (n/a).

Table with 2 columns: Non-Standard Source of Payment, Total Percentage (%). Rows include State/Local Government (n/a), Commercial (n/a), Medicare Managed Care (n/a), Medicaid Managed Care (0.00%), Commercial HMO (n/a), Charity (95%), Missing/Invalid (n/a).

Severity Index = All patients admitted have been determined to be danger

to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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PROVIDER: St Joseph Reg Health Center  
THCIC ID: 002001  
QUARTER: 2  
YEAR: 2001

Certified with comments

St. Joseph Regional Health Center

Data Correction - There is a duplicate account for an expired patient within the DRG 477 population. Please disregard one of the accounts.

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

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for St. Joseph Regional Health Center charity care, based on established rates during the calendar year of 2001 was \$9,375,603 (this includes charity care for Grimes St. Joseph).

Patient Mix - All statistics for St. Joseph Regional Health Center include patients from our Skilled Nursing, Rehabilitation, and Acute Care populations. Our Skilled Nursing and Rehabilitation units are long-term care units. Because of this Mortality and Length of Stay may be skewed. This will prohibit any meaningful comparisons between St. Joseph Regional Health Center and any "acute care only" facilities.

Physicians - All physician license numbers and names have been validated as accurate but some remain unidentified in the THCIC Practitioner Reference Files. Mortalities reported may be related to physicians other than the attending Physician. The attending physician is charged with the procedures requested or performed by the consulting or specialist physicians.

Diagnosis and Procedures - Data submitted to the state may be incomplete for some patients due to the limitation on the number of diagnosis and procedures codes allowed. The data is limited to nine diagnoses codes and six procedure codes per patient visit.

Cost and Charges - The state requires that we submit revenue information including charges. It is important to note that charges do not reflect actual reimbursement received, nor do they reflect the actual cost of providing the services. Typically actual payments received are much less than the charges due to managed care-negotiated discounts, denial of payment by insurance companies, contractual allowances, as well as charity and un-collectable accounts. The relationship between cost of care, charges, and the revenue a facility receives is extremely complex. Comparing costs of care from one hospital to the next may result in unreliable results.

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status. This grouper can only use the limited number of procedure and diagnosis codes available in the data file (nine diagnosis and six procedure codes). If all the patient's diagnosis codes were available the APR-DRG assignment may possibly differ from the APR-DRG assigned by THCIC. The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.

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PROVIDER: Matagorda General Hospital
THCIC ID: 006000
QUARTER: 2
YEAR: 2001

Certified with comments

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

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PROVIDER: Matagorda General Hospital
THCIC ID: 006001
QUARTER: 2
YEAR: 2001

Certified with comments

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

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PROVIDER: CHRISTUS St. Joseph Hospital
THCIC ID: 015000
QUARTER: 2
YEAR: 2001

Certified with comments

Qt 2 2001

St. Joseph certified the data but could not account for 10 patients due to processing the patients after the data was submitted.

During this time period St. Joseph Hospital provided charity care for 238 patients with the total charges (-1,763,364.31) dollars. The system didn't identify these patients.

St. Joseph data didn't correspond to the newborn admission, according to our data we had 46 premature infants and 219 sick infants and 833 normal newborn.

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PROVIDER: Baylor Med Ctr at Garland

THCIC ID: 027000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### Submission Timing

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

#### Physician Identification

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

#### 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 universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

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

#### Normal Newborns

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Baylor's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

#### Race/Ethnicity

There are no national standards regarding patient race categorization so hospitals may not have the same designations from which patients can choose. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent

across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/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 identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 7% of the primary payers originally categorized as "Other" were recategorized as "Self Pay". Also 14% of the secondary payers originally categorized as "Commercial", 5% categorized as "Medicaid", 2% categorized as "Other" and 3% categorized as "Missing/Invalid" were recategorized as "Medicare."

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

Cost/ Revenue Codes

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

Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

=====
PROVIDER: Kindred Hosptial Dallas
THCIC ID: 028000
QUARTER: 2
YEAR: 2001

Certified with comments

We are a Long Term Acute Care Hospital so we have a much greater average length of stay. In addition, our hospital averages a higher CMI (acuity index) which does result in a higher mortality rate than short term acute care hospitals.

=====
PROVIDER: Good Shepherd Medical Center
THCIC ID: 029000
QUARTER: 2
YEAR: 2001

Certified with comments

I have been corresponding with Dr. Burns with the Council. Commonwealth sums the 0001 revenue codesw and THIN sums the 90 record which give two

different sums. I have had Meditech review both areas of the file which is generated for the THCIC claim form. The 540 and 547 revenue codes were not generating dollar amounts. This has been corrected, and should show in the fourth quarter generation for 2001 since the third quarter has already been sent off. This should explain the difference in the total charges on the THIN report and the THCIC report.

=====

PROVIDER: Providence Health Center  
THCIC ID: 040000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Of total deaths, 20 (24%) were hospice patients.

=====

PROVIDER: Madison St. Joseph Health Center  
THCIC ID: 041000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Madison St. Joseph Health Center

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

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Madison St. Joseph Health Center charity care, based on established rates during the calendar year of 2001 was \$309,423.

Patient Mix - All statistics for Madison St. Joseph Health Center include patients from our Skilled Nursing, and Acute Care populations. Our Skilled Nursing unit is a long-term care unit. Because of this Mortality and Length of Stay may be skewed. This will prohibit any meaningful comparisons between Madison St. Joseph Health Center and any "acute care only" facilities.

Physicians - All physician license numbers and names have been validated as accurate but some remain unidentified in the THCIC Practitioner Reference Files. Mortalities reported may be related to physicians other than the attending Physician. The attending physician is charged with the procedures requested or performed by the consulting or specialist physicians.

Diagnosis and Procedures - Data submitted to the state may be incomplete for some patients due to the limitation on the number of diagnosis and procedures codes allowed. The data is limited to nine diagnoses codes and six procedure codes per patient visit.

Cost and Charges - The state requires that we submit revenue information including charges. It is important to note that charges do not reflect

actual reimbursement received, nor do they reflect the actual cost of providing the services. Typically actual payments received are much less than the charges due to managed care-negotiated discounts, denial of payment by insurance companies, contractual allowances, as well as charity and un-collectable accounts. The relationship between cost of care, charges, and the revenue a facility receives is extremely complex. Comparing costs of care from one hospital to the next may result in unreliable results.

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status. This grouper can only use the limited number of procedure and diagnosis codes available in the data file (nine diagnosis and six procedure codes). If all the patient's diagnosis codes were available the APR-DRG assignment may possibly differ from the APR-DRG assigned by THCIC. The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper.

Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.

=====

PROVIDER: Trinity Medical Center  
THCIC ID: 042000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### DATA Content

This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 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; this was a unique, untried use of this data as far as hospitals are concerned.

#### Submission Timing

The hospital estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period.

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

#### 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 the patient's hospitalization, sometimes significantly.

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

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

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedures codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes in 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 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

#### Specialty Services

The data submitted does not have any specific data field to capture unit of service or expand in the specialty service (such as rehab) provided to a patient. Services used by patients in rehab may be very different from those used in other specialties. The data is limited in its ability to categorize patient type.

#### 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 as long as or longer than 999 days, therefore, it is not anticipated that this limitation will affect this data. The hospital does have an inpatient rehabilitation unit whose patients stay an average of 12 days. This may skew the data when combined with other acute care patient stays.

#### Normal Newborns

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. The hospital's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

#### Race/Ethnicity

During the hospital's registration process, the registration clerk does routinely complete patient's race and/or ethnicity field. The race data element is sometimes subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally

used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

#### Cost/Revenue

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 negotiated discounts with 3rd party payors. Charges also do not reflect the actual costs to deliver the care that each patient needs.

#### Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, the hospital did not have an efficient mechanism to edit and correct the data. In addition, it is not feasible to perform encounter level audits at this time.

=====

PROVIDER: Huguley Health Systems  
THCIC ID: 047000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### Data Content

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of March 4, 2002.

Under the requirement we are unable to alter our comments after today. If any errors are discovered in our data after this point we will be unable to communicate these due to THCIC. This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

#### Submission Timing

The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cutoff data 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 universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as

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

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do 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 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected. Also, the state's reporting system does not allow for severity adjustment at this time.

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 Clarification

All physician license numbers and names have been validated with the physician and the website recommended by the state. One physician's name was incorrectly entered on his state license and is recorded incorrectly in the THCIC Practitioner Reference File. This physician had two encounters for the specified reporting quarter.

#### 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.

The state's guidelines do not allow for differentiation for acute and long-term care patients in statistics. Skilled nursing patients routinely have longer length of stay than acute care patients and therefore should not be included together in statistics. The healthcare industry generally differentiates these two classifications.

#### Race/Ethnicity

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are not national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population serviced by the hospital.

#### Certification Process

Due to the infancy of the state reporting process and the state's computer

system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, we did not have an efficient mechanism to edit and correct the data. In addition, due to patient volume and time constraints, it is not feasible to perform encounter level audits.

=====

PROVIDER: College Station Medical Center  
THCIC ID: 071000  
QUARTER: 2  
YEAR: 2001

Certified with comments

1. The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes.
2. The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient.
3. The relationship between cost of care, charges and the revenue that a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.
4. The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.
5. There is tremendous uncertainty about how robust physician linkages will be done across hospitals.
6. Race/Ethnicity classification is not done systematically within or between facilities. Caution should be used when analyzing this data within one facility and between facilities.
7. Mortality's reported may be related to physicians other than the attending physician.
8. Mortality and length of stay may be skewed because of the Skilled Nursing Facility.

=====

PROVIDER: Tomball Regional Hospital  
THCIC ID: 076000  
QUARTER: 2  
YEAR: 2001

Elect not to certify

The information reported in the report is misleading to the general public.

The attending physician is charged with the procedures requested or performed by the consulting or specialist physiicans due to the acuity and needs of the patient.

Physician has extremely high mortality rate because he only treats end stage cancer patients in Hospice Care.

No allowance is made for procedures by specialists, mortality, etc.

The data reported for patient ethnicity is incorrect due to a mapping problem within the facility.

=====
PROVIDER: CHRISTUS St Josephs Health System
THCIC ID: 095000
QUARTER: 2
YEAR: 2001

Certified with comments

Four encounters were taken by THCIC's version of the grouper, and placed in MDC 14, and reported on the certification summary report as Newborns and OB. These encounters were not births, but were adult patients with obstetrically related cases. We felt this comment was necessary, as our facility did not have an OB department, at this time.

=====
PROVIDER: Covenant Medical Center Lakeside
THCIC ID: 109000
QUARTER: 2
YEAR: 2001

Certified with comments

January 2001 was the last month we had a birthing center at Covenant Medical Center Lakeside.

Data does not accurately reflect the number of charity cases for the time period. This is due to internal processing for determination of the source of payment. 4% of total discharges were charity for 1st Quarter 2001.

=====
PROVIDER: St Lukes Episcopal Hospital
THCIC ID: 118000
QUARTER: 2
YEAR: 2001

Certified with comments

The data reports for Quarter 2, 2001 do not accurately reflect patient volume or severity.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that are a snapshot of claims one month following quarter-end. If the encounter has not yet been billed, data will not be reflected in this quarter. The discharge statuses of Hospice/Home and Hospice/Medical Facility are understated due to the data processing vendor's failure to recognize these status codes.

Severity

Descriptors for newborn admissions are based on nation billing data elements (UB92) and definitions of each element can and do vary from hospital to hospital. Because of the absence of universal definitions for normal delivery, premature delivery and sick baby, this category cannot be used

for comparison across hospitals. The DRG is the only somewhat meaningful description of the infant population born at a facility. More importantly, not all clinically significant conditions can be captured and reflected in the various billing data elements including the ICD-9-CM diagnosis coding system such as ejection fraction. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

=====

PROVIDER: The Methodist Hospital  
THCIC ID: 124000  
QUARTER: 2  
YEAR: 2001

Certified with comments

TMH has 29 missing accounts from the certification file.

We have some physician UPIN numbers that are unidentified on the State's file, but according to websites, they are correct.

=====

PROVIDER: Angleton-Danbury General Hospital  
THCIC ID: 126000  
QUARTER: 2  
YEAR: 2001

Certified with comments

\*No comments received by THCIC.

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PROVIDER: Providence Memorial Hospital  
THCIC ID: 130000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### Discharge Disposition Clarification

THCIC Certification Summary for 2nd Quarter 2001 reflects 348 encounters for category, "Discharge/Transfer to Home Health", some of which should be reflected under category, "Hospice/Home". This has been identified to be a mapping issue and is currently being addressed. Data will be captured as of 9/4/01 and will be reflected with 4th Quarter 2001 data.

=====

PROVIDER: Navarro Regional Hospital  
THCIC ID: 141000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Navarro Regional Hospital is an acute general medical-surgical hospital with the additional services of a Skilled Nursing Facility and an Acute Rehabilitation Unit. The data in the public release file may or may not adequately allow separation of patients in the acute hospital from those in the other two units. Admixture of all three units can lead to increases for acute hospitals alone. It is notable that 7 of the 42 deaths in the second quarter of 2001 occurred in the two non-acute units, and that in at least 29 of the deaths, the patients or family members had requested that full efforts to maintain life not be pursued (Advanced Directive,

Living Will or Do Not Resuscitate orders).

=====

PROVIDER: Margaret Jonsson Charlton Methodist Hospital  
THCIC ID: 142000  
QUARTER: 2  
YEAR: 2001

Certified with comments

CHARLTON METHODIST HOSPITAL

CERTIFICATION COMMENTS

DATA CONTENT

This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care. The data submitted are certified to be accurate representations of the billing data recorded, to the best of our knowledge. The data is not certified to represent the complete set of data available on all inpatients but rather that data which was reported to a particular payer as required by that payer.

PHYSICIAN REVIEW OF THE DATA

Physicians admitting inpatients to Charlton, from time to time, review physician specific data that is generated from our internal computer systems. Medical Center did not attempt to have every physician individually review each patient in the actual data set returned to us by the State. We matched the State generated reports to internally generated reports to ensure data submission accuracy. We then reviewed these reports with Physician leadership who assisted us in generating the comments contained herein.

SUBMISSION TIMING

The State requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission. Claims billed in the subsequent quarter for discharges of a previous quarter will be submitted to the State in the subsequent quarter's submission.

It should also be noted that the payer might deny all or part of a bill for which an adjustment might be made on our internal data systems. The process of appealing a denied claim or service and coming to final resolution can take as long as a year to resolve with a payer. Obviously any outcome of these processes would not be reflected in a quarter's data.

