General Comments on 1st Quarter 2014 Data

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

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

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

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

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

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

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

==
PROVIDER: Austin State Hospital
THCIC ID: 000100
 QUARTER: 1
    YEAR: 2014

Certified With Comments

PROVIDER: Austin State Hospital
THCIC   ID: 000100
QUARTER: 1 2014

Certified with comments

Due to the system limitations, note that this is just an estimate and relates to identified source if 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 report 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 PaymentTotal Percentage (%)

Self-Pay2.52%
Worker's Compn/a
Medicare10.48%
Other Federal Programs8.06%
Commercial3.71%
Blue Crossn/a
Champus0.18%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a
Medicaid Managed Care0.02%
Commercial HMOn/a
Charity75%
Missing/Invalidn/a

Severity Index = All patients admitted have been determined to be a 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.

==
PROVIDER: Big Spring State Hospital
THCIC ID: 000101
 QUARTER: 1
    YEAR: 2014

Certified With Comments

PROVIDER: Big Spring State Hospital
THCIC   ID: 000101
QUARTER: 1 YEAR: 2014

Certified with comments

Due to the system limitations, note that this is just an estimate and relates to identified source if 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 report 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 PaymentTotal Percentage (%)

Self-Pay2.%
Worker's Compn/a
Medicare4.91%
Other Federal Programsn/a
Commercial1.49%
Blue Crossn/a
Champus1.06%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a
Medicaid Managed Care0.00%
Commercial HMOn/a
Charity81%
Missing/Invalidn/a

Severity Index = All patients admitted have been determined to be a 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.

==
PROVIDER: Rio Grande State Center
THCIC ID: 000104
 QUARTER: 1
    YEAR: 2014

Certified With Comments

PROVIDER: Rio Grande State Center
THCIC ID: 000104
QUARTER: 4 YEAR: 2014

Certified with comments

Due to the system limitations, note that this is just an estimate and relates to identified source if 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 report 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 PaymentTotal Percentage (%)

Self-Pay0.55%
Worker's Compn/a
Medicare5.92%
Medicaid7.32%
Other Federal Programsn/a
Commercial.87%
Blue Crossn/a
Champus0.32%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Care0.00%
Commercial HMOn/a
Charity85%
Missing/Invalidn/a

Severity Index = All patients admitted have been determined to be a 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.

==
PROVIDER: UT MD Anderson Cancer Center
THCIC ID: 000105
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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PROVIDER: Kerrville State Hospital
THCIC ID: 000106
 QUARTER: 1
    YEAR: 2014

Certified With Comments

PROVIDER: Kerrville State Hospital
THCIC ID: 000106
QUARTER: 1 YEAR: 2014

Certified with comments

Due to the system limitations, note that this is just an estimate and relates to identified source if 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 report 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 PaymentTotal Percentage (%)

Self-Pay4.90%
Worker's Compn/a
Medicare2.92%
Medicaid12.21%
Other Federal Programsn/a
Commercial2.95%
Blue Crossn/a
Champus0.00%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Care0.00%
Medicaid Managed Caren/a
Commercial HMOn/a
Charity77%
Missing/Invalidn/a

Severity Index = All patients admitted have been determined to be a 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: 1
    YEAR: 2014

Certified With Comments

PROVIDER: Rusk State Hospital
THCIC ID: 000107
QUARTER: 1 YEAR: 2014

Certified with comments

Due to the system limitations, note that this is just an estimate and relates to identified source if 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 report 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 PaymentTotal Percentage (%)

Self-Pay1.65%
Worker's Compn/a
Medicare9.15%
Medicaid5.18%
Other Federal Programsn/a
Commercial1.99%
Blue Cross0.00%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a
Medicaid Managed Care0.12%
Commercial HMOn/a
Charity82%
Missing/Invalidn/a

Severity Index = All patients admitted have been determined to be a 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: 1
    YEAR: 2014

Certified With Comments

PROVIDER: San Antonio State Hospital
THCIC ID: 000110
QUARTER: 13 YEAR: 2014

Certified with comments

Due to the system limitations, note that this is just an estimate and relates to
identified source if 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 report 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 PaymentTotal Percentage (%)

Self-Pay0.87%
Worker's Compn/a
Medicare8.65%
Medicaid15.43%
Other Federal Programsn/a
Commercial1.46%
Blue Crossn/a
Champus0.44%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a
Medicaid Managed Care0.12%
Commercial HMOn/a
Charity73%
Missing/Invalidn/a

Severity Index = All patients admitted have been determined to be a 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: 1
    YEAR: 2014

