

General Comments on 2nd Quarter 2007 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.

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PROVIDER: Austin State Hospital  
THCIC ID: 000100  
QUARTER: 2  
YEAR: 2007

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.

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

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

Standard Source of Payment	Total Percentage (%)
Self-Pay	2.52%
Worker's Comp	n/a
Medicare	10.48%
Other Federal Programs	8.06%
Commercial	3.71%
Blue Cross	n/a
Champus	0.18%
Other	n/a
Missing/Invalid	n/a

Non Standard Source of Payment Total Percentage (%)

State/Local Government	n/a	n/a
Commercial		n/a
Medicare Managed Care	n/a	
Medicaid Managed Care	0.02%	
Commercial HMO	n/a	
Charity	75%	
Missing/Invalid	n/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: Big Spring State Hospital  
 THCIC ID: 000101  
 QUARTER: 2  
 YEAR: 2007

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.

Hospital Comments, 2q2007.txt

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

Standard Source of Payment	Total Percentage (%)
Self-Pay	2.0%
Worker's Comp	n/a
Medicare	4.91%
Other Federal Programs	n/a
Commercial	1.49%
Blue Cross	n/a
Champus	1.06%
Other	n/a
Missing/Invalid	n/a

Non Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.00%
Commercial HMO	n/a
Charity	81%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be 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: Rio Grande State Center  
 THCIC ID: 000104  
 QUARTER: 2  
 YEAR: 2007

Certified with comments

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

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data 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 Payment	Total Percentage (%)	
Self-Pay		0.55%
Worker's Comp	n/a	
Medicare		5.92%
Medicaid		7.32%
Other Federal Programs	n/a	
Commercial		.87%
Blue Cross		n/a
Champus	0.32%	
Other		n/a
Missing/Invalid	n/a	

Non Standard Source of Payment	Total Percentage (%)	
State/Local Government	n/a	
Commercial		n/a
Medicare Managed Care	0.00%	
Commercial HMO	n/a	
Charity	85%	
Missing/Invalid	n/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: UT MD Anderson Cancer Center  
 THCIC ID: 000105  
 QUARTER: 2  
 YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Kerrville State Hospital  
 THCIC ID: 000106  
 QUARTER: 2  
 YEAR: 2007

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 Payment	Total Percentage (%)
Self-Pay	4.90%
Worker's Comp	n/a
Medicare	2.92%
Medicaid	12.21%
Other Federal Programs	n/a
Commercial	2.95%
Blue Cross	n/a
Champus	0.00%
Other	n/a
Missing/Invalid	n/a

Non Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	0.00%
Medicaid Managed Care	n/a
Commercial HMO	n/a
Charity	77%
Missing/Invalid	n/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: 2  
 YEAR: 2007

Certified with comments

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

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data 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	Total Percentage (%)
Self-Pay	1.65%
Worker's Comp	n/a

Hospital Comments, 2q2007.txt

Medicare		9.15%
Medicaid		5.18%
Other Federal Programs	n/a	
Commercial		1.99%
Blue Cross		0.00%
Other		n/a
Missing/Invalid	n/a	

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

Severity Index = All patients admitted have been determined to be 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: 2  
 YEAR: 2007

Certified with comments

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

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data 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 Payment	Total Percentage (%)	
Self-Pay		0.87%
Worker's Comp	n/a	
Medicare		8.65%
Medicaid		15.43%
Other Federal Programs	n/a	
Commercial		1.46%
Blue Cross		n/a

Hospital Comments, 2q2007.txt

Champus	0.44%	
Other		n/a
Missing/Invalid	n/a	

Non Standard Source of Payment	Total Percentage (%)	
State/Local Government	n/a	
Commercial		n/a
Medicare Managed Care	n/a	
Medicaid Managed Care	0.12%	
Commercial HMO	n/a	
Charity	73%	
Missing/Invalid	n/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: 2  
 YEAR: 2007

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 Payment	Total Percentage (%)	
Self-Pay		1.29%
Worker's Comp	n/a	
Medicare		11.18%
Medicaid		3.10%
Other Federal Programs	n/a	
Commercial		0.36%
Blue Cross		n/a
Champus	0.00%	
Other		n/a
Missing/Invalid	n/a	

Hospital Comments, 2q2007.txt

Non Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.00%
Commercial HMO	n/a
Charity	84%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be 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: 2  
 YEAR: 2007