OMISSION OF OBSERVATION PATIENTS

The reported data only include inpatient status cases. For various conditions,

such as chest pain,  
there are observation patients that are treated effectively in a short  
non-inpatient stay and are  
never admitted into an inpatient status. The ratio for Charlton Methodist  
Hospital is about 1  
observation patient for every 10 inpatients. Thus, calculations of inpatient  
volumes and length of  
stay may not include all patients treated in our hospital.

#### DIAGNOSIS AND PROCEDURES

The state and billing regulations require us to submit diagnoses and procedures  
in ICD-9-CM  
standard codes. The hospital can code up to 25 diagnosis codes and 25  
procedure codes. The  
state data submission requirements limit us to the first nine diagnosis  
codes and the first six  
procedure codes. As a result, the data sent by us do meet state requirements  
but may not reflect  
all the codes an individual patient's record may have been assigned. Approximately  
13% of  
Charlton Methodist Hospital's patient population have more than nine diagnoses  
and/or six  
procedures assigned.

Therefore, those patients with multiple diseases and conditions (more  
diagnoses and procedures)  
are less accurately reflected by the 1450 format. It then stands to reason  
that hospitals, which  
treat sicker patients, are likewise less accurately reflected. Further,  
true total volumes for a  
diagnosis or procedure may not be represented by the State's data file,  
which therefore make  
percentage calculations such as mortality rates or severity of illness  
adjustments inaccurate.

Charlton Methodist Hospital adheres to national coding standards but it  
should be noted that  
coding cannot establish cause and effect (ie. Infection coded, but does  
not identify whether  
present upon admission or developed in-house; fall coded, but does not  
identify whether the fall  
occurred prior to or during hospitalizations.). It is also difficult  
to distinguish between a co-  
morbidity and a complication.

#### NORMAL NEWBORNS

Admission Source or Admission Type codes are not the best way to reflect  
the pre-maturity or  
illness of an infant. Per State data submission regulation, if Admission  
Type is coded as a  
"newborn" then Admit Source is a code used to delineate the type of birth  
as "normal newborn"  
"premature delivery" "sick baby" and "extra-mural birth." Admission  
type is a code used to  
classify a baby as a newborn only if the baby was actually born in the  
reporting hospital. A very  
sick baby, transferred from another hospital or facility will be coded  
as an Admission Type of  
"Emergency" and Admission Source of "Xfer from Hospital." The actual conditions  
and

experiences of an infant in our facility are captured elsewhere in the data file, namely, in the ICD-9-CM diagnoses and procedures codes.

#### RACE AND ETHNICITY CODES

We are concerned about the accuracy of the State mandated race and ethnicity codes. Some patients decline to answer our inquiries about their race or ethnic classification. We certify that the race and ethnicity codes we submit represent nothing more than the patient's own classification or our best judgment.

#### 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's identification must be categorized into the appropriate standard and non-standard source of payment value. It is important to note that sometimes, many months after billing and THCIC data submission, a provider may be informed of a retroactive change in a patient's eligibility for a particular payer. This will cause the Source of Payment data to be inaccurate as reported in the quarter's snapshot of the data. The categories most effected are "Self Pay" and "Charity" shifting to "Medicaid" eligible.

#### REVENUE CODE AND CHARGE DATA

The charge data submitted by revenue code represents Methodist's charge structure, which may or may not be the same for a particular procedure or supply as another provider.

#### CAUTION ON THE USE OF DATA WITH SMALL NUMBERS OF CASES IN PERCENTAGE COMPARISONS

Besides the data limitations mentioned above, the number of cases that aggregate into a particular diagnosis, procedure or Diagnosis Related Grouping could render percentage calculations statistically non-significant if the number of cases is too small.

#### SEVERITY ADJUSTMENT SCORES

THCIC is responsible for providing and maintaining a tool to assign an All-patient Refined (APR) Diagnosis Related Group (DRG) severity score for each encounter at their data processing center. Charlton Methodist Hospital neither creates nor submits the APR DRG contained in the data sets.

#### PHYSICIAN LICENSE NUMBER ERRORS

All physician license numbers and names have been validated with the physician's paper license and the license web-site as accurate even though some remain unidentified in the THCIC Practitioner Reference Files. This is due to the THCIC's delay in obtaining updated state license

information

=====

PROVIDER: University Medical Center  
THCIC ID: 145000  
QUARTER: 2  
YEAR: 2001

Certified with comments

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

=====

PROVIDER: Covenant Hospital Plainview  
THCIC ID: 146000  
QUARTER: 2  
YEAR: 2001

Certified with comments

The data reviewed by hospital staff and physicians appears, to the best of our knowledge, to be correct and accurate.

It is the practice of the hospital to review all unusual occurrences or length of stay cases via the medical staff's peer review process.

Outliers seen in this quarter's data have been reviewed with appropriate medical staff.

Please consider this unaudited data. As accounts move through the billing and collections cycle, financial classifications may change based on additional information obtained.

Financial data does not necessarily correlate to quality outcomes data. It is the policy of the facility to provide the highest quality possible given the medical condition and resources available.

=====

PROVIDER: The Institute for Rehabilitation & Research  
THCIC ID: 164000  
QUARTER: 2  
YEAR: 2001

Certified with comments

TIRR (The Institute for Rehabilitation and Research) was founded in 1959 in Houston's Texas Medical Center by William A. Spencer, MD. Dr. Spencer articulated a rehabilitation philosophy of maximizing independence and quality of life that continues to guide the development of our programs.

This guiding philosophy includes providing appropriate medical intervention, helping the patient establish realistic goals and objectives, and supporting the patient to maintain personal integrity and family and social ties.

TIRR is an internationally known, fully accredited teaching hospital that specializes in medical care, education and research in the field of catastrophic injury. It has been recognized every year in a nationwide survey of physicians by U.S. News & World Report as one of the best hospitals in America.

The hospital's research into developing improved treatment procedures has substantially reduced secondary complications of catastrophic injuries as well as average lengths of stay. TIRR is one of only three hospitals

in the country that has Model Systems designation for both its spinal cord and brain injury programs.

Our programs are outcome-oriented with standardized functional scales by which to measure a patient's progress. Some of these programs are:

Spinal Cord Injury. Since 1959, TIRR has served over 3,000 patients with spinal cord injuries and has built an international reputation as a leader in innovative treatment, education and research. TIRR was one of the first centers to be designated by NIDRR (National Institute on Disability and Rehabilitation Research) as a regional model spinal cord injury system for exemplary patient management and research, a designation it has maintained since 1972.

Brain Injury. The Brain Injury Program at TIRR admits patients who have brain injuries resulting from trauma, stroke, tumor, progressive disease, or metabolic dysfunction. The Program is designated as a Model System for Rehabilitation for Persons with Traumatic Brain Injury by the NIDRR and as a Rehabilitation Research and Training Center on Rehabilitation Interventions Following Traumatic Brain Injury.

Amputee. The Amputee Program serves patients with traumatic amputations, congenital limb deficiencies, and disease related amputations. TIRR is uniquely experienced in complex multiple limb loss associated with trauma and electrical burns and with amputations associated with diabetes mellitus and peripheral vascular disease.

Comprehensive Rehabilitation. TIRR's skills and expertise in caring for patients with central nervous system disorders such as spinal cord injury and brain injury transfer well to those admitted to the comprehensive rehabilitation program who may also have some weakness or loss of sensation, coordination or mobility. This program serves patients with diagnoses including simple and multiple fractures, arthritis, deconditioning after medical complex disorders, multiple sclerosis, post-polio syndrome, complications from burns, etc.

Pediatric Program. The Pediatric Program at TIRR admits children with congenital or acquired physical and/or cognitive impairments. The program usually treats children from infancy to 16 years of age.

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PROVIDER: Medical Center Hospital
THCIC ID: 181000
QUARTER: 2
YEAR: 2001

Certified with comments

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

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PROVIDER: Harris Methodist H.E.B.
THCIC ID: 182000
QUARTER: 2
YEAR: 2001

Certified with comments

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

#### Diagnosis and Procedures

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

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

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

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 15% of Harris Methodist HEB's patient population have more than nine diagnoses and/ or six procedures assigned.

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 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure

codes. As a result, the data sent by us do 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 1450 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. THR recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

#### Race/Ethnicity

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. This issue has both federal and state law implications, as well as, ethical and clinical ramifications. Harris Methodist HEB is pursuing better methods for collecting this information. Additionally, the THCIC in a recent Board meeting (December 7, 2001) indicated that the THCIC would be creating guidelines for use by hospitals to assist with more accurate collection of this information.

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

Cost/ Revenue Codes

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

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PROVIDER: Texoma Medical Center
THCIC ID: 191000
QUARTER: 2
YEAR: 2001

Certified with comments

Data Source. The source of this data, the electronic 1450, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.

- \* The 1450 data file limits the diagnosis codes to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and an E-code field.
\* The procedure codes are limited to six (principal plus five secondary).
\* The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization.
\* The Hospital can only list 4 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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

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

Severity Adjustment. THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores. The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status.
\* The program can only use the codes available in the 1450 data file, e.g., nine diagnosis and six procedure codes. If all the patient's diagnosis codes were available the assignment may be different than when limited to those available in the 1450 data.

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

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PROVIDER: Reba McEntire Center for Rehabilitation
THCIC ID: 191001
QUARTER: 2
YEAR: 2001

Certified with comments

Data Source. The source of this data, the electronic 1450, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.

\* The 1450 data file limits the diagnosis codes to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and an E-code field.

\* The procedure codes are limited to six (principal plus five secondary).

\* The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization.

\* The Hospital can only list 4 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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

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

Severity Adjustment. THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores.

The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status.

\* The program can only use the codes available in the 1450 data file, e.g., nine diagnosis and six procedure codes. If all the patient's diagnosis codes were available the assignment may be different than when limited to those available in the 1450 data.

Timing of Data Collection. Hospitals must submit data to THCIC no later than 60 days after the close of the quarter.

\* Not all claims may have been billed at this time.

\* Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

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PROVIDER: Texoma Medical Center Behavioral Health Center

THCIC ID: 191002

QUARTER: 2

YEAR: 2001

Certified with comments

Data Source. The source of this data, the electronic 1450, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.

\* The 1450 data file limits the diagnosis codes to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and an E-code field.

\* The procedure codes are limited to six (principal plus five secondary).

\* The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization.

\* The Hospital can only list 4 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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

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

Severity Adjustment. THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores.

The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status.

\* The program can only use the codes available in the 1450 data file, e.g., nine diagnosis and six procedure codes. If all the patient's diagnosis codes were available the assignment may be different than when limited to those available in the 1450 data.

Timing of Data Collection. Hospitals must submit data to THCIC no later than 60 days after the close of the quarter.

\* Not all claims may have been billed at this time.

\* Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

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PROVIDER: Texoma Restorative Care SNU  
THCIC ID: 191004  
QUARTER: 2  
YEAR: 2001

Certified with comments

Data Source. The source of this data, the electronic 1450, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.

\* The 1450 data file limits the diagnosis codes to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and an E-code field.

\* The procedure codes are limited to six (principal plus five secondary).

\* The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization.

\* The Hospital can only list 4 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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

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

Severity Adjustment. THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores.

The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status.

\* The program can only use the codes available in the 1450 data file,

e.g., nine diagnosis and six procedure codes. If all the patient's diagnosis codes were available the assignment may be different than when limited to those available in the 1450 data.

Timing of Data Collection. Hospitals must submit data to THCIC no later than 60 days after the close of the quarter.

\* Not all claims may have been billed at this time.

\* Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

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PROVIDER: Medical Center of Plano  
THCIC ID: 214000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Patient Confidentiality:

The current data submission format does not identify individual patients, therefore, in theory protecting patient confidentiality. However, if the sample size used for analysis is small, individual patients might be identifiable. In many hospitals, the number of patients discharged in a quarter in a race category of Black, Asian or American Indian, for example; could be <5. With such a small cell size, there may be only one black male in the community-thereby making the individual identifiable violating his right to have his medical information confidential.

Data Content:

The state requires the hospital to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 electronic claim format. The 1450 data is administrative and is collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality. The state specifications require additional data places programming burdens on the hospital which are above and beyond the process of billing. Although the unique data (e.g. standard and non-standard payer codes, race, and ethnicity) may have errors, the public should not conclude that billing data sent to our payers are inaccurate.

Timing of Data Collection:

Hospitals must submit data to THCIC no later than 60 days after the close of the quarter. Not all claims may have been billed at this time. The submitted data may not capture all discharge claims. Internal data may be updated later and appear different than the data on the claim (if the payment is not impacted, hospitals do not usually rebill when a data field is changed internally).

Diagnosis and Procedures:

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnosis and procedures that the state allows us to include for each patient. The 1450 data file limits the diagnosis codes to nine, and procedure codes are limited to six. The fewer the codes, the less information is available to evaluate the patient's outcomes and service utilization. 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 universal standard called the International Classification of Disease, or ICD-9-CM. The federal government mandates this 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. Due to the limit set by the state of nine diagnoses codes and six procedure codes, the data sent by us meets their criteria 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 1450 format. It then stands to reason that hospitals which treat sicker patients are likewise less accurately reflected.

#### Normal Newborns:

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Medical Center of Plano's registration process defaults to "normal delivery" as the admission source. (Other options include premature delivery, sick baby extramural birth, or information not available). Often times the true nature of the newborn's condition is not known at the time of entry into the system. The actual experience of the newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnoses.

Admission source does not give an accurate picture.

#### Race/Ethnicity:

During the registration process, the clerk routinely inquires as to a patient's race and/or ethnicity. If the patient is able and/or willing to give this information, it is recorded as the patient states. Patients may refuse or be unable due to condition to respond to this question.

There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals.

Thus, epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

#### 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, denial of payment by insurance companies and DRG payments by Medicare. Charges also do not reflect the actual cost to deliver the care that each patient needs.

#### Specialty Services:

The 1450 data format does not have a specific data field to capture unit of service or to expand on the specialty service(s) provided to a patient.

Services used by and outcomes expected of patients on hospice units, rehabilitation units and skilled nursing facility beds are very different from hospital acute care services. The state is currently working to categorize patient type. Inclusion of these specialty services can significantly impact outcome and resource consumption analysis. (e.g. lengths of stay, mortality and cost comparisons) Medical Center of Plano has a skilled

nursing facility whose patients are included in the data.

Payer Codes:

The payer codes utilized in the state database were defined by the state.

These definitions are not standardized. Each hospital may map differently.

Charity and self-pay patients are difficult to assign in the data submitted to the state. Hospitals are often not able to determine whether or not a patient's charges will be considered "charity" until long after discharge (after the claim has been generated) and when other potential payment sources have been exhausted. This will not be reflected in the state data submission due to the timing involved.

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PROVIDER: Harris Methodist Fort Worth

THCIC ID: 235000

QUARTER: 2

YEAR: 2001

Certified with comments

CLINICAL DATA:

The THCIC data conforms to the HCFA 1450 file specifications. The 1450 data is administrative and collected for billing purposes. It is not clinical data and should be used cautiously to evaluate health care quality.