Certified With Comments

PROVIDER: Terrell State Hospital
THCIC ID: 000111
QUARTER: 1 YEAR: 2014

Certified with comments

Due to the system limitations, note that this is just an estimate and relates to
identified source if 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 report 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 PaymentTotal Percentage (%)

Self-Pay1.29%
Worker's Compn/a
Medicare11.18%
Medicaid3.10%
Other Federal Programsn/a
Commercial0.36%
Blue Crossn/a
Champus0.00%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a
Medicaid Managed Care0.00%
Commercial HMOn/a
Charity84%
Missing/Invalidn/a

Severity Index = All patients admitted have been determined to be a 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: North Texas State Hospital
THCIC ID: 000114
 QUARTER: 1
    YEAR: 2014

Certified With Comments

PROVIDER: North Texas State Hospital - Vernon
THCIC ID: 000114
QUARTER: 1 YEAR: 2014

Certified with comments

Due to the system limitations, note that this is just an estimate and relates to
identified source if 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 report 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 PaymentTotal Percentage (%)

Self-Pay1.11%
Worker's Compn/a
Medicare0.30%
Medicaid15.23%
Other Federal Programsn/a
Commercial2.16%
Blue Crossn/a
Champus0.13%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a
Medicaid Managed Care0.05%
Commercial HMOn/a
Charity81%
Missing/Invalidn/a

Severity Index = All patients admitted have been determined to be a 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.

==
PROVIDER: Waco Center for Youth
THCIC ID: 000117
 QUARTER: 1
    YEAR: 2014

Certified With Comments

PROVIDER: Waco Center for Youth
THCIC ID: 000117
QUARTER: 1 YEAR: 2014

Certified with comments

Due to the system limitations, note that this is just an estimate and relates to identified source if 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 report 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 PaymentTotal Percentage (%)

Self-Pay2.01%
Worker's Compn/a
Medicaren/a
Medicaid1.06%
Other Federal Programsn/a
Commercial1.19%
Blue Crossn/a
Champus0.47%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a
Medicaid Managed Care0.00%

Commercial HMOn/a
Charity95%
Missing/Invalidn/a

Severity Index = All patients admitted have been determined to be a 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.

===
PROVIDER: El Paso Psychiatric Center
THCIC ID: 000118
 QUARTER: 1
    YEAR: 2014

Certified With Comments

PROVIDER: EL Paso Psychiatric Center
THCIC ID: 000118
QUARTER: 1 YEAR: 2014

Certified with comments

Due to the system limitations, note that this is just an estimate and relates to
identified source if 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 report 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 PaymentTotal Percentage (%)

Self-Pay0%
Worker's Comp0%
Medicare22%
Other Federal Programs6%
Commercialembedded in Commercial%
Blue Crossembedded in Commercial%
Champus60%
Other0%
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Government60%
Commercial PPO0%

Medicare Managed Care0%
Medicaid Managed Care0%
Commercial HMO0%
Charity0%
Missing/Invalid40%

Severity Index = All patients admitted have been determined to be a 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.

===
PROVIDER: Baptist St Anthonys Hospital
THCIC ID: 001000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

I elect to certify this data is accurate to the best of my knowledge as of this
date of certification.

===
PROVIDER: Good Shepherd Medical Center-Marshall
THCIC ID: 020000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

===
PROVIDER: Baylor Medical Center-Garland
THCIC ID: 027000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

Physician Identification
All physician license numbers and names have been validated as accurate
against a physician reference file that is derived from information provided

by the Texas Board of Medical Examiners. Those physicians not yet assigned
a state license number at the time of data submission are given temporary
numbers by the hospital for state reporting purposes. Due to the "lag"
time between when the physician is licensed and when THCIC receives the
information, some physicians may remain unidentified in the THCIC Practitioner
Reference Files.

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

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

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

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

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

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

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

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

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

==
PROVIDER: Good Shepherd Medical Center
THCIC ID: 029000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

==
PROVIDER: Baylor Medical Center at Carrollton
THCIC ID: 042000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

PROVIDER: Baylor Medical Center Carrollton
THCIC ID: 042000
QUARTER: 1
YEAR: 2014

Certified with comments

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

Physician Identification
All physician license numbers and names have been validated as accurate
against a physician reference file that is derived from information provided
by the Texas Board of Medical Examiners. Those physicians not yet assigned
a state license number at the time of data submission are given temporary

numbers by the hospital for state reporting purposes. Due to the "lag"
time between when the physician is licensed and when THCIC receives the
information, some physicians may remain unidentified in the THCIC Practitioner
Reference Files.