Certified with comments

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

Admission Type = Because of system constraints, all admissions on the encounter records are reported as urgent. The data 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 Payment	Total Percentage (%)
Self-Pay	1.85%
Worker's Comp	n/a
Medicare	5.68%
Medicaid	8.22%
Other Federal Programs	n/a
Commercial	2.73%
Blue Cross	n/a
Champus	0.47%
Other	n/a
Missing/Invalid	n/a

Non Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a



Hospital Comments, 2q2007.txt

Commercial PPO	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.02%
Commercial HMO	n/a
Charity	81%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be 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: Waco Center for Youth  
 THCIC ID: 000117  
 QUARTER: 2  
 YEAR: 2007

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 Payment	Total Percentage (%)
Self-Pay	2.01%
Worker's Comp	n/a
Medicare	n/a
Medicaid	1.06%
Other Federal Programs	n/a
Commercial	1.19%
Blue Cross	n/a
Champus	0.47%
Other	n/a
Missing/Invalid	n/a

Non Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.00%
Commercial HMO	n/a

Charity  
Missing/Invalid

95%  
n/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: 2  
YEAR: 2007

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 Payment	Total Percentage (%)
Self-Pay	0%
Worker's Comp	0%
Medicare	22%
Other Federal Programs	6%
Commercial	embedded in Commercial%
Blue Cross	embedded in Commercial%
Champus	60%
Other	0%
Missing/Invalid	n/a

Non Standard Source of Payment	Total Percentage (%)
State/Local Government	60%
Commercial PPO	0%
Medicare Managed Care	0%
Medicaid Managed Care	0%
Commercial HMO	0%
Charity	0%
Missing/Invalid	40%

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: St Joseph Regional Health Center  
THCIC ID: 002001  
QUARTER: 2  
YEAR: 2007

Certified with comments

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

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for St. Joseph Regional Health Center charity care, based on established rates for the first two quarters of 2007 was \$14,529,718.

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

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

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

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

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status. This grouper can only use the limited number of procedure and diagnosis codes available in the data file (nine diagnosis and six procedure codes). If all the patient's diagnosis codes were available the APR-DRG assignment may possibly differ from the APR-DRG assigned by THCIC. The

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

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PROVIDER: Matagorda General Hospital  
THCIC ID: 006000  
QUARTER: 2  
YEAR: 2007

Certified with comments

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

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PROVIDER: Matagorda General Hospital  
THCIC ID: 006001  
QUARTER: 2  
YEAR: 2007

Certified with comments

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

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PROVIDER: Marshall Regional Medical Center  
THCIC ID: 020000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Moved to a new computer system

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PROVIDER: Baylor Medical Center-Garland  
THCIC ID: 027000  
QUARTER: 2  
YEAR: 2007

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. With this in mind, approximately 8% of the primary payers originally categorized as "Medicaid" were recategorized as "Managed Care". And 12% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self-Pay".

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.

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PROVIDER: Kindred Hospital-Dallas  
THCIC ID: 028000  
QUARTER: 2  
YEAR: 2007

Certified with comments

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

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PROVIDER: Kindred Hospital-Dallas Walnut Hill  
THCIC ID: 028002  
QUARTER: 2  
YEAR: 2007

Certified with comments

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

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PROVIDER: Madison St Joseph Health Center  
THCIC ID: 041000  
QUARTER: 2  
YEAR: 2007

Certified with comments

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

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Madison St. Joseph Health Center charity care, based on established rates for the first two quarters of 2007 was \$165,525.

Patient Mix - All statistics for Madison St. Joseph Health Center include patients from our Skilled Nursing, and Acute Care populations. Our Skilled

Nursing unit is a long-term care unit. Because of this Mortality and Length of Stay may be skewed. This will prohibit any meaningful comparisons between Madison St. Joseph Health Center and any "acute care only" facilities.

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

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

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

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

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PROVIDER: Trinity Medical Center  
THCIC ID: 042000  
QUARTER: 2  
YEAR: 2007

Certified with comments

DATA Content

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

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

Submission Timing

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

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

date will not be included in the quarterly submission file sent in.

#### Diagnosis and Procedures

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

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

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

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedures codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes in an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

#### Specialty Services

The data submitted does not have any specific data field to capture unit of service or expand in the specialty service (such as rehabilitation) provided to a patient. Services used by patients in rehabilitation may