The 1450 data file limits the diagnosis codes to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and an E-code field.

The use of E-Codes (i.e. injury source) is optional in Texas and Harris Methodist Fort Worth does not collect these codes in the trauma or motor vehicle accident admissions. This can result in erroneous evaluation of injury sources if researchers do not understand the limitations of this data field.

The procedure codes are limited to six (principal plus five secondary) procedures. The fewer the codes the less information is available to evaluate the patient's outcome and service utilization. When the patient has more codes in the medical record than allowed in the 1450 files, the hospital must select only nine diagnosis codes and six procedure codes. Hospitals populate these fields differently so there is no standardization.

Since there is this limited number of diagnosis and procedure codes used and no standardization on how hospitals are assigning these codes, there are obvious inherent problems with this data. Using this type of data to evaluate quality and outcomes cannot portray an accurate picture of quality measurements or outcomes.

THCIC is using the 3M-APR-DRG system to assign the "All-Patient Refined (APR) DRG", severity and risk of mortality scores. The assignment is made by evaluation of the patient's age, sex, diagnosis and procedure codes, and discharge status. This program can only use the codes available in the 1450 file (i.e. 9 diagnoses and 6 procedure codes). If all the patient's diagnoses and procedure codes were available, the assignment may be different than when it is limited to only those on the 1450 file.

ADMIT TYPE AND SOURCE:

Problems have been identified with the newborn source codes. The data collection source for the THCIC newborn (i.e. normal delivery, premature,

sick baby or extramural birth) is an admission code assigned by the admission clerk. This does not give an accurate description of the severity of illness in the newborn. The more precise area to collect this information would be from the infant's diagnosis codes assigned on discharge.

#### PAYOR CODE/COSTS:

The payor codes utilized in the THCIC database were defined by the State and are not using standard payor information from the claim. The mapping process of specific payors to the THCIC payor codes was not standardized by THCIC. Therefore, each hospital may map differently which can create variances in coding.

Few hospitals have been able to assign the "Charity" payor code in the data submitted to THCIC. Hospitals are not able to determine whether or not charges will be considered "charity" until long after dismissal when all potential payment sources have been exhausted.

It is important to note that charges do not reflect actual payments to the hospital to deliver care. Actual payments are substantially reduced by managed care contracts, payor denials and contractual allowances, as well as charity and uncollectable accounts.

#### RACE AND ETHNICITY:

Race and ethnicity are not required in the HCFA 1450 specifications, these data elements are unique to THCIC. Each hospital must independently map their specific codes to the State race code category.

The collection, documentation and coding of race and ethnicity vary considerably across hospitals. Some hospitals do not ask the patient, rather an admission clerk makes a subjective decision. Also, each hospital may designate a patient's race/ethnicity differently.

Many hospitals do not collect ethnicity as a separate category. They may collect race e.g. Hispanic, which defaults to ethnicity and then to whatever the hospitals have mapped to that category. The lack of standardization may result in apparently significant differences among hospitals' reported racial mix; therefore, making comparisons invalid and inaccurate.

#### SPECIALTY SERVICE:

The 1450 data does not have any specific field to capture unit of service or to expand on the specialty service(s) provided to a patient. THCIC is using codes from the bill type and accommodation revenue codes in an attempt to distinguish specialty services.

Services used by and outcomes expected of patients on the hospice units, in rehab,, in skilled nursing areas and other specialty areas are very different. The administrative data has inherent limitations and will impact the evaluation of health cares services provided.

#### TIMING OF DATA COLLECTION:

Hospitals are required to submit data to THCIC no later than 60 days after the close of the quarter. Not all claims have been billed in this time period. Depending on how data is collected and the timing of the billing cycle all hospitals discharges may not be captured.

Internally the data may be updated after submission, then it will be different

from the data submitted to THCIC. This makes it difficult to evaluate the accuracy and completeness of the THCIC data file against internal systems.

PHYSICIAN DATA:

The certification files identifying physicians show conflicts in several physicians' data and THCIC's certification data. Harris Methodist Fort Worth has attempted to verify the state license number and name of physicians using the State Board of Licensing information. It appears that the physician data being submitted by Harris to THCIC matches name and number provided in the State Board of Licensing database. Therefore, these conflicts between apparently accurate physician data being submitted and THCIC's physician database make it difficult to evaluate the accuracy of the physician level data.

CERTIFICATION PROCESS:

Harris Methodist Fort Worth has policies and procedures in place to validate the accuracy of the discharge data and corrections submitted within the limitations previously stated. To the best of our knowledge, all errors and omissions currently known to the hospital have been corrected and the data is accurate and complete.

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PROVIDER: Henderson Memorial Hospital
THCIC ID: 248000
QUARTER: 2
YEAR: 2001

Elect not to certify

Race and ethnicity reported as missing or invalid for 22% of our patients. We are investigating the cause of this problem. Non-Standard source of payment issues still exist, but will be corrected when we implement new UB92 changes in conjunction with our HIPAA remediation.

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PROVIDER: Methodist Medical Center
THCIC ID: 255000
QUARTER: 2
YEAR: 2001

Certified with comments

METHODIST MEDICAL CENTER

CERTIFICATION COMMENTS

DATA CONTENT

This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care. The data submitted are certified to be accurate representations of the billing data recorded, to the best of our knowledge. The data is not certified to represent the complete set of data available on all inpatients but rather that data which was reported to a particular payer as required by that payer.

PHYSICIAN REVIEW OF THE DATA

Physicians admitting inpatients to Methodist, from time to time, review

physician specific data that is generated from our internal computer systems. Medical Center did not attempt to have every physician individually review each patient in the actual data set returned to us by the State. We matched the State generated reports to internally generated reports to ensure data submission accuracy. We then reviewed these reports with Physician leadership who assisted us in generating the comments contained herein.

#### SUBMISSION TIMING

The State requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission. Claims billed in the subsequent quarter for discharges of a previous quarter will be submitted to the State in the subsequent quarter's submission.

It should also be noted that the payer might deny all or part of a bill for which an adjustment might be made on our internal data systems. The process of appealing a denied claim or service and coming to final resolution can take as long as a year to resolve with a payer. Obviously any outcome of these processes would not be reflected in a quarter's data.

#### OMISSION OF OBSERVATION PATIENTS

The reported data only include inpatient status cases. For various conditions, such as chest pain, there are observation patients that are treated effectively in a short non-inpatient stay and are never admitted into an inpatient status. The ratio for Methodist Medical Center is about 1.73 observation patients for every 10 inpatients. Thus, calculations of inpatient volumes and length of stay may not include all patients treated in our hospital.

#### DIAGNOSIS AND PROCEDURES

The state and billing regulations require us to submit diagnoses and procedures in ICD-9-CM standard codes. The hospital can code up to 25 diagnosis codes and 25 procedure codes. The state data submission requirements limit us to the first nine diagnosis codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but may not reflect all the codes an individual patient's record may have been assigned. Approximately 20% of Methodist Medical Center's patient population have more than nine diagnoses and/or six procedures assigned.

Therefore, those patients with multiple diseases and conditions (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which

treat sicker patients, are likewise less accurately reflected. Further, true total volumes for a diagnosis or procedure may not be represented by the State's data file, which therefore make percentage calculations such as mortality rates or severity of illness adjustments inaccurate.

Methodist Medical Center adheres to national coding standards but it should be noted that coding cannot establish cause and effect (ie. Infection coded, but does not identify whether present upon admission or developed in-house; fall coded, but does not identify whether the fall occurred prior to or during hospitalizations.). It is also difficult to distinguish between a co-morbidity and a complication.

#### NORMAL NEWBORNS

Admission Source or Admission Type codes are not the best way to reflect the pre-maturity or illness of an infant. Per State data submission regulation, if Admission Type is coded as a "newborn" then Admit Source is a code used to delineate the type of birth as "normal newborn" "premature delivery" "sick baby" and "extra-mural birth." Admission type is a code used to classify a baby as a newborn only if the baby was actually born in the reporting hospital. A very sick baby, transferred from another hospital or facility will be coded as an Admission Type of "Emergency" and Admission Source of "Xfer from Hospital." Methodist Medical Center operates a level 3 critical care nursery, which receives transfers from other facilities. The actual conditions and experiences of an infant in our facility are captured elsewhere in the data file, namely, in the ICD-9-CM diagnoses and procedures codes.

#### RACE AND ETHNICITY CODES

We are concerned about the accuracy of the State mandated race and ethnicity codes. Some patients decline to answer our inquiries about their race or ethnic classification. We certify that the race and ethnicity codes we submit represent nothing more than the patient's own classification or our best judgment.

#### 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's identification must be categorized into the appropriate standard and non-standard source of payment value. It is important to note that sometimes, many months after billing and THIC data submission, a provider may be informed of a retroactive change in a patient's eligibility for a particular payer. This will cause the Source of Payment data to be

inaccurate as reported in the quarter's snapshot of the data. The categories most effected are "Self Pay" and "Charity" shifting to "Medicaid" eligible.

REVENUE CODE AND CHARGE DATA

The charge data submitted by revenue code represents Methodist's charge structure, which may or may not be the same for a particular procedure or supply as another provider.

CAUTION ON THE USE OF DATA WITH SMALL NUMBERS OF CASES IN PERCENTAGE COMPARISONS

Besides the data limitations mentioned above, the number of cases that aggregate into a particular diagnosis, procedure or Diagnosis Related Grouping could render percentage calculations statistically non-significant if the number of cases is too small.

SEVERITY ADJUSTMENT SCORES

THCIC is responsible for providing and maintaining a tool to assign an All-patient Refined (APR) Diagnosis Related Group (DRG) severity score for each encounter at their data processing center. Methodist Medical Center neither creates nor submits the APR DRG contained in the data sets.

PHYSICIAN LICENSE NUMBER ERRORS

All physician license numbers and names have been validated with the physician's paper license and the license web-site as accurate even though some remain unidentified in the THCIC Practitioner Reference Files. This is due to the THCIC's delay in obtained updated state license information

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PROVIDER: Harris Methodist Erath County
THCIC ID: 256000
QUARTER: 2
YEAR: 2001

Certified with comments

HARRIS METHODIST ERATH COUNTY CERTIFIED WITH COMMENTS

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 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 diagnosis and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government.

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

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

This makes it difficult to obtain accurate information regarding things such as complication rates.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnosis and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do 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 procedures, 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 1450 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. HARRIS METHODIST ERATH COUNTY HOSPITAL recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

#### Race/Ethnicity

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. This issue has both federal and state law implications, as well as, ethical and clinical ramifications. HARRIS METHODIST ERATH COUNTY HOSPITAL is pursuing better methods for collecting this information. Additionally, the THCIC in a recent Board meeting indicated that the THCIC would be creating guidelines for use by hospitals to assist with more accurate collection of this information.

#### 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 identification 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 PTO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

#### Cost/Revenue Codes

The state requires that hospital 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 of insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

#### Recommendations

HARRIS METHODIST ERATH COUNTY HOSPITAL recommends that THCIC have a press release making the public aware of the data being collected. The general public does not realize that this information is being collected and that state law requires it. There needs to be more education for the Texas residents as to what is being collected, problems that still exist in the collection of the data, how the information will be used and the benefit they will receive. HARRIS METHODIST ERATH COUNTY is committed to a quality state data reporting mechanism and is committed to assisting with resolution of THCIC issues as they arise in the best interest of Texas residents.

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PROVIDER: Houston Community Hospital  
THCIC ID: 261000  
QUARTER: 2

YEAR: 2001

Elects not to certify.

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PROVIDER: RE Thomason General Hospital  
THCIC ID: 263000  
QUARTER: 2  
YEAR: 2001

Certified with comments

In this database only one primary physician is allowed. This represents the physician at discharge in this institution. At an academic medical center such as Thomason, patients are cared for by teams of physicians that 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. Additional opportunities for improvement have been identified and are being addressed.

NEWBORN ADMISSION

Errors in Newborn Admissions were identified. Concerns related to admission source have been identified and efforts are underway to correct this issue. Based on coding information, the following are corrected figures:

Normal Deliveries	= 813
Premature Deliveries	= 134
Sick Babies	= 240
Extramural	= Data not available

Total Newborns 2Q2001 = 1187

PAYOR MIX

Mapping problems were identified in primary payer source. Thomason is currently working with the vendor to address this issue.

The following is the corrected information:

Charity	= 485
Commercial	= 441
Medicaid	= 2363
Medicare	= 344
Self Pay	= 799
Total Encounter	= 4432

Other Comments being submitted

Discharge Status:

Discharge to Home or Self Care	= 4148
Discharge transfer to another institution	= 156
Discharge transfer to Home Health	= 45
Left AMA	= 32
Expired	= 59

The THCIC data shows a higher number of discharge status of death than reflected in the hospital's internal data. Users of the data are encouraged to consider this when using the discharge status data field.

Race and Ethnicity a variance was noted in the following:

Asian or Pacific Islander less than 1% difference
Hispanic Origin less than 1% difference
Not of Hispanic Origin less than 1% difference

Efforts are underway to address identified issues and to correct for future data submissions

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PROVIDER: Sierra Medical Center  
THCIC ID: 266000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Admission Type: Unknown  
Facility captures data for admission type Other/OB, which does not map to admission types available through THCIC reporting. Admission type Unknown reflects admissions under category of Other/OB.

Newborn Admissions  
THCIC Certification Summary for 2nd Quarter 2001 reflects 7 encounters for category, "Information Not Available", which should be reflected under category, "Normal Delivery".

Non-standard Source of Payment  
Under category Missing/Invalid, mapping issue has been corrected and is scheduled for release within the next quarter.

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PROVIDER: Methodist Diagnostic Hospital  
THCIC ID: 267000  
QUARTER: 2  
YEAR: 2001

Certified with comments

DCH has 27 accounts missing from the certification file.

We have some physicians UPIN numbers that are unidentified on the Stare's file, but according to websites, they are correct.

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PROVIDER: Baylor Med Ctr Ellis County  
THCIC ID: 285000  
QUARTER: 2  
YEAR: 2001

Certified with comments

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

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

## Reference Files.

### 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 universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

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

### Race/Ethnicity

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

### Standard/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 identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 3% of the primary payers originally categorized as "Self Pay" and 3% categorized as "Medicaid" were recategorized as "Commercial".

Also 13% of the secondary payers originally categorized as "Commercial", 8% categorized as "Medicaid" and 3% categorized as "Missing/Invalid" were recategorized as "Medicare".