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

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

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

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

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

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

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

"Asian or Pacific Islander" encounters are not broken out separately
but are included in the "Other" race category.

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

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

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

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

===
PROVIDER: Texas Health Huguley Hospital
THCIC ID: 047000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge
data for THCIC mandatory reporting requirements as of December 1, 2014. If any
errors are discovered in our data after this point, we will be unable to
communicate these due to THCIC. This data is administrative data, which
hospitals collect for billing purposes, and not clinical data, from which you
can make judgments about patient care.

Submission Timing

The State requires us to submit a snapshot of billed claims, extracted from our
database approximately 20 days following the close of the calendar year quarter.
Any discharged patient encounters no billed by this cut-off date will not be
included in the quarterly submission file sent in.

Diagnosis and Procedures

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

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

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

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

Physician

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

One accounts with MS-DRG's 374 the physician did not interface between our
internal systems and was unable to be corrected in the THCIC file before the
deadline. Three accounts with the following MS-DRG's 872, 380 and 254 were
originally mapped to incorrect physicians but have been corrected in our
internal system although unable to be corrected in the permanent THCIC file.

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

==
PROVIDER: St Lukes Episcopal Hospital
THCIC ID: 118000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

The data reports for Quarter 1, 2014 do not accurately reflect patient volume or
severity.

Patient Volume

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

Severity

Not all clinically significant conditions, such as the hearts ejection fraction,

can be captured and reflected in the various billing data elements including the
ICD-9-CM diagnosis coding system. As a result, the true clinical picture of the
patient population cannot be adequately demonstrated using admissions and
billing data.

==
PROVIDER: University Medical Center
THCIC ID: 145000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

==
PROVIDER: Texas Health Harris Methodist HEB
THCIC ID: 182000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

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

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage
calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure,
percentage of patients in each severity of illness category). It would be obvious; therefore, those
sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately
reflected.
Length of Stay
The length of stay data element contained in the states certification file is only three
characters long. Thus any patients discharged with a length of stay greater than 999 days will not
be accurately stored within the certification database. It is rare that patients stay longer than
999 days, therefore, it is not anticipated that
this limitation will affect this data.
Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.

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

Race/Ethnicity

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

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

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

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

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PROVIDER: The Heart Hospital Baylor Denton
THCIC ID: 208100
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

Physician Identification
All physician license numbers and names have been validated as accurate against a physician reference file that is derived from information provided by the Texas Board of Medical Examiners. Those physicians not yet assigned a state license number at the time of data submission are given temporary

numbers by the hospital for state reporting purposes. Due to the "lag"
time between when the physician is licensed and when THCIC receives the
information, some physicians may remain unidentified in the THCIC Practitioner
Reference Files.

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

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

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

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

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

Standard Source of Payment
The standard source of payment codes are an example of data required by the
state that is not contained within the standard UB92 billing record. In order
to meet this requirement each payer identification must be categorized into the
appropriate standard source of payment value. It should also be noted that the
primary payer associated to the patient's encounter record may change over time.
Additionally, those payers identified contractually as both "HMO and PPO"
are categorized as "Commercial PPO". Thus any true managed care comparisons
by contract type (HMO vs. PPO) may result in inaccurate analysis.

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

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

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

===
PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth
THCIC ID: 235000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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PROVIDER: Wise Regional Health System
THCIC ID: 254000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

The data for 1Q2014 is being certified with comment. All reported data is
accurate and correct at the specific point in time that the data files are
generated. Information is subject to change after files are generated and
submitted to THCIC; any changes would be information collected or updated during
the normal course of business.

===
PROVIDER: Wise Regional Health System
THCIC ID: 254001
 QUARTER: 1
    YEAR: 2014

Certified With Comments

The data for 1Q2014 is being certified with comment. All reported data is
accurate and correct at the specific point in time that the data files are
generated. Information is subject to change after files are generated and
submitted to THCIC; any changes would be information collected or updated during
the normal course of business.

===
PROVIDER: Texas Health Harris Methodist Hospital-Stephenville
THCIC ID: 256000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

The state requires us to submit inpatient claims, by quarter year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI
electronic claim format. Then the state specifications require additional data
elements to be included over and above that. Adding those additional data
places programming burdens on the hospital since it is over and above the actual

hospital billing process. Errors can occur due to this additional programming,
but the public should not conclude that billing data sent to our payers is
inaccurate. These errors have been corrected to the best of our knowledge.