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

### Cost/ Revenue Codes

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

### Certification Process

Due to the infancy of the state reporting process and the state's computer

system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Baylor Medical Center at Irving  
THCIC ID: 300000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### Submission Timing

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

#### Physician Identification

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

#### Medical Record Number

It has been discovered that the medical record number has been submitted incorrectly. The medical record number field erroneously reflects the patient account number rather than the unique medical record number.

#### 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 universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

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

#### Normal Newborns

The best way to focus on severity of illness regarding an infant would

be to check the infant's diagnosis at discharge, not the admitting source code. Baylor's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

#### Race/Ethnicity

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

#### Standard/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 identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 7% of the encounters originally categorized as "Blue Cross" were recategorized as "Commercial" and 3% categorized as "Other" were recategorized as "Self Pay". Also, 8% of the secondary payers originally categorized as "Commercial", 8% categorized as "Missing/Invalid", 2% categorized as "Self Pay", 2% categorized as "Medicaid" and 2% categorized as "Blue Cross" were all recategorized as "Medicare".

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

#### Cost/ Revenue Codes

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

#### Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Baylor Health Center at Irving-Coppell

THCIC ID: 300001

QUARTER: 2

YEAR: 2001

Certified with comments

#### Submission Timing

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

#### Physician Identification

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

#### Medical Record Number

It has been discovered that the medical record number has been submitted incorrectly. The medical record number field erroneously reflects the patient account number rather than the unique medical record number.

#### 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 universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

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

#### Normal Newborns

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Baylor's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

#### Race/Ethnicity

There are no national standards regarding patient race categorization so hospitals may not have the same designations from which patients can choose. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent

across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/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 identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 12% of the encounters originally categorized as "Blue Cross" were recategorized as "Commercial". Also, 3% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Commercial".

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

Cost/ Revenue Codes

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

Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Memorial Hermann Memorial City Hospital
THCIC ID: 302000
QUARTER: 2
YEAR: 2001

Certified with comments

On 5/31/01 Memorial Hermann Memorial City underwent a computer conversion which required 228 patients to be discharged off of one system and readmitted to another. Thus the profiles of these patients, and particularly their length of stays and charges, are split amongst the two systems. These 228 patients account for 4% of the quarter's discharges.

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PROVIDER: Presbyterian Hospital of Kaufman
THCIC ID: 303000
QUARTER: 2
YEAR: 2001

Certified with comments

PRESBYTERIAN HOSPITAL OF KAUFMAN CERTIFIED WITH COMMENTS

## Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

## Diagnosis and Procedures

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

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

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

This makes it difficult to obtain accurate information regarding things such as complication rates.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do 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 1450 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. PRESBYTERIAN HOSPITAL OF KAUFMAN recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

#### Race/Ethnicity

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

#### Standard/Non-Standard Source of Payment

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

Recommendations

PRESBYTERIAN HOSPITAL OF KAUFMAN recommends that THCIC do more education for the consumer on the data being collected. The general public does not realize that this information is being collected and that state law requires it. There needs to be more education for the Texas residents as to what is being collected, problems that still exist in collection of the data, how the information will be used, and the benefit they will receive. PRESBYTERIAN HOSPITAL OF KAUFMAN is committed to a quality state data reporting mechanism and is committed to assisting with resolution of THCIC issues as they arise in the best interest of Texas residents.

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PROVIDER: Mesquite Community Hospital  
THCIC ID: 315001  
QUARTER: 2  
YEAR: 2001

Elects not to certify.

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PROVIDER: Baylor University Medical Center  
THCIC ID: 331000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Submission Timing

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

Physician Identification

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

Medical Record Format

It has been discovered that the medical record number has been submitted in the incorrect format. The medical record number field is currently being populated with a 12 digit number. The pure medical record number of 6 digits has been concatenated with an additional 6 digit suffix. To obtain the unique patient identifier, the 6 digit suffix must be stripped.

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. Approximately 20 % of Baylor's patient population have more than nine diagnoses and/or six procedures assigned.

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

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

#### Normal Newborns

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Baylor's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

#### Mortalities

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

#### Race/Ethnicity

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

#### 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 identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. Upon review approximately 3% of the primary payers originally categorized as "Blue Cross" were recategorized as "Commercial". Also 12% of the secondary payers originally categorized as "Commercial", 3% categorized as "Other", 3% categorized as "Blue Cross" and 3% categorized as "Medicaid" were recategorized as "Medicare".

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

Cost/ Revenue Codes

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

Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

=====
PROVIDER: Cook Children's Medical Center
THCIC ID: 332000
QUARTER: 2
YEAR: 2001

Elect not to certify

Cook Children's Medical Center has elected to not certify the second quarter 2001 discharge encounter data as returned by the Texas Health Care Information Council for the following reasons:

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 total of ten diagnoses and six procedures. Patients with more than ten diagnoses or six procedures will be missing information from the database. This is especially true in complex cases where a patient has multiple major illnesses and multiple surgeries over an extended stay.

=====
PROVIDER: Daughters of Charity Brackenridge
THCIC ID: 335000
QUARTER: 2
YEAR: 2001

Certified without comments

As the public teaching hospital in Austin and Travis County, Brackenridge

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. Brackenridge has a perinatal program that serves a population that includes mothers with late or no prenatal care. Brackenridge 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 costs of care, lengths of stay and mortality rates.

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

All physician license numbers and names have been validated with the physician and the website(s) as accurate but some remain unidentified in the THCIC Practitioner Reference Files. These data are submitted by the hospital as their best effort to meet statutory requirements.

=====

PROVIDER: Daughters of Charity Childrens Hospital of Austin  
THCIC ID: 335001  
QUARTER: 2  
YEAR: 2001

Certified with comments

Children's Hospital of Austin is the only children's hospital in the Central Texas Region. Children's serves severely ill and/or injured children requiring intensive resources which increases the hospital's costs of care, lengths of stay and mortality rates. In addition, the hospital includes a Neonatal Intensive Care Unit (NICU) which serves very seriously ill infants, which substantially increases costs of care, lengths of stay and mortality rates. All physician license numbers and names have been validated with the physician and the website(s) as accurate but some remain unidentified in the THCIC Practitioner Reference Files. These data are submitted by the hospital as their best effort to meet statutory requirements.

=====

PROVIDER: Medical City Dallas Hospital  
THCIC ID: 340000  
QUARTER: 2  
YEAR: 2001

Certified with comments

MCDH treats high risk neonatal, pediatric and transplant patients. SNF and Rehab patient data is included. Diagnostic and procedure information is not comprehensive.

=====

PROVIDER: Denton Regional Medical Center  
THCIC ID: 336001  
QUARTER: 2  
YEAR: 2001

Certified with comments

When reviewing the data for Denton Regional Medical Center, please consider the following:

The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes.

The cost of care, charges, and the revenue a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to another may result in unreliable results.

All statistics for Denton Regional include the acute care services as well as the Rehabilitation Department, a long-term care unit. This may preclude any meaningful comparisons between Denton Regional Medical Center and an "acute care only" provider.

Elderly individuals are more apt to use the long-term inpatient services provided by Denton Regional. This is reflected in the age breakdown.

Admission source data is not collected and grouped at Denton Regional in the same manner as displayed.

Under the Standard Source of Payment, please note that statistics in the "Commercial" category also include managed care providers.

The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Denton Regional is unable to comment on the accuracy of this report.

=====

PROVIDER: West Houston Medical Center  
THCIC ID: 337000  
QUARTER: 2  
YEAR: 2001

Certified with comments

\*Comments not received by THCIC.

=====

PROVIDER: Memorial Hermann Hospital  
THCIC ID: 347000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Hermann Hospital was closed from June 9th, 2001 through July 16th, 2001 due to severe flooding which led to a loss of electrical power, telephone systems and water power. Thus total discharges are roughly one third less than the usual discharge total.

=====

PROVIDER: Smithville Regional Hospital  
THCIC ID: 385000  
QUARTER: 2  
YEAR: 2001

Certified with comments

We have not been routinely collecting race information on out patients due to patient resentment. Since this has been designated a a required item, we are currently attempting to collect this data. Discharge information is extracted by computer and has not been reviewed closely.

=====

PROVIDER: Nacogdoches Medical Center  
THCIC ID: 392000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### DATA Content

This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 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; this was a unique, untried use of this data as far as hospitals are concerned.

#### Submission Timing

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

#### 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 the patient's hospitalization, sometimes significantly.

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

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

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedures codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes in an individual patient's record which 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). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

#### Specialty Services

The data submitted does not have any specific data field to capture unit of service or expand in the specialty service (such as rehab) provided to a patient. Services used by patients in rehab may be very different from those used in other specialties. The data is limited in its ability to categorize patient type.

#### 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 as long as or longer than 999 days, therefore, it is not anticipated that this limitation will affect this data. The hospital does provide oncology services. The length of stay for this patient population is generally longer compared to other acute care patients. This may skew the data when combined with other acute care patient stays.

#### Normal Newborns

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. The hospital's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

#### Race/Ethnicity

During the hospital's registration process, the registration clerk does routinely complete patient's race and/or ethnicity field. The race data element is sometimes subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

#### Cost/Revenue

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 cost for performing the service. Typically actual payments are much less than charges due to negotiated discounts with 3rd party payors. Charges also do not reflect the actual costs to deliver the care that each patient needs.

#### Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, the hospital did not have an efficient mechanism to edit and correct the data. In addition, it is not feasible to perform encounter level audits at this time.

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PROVIDER: Medical Center of Lewisville  
THCIC ID: 394000  
QUARTER: 2  
YEAR: 2001

#### Certified without comments

1. This data is administrative and claims data only. It is not clinical research data. There may be inherent limitations in using this data to compare clinical outcomes.
2. This data only contains a subset of the diagnoses and procedure codes. This limits the ability to access all of the diagnoses and procedures

relative to each patient.

3. The relationship between the cost of patient care, charges, and the payment that a facility receives is very complex. Inferences made in comparing the cost of patient care, charges and payments from one hospital to another may result in unreliable results.

4. The severity grouping assignments performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Also, the lack of knowledge regarding how this grouper calculates the severity adjustments can greatly impact the interpretation of the data.

5. There is great uncertainty about how the physician linkages will be done across hospitals.

6. Race and ethnicity classification is not done systematically within, or between facilities. Caution should be used when analyzing this data within one facility and when comparing one facility to another,

7. This data includes skilled nursing patients. The average length of stay for a skilled nursing patient is normally higher than that of an acute care patient.

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PROVIDER: Nix Health Care System
THCIC ID: 396000
QUARTER: 2
YEAR: 2001

Certified with comments

\*Comments not received by THCIC.

=====
PROVIDER: CHRISTUS Spohn Hospital Memorial
THCIC ID: 398000
QUARTER: 2
YEAR: 2001

Certified with comments

CHRISTUS Spohn Hospital Memorial is a Level III Regional Trauma Center serving a twelve county region.

CHRISTUS Spohn Hospital Memorial is a teaching hospital with a Family Practice Residency Program based at the hospital.

We believe that the discharge encounter data as returned by the Texas Health Care Information Council for calendar quarter two/2001 represents the patient population of CHRISTUS Spohn Hospital Memorial.

=====
PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
QUARTER: 2
YEAR: 2001

Certified with comments

JPS Health Network
Comments on THCIC Data Submission
For

Quarter 2 2001

## Introduction

John Peter Smith Hospital (JPSH) is operated by the JPS Health Network under the auspices of the Tarrant County Hospital District. The JPS Health Network is accredited by the Joint Commission on Accreditation of Health Care Organizations as an integrated health network. In addition, JPSH holds JCAHO accreditation as a hospital.

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

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

In addition to JPSH, the JPS Health Network operates community-based health centers located in medically underserved areas of Tarrant County, a home health agency, school-based health centers, special outpatient programs for substance abusing pregnant women and a wide range of wellness education programs. A free medical information service, InfoNurse, is staffed 24 hours a day, seven days a week by licensed nurses.

## Data Comments

This inpatient data was submitted to meet requirements of the State of Texas for reporting second quarter 2001 inpatient hospital discharge data.

The data used by the Texas Health Care Information Council (THCIC) is administrative and collected for billing purposes, and it should be noted that the data is a "snapshot" at the time of the file production and not of the final disposition of claim data to the payor. It is not clinical data and should be cautiously used to evaluate health care quality. Also, the use of only one quarter's data to infer statistical meaning can lead to misinterpretation.

## Patient Relationship to Insured

When the payor source for patients is changed after discharge, the relationship between the payor source and the insured is defaulted to "unknown". JPS is addressing this limitation of the system and new expanded name and address fields are planned for installation in 2002.

## Country

The data entry fields within the JPS registration system are limited, preventing any country designation to be entered. All patients for JPSH have USA listed as their country. This limitation will be addressed and corrected with the new expanded name and address fields that are planned for installation in 2002.

## Physician Master File

A patient may have several attending physicians throughout his/her course of stay due to the rotation of physicians to accommodate teaching responsibilities.

This rotation may result in an under-representation of true attending physicians.

Diagnoses and Procedures

The data submitted matches the State's reporting requirements but may be incomplete due to a limitation on the number of diagnosis and procedure codes the State allows for each patient. Some patients may have greater than nine diagnoses or more than six procedures performed. This limitation can affect any comparisons.

Length of Stay

Some of our patients require increased length of stay. Reasons for increased length of stay are:

- JPSH is a major trauma center, many patients have suffered multiple system trauma.
- JPSH operates a SNF (skilled nursing facility) unit.
- JPSH operates an inpatient psychiatric unit in which many patients are court-committed and length of stay is determined by the legal system.
- Many of our patients have limited financial resources making it impossible for them to secure intermediate care. This, in turn, often limits their discharge options and they remain at JPSH longer than would otherwise be the case.

Physician Comments

Prior to submission of this data, physicians and other medical staff providers were given a reasonable opportunity to review the discharge files for which they were listed as the attending or treating physician. The aggregate comments of the physicians follow:

- JPSH cares for an indigent population, which often has limited resources to transfer care to home care agencies, skilled nursing units or nursing homes. This may produce an increase in the reported length of stay while outpatient resources are developed to which care can be transferred.
- JPSH functions as a regional receiving facility for trauma. The admission of patients with complicated multi-system injuries increases hospital costs and hospitalization needs beyond that which may be seen with facilities that do not function as regional trauma referral sites.

We are certifying the State data file, with comments.

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PROVIDER: United Regional Health Care System - 8th St Cmps  
 THCIC ID: 417000  
 QUARTER: 2  
 YEAR: 2001

Certified with comments

Data Content

There are several factors to be considered when reviewing this data file.

Hospitals are required to submit data to THCIC no later than 60 days after the close of the quarter. Not all claims have been billed in this time period. Depending on how the data is collected and the timing of the billing cycle all hospital discharges may not be captured.

Internal data may be updated after submission and then will be different than the data submitted to THCIC. This makes it difficult to evaluate the accuracy and completeness of the THCIC data files against internal systems.