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

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

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

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

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

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

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

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

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

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

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

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

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PROVIDER: University Medical Center of El Paso
THCIC ID: 263000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

Through performance improvement process, we review the data and strive to make

changes to result in improvement.

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PROVIDER: Baylor Scott & White Medical Center at Waxahachie
THCIC ID: 285000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

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

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

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

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

Standard Source of Payment
The standard source of payment codes are an example of data required by the
state that is not contained within the standard UB92 billing record. In order
to meet this requirement each payer identification must be categorized into the
appropriate standard source of payment value. It should also be noted that the
primary payer associated to the patient's encounter record may change over time.
Additionally, those payers identified contractually as both "HMO and PPO"
are categorized as "Commercial PPO". Thus any true managed care comparisons
by contract type (HMO vs. PPO) may result in inaccurate analysis.

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

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

===
PROVIDER: Texas Health Presbyterian Hospital - WNJ
THCIC ID: 297000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Continue to work with vendor to reduce errors.

===
PROVIDER: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

The state requires us to submit inpatient claims, by quarter year, gathered from

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

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

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

The codes also do not distinguish between conditions present at the time of the
patient's admission to the hospital and those occurring during hospitalization.
For example, if a code indicating an infection is made, it is not always
possible to determine if the patient had an infection prior to admission, or
developed an infection during their hospitalization. This makes it difficult to
obtain accurate information regarding things such as complication rates. The
data submitted matches the state's reporting requirements but may be incomplete
due to a limitation on the number of diagnoses and procedures the state allows
us to include for each patient. In other words, the state's data file may not
fully represent all diagnoses treated by the hospital or all procedures
performed, which can alter the true picture of a patient's hospitalization,
sometimes significantly. The codes are assigned based on documentation in the
patient's chart and are used by hospitals for billing purposes. The hospital can
code up to 99 diagnoses and 99 procedures for each patient record. The state is
requiring us to submit ICD-9-CM data on each patient but has limited the number
of diagnoses and procedures to the first 25 diagnoses codes and the first 25
procedure codes. As a result, the data sent by us does meet state requirements
but cannot reflect all the codes an individual patient's record may have been
assigned. This means also that true total volumes may not be represented by the
state's data file, which therefore make percentage calculations inaccurate (i.e.
mortality percentages for any given diagnosis or procedure, percentage of
patients in each severity of illness category). It would be obvious; therefore,
those sicker patients (more diagnoses and procedures) are less accurately
reflected by the 837 format. It then stands to reason that hospitals, which
treat sicker patients, are likewise less accurately reflected.

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

Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate
whether the baby was a normal newborn, premature delivery, sick baby, extramural
birth, or information not available. The best way to focus on severity of

illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.

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

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

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

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

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

===
PROVIDER: Texas Health Harris Methodist Hospital Cleburne
THCIC ID: 323000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI

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

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

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

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

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

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

Length of Stay
The length of stay data element contained in the states certification file is
only three characters long. Thus any patients discharged with a length of stay
greater than 999 days will not be accurately stored within the certification
database. It is rare that patients stay longer than 999 days, therefore, it is
not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate
whether the baby was a normal newborn, premature delivery, sick baby, extramural

birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.

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

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

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

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

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

==
PROVIDER: Baylor University Medical Center
THCIC ID: 331000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

PROVIDER: Baylor University Medical Center
THCIC ID: 331000
QUARTER: 1
YEAR: 2014

Certified with comments

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

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

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

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

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

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

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

Mortalities
Due to insurance payer requirements, organ donor patients are readmitted

and expired in the system to address the issues of separate payers. This
results in double counting some "expired" cases which will increase the
mortality figure reported and not accurately reflect the actual number
of mortalities.

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

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

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

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

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

==
PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Cook Children's Medical Center has submitted and certified 1st QUARTER
2014 npatient, outpatient surgery and outpatient radiology encounters to
the Texas Health Care Information Council with the following possible data
concerns based on the required submission method.

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

Post-operative infections

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

Comparative complication reports reflecting the above conditions could
misstate the true conditions at Cook Children's Medical Center for the
1st QUARTER OF 2014

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

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

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

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PROVIDER: University Medical Center-Brackenridge
THCIC ID: 335000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

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

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

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PROVIDER: Coryell Memorial Hospital
THCIC ID: 346000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Due to issues involving migration to a new electronic health record during the
first quarter reporting period, not all patient encounters were included in this
file.

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PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

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

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PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

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

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

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

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

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

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

Hospital Comments, 1Q2014.txt

Therefore, admission source does not always give an accurate picture.