#### Source of Payment

Please note that the Source of Payment code based on our current internal data files might be different than the Source of Payment code reflected in the THCIC data file because the primary payer for a patient record might change over time.

#### Newborn Admissions

The state pulls newborn admission statistics from the admission source code rather than the final diagnosis code. The admission source is entered at registration when the status of the newborn is unknown and does not give an accurate picture. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. The final ICD-9 diagnosis provides a more appropriate reflection of the newborn's condition.

#### Diagnosis/Procedure Codes

Patient records may be incomplete in that the number of diagnosis and procedure codes we can include in the state file is limited. A patient may have many more codes within the hospital database that reflects a more precise picture of the patient's condition.

#### 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 a variety of circumstances. Charges also do not reflect the actual cost to deliver the care that each patient needs.

#### Certification Process

The state reporting process as well as the computer system development for state reporting by hospitals is in its infancy. Therefore, the state reporting data is not as complete and thorough as it will be in the future. Conclusions regarding patient care or hospital practices should not be drawn from the data contained in this file. This data is administrative data collected for billing purposes and not clinical data regarding patient care.

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PROVIDER: United Regional Health Care System - 11th St Camps  
THCIC ID: 417001  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### Data Content

There are several factors to be considered when reviewing this data file.

Hospitals are required to submit data to THCIC no later than 60 days after the close of the quarter. Not all claims have been billed in this time period. Depending on how the data is collected and the timing of the billing cycle all hospital discharges may not be captured.

Internal data may be updated after submission and then will be different than the data submitted to THCIC. This makes it difficult to evaluate the accuracy and completeness of the THCIC data files against internal systems.

#### Source of Payment

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#### Diagnosis/Procedure Codes

Patient records may be incomplete in that the number of diagnosis and procedure codes we can include in the state file is limited. A patient may have many more codes within the hospital database that reflects a more precise picture of the patient's condition.

#### 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 a variety of circumstances. Charges also do not reflect the actual cost to deliver the care that each patient needs.

#### Certification Process

The state reporting process as well as the computer system development for state reporting by hospitals is in its infancy. Therefore, the state reporting data is not as complete and thorough as it will be in the future. Conclusions regarding patient care or hospital practices should not be drawn from the data contained in this file. This data is administrative data collected for billing purposes and not clinical data regarding patient care.

=====

PROVIDER: Arlington Memorial Hospital  
THCIC ID: 422000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### Data Content

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

The state requires hospitals to submit inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. The state specifications require additional data elements to be included over and above that. Adding those additional data items places programming and other operational burdens on the hospital since it is "over and above" the data required in the actual hospital billing process. Errors can occur because of this process, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of the hospital's knowledge.

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

#### Diagnosis and Procedures

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

One limitation of using the ICD-9-CM system is that there does not exist

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

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, making 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 assigned, 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 hospitals 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 hospital can code an unlimited number of diagnoses and procedures for each patient record. But, the state has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by the hospital do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This also means that true total volumes may not be represented in the state's data file, therefore making percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category).

#### Race/Ethnicity

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's ethnicity. In fact, there is not a field for ethnicity in the hospital's computer system. Therefore, all patients are being reported in the "Other" ethnicity category.

Race is an element the hospital does attempt to collect at admission. However, many patients refuse to answer this question and therefore, the registration clerks are forced to use their best judgment or answer unknown to this question.

Any assumptions based on race or ethnicity will be inaccurate.

#### 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 identification 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 correctly in the hospital's

computer system

as both "HMO, and PPO" are categorized as "Commercial PPO" in the state file. Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Revenue

The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received. Typically actual payments are much less than charges due to bad debts, charity adjustments, managed care-negotiated discounts, denial of payment by insurance companies and government programs which pay less than billed charges.

Charity Care

THCIC assumes charity patients are identified in advance and reports charges in a charity financial class as the amount of charity care provided in a given period. In actuality, charity patients are usually not identified until after care has been provided and in the hospital's computer system charity care is recorded as an adjustment to the patient account, not in a separate financial class. Therefore, the THCIC database shows no charity care provided by the hospital for the quarter when in fact the hospital provided over \$1,885,485 in charity care during this time period.

Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and as thorough as all parties would like to see in the future. Within the constraints of the current THCIC process the data is certified to the best of our knowledge as accurate.

=====
PROVIDER: El Campo Memorial Hospital
THCIC ID: 426000
QUARTER: 2
YEAR: 2001

Certified with comments

For the second quarter of 2001 there were 247 claims submitted. Of these 247, no claims were denied with error codes. Only two claims were included on this report due to info code 992. This computes to a .01% error rate which requires no corrections. With this in mind we are certifying our second quarter of 2001 data with the above comments.

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PROVIDER: Presbyterian Hospital of Dallas
THCIC ID: 431000
QUARTER: 2
YEAR: 2001

Certified with comments

PRESBYTERIAN HOSPITAL OF DALLAS CERTIFIED WITH COMMENTS

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require

additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

#### Diagnosis and Procedures

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

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

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

This makes it difficult to obtain accurate information regarding things such as complication rates.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do 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 1450 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. PRESBYTERIAN HOSPITAL OF DALLAS recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

#### Race/Ethnicity

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

#### 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 identification 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.

#### Recommendations

PRESBYTERIAN HOSPITAL OF DALLAS recommends that THCIC do more education for the consumer on the data being collected. The general public does not realize that this information is being collected and that state law

requires it. There needs to be more education for the Texas residents as to what is being collected, problems that still exist in collection of the data, how the information will be used, and the benefit they will receive. PRESBYTERIAN HOSPITAL OF DALLAS is committed to a quality state data reporting mechanism and is committed to assisting with resolution of THCIC issues as they arise in the best interest of Texas residents.

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PROVIDER: Brazosport Memorial Hospital  
THCIC ID: 436000  
QUARTER: 2  
YEAR: 2001

Certified with comments

NOTES/COMMENTS:

1. Brazosport Memorial Hospital's length of stay statistics include its physical rehabilitation and skilled nursing units, which appropriately have longer lengths of stay. In 1999, the ALOS for acute med/surg patients was 3.5 days.
2. Some average charges may be skewed by one or two very high charge patients and the inclusion of physical rehabilitation and skilled nursing patients.
3. Psych/CD services were closed September 30,1999. Charges for those services during the first two quarters of 1999 may include charges for treatment of physical diagnoses in conjunction with their psych/cd treatment.
4. Number of expired patients may be somewhat increased over expected due to inclusion of skilled nursing unit statistics.

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PROVIDER: CHRISTUS St. Elizabeth Hospital  
THCIC ID: 444000  
QUARTER: 2  
YEAR: 2001

Certified with comments

NORMAL NEWBORNS

Capturing newborn admission source at time of registration does not always depict the severity of the infant. Using final DRG or primary diagnosis would give a better picture of the types of newborns cared for at St. Elizabeth Hospital. The following data is a reflection of the types of newborns for this period by DRG's:

DRG 385 Neonates, died or transferred to another facility	10
DRG 386 Extreme Immaturity or Respiratory Distress Syndrome	19
DRG 387 Prematurity with major problems	6
DRG 388 Prematurity without major problems	7
DRG 389 Full Term Neonate with major problems	34
DRG 390 Neonate with other significant problems	58
DRG 391 Normal newborn	340

STANDARD/NON-STANDARD SOURCE OF PAYMENT

At the time of data submission, a high percentage of discharges categorized as "self pay" are pending eligibility for another funding source, including Medicare, Medicaid, or charity and therefore not reflected.

During this time period St. Elizabeth Hospital provided charity to 475

patients for a total of 6.3 million dollars.

#### DIAGNOSIS AND PROCEDURES

The data submission matches the state's reporting requirements but may be incomplete due to a limitation of the number of diagnosis 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 hospital's or physician's severity level.

#### ATTENDING PHYSICIANS

Procedural changes are underway to enable accurate reporting as defined by THCIC

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PROVIDER: Presbyterian Hospital of Winnsboro  
THCIC ID: 446000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### PRESBYTERIAN HOSPITAL OF WINNSBORO CERTIFIED WITH COMMENTS

##### Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

##### Diagnosis and Procedures

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

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

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

This makes it difficult to obtain accurate information regarding things such as complication rates.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do 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 1450 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. PRESBYTERIAN HOSPITAL OF WINNSBORO recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

#### Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide

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

#### Standard/Non-Standard Source of Payment

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

#### Recommendations

PRESBYTERIAN HOSPITAL OF WINNSBORO recommends that THCIC do more education for the consumer on the data being collected. The general public does not realize that this information is being collected and that state law requires it. There needs to be more education for the Texas residents as to what is being collected, problems that still exist in collection of the data, how the information will be used, and the benefit they will receive. PRESBYTERIAN HOSPITAL OF WINNSBORO is committed to a quality state data reporting mechanism and is committed to assisting with resolution of THCIC issues as they arise in the best interest of Texas residents.

=====

PROVIDER: St Paul Medical Center  
THCIC ID: 448000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### Operating Physician

The data structure provided by THCIC allows for one attending and one operating physician assignment. However, patients frequently undergo multiple surgeries where different surgeons perform multiple procedures. Assigning all of those procedures to a single "operating physician" will frequently attribute surgeries to the wrong physician.

#### Specialty Services

The 1450 data does not have a specific data field to capture unit of service or to expand on the specialty services provided to a patient. St. Paul's hospital characteristics are provided by using codes from bill type and accommodation revenue codes in an attempt to distinguish, at the patient level, use of specialty services. Services used by and outcomes expected

of patients in our hospice, NICU, rehab, transplant and psychiatric facility beds are very different and the administrative data has inherent limitations.

#### Standard/Non-Standard Source of Payment

The payer codes utilized in the THCIC database were defined by the state and are not using standard payer information from the claim. The mapping process of specific payers to the THCIC payer codes was not standardized by THCIC; therefore, each hospital may map differently which can create variances in coding. 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.

Charity patients are not identified until after discharge when other potential payment sources have been processed. St. Paul Medical Center provided over \$1.7 million dollars in charity care for quarter 2, 2001 and this is not reflected in the state data submission due to the timing.

#### Certification Process

St. Paul Medical Center has policies and procedures in place to validate and assure the accuracy of the discharge encounter data submitted. We have provided physicians a reasonable opportunity to review the discharge data of patients for which they were the attending or treating physician. To the best of our knowledge the data submitted is accurate and complete.

=====

PROVIDER: RHD Memorial Medical Center  
THCIC ID: 449000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### DATA Content

This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The state requires us to submit inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 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; this was a unique, untried use of this data as far as hospitals are concerned.

#### Submission Timing

The hospital estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period.

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

#### 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 the patient's hospitalization, sometimes significantly.

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

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

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedures codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes in 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 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

#### Specialty Services

The data submitted does not have any specific data field to capture unit of service or expand in the specialty service (such as rehab) provided to a patient. Services used by patients in rehab may be very different from those used in other specialties. The data is limited in its ability to categorize patient type.

#### 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 as long as or longer than 999 days, therefore, it is not anticipated that this limitation will affect this data. The hospital does have an inpatient rehabilitation unit whose patients stay an average of 12 days. This may skew the data when combined with other acute care patient stays.

#### Normal Newborns

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. The hospital's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

#### Race/Ethnicity

During the hospital's registration process, the registration clerk does routinely complete patient's race and/or ethnicity field. The race data element is sometimes subjectively captured and the ethnicity data element

is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

#### Cost/Revenue

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 negotiated discounts with 3rd party payors. Charges also do not reflect the actual costs to deliver the care that each patient needs.

#### Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. During the current certification phase, the hospital did not have an efficient mechanism to edit and correct the data. In addition, it is not feasible to perform encounter level audits at this time.

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PROVIDER: Midland Memorial Hospital  
THCIC ID: 452000  
Quarter: 2  
Year: 2001

Elects not to certify.

=====

PROVIDER: Memorial Rehabilitation Hospital  
THCIC ID: 452001  
Quarter: 2  
Year: 2001

Elects not to certify.

=====

PROVIDER: DeTar Hospital Navarro  
THCIC ID: 453000  
Quarter: 2  
Year: 2001

Certified with comments

DeTar Hospital Navarro has a Skilled Nursing Unit which has been in operation for several years.

DeTar Hospital Navarro also maintains a Rehabilitation Unit.

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DeTar Hospital North  
THCIC ID: 453001  
Quarter: 2  
Year: 2001

Certify with comments

DeTar Hospital North has a Psychiatric Unit in operation.

=====
PROVIDER: Covenant Medical Center
THCIC ID: 465000
QUARTER: 2
YEAR: 2001

Certified with comments

Data does not accurately reflect the hospital's newborn population.
Total Births = 628
Live = 517
Premature = 111

Data does not accurately reflect the number of charity cases for the time
period.
This is due to internal processing for determination of the source of
payment.
4% of total discharges were charity for 2nd Quarter 2001.

=====
PROVIDER: Memorial Medical Center - Livingston
THCIC ID: 466000
QUARTER: 2
YEAR: 2001

Certified with comments

Data is submitted in a standard UB92 format. Conclusions drawn from the
data are subject to error caused by the inability of the hospital to communicate
complete data due to system mapping, and normal clerical errors. Such
data as race, ethnicity and non-standard source of payment are not sent
to payors and may not be part of the hospital's standard data collection
process and therefore may contain errors. Data users should not conclude
that the billing data sent to payors is inaccurate. The data submitted
by hospitals is their best effort to meet statutory requirements.

=====
PROVIDER: Harris Methodist Northwest
THCIC ID: 469000
QUARTER: 2
YEAR: 2001

Certified with comments

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

The state requires us to submit inpatient claims, by quarter year, gathered
from a form called an UB92, in a standard government format called HCFA
1450 EDI electronic claim format. Then the state specifications require
additional data elements to be included over and above that. Adding those
additional data places programming burdens on the hospital since it is
"over and above" the actual hospital billing process. Errors can occur
due to this additional programming, but the public should not conclude
that billing data sent to our payers is inaccurate. These errors have
been corrected to the best of our knowledge.

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

### Diagnosis and Procedures

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

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

accurate comparison of hospital or physician performance.

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

This makes it difficult to obtain accurate information regarding things such as complication rates.

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

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do 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 1450 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.

### Race/Ethnicity

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race and ethnicity data elements are subjectively captured. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently

map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

#### Standard/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 identification 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.

#### Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and as thorough as all parties would like to see in the future. Within the constraints of the current THCIC process the data is certified to the best of our knowledge as accurate.

=====

PROVIDER: Parkland Memorial Hospital  
THCIC ID: 474000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### General Information

Parkland Health & Hospital System comprises a network of neighborhood-based health centers and Parkland Memorial Hospital, which was established in 1894 to care for the city's poor. Today, the hospital is often ranked among the 25 best hospitals in the United States - public or private. Due to Parkland's affiliation with the University of Texas Southwestern Medical Center, the finest in medical care is now available to all Dallas County residents.