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

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

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

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

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

===
PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is over and above the actual

hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

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

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates. The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

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

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health 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 identifier must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both HMO, and PPO are categorized as Commercial PPO. Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

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

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

==
PROVIDER: DeTar Hospital-Navarro
THCIC ID: 453000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

Referral Call Center. To learn more, please visit our website at www.detar.com.

==
PROVIDER: Riverside General Hospital
THCIC ID: 460000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Individuals that performed the input work for this time period are no longer
with the hospital. I certify that I do see the 4 claims as listed.

==
PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

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

Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges.

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

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

==
PROVIDER: Parkland Memorial Hospital
THCIC ID: 474000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Parkland Health & Hospital System comprises a network of neighborhood-based
health centers and Parkland Memorial Hospital, which was established in
1894. The Parkland System is a $995 million enterprise that is licensed
for 968 beds and employs approximately 9,988 staff. 11,804 adult patients
received inpatient care this quarter. The hospital delivered over 10,000
newborns during the 12 month period ending March 2014.

Specific Data Concerns

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

==
PROVIDER: Seton Medical Center
THCIC ID: 497000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

===
PROVIDER: Baylor Regional Medical Center-Grapevine
THCIC ID: 513000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

I have validated the Q1 2014 THCIC Data. IP looks great.

===
PROVIDER: Seton Highland Lakes Hospital
THCIC ID: 559000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Seton Highland Lakes, a member of the Seton Family of hospitals, is a 25 bed
acute care facility located between Burnet and Marble Falls on Highway 281. The
hospital offers 24- hour Emergency services, plus comprehensive diagnostic and
treatment services for residents in the surrounding area. Seton Highland Lakes
also offers Home Health and Hospice service. For primary and preventative care,
Seton Highland Lakes offers clinics is Burnet, Marble Falls, Bertram, Lampasas
and a pediatric mobile clinic in the county.
This facility is designated by the Center for Medicare and Medicaid Services as
a Critical Access Hospital and is fully accredited by the Joint Commission on
Accreditation of Healthcare Organization under its Critical Access designation
program.

===
PROVIDER: Baylor Specialty Hospital
THCIC ID: 586000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

The BSH & OCH IP Discharges totals are slightly different than what I count but
are within reasonableness. But the distribution mix by charges, admission type,
point of origin, discharge status, DRGs, procedures, demographics, etc all
appear reasonable.

===
PROVIDER: Texas Health Harris Methodist Hospital-Southwest Fort Worth
THCIC ID: 627000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

The state requires us to submit inpatient claims, by quarter year, gathered from
a form called an UB92, in a standard government format called HCFA 837 EDI

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

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

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

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

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

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

Length of Stay
The length of stay data element contained in the states certification file is
only three characters long. Thus any patients discharged with a length of stay
greater than 999 days will not be accurately stored within the certification
database. It is rare that patients stay longer than 999 days, therefore, it is
not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate
whether the baby was a normal newborn, premature delivery, sick baby, extramural

birth, or information not available. The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Many hospital information systems and registration process defaults to normal delivery as the admission source. Therefore, admission source does not always give an accurate picture.

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

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

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

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

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

==
PROVIDER: Texas Health Specialty Hospital-Fort Worth
THCIC ID: 652000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

The state requires us to submit inpatient claims, by quarter year, gathered from

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

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

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

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

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

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

Length of Stay
The length of stay data element contained in the states certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.
Admit Source data for Normal Newborn
Texas Health Specialty Hospital does not have a newborn population.

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

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

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

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

===
PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

encounter volume.

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

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

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

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

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

Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate
whether the baby was a normal newborn, premature delivery, sick baby, extramural
birth, or information not available. The best way to focuson 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 normaldelivery as the admission source. Therefore, admission
source does not always give an accurate
picture.

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

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

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

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

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

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PROVIDER: HEALTHSOUTH Plano Rehab Hospital
THCIC ID: 670000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Results may not be 100% accurate.

==
PROVIDER: CHRISTUS Dubuis Hospital-Beaumont
THCIC ID: 708000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation
of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in
many aspects. Therefore relevant comparisons should be made with only other
Long Term Acute Hospitals. Only acutely ill patients requiring an average
length of stay of approximately 25 days are admitted to Dubuis Hospital per our
designation as Long Term Acute. Therefore our length of stay is much longer
than a regular Short Term Hospital. In addition, our patient mix is
predominately elderly as they most often have more serious illnesses with more
frequent secondary problems. Subsequently they require a longer hospital l stay
than the younger population.