The Parkland System is a \$675.9 million enterprise that is licensed for 990 beds and employs approximately 5,500 staff. It's Trauma Center is internationally renowned for excellence and many other medical services are equally state of the art including: burn treatment, epilepsy, kidney/pancreas transplants, cardiovascular services, diabetes treatment, gastroenterology, radiology, neonatal intensive care, and high risk pregnancy.

The hospital delivers more babies than any other hospital in the US - 15,181 babies in fiscal year 2000. The hospital's Burn Center was established in 1962, and since then has treated more burn patients than any other civilian burn center in the world. In 1964, the hospital performed the first kidney transplant in Texas. Since then, its transplant success among African-Americans is the nation's best.

Parkland's network of neighborhood-based health centers is based in low-income areas to ensure the poor have access to preventive health care. The network, called "Community Oriented Primary Care," was established in 1989; there are now 9 neighborhood health centers. In addition to the health care professionals who staff the clinics, many of the locations also have social service agencies located under the same roof - providing a one-stop-shopping approach to health services.

Parkland's innovative approach to providing community responsive health care in Dallas County has resulted in many service honors including: the Foster G. McGraw Award for Excellence in Community Service, the John P. McGovern Humanitarian Medicine Award, and a Public Service Excellence Award from the Public Employees Roundtable.

Specific Concerns

There is a concern at Parkland, as with other reporting hospitals, that no ethnicity category for Hispanics exists. A significant number of Parkland's patients are Hispanic, yet according to the data set they are classified as either White-Hispanic or Black-Hispanic. The reporting data set needs to provide a category for this ethnicity to accurately reflect the hospital's demographics.

Another concern is the convention by which patients are assigned to primary physicians. In this database only one primary physician is allowed and in our institution this represents the physician at the time of discharge. In the reality of an academic medical center such as Parkland, teams of physicians rotating at varying intervals care for patients. Therefore, many patients, particularly long-term patients such as those in the neonatal nursery, are actually managed by as many as three to four different teams. Thus, the practice of attributing patient outcomes to the report card of a single physician results in misleading information.

Physicians are assigned as attending physicians and matched to the procedures they perform using unique identifiers. One of our physicians is attributed with procedures and is correctly identified in our submission claims using the state unique identifier, but the identifier is not included in the master file the data is graded against.

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PROVIDER: Nacogdoches Memorial Hospital
THCIC ID: 478000
QUARTER: 2
YEAR: 2001

Certified with comments

\*Comments not received by THCIC.

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PROVIDER: Knapp Medical Center
THCIC ID: 480000
QUARTER: 2
YEAR: 2001

Certified with comments

KNAPP MEDICAL CENTER THCIC DISCLAIMER STATEMENT AND COMMENTS FOR SECOND QUARTER 2001

DISCLAIMER STATEMENT

Knapp Medical Center has compiled the information set forth above in compliance with the procedures for THCIC certification process. All information that is being submitted has been obtained from Knapp Medical Center's records. The information being provided by Knapp Medical Center is believed to be true and accurate at the time of this submission. The information being submitted has been taken from other

records kept by Knapp Medical Center and the codes typically used in those records do not conform to the codes required in THCIC certification process. Knapp Medical Center has used its best efforts and submits this information in good faith compliance with THCIC certification process. Any variances or discrepancies in the information provided is the result of Knapp Medical Center's good faith effort to conform the information regularly compiled with the information sought by THCIC.

CHARITY COMMENT

Knapp Medical Center has a long tradition of providing charity care for the population it serves. Prior to designation as charity, program qualification attempts are exhausted. This results in designation of charity being made after the patient is discharged, sometimes many months. Patient specific charity amounts are not available, therefore, at the time of submission of data to THCIC. Due to the impracticality at this time of identifying specific patients designated as charity and submitting corrections, the aggregate amount of charity provided during the Second Quarter 2001 was \$ 983,968.12 for 91 patients.

=====
PROVIDER: Daughters of Charity Seton Medical Center
THCIC ID: 497000
QUARTER: 2
YEAR: 2001

Certified with comments

Seton Medical Center 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. Neonatal Intensive Care Units serve very seriously ill infants substantially increasing costs, lengths of stay and mortality rates. As a regional referral center and tertiary care hospital for cardiac and critical care services, Seton Medical Center receives numerous transfers from hospitals not able to serve a more complex mix of patients. The 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.

Seton Medical Center recently discovered a problem in data relating to its skilled nursing facility (SNF) patients. This reporting problem affects all SNF patient records which were incorrectly submitted under bill type 111 instead of correct bill type 211. Among other things, this may make it difficult for researchers to accurately separate SNF patients from general medical/surgical patients treated within the Hospital. The Hospital has corrected the reporting problem for future data submissions.

=====
PROVIDER: Daughters of Charity Seton Southwest
THCIC ID: 497001
QUARTER: 2
YEAR: 2001

Certified with comments

All physician license numbers and names have been validated with the physician and the website(s) as accurate but some remain unidentified in the THCIC Practitioner Reference Files. The data are submitted by hospital as their best effort to meet statutory requirements.

=====

PROVIDER: Daughters of Charity Seton Northwest  
THCIC ID: 497002  
QUARTER: 2  
YEAR: 2001

Certified with comments

All physician license numbers and names have been validated with the physician and the website(s) as accurate but some remain unidentified in the THCIC Practitioner Reference Files. The data are submitted by hospital as their best effort to meet statutory requirements.

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PROVIDER: Conroe Regional Medical Center  
THCIC ID: 508001  
QUARTER: 2  
YEAR: 2001

Certified with comments

This data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes.

The public data will only contain a subset of the diagnosis and procedure codes relative to each patient.

The relationship between cost of care, charges, and the revenue that a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.

Race/Ethnicity classification is not done systematically within or between facilities. Caution should be used when analyzing this data within one facility and between facilities.

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PROVIDER: Doctors Hospital  
THCIC ID: 511000  
QUARTER: 2  
YEAR: 2001

Certified with comments

As stated in our action plan, we have changed our process for capturing the data for comparison to the state data. However, we will not be able to make this comparison until we receive the state data for quarter 1, 2002.

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PROVIDER: Baylor Medical Center Grapevine  
THCIC ID: 513000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Submission Timing

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

#### Physician Identification

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

#### 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 universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

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

#### Race/Ethnicity

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

#### Standard/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 identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, 7% of the secondary payers originally categorized as "Commercial", 2% categorized as "Medicaid and 2% categorized as "Missing/Invalid" were recategorized as "Medicare".

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

#### Cost/ Revenue Codes

The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the

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

Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

=====
PROVIDER: Memorial Hermann Katy Hospital
THCIC ID: 534001
QUARTER: 2
YEAR: 2001

Certified with comments

89 Blue Cross patients are appearing in the Commercial HMO/PPO standard source of payment categories. 117 Medicaid Managed Care patients are appearing in the Medicaid standard source of payment category. 25 Medicare Managed Care patients are appearing in the Commercial HMO standard source of payment category.

'Urgent' admission type patients are appearing under 'Elective' admission type patients.

=====
PROVIDER: Scott & White Memorial Hospital
THCIC ID: 537000
QUARTER: 2
YEAR: 2001

Elect not to certify

We are currently working on a method for internal validation of physician assignment which will provide a better comfort level for our medical staff in the release of this data to the public. A mapping issue has been discovered in regard to charity care that is currently being investigated as well.

We chose not to certify this data until these issues are resolved.

=====
PROVIDER: Baylor/Richardson Medical Center
THCIC ID: 549000
QUARTER: 2
YEAR: 2001

Certified with comments

Diagnosis and Procedures

The UB92 claims data format which the state is requiring hospitals to submit, only accepts the first 9 diagnosis codes and the first 6 procedure codes. As a result, the data from the UB92 will not reflect every code from an individual patient record that was assigned. Thus the state's data file may not fully represent all diagnoses treated, or all procedures performed, by the hospital. Therefore total volumes and severity of illness indicators represented by the state required UB92 data file, may not be

accurate, making percentage calculations inaccurate.

Race/Ethnicity

Although race/ethnicity is an admission field, the hospital does sometimes encounter difficulties in obtaining race/ethnicity information. These difficulties are due to a variety of reasons, including information not supplied by the patient. Thus analysis of these two data fields may not accurately describe the true population served by the hospital. Efforts to improve the accuracy of this information are ongoing. The hospital does not discriminate based on race, color, ethnicity, gender or national origin.

Cost/ Revenue Codes

The state data files will include charge information. It is important to understand that charges do not equal payments received by the hospital. Payments due to managed care-negotiated discounts and denial of payment by insurance companies, will always be much less than charges. Also, charges do not reflect the actual cost for care that each patient receives.

Quality and Validity of the process

Processes are in place to verify the integrity and validity of the claims data. For this reason, steps are taken to ensure that the information sent to the state mirrors what is contained within the hospitals source system. On rare occasions, if a case was not billed prior to data submission, that patient will not be included in the current submission, nor will it be included in any future data submissions. An example of why this would occur, is the patient is discharged on the last day of the calendar quarter, and not allowing adequate time to issue a bill or the case was extremely complex requiring extra time for coding.

Insurance - Source of Payment Data

The Standard Source of Payment 2 data reflects 76.90% missing / invalid and the non-standard source of payment 2 reflects 99.22% missing / invalid. This data is incorrect due to an error in the THCIC software (Certview). This software problem is also causing the non-standard source of payment 1 to reflect 45.76% missing / invalid. This will continue until the error in the THCIC software is corrected.

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PROVIDER: Tyler County Hospital
THCIC ID: 569000
QUARTER: 2
YEAR: 2001

Certified with comments

\*Comments not received by THCIC.

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PROVIDER: Wagner General Hospital
THCIC ID: 574000
QUARTER: 2
YEAR: 2001

Certified with comments

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

=====
PROVIDER: Baylor Specialty Hospital

THCIC ID: 586000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### Submission Timing

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

#### Physician Identification

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

#### Medical Record Format

It has been discovered that the medical record number has been submitted in the incorrect format. The medical record number field is currently being populated with a 12 digit number. The pure medical record number of 6 digits has been concatenated with an additional 6 digit suffix. To obtain the unique patient identifier, the 6 digit suffix must be stripped.

#### Diagnosis and Procedures

BSH is different from most hospitals submitting data to the state. We provide complex medical services to patients who have experienced a catastrophic illness and/or complex body system failure that requires coordinated, intensive treatment and care. Many of the patients have received emergency care and stabilizing treatment at another acute care hospital. They are admitted to BSH to continue their recovery and focus on improving their medical condition and/or functional ability in order to improve their quality of life to the fullest extent possible.

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 universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

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

Patient diagnoses and procedures for a particular hospital stay at BSH are assigned ICD-9-CM codes according to standard coding practices. Because of our unique patient population, however, comparisons against all other hospitals in the database would not be accurate. It is unclear whether coding practice across all long term acute care hospitals is consistent, so caution should be used when making comparisons and/or drawing conclusions from the data.

#### Length of Stay

Medical recovery at BSH can be a long, arduous process depending on the severity of illness or injury. Due to the unique nature of medically complex patients, length of stay data cannot accurately be compared with data from hospitals that primarily treat an acute or emergent episode of illness or injury.

#### Race/Ethnicity

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

Upon review, it was discovered that approximately 8% of the "White" encounters were erroneously categorized under the state defined "Other" race code.

#### 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 identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. With this in mind, approximately 35% of the secondary payers originally categorized as "Commercial", 13% categorized as "Blue Cross", 15% categorized as "Medicaid" and 2% categorized as "Other" were recategorized as "Medicare".

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

#### Cost/ Revenue Codes

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

#### Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. Given the current certification software, there is not an efficient mechanism to

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

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PROVIDER: Baylor Specialty Hospital  
THCIC ID: 586001  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### Submission Timing

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

#### Physician Identification

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

#### Medical Record Format

It has been discovered that the medical record number has been submitted in the incorrect format. The medical record number field is currently being populated with a 12 digit number. The pure medical record number of 6 digits has been concatenated with an additional 6 digit suffix. To obtain the unique patient identifier, the 6 digit suffix must be stripped.

#### Diagnosis and Procedures

BSH is different from most hospitals submitting data to the state. We provide complex medical services to patients who have experienced a catastrophic illness and/or complex body system failure that requires coordinated, intensive treatment and care. Many of the patients have received emergency care and stabilizing treatment at another acute care hospital. They are admitted to BSH to continue their recovery and focus on improving their medical condition and/or functional ability in order to improve their quality of life to the fullest extent possible.

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 universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

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

Patient diagnoses and procedures for a particular hospital stay at BSH are assigned ICD-9-CM codes according to standard coding practices. Because of our unique patient population, however, comparisons against all other hospitals in the database would not be accurate. It is unclear whether coding practice across all long term acute care hospitals is consistent, so caution should be used when making comparisons and/or drawing conclusions from the data.

#### Length of Stay

Medical recovery at BSH can be a long, arduous process depending on the severity of illness or injury. Due to the unique nature of medically complex patients, length of stay data cannot accurately be compared with data from hospitals that primarily treat an acute or emergent episode of illness or injury.

#### Race/Ethnicity

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

Upon review, it was discovered that 8% of the "White" encounters were erroneously categorized under the state defined "Other" race code.

#### 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 identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. With this in mind, approximately 3% of the primary payers originally categorized as "Medicare" were recategorized as "Commercial". Also, 30% of the secondary payers originally categorized as "Commercial", 8% categorized as "Medicaid" and 3% categorized as "Blue Cross" were recategorized as "Medicare".

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

#### Cost/ Revenue Codes

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

Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

=====
PROVIDER: CHRISTUS St John Hospital
THCIC ID: 600000
QUARTER: 2
YEAR: 2001

Certified with comments

St. John Hospital certified the 2 quarter 2001 data, but could not account for 3 patients whose accounts were processed after the date of the original data submission.

During this interval, St. John Hospital provided charity for 24 patients with charges of (-\$275,229.58 ). The system did not identify these patients as recipients of charity care.

=====
PROVIDER: South Austin Hospital
THCIC ID: 602000
QUARTER: 2
YEAR: 2001

Certified with comments

Data submitted by South Austin Hospital includes Skilled Nursing Facility as well as Acute patients, effectively increasing our lengths of stay.

The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes. Race/ethnicity classification is not done systematically with or between facilities. Caution should be used when analyzing the data within one facility and between facilities. The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient. The relationship between cost of care, charges and revenue that a facility receives is extremely complex. Charity patients are a subset of our self-pay category. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.

The severity grouping assignment performed by the State using the APR-DRG grouper cannot be replicated by facilities unless they purchase the grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.

There is tremendous uncertainty about how robust physician linkages will be done across hospitals.

=====
PROVIDER: Memorial Hermann Fort Bend Hospital
THCIC ID: 609001
QUARTER: 2
YEAR: 2001

Certified with comments

70 Blue Cross patients are appearing in the Commercial HMO/PPO standard source of payment categories. 59 Medicaid Managed Care patients are appearing in the Medicaid standard source of payment category. 46 Medicare Managed Care patients are appearing in the Commercial HMO standard source of payment category.

'Urgent' admission type patients are appearing under 'Elective' admission type patients.

=====

PROVIDER: Triad Denton Community Hospital  
THCIC ID: 624001  
QUARTER: 2  
YEAR: 2001

Certified with comments

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.

The systems and processes have been improved through the implementation of a new information system that will minimize the opportunity for errors from 3Q01 and forward.

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PROVIDER: Harris Methodist Southwest  
THCIC ID: 627000  
QUARTER: 2  
YEAR: 2001

Certified with comments

This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

The State requires us to submit inpatient claims, by quarter/year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. 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 your payers is inaccurate; this was a unique, untried use of this data as far as the hospitals are concerned.

Several issues might affect the accuracy of any data gathered in this manner:

1. The State requires us to submit a "snapshot" of billed claims, extracted from our database approximately 20 days following the close of the quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.
2. 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. Approximately 20% of HMSW patient population have more than nine diagnoses and/or six procedures assigned.

The State is requiring us to submit ICD9 data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses and the first six procedure codes. As a result, the data sent by us do 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 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

3. 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.

4. 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. HMSW's normal hospital registration process defaults to "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD9 diagnoses. Admission source does not give an accurate picture.

5. 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. This issue has both federal and state law implications, as well as ethical and clinical ramifications. HMSW is pursuing better methods for collecting this data. Additionally, the THCIC in a recent Board meeting (December 7, 2001) indicated that the THCIC would be creating guidelines for use by hospitals to assist with more accurate collection of this information.

6. The standard and non-standard sources of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard 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. Once again, due to continued "mapping" problems, HMSW appears to have no Charity patients which is incorrect.

7. 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.

RECOMMENDATIONS:

Harris Methodist Southwest Hospital recommends that THCIC have a press release making the public aware of the data being collected. The general public does not realize that this information is being collected and that state law requires it. There needs to be more education for Texas residents as to what is being collected, problems that still exist in collection of the data, how the information will be used, and the benefit they will receive. Harris Methodist Southwest Hospital is committed to a quality state data reporting mechanism and is committed to assisting with resolution of THCIC issues as they arise in the best interest of Texas residents.

=====

PROVIDER: Baylor Institute for Rehab at Gaston  
THCIC ID: 642000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Submission Timing

Baylor Institute for Rehabilitation (BIR) estimates that our data volumes for the calendar year time period submitted may include 92% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in. BIR has a 10-day billing cycle; therefore we will have a higher percentage of incomplete encounters than hospitals with a 30-day billing cycle.

Physician Identification

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

Diagnosis and Procedures

BIR is different from most hospitals submitting data to the state. We provide comprehensive medical rehabilitation services to patients who have lost physical or mental functioning as a result of illness or injury. Many of these patients have already received emergency care and stabilizing treatment at an acute care hospital. They are admitted to BIR to continue their recovery and focus on improving their functional ability in order to improve their quality of life to the fullest extent possible.

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 universal standard called the International Classification

of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

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

Patient diagnoses and procedures for a particular hospital stay at BIR are assigned ICD-9-CM codes according to standard coding practices. Because of our unique patient population, however, comparisons against all other hospitals in the database would not be accurate. It is unclear whether coding practice across all comprehensive medical rehabilitation facilities is consistent, so caution should be used when making comparisons and/or drawing conclusions from the data.

#### Length of Stay

Medical rehabilitation at BIR can be a long, arduous process depending on the severity of illness or injury. Due to the unique nature of rehabilitation services, length of stay data cannot accurately be compared with data from hospitals that primarily treat an acute or emergent episode of illness or injury.

#### Race/Ethnicity

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

#### Standard/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 identification must be categorized into the appropriate standard and non-standard source of payment value. With this in mind, approximately 2% of the primary payers originally categorized as "Other" were recategorized as "Self Pay" and 2% categorized as "Medicare" were recategorized as "Commercial". Also, 37% of the secondary payers originally categorized as "Commercial" and 7% categorized as "Medicaid" were recategorized as "Medicare".

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

#### Cost/Revenue Codes

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

Charges also do not reflect the actual cost to deliver the care that each patient needs.

#### Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Harris Continued Care Hospital
THCIC ID: 652000
QUARTER: 2
YEAR: 2001

Certified with comments

All admission sources are transfer from hospital. All admission types are elective.

=====
PROVIDER: Zale Lipshy University Hospital
THCIC ID: 653000
QUARTER: 2
YEAR: 2001

Certification with Comments

Zale Lipshy University Hospital
5151 Harry Hines Blvd.
Dallas, TX 75235-7786

- 1. Zale Lipshy University Hospital is an academic teaching hospital.
2. Zale Lipshy University Hospital is a private, adult referral hospital located adjacent to the University of Texas Southwestern Medical Center.
3. Zale Lipshy University Hospital does not routinely provide for the following types of medical services: Obstetrics and Pediatrics. Emergency Services are provided through another campus facility.
4. Zale Lipshy University Hospital does not have the APR-DRG codes to check our risk stratification at this time.
5. Zale Lipshy University Hospital charity care cases are determined after final billing; therefore, they are not quantified in this report.
6. Identification of clinic and physician referral admission sources are used interchangeably.
7. Zale Lipshy University Hospital codes for admission source use correctional facility code (UC) and court ordered admission code (TB) as one code (8).

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PROVIDER: Presbyterian Hospital of Plano
THCIC ID: 664000
QUARTER: 2
YEAR: 2001

Certified with comments

PRESBYTERIAN HOSPITAL OF PLANO CERTIFIED WITH COMMENTS

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

#### Diagnosis and Procedures

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

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

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

This makes it difficult to obtain accurate information regarding things such as complication rates.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnosis codes and the first six procedure codes. As a result, the data sent by us do 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 1450 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. PRESBYTERIAN HOSPITAL OF PLANO recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

#### Race/Ethnicity

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

#### Standard/Non-Standard Source of Payment

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

#### Recommendations

PRESBYTERIAN HOSPITAL OF PLANO recommends that THCIC do more education

for the consumer on the data being collected. The general public does not realize that this information is being collected and that state law requires it. There needs to be more education for the Texas residents as to what is being collected, problems that still exist in collection of the data, how the information will be used, and the benefit they will receive. PRESBYTERIAN HOSPITAL OF PLANO is committed to a quality state data reporting mechanism and is committed to assisting with resolution of THCIC issues as they arise in the best interest of Texas residents.

=====

PROVIDER: Columbia Kingwood Medical Center  
THCIC ID: 675000  
QUARTER: 2  
YEAR: 2001

Certified with comments

The data for Kingwood Medical Center includes acute, skilled, rehabilitation, and hospice patients.

=====

PROVIDER: Burleson St. Joseph Health Center of Caldwell  
THCIC ID: 679000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Burleson St. Joseph Health Center

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

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Burleson St. Joseph Health Center charity care, based on established rates during the calendar year of 2001 was \$328,205.

Patient Mix - All statistics for Burleson St. Joseph Health Center include patients from our Skilled Nursing, and Acute Care populations. Our Skilled Nursing unit is a long-term care unit. Because of this Mortality and Length of Stay may be skewed. This will prohibit any meaningful comparisons between Burleson St. Joseph Health Center and any "acute care only" facilities.

Physicians - All physician license numbers and names have been validated as accurate but some remain unidentified in the THCIC Practitioner Reference Files. Mortalities reported may be related to physicians other than the attending Physician. The attending physician is charged with the procedures requested or performed by the consulting or specialist physicians.

Diagnosis and Procedures - Data submitted to the state may be incomplete for some patients due to the limitation on the number of diagnosis and procedures codes allowed. The data is limited to nine diagnoses codes and six procedure codes per patient visit.

Cost and Charges - The state requires that we submit revenue information including charges. It is important to note that charges do not reflect actual reimbursement received, nor do they reflect the actual cost of providing the services. Typically actual payments received are much less than the charges due to managed care-negotiated discounts, denial of payment by insurance companies, contractual allowances, as well as charity and un-collectable accounts. The relationship between cost of care, charges, and the revenue a facility receives is extremely complex. Comparing costs of care from one hospital to the next may result in unreliable results.

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status. This grouper can only use the limited number of procedure and diagnosis codes available in the data file (nine diagnosis and six procedure codes). If all the patient's diagnosis codes were available the APR-DRG assignment may possibly differ from the APR-DRG assigned by THCIC. The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper.

Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.

=====

PROVIDER: Kell West Regional Hospital  
THCIC ID: 681400  
QUARTER: 2  
YEAR: 2001

Certified with comments

\*Comments not received by THCIC.

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PROVIDER: Covenant Children's Hospital  
THCIC ID: 686000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Data does not accurately reflect the number of charity cases for the time period. This is due to internal processing for determination of the source of payment.

4% of total discharges were charity for 2nd Quarter 2001.

=====

PROVIDER: HEALTHSOUTH Rehab Hospital of Tyler  
THCIC ID: 692000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Some data elements may not reflect one hundred percent accuracy.

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PROVIDER: HEALTHSOUTH Rehab Hospital North Houston  
THCIC ID: 695000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Patient Discharge Status should read as follows:

Discharge to Home or Self Care	154
Discharge/Transfer to Gen. Hospital	31
Discharge/Transfer to SNF	28
Discharge/Transfer to Other Institution	8
Discharge/Transfer to Home Health	33
Left AMA	1

=====

PROVIDER: The Corpus Christi Medical Center - Bay Area  
THCIC ID: 703000  
QUARTER: 2  
YEAR: 2001

Certified with comments

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the accuracy of these numbers cannot be verified.

Due to mapping issues, some Commercial accounts were incorrectly mapped as Medicaid/Medicaid Managed Care accounts under non-standard source of payment.

Corpus Christi Medical Center maintains that under Non-Standard source of payment, accounts that are summarized as missing/invalid are neither missing nor invalid, but are accounts that are not required to be additionally categorized and should be listed as "blank" or "not-applicable".

=====

PROVIDER: The Corpus Christi Medical Center - Doctors Regional  
THCIC ID: 703002  
QUARTER: 2  
YEAR: 2001

Certified with comments

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the accuracy of these numbers cannot be verified.

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=====

PROVIDER: The Corpus Christi Medical Center - The Heart Hospital  
THCIC ID: 703003  
QUARTER: 2  
YEAR: 2001

Certified with comments

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the accuracy of these numbers cannot be verified.

Due to mapping issues, some Commercial accounts were incorrectly mapped as Medicaid/Medicaid Managed Care accounts under non-standard source of payment.

Corpus Christi Medical Center maintains that under Non-Standard source of payment, accounts that are summarized as missing/invalid are neither missing nor invalid, but are accounts that are not required to be additionally categorized and should be listed as "blank" or "not-applicable".

=====

PROVIDER: Texoma Medical Center Restorative Care Hospital  
THCIC ID: 705000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Data Source. The source of this data, the electronic 1450, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.

- \* The 1450 data file limits the diagnosis codes to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and an E-code field.
- \* The procedure codes are limited to six (principal plus five secondary).
- \* The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization.
- \* The Hospital can only list 4 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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

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

Severity Adjustment. THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores.

The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status.

- \* The program can only use the codes available in the 1450 data file, e.g., nine diagnosis and six procedure codes. If all the patient's diagnosis codes were available the assignment may be different than when limited to those available in the 1450 data.

Timing of Data Collection. Hospitals must submit data to THCIC no later than 60 days after the close of the quarter.

- \* Not all claims may have been billed at this time.
- \* Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

=====

PROVIDER: Dubuis Hospital of Beaumont  
THCIC ID: 708000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects.

Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital. In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

=====

PROVIDER: Dubuis Hospital of Port Arthur  
THCIC ID: 708001  
QUARTER: 2  
YEAR: 2001

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects.

Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital. In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

=====

PROVIDER: Our Children's House at Baylor  
THCIC ID: 710000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### Submission Timing

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

#### Physician Identification

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

## Reference Files.

### Medical Record Format

It has been discovered that the medical record number has been submitted in the incorrect format. The medical record number field is currently being populated with a 12 digit number. The pure medical record number of 6 digits has been concatenated with an additional 6 digit suffix. To obtain the unique patient identifier, the 6 digit suffix must be stripped.

### Diagnosis and Procedures

OCH is different from most hospitals submitting data to the state. We provide complex medical services to patients who have experienced a catastrophic illness, congenital anomalies and/or complex body system failure that requires coordinated, intensive treatment and care. Many of the patients have received emergency care and stabilizing treatment at another acute care hospital or another children's acute care hospital. They are admitted to OCH to continue their recovery and focus on improving their medical condition.

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 universal standard called the International Classification of Disease, or ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

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

Patient diagnoses and procedures for a particular hospital stay at OCH are assigned ICD-9-CM codes according to standard coding practices. Because of our unique patient population, however, comparisons against all other hospitals in the database would not be accurate. It is unclear whether coding practice across all Children's hospitals is consistent, so caution should be used when making comparisons and/or drawing conclusions from the data.

### Length of Stay

Medical recovery at OCH can be a long, arduous process depending on the severity of illness or injury. Due to the unique nature of medically complex patients, length of stay data cannot accurately be compared with data from hospitals that primarily treat an acute or emergent episode of illness or injury.

### Race/Ethnicity

There are no national standards regarding patient race categorization so hospitals may not have the same designations from which patients can choose. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent

across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/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 identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. Upon review approximately 3% of the primary payers originally categorized as "Blue Cross" were recategorized as "Commercial". Also, 3% of the secondary payers originally categorized as "Medicaid" were recategorized as "Commercial".

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

Cost/ Revenue Codes

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

Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

=====
PROVIDER: The COMPASS Hospital of San Antonio
THCIC ID: 711000
QUARTER: 2
YEAR: 2001

Certified with comments

Software error. Corrected on 3rd quarter 2001

=====
PROVIDER: CHRISTUS St Michael Rehab Hospital
THCIC ID: 713000
QUARTER: 2
YEAR: 2001

Certified with comments

Accurate to the best of my knowledge
Don Beeler
CEO/Administrator

=====
PROVIDER: CHRISTUS St Catherine Health & Wellness Center
THCIC ID: 715900
QUARTER: 2

YEAR: 2001

Certified with comments

Christus St. Catherine Hospital provided charity care for 20 patients with charges totalling \$165,268.63 during the second quarter, 2001. This data did not transfer from the hospital to THCIC.