==
PROVIDER: CHRISTUS Dubuis Hospital-Port Arthur
THCIC ID: 708001
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation
of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in
many aspects. Therefore relevant comparisons should be made with only other
Long Term Acute Hospitals. Only acutely ill patients requiring an average
length of stay of approximately 25 days are admitted to Dubuis Hospital per our
designation as Long Term Acute. Therefore our length of stay is much longer
than a regular Short Term Hospital. In addition, our patient mix is
predominately elderly as they most often have more serious illnesses with more
frequent secondary problems. Subsequently they require a longer hospital l stay
than the younger population.

==
PROVIDER: Red River Hospital
THCIC ID: 709001
 QUARTER: 1
    YEAR: 2014

Certified With Comments

1Q.2014.on.8.8.14

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PROVIDER: Our Childrens House Baylor

THCIC ID: 710000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

The BSH & OCH IP Discharges totals are slightly different than what I count but
are within reasonableness. But the distribution mix by charges, admission type,
point of origin, discharge status, DRGs, procedures, demographics, etc all
appear reasonable.

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PROVIDER: Texas Health Seay Behavioral Health Center
THCIC ID: 720000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

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

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

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

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

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

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

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

Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for
use by hospitals. These guidelines will provide better clarity for the accurate collection of this
data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that

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

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

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

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

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PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

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

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

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates. The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

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

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health 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 identifier must be
categorized into the appropriate standard and non-standard source of payment
value. These values might not accurately reflect the hospital payer information,
because those payers identified contractually as both HMO, and PPO are
categorized as Commercial PPO. Thus any true managed care comparisons by
contract type (HMO vs. PPO) may result in inaccurate analysis.

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

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

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PROVIDER: Texas Health Heart & Vascular Hospital
THCIC ID: 730001
 QUARTER: 1
    YEAR: 2014

Certified With Comments

THHV - Inpatient

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

Disease, or ICD-9-CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations, a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An apples to apples comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.
The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.
The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.
The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.
Length of Stay
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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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patient discharges to home as opposed to rehab. THR will communicate this issue
and the plan to address this issue in writing to the THCIC Executive Director

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PROVIDER: St Lukes Hospital at the Vintage
THCIC ID: 740000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

The data reports for Quarter 1, 2014 do not accurately reflect patient volume or
severity.

Patient Volume

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

Severity

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

===
PROVIDER: Houston Hospital for Specialized Surgery
THCIC ID: 758000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

I am certifying the inpatient data. There appears to be no outpatient data
reported. As I was not involved with the submission of the data I cannot speak
as to why it was not submitted.

===
PROVIDER: Texas Health Springwood Hospital
THCIC ID: 778000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Data Content
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UB92, in a standard government format called HCFA 837 EDI electronic claim
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physician's subjective criteria for defining a diagnosis. For example, while
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hemoglobin level falls below 9.5, another physician may not diagnose the patient
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by the physician to determine that diagnosis was different.   An apples to
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possible to determine if the patient had an infection prior to admission, or
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the hospital or all procedures performed, which can alter the true picture of a patient's
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and procedures to the first 25 diagnoses codes and the first 25 procedure codes.
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which therefore make percentage
calculations inaccurate (i.e. mortality percentages for any given diagnosis or
procedure,
percentage of patients in each severity of illness category). It would be

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

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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 focuson 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 normaldelivery as the admission source. Therefore, admission
source does not always give an accurate picture.

If admission source is used to examine length of stay or mortality for normal
neonates using the
admit source to identify the cases, the data will reflect premature and sick
babies mixed in with
the normal newborn data. Texas Health Springwood 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 theTHCIC requirement. Our admissions staff indicates
that many patients are very sensitive about providing race and ethnicity
information. Therefore, depending on the circumstances of the patient's
admission, race and ethnicity data may be subjectively collected. Therefore,
the race and ethnicity data may not provide an accurate representation of the
patient population for a facility.

Standard/Non-Standard Source of Payment
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These values might not accurately reflect the hospital payer information,
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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
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Cost/ Revenue Codes
The state requires that hospitals submit revenue information including charges.
It is important to
note that charges are not equal to actual payments received by the hospital or

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

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

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PROVIDER: Baylor Heart & Vascular Center
THCIC ID: 784400
 QUARTER: 1
    YEAR: 2014

Certified With Comments

The IP Discharges total appears low I count 533. This report has 508. But the
distribution mix by charges, admission type, point of origin, discharge status,
DRGs, procedures, demographics, etc all appear reasonable.

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PROVIDER: South Texas Spine & Surgical Hospital
THCIC ID: 786800
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Data approved for certification.

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PROVIDER: Dubuis Hospital-Paris
THCIC ID: 787500
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation
of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals
in many aspects. Therefore relevant comparisons should be made with only
other Long Term Acute Hospitals. Only acutely ill patients requiring
an average length of stay of approximately 25 days are admitted to Dubuis
Hospital per our designation as Long Term Acute. Therefore our length
of stay is much longer than a regular Short Term Hospital. In addition,
our patient mix is predominately elderly as they most often have more
serious illnesses with more frequent secondary problems. Subsequently
they require a longer hospital l stay than the younger population

===
PROVIDER: CHRISTUS St Michael Health System
THCIC ID: 788001
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Certify to the best of my knowledge.

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PROVIDER: Christus St Michael Hospital Atlanta
THCIC ID: 788003
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Certifiy to the best of my knowledge.

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PROVIDER: St Lukes The Woodlands Hospital
THCIC ID: 793100
 QUARTER: 1
    YEAR: 2014

Certified With Comments

The data reports for Quarter 1, 2014 do not accurately reflect patient volume or
severity.

Patient Volume

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

Severity

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

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PROVIDER: Dubuis Hospital-Corpus Christi
THCIC ID: 797001
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation
of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in
many aspects. Therefore relevant comparisons should be made with only other
Long Term Acute Hospitals. Only acutely ill patients requiring an average
length of stay of approximately 25 days are admitted to Dubuis Hospital per our
designation as Long Term Acute. Therefore our length of stay is much longer
than a regular Short Term Hospital. In addition, our patient mix is
predominately elderly as they most often have more serious illnesses with more
frequent secondary problems. Subsequently they require a longer hospital l stay
than the younger population.

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PROVIDER: Seton Southwest Hospital
THCIC ID: 797500
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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PROVIDER: Seton Northwest Hospital
THCIC ID: 797600
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

==
PROVIDER: Texas Health Harris Methodist Hospital Southlake
THCIC ID: 812800
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Files may contain duplicate or missing claims

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PROVIDER: Texas Institute for Surgery-Texas Health Presbyterian-Dallas
THCIC ID: 813100
 QUARTER: 1
    YEAR: 2014

Certified With Comments

File may contain duplicates or missing claims

==
PROVIDER: Baylor Regional Medical Center-Plano
THCIC ID: 814001
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Submission Timing
Baylor estimates that our data volumes for the calendar year time period

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

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

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

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

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

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

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

Standard Source of Payment

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

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

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

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

===
PROVIDER: Texas Health Center-Diagnostics & Surgery Plano
THCIC ID: 815300
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Files may contain duplicate or missing claims

===
PROVIDER: Texas Health Presbyterian Hospital-Denton
THCIC ID: 820800
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

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

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates. The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

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

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

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

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

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

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

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

===
PROVIDER: Dubuis Hospital-Texarkana
THCIC ID: 822000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation
of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in
many aspects. Therefore relevant comparisons should be made with only other
Long Term Acute Hospitals. Only acutely ill patients requiring an average
length of stay of approximately 25 days are admitted to Dubuis Hospital per our
designation as Long Term Acute. Therefore our length of stay is much longer
than a regular Short Term Hospital. In addition, our patient mix is
predominately elderly as they most often have more serious illnesses with more
frequent secondary problems. Subsequently they require a longer hospital l stay
than the younger population.

===
PROVIDER: Good Shepherd Medical Center-Linden
THCIC ID: 822100
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

===
PROVIDER: University Behavioral Health-Denton
THCIC ID: 826800
 QUARTER: 1
    YEAR: 2014

Certified With Comments

I was not an employee during this time and there appears to be no way to fix the
claims that need correcting during that time.

===
PROVIDER: St Davids Georgetown Hospital
THCIC ID: 835700
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Reports reviewed by G. Hines

===
PROVIDER: Texoma Medical Center
THCIC ID: 847000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

CERITIFED BY ATHENA SANDERS

===
PROVIDER: Dubuis Hospital-Texarkana-Wadley
THCIC ID: 847600
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation
of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in
many aspects. Therefore relevant comparisons should be made with only other
Long Term Acute Hospitals. Only acutely ill patients requiring an average
length of stay of approximately 25 days are admitted to Dubuis Hospital per our
designation as Long Term Acute. Therefore our length of stay is much longer
than a regular Short Term Hospital. In addition, our patient mix is
predominately elderly as they most often have more serious illnesses with more
frequent secondary problems. Subsequently they require a longer hospital l stay

than the younger population.