=====
PROVIDER: Padre Behavioral Hospital
THCIC ID: 716500
QUARTER: 2
YEAR: 2001

Certified with comments

The data for this quarter indicates all admission sources are "physician". This is not accurate. The data also indicates 2 discharges with a race of "other". This is not accurate.

=====
PROVIDER: Cornerstone Rehabilitation Hospital
THCIC ID: 716600
QUARTER: 2
YEAR: 2001

Certified with comments

Cornerstone Rehabilitation Hospital is currently working with our software vendor (Meditech) to correct erroneous information in all race/ethnicity sections.

=====
PROVIDER: LifeCare Specialty Hosps of Dallas
THCIC ID: 717000
QUARTER: 2
YEAR: 2001

Certified with comments

Reason:
Internal data compares with THCIC data in all areas except for minor differences in patient race and ethnicity. Internal data for patient race and ethnicity is not accurate and corrective actions have been put in place, and should be corrected beginning with 4th quarter 2001 data.

Patient race/ethnicity: approximately 50% is white, 40% black, and 10% Hispanic

=====
PROVIDER: The Physicians Centre
THCIC ID: 717500
QUARTER: 2
YEAR: 2001

Certified with comments

Certification Comments for 2nd Quarter THCIC Submission

The following items were submitted with errors on transmission and need noting for correction.

Actual Reported
Patient D/C Status

D/C Transfer to Other Institution	9		8
D/C Transfer to Home Health	0		1
Admission Source			
Physician		208	
207			
Emergency Room	4		5
Patient Location			
In State		209	
208			
Out of State		3	
4			
Patient Race			
White		155	
161			
Other		47	
41			
Patient Ethnicity			
Hispanic		18	
19			
Not of Hispanic Origin	193		194
Total Charges	\$2,157,972.16		\$2,161,828.16

	Reported	Actual		Reported	Actual
	SOP2	SOP2		SOP1	SOP1
A Self Pay				5	5
	0	147			
B Worker's Comp			11	12	
0	0				
F Commercial			72	71	
34	35				
Missing/Invalid					
148		0			

The above listed corrections were related to vendor mapping issues. The difference in the charges is related to items that were added/corrected after data was submitted to THCIC on 7/19/01. One item worth noting is a revenue code omitted (r/t vendor mapping) that has now been corrected.

This revenue code is for Carotid Ultrasounds and makes up \$2148.00 of the \$3856.00 difference in charges.

=====

PROVIDER: Kindred Hospital White Rock  
 THCIC ID: 719400  
 QUARTER: 2  
 YEAR: 2001

Certified with comments

\*Comments not received by THCIC.

=====

PROVIDER: Seay Behavioral Health Center  
 THCIC ID: 720000  
 QUARTER: 2  
 YEAR: 2001

Certified with comments

PRESBYTERIAN SEAY BEHAVIORIAL CENTER CERTIFIED WITH COMMENTS

Data Content

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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.

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#### Admit Source data for Normal Newborn

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

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#### Race/Ethnicity

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

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#### Recommendations

PRESBYTERIAN SEAY BEHAVIORIAL CENTER recommends that THCIC do more education for the consumer on the data being collected. The general public does not realize that this information is being collected and that state law requires it. There needs to be more education for the Texas residents as to what is being collected, problems that still exist in collection of the data, how the information will be used, and the benefit they will receive. PRESBYTERIAN SEAY BEHAVIORIAL CENTER is committed to a quality state data reporting mechanism and is committed to assisting with resolution of THCIC issues as they arise in the best interest of Texas residents.

=====

PROVIDER: Presbyterian Hospital of Allen  
THCIC ID: 724200  
QUARTER: 2  
YEAR: 2001

Certified with comments

PRESBYTERIAN HOSPITAL OF ALLEN CERTIFIED WITH COMMENTS

#### 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-9-CM. This is mandated by the federal government.

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

or physician performance.

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

This makes it difficult to obtain accurate information regarding things such as complication rates.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do 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 1450 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. PRESBYTERIAN HOSPITAL OF ALLEN recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

#### Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would

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

#### Standard/Non-Standard Source of Payment

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

#### Recommendations

PRESBYTERIAN HOSPITAL OF ALLEN recommends that THCIC do more education for the consumer on the data being collected. The general public does not realize that this information is being collected and that state law requires it. There needs to be more education for the Texas residents as to what is being collected, problems that still exist in collection of the data, how the information will be used, and the benefit they will receive. PRESBYTERIAN HOSPITAL OF ALLEN is committed to a quality state data reporting mechanism and is committed to assisting with resolution of THCIC issues as they arise in the best interest of Texas residents.

=====

PROVIDER: Methodist Willowbrook Hospital  
THCIC ID: 724700  
QUARTER: 2  
YEAR: 2001

Certified with comments

Some of our mapping was incorrect for the race codes for our Q2 data, which has now been corrected and will reflect this information in Q3. That is why our Q2 data reflects not having admitted any African American Patients.

When our physician dictionaries were created they were missing the distinguishing letter between TX and their license number. This has now been corrected and Commonwealth is helping us correct any residual problems with our Q3 data.

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PROVIDER: SCCI Hospital El Paso  
THCIC ID: 727100

QUARTER: 2  
YEAR: 2001

Certified with comments

\*Comments not received by THCIC.

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PROVIDER: El Paso Specialty Hospital  
THCIC ID: 728200  
QUARTER: 2  
YEAR: 2001

Certified with comments

\*Comments not received by THCIC.

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PROVIDER: Grimes St Joseph Health Center  
THCIC ID: 728800  
QUARTER: 2  
YEAR: 2001

Certified with comments

Grimes St. Joseph Health Center

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

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Grimes St. Joseph Health Center charity care, based on established rates during the calendar year of 2001 is included in the charity care number for St. Joseph Regional Health Center which is \$9,375,603.

Patient Mix - Grimes St. Joseph Health Center is a "Critical Access Hospital". Because of this Mortality and Length of Stay may be skewed. This will prohibit any meaningful comparisons between Grimes St. Joseph Health Center and other acute care facilities.

Physicians - All physician license numbers and names have been validated as accurate but some remain unidentified in the THCIC Practitioner Reference Files. Mortalities reported may be related to physicians other than the attending Physician. The attending physician is charged with the procedures requested or performed by the consulting or specialist physicians.

Diagnosis and Procedures - Data submitted to the state may be incomplete for some patients due to the limitation on the number of diagnosis and procedures codes allowed. The data is limited to nine diagnoses codes and six procedure codes per patient visit.

Cost and Charges - The state requires that we submit revenue information including charges. It is important to note that charges do not reflect actual reimbursement received, nor do they reflect the actual cost of providing the services. Typically actual payments received are much less

than the charges due to managed care-negotiated discounts, denial of payment by insurance companies, contractual allowances, as well as charity and un-collectable accounts. The relationship between cost of care, charges, and the revenue a facility receives is extremely complex. Comparing costs of care from one hospital to the next may result in unreliable results.

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status. This grouper can only use the limited number of procedure and diagnosis codes available in the data file (nine diagnosis and six procedure codes). If all the patient's diagnosis codes were available the APR-DRG assignment may possibly differ from the APR-DRG assigned by THCIC. The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper.

Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.

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PROVIDER: TIRR LifeBridge  
THCIC ID: 735000  
QUARTER: 2  
YEAR: 2001

Certified with comments

TIRR LifeBridge merged with The Institute for Rehabilitation and Research (TIRR) on 5/31/01. Patients who were in-house on 5/31/01 were transferred to TIRR.

TIRR LifeBridge was a fully accredited teaching specialty hospital that provided medical transitional and general rehabilitation. The philosophy of LifeBridge was to assist patients in attaining the highest level of function possible within the resources available to them. LifeBridge worked closely with the patient and his/her family and the External Case Manager to provide care effectively at an appropriate level. Patient care was offered in general clinical services including:

- \* Stroke
- \* Cancer Recovery
- \* Wound and Skin Care Management
- \* Post Surgical Care
- \* General Rehabilitation
- \* Neuromuscular Complications of Diseases or Injuries
- \* Ventilator and Other Respiratory Care
- \* Brain Injury Recovery, Including Coma
- \* Complex Diabetes
- \* Orthopedics

#### Types of Services

General rehabilitation services were provided for patients who had limited tolerance for participation or benefit from a comprehensive acute rehabilitation program. Medical transitional services were designed for patients who needed specialized care for medical issues that did not require an acute care hospital setting. The types of services include:

- \* Pulmonary/Ventilator
- \* Strength/Endurance Exercises
- \* Complex Wound Care
- \* Speech/Language Intervention
- \* Bowel/Bladder Training

- \* Alternative Communication Techniques
- \* Positioning
- \* ADL Training
- \* Patient/Family/Attendant Training
- \* Mobility Training
- \* Gait Training

=====

PROVIDER: Southwest Mental Health Center  
THCIC ID: 737000  
QUARTER: 2  
YEAR: 2001

Certified without comments

We have been experiencing problems with the medical office management software that our business office currently uses. The software has difficulty incorporating all patients admitted into batches. SMHC has corrected this discrepancy beginning with the third quarter 2001 data. There are 75 patients missing from second quarter's data set.

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PROVIDER: Mission Vista Hospital Co.  
THCIC ID: 751000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Software error correction made for 3rd quarter 2001

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PROVIDER: Glen Oaks Hospital  
THCIC ID: 754000  
QUARTER: 2  
YEAR: 2001

Certified with comments, corrections requested

One discharge showing a discharge code of 20620 should be corrected to show 29633. This was a 17 day stay for a 35 year old patient.

=====

PROVIDER: Harris Methodist Springwood  
THCIC ID: 778000  
QUARTER: 2  
YEAR: 2001

Certified with comments

#### Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

#### Diagnosis and Procedures

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

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

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

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 2% of Harris Methodist HEB's patient population have more than nine diagnoses and/ or six procedures assigned.

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 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do 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 1450 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. THR recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

#### Race/Ethnicity

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. This issue has both federal and state law implications, as well as, ethical and clinical ramifications. Harris Methodist HEB is pursuing better methods for collecting this information. Additionally, the THCIC in a recent Board meeting (December 7, 2001) indicated that the THCIC would be creating guidelines for use by hospitals to assist with more accurate collection of this information.

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

#### Cost/ Revenue Codes

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

=====

PROVIDER: CHRISTUS St Michael Health System  
THCIC ID: 788000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Accurate to the best of my knowledge  
Don Beeler  
CFO/Administrator

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PROVIDER: Texas Orthopedic Hospital  
THCIC ID: 792000  
QUARTER: 2  
YEAR: 2001

Certified with comments

February 25, 2002

Texas Health Care Information Council  
4900 N. Lamar Blvd., #3407  
Austin, TX 78751-2399

Dear Sir or Madam:

I do not elect to certify second quarter 2001 data for Texas Orthopedic Hospital due to the fact Texas Orthopedic Hospital is licensed as a 49 bed acute care hospital which operates as an ambulatory specialty orthopedic facility. Approximately 80% of all surgical procedures are performed on an outpatient basis. Because of the specialty nature and the high percentage of outpatient surgeries, Texas Orthopedic Hospital has a uniqueness that would limit the general population's ability to form an accurate opinion or decision on the quality of services provided.

The data enclosed does not reflect the actual practice of the individual surgeons and the care given to the inpatient population. Texas Orthopedic Hospital, as a top 100 orthopedic hospital ranked by HCIA, is a referral center and the individual physicians accept referrals from other physicians for patient's which may have had a malfunction of an internal orthopedic device or an infection, which needs to be surgically corrected. It is imperative that individuals looking at the data be aware of these facts so that frequently listed diagnoses of 996.4 and/or 996.66 be interpreted as a result of the patient's primary surgery, as performed by the treating physician. These may well be referred cases for which the original treating physician is not comfortable correcting through surgical means. They do not reflect the practice of the individual Texas Orthopedic Hospital surgeon, i.e., complication of his work. Therefore, the data presented by THCIC to the public could be misinterpreted and not truly reflect the high quality outcomes and superb care our patients receive.

Sincerely,

Beryl O. Ramsey  
Chief Executive Officer

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PROVIDER: North Austin Medical Center  
THCIC ID: 797000  
QUARTER: 2  
YEAR: 2001

Certified with comments

1 The relationship between cost of care, charges, and revenue is complex. Inferences drawn from comparing different facilities' charges may be unreliable.

2 Charity care is not accurately reflected in the source of payment data. Patients who have no insurance are initially identified as "Self-Pay," but frequently become "Charity" after it is determined that they are unable to pay and do not qualify for any federal or state programs.

3 The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.

=====
PROVIDER: Kindred Hospital Bay Area
THCIC ID: 801000
QUARTER: 2
YEAR: 2001

Certified with comments

Kindred Hospital Bay Area is a Long Term Actute Care Facility

=====
PROVIDER: IHS Hospital Plano
THCIC ID: 805000
QUARTER: 2
YEAR: 2001

Certify with comments:

System software issues which resulted in physician numbers entered incorrectly. Problem resolved in 4th quarter 2001. However, some 2nd quarter claims may be affected. Financial status for two (2) patients changed (i.e. 75 Medicare, 10 Commercial and 3 BlueCross BlueShield).

=====
PROVIDER: Dubuis Hospital of Houston
THCIC ID: 807000
QUARTER: 2
YEAR: 2001

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects.

Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital. In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

=====
PROVIDER: Harris Continued Care Hospital
THCIC ID: 810000
QUARTER: 2
YEAR: 2001

Certified with comments

All Admission types are elective. All Admission Sources are "transfer from hospital".

=====

PROVIDER: Las Colinas Medical Center  
THCIC ID: 814000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Las Colinas Medical Center Newborn statistics should indicate:

Normal Delivery = 282  
Premature Delivery = 0  
Sick Baby = 2  
Extramural Birth = 0  
Info Not Available = 0

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PROVIDER: SCCI Hospital - San Angelo  
THCIC ID: 819000  
QUARTER: 2  
YEAR: 2001

Certified with comments

There were four patient's whose information did not come across for certification.

=====

PROVIDER: Dubuis Hospital of Texarkana  
THCIC ID: 822000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals. Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital. In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

=====

PROVIDER: Methodist Health Center - Sugar Land  
THCIC ID: 823000  
QUARTER: 2  
YEAR: 2001

Certified with comments

Missing 4 accounts.  
Physician UPIN numbers are correct.

=====

PROVIDER: HEALTHSOUTH Integrated Medical Plaza of Pecan Valley  
THCIC ID: 824000  
QUARTER: 2  
YEAR: 2001

Certified with comments

1 UPIN Number was incorrect  
2 patients data entered twice

=====

PROVIDER: Cornerstone Regional Hospital LLC  
THCIC ID: 830000  
QUARTER: 2  
YEAR: 2001

Certified with comments

\*Comments not received by THCIC.