===
PROVIDER: Dell Childrens Medical Center
THCIC ID: 852000
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

===
PROVIDER: Texas Health Presbyterian Hospital-Rockwall
THCIC ID: 859900
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Files may contain duplicate and missing claims

===
PROVIDER: Seton Medical Center Williamson
THCIC ID: 861700
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

===
PROVIDER: Kate Dishman Rehab Hospital
THCIC ID: 861900
 QUARTER: 1
    YEAR: 2014

Certified With Comments

All of Kate Dishman admissions are Elective. We have one listed as Urgent. It

was also elective.

==
PROVIDER: CHRISTUS Dubuis Hospital-Bryan
THCIC ID: 864800
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation
of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in
many aspects. Therefore relevant comparisons should be made with only other
Long Term Acute Hospitals. Only acutely ill patients requiring an average
length of stay of approximately 25 days are admitted to Dubuis Hospital per our
designation as Long Term Acute. Therefore our length of stay is much longer
than a regular Short Term Hospital. In addition, our patient mix is
predominately elderly as they most often have more serious illnesses with more
frequent secondary problems. Subsequently they require a longer hospital l stay
than the younger population.

==
PROVIDER: TrustPoint Hospital
THCIC ID: 865800
 QUARTER: 1
    YEAR: 2014

Elected Not to Certify

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

==
PROVIDER: St Lukes Sugar Land Hospital
THCIC ID: 869700
 QUARTER: 1
    YEAR: 2014

Certified With Comments

The data reports for Quarter 1, 2014 do not accurately reflect patient volume or
severity.

Patient Volume

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

Severity

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

==
PROVIDER: Seton Medical Center Hays

THCIC ID: 921000
 QUARTER: 1
     YEAR: 2014

Certified With Comments

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

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

==
PROVIDER: St Lukes Lakeside Hospital
THCIC ID: 923000
 QUARTER: 1
     YEAR: 2014

Certified With Comments

The data reports for Quarter 1, 2014 do not accurately reflect patient volume or
severity.

Patient Volume

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

Severity

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

==
PROVIDER: Texas Health Presbyterian Hospital Flower Mound
THCIC ID: 943000
 QUARTER: 1
     YEAR: 2014

Certified With Comments

Files may contain duplicate or missing claims

==
PROVIDER: Baylor Medical Center McKinney
THCIC ID: 971900
 QUARTER: 1
     YEAR: 2014

Certified With Comments

Submission Timing
Baylor estimates that our data volumes for the calendar year time period

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

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

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

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

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

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

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

Standard Source of Payment
The standard source of payment codes are an example of data required by the

state that is not contained within the standard UB92 billing record. In order
to meet this requirement each payer identification must be categorized into the
appropriate standard source of payment value. It should also be noted that the
primary payer associated to the patient's encounter record may change over time.
Additionally, those payers identified contractually as both "HMO and PPO"
are categorized as "Commercial PPO". Thus any true managed care comparisons
by contract type (HMO vs. PPO) may result in inaccurate analysis.

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

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

==
PROVIDER: Texas Health Harris Methodist Hospital Alliance
THCIC ID: 972900
 QUARTER: 1
    YEAR: 2014

Certified With Comments

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

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

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

Diagnosis and Procedures
Patient diagnoses and procedures for a particular outpatient hospital stay are
coded by the
hospital using a universal standard called the International Classification of
Disease (ICD-9-CM)
and Current Procedural Terminology Codes (CPT Codes). This is mandated by the
federal government. The hospital complies with the guidelines for assigning

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

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

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

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

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

Admit Source data for Normal Newborn
When the Admit type is equal to newborn, the admit source should indicate
whether the baby was a normal newborn, premature delivery, sick baby, extramural
birth, or information not available. The best way to focus on severity of
illness regarding an infant would be to check the infant's diagnosis at
discharge, not the admitting source code. Many hospital information systems and
registration process defaults to normal delivery as the admission source.
Therefore, admission source does not always give an accurate picture.
If admission source is used to examine length of stay or mortality for normal
neonates using the admit source to identify the cases, the data will reflect
premature and sick babies mixed in with the normal newborn data.Texas Health
Alliance recommends use of ICD9 coding data to identify neonates. This
methodology will ensure correct identification of the clinical status of the
newborn admission.

Race/Ethnicity
As of the December 7, 2001, the THCIC Board indicated that they would be
creating guidelines for

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

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

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

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

===
PROVIDER: Dallas Behavioral Healthcare Hospital
THCIC ID: 973400
 QUARTER: 1
    YEAR: 2014

Certified With Comments

Certifying data without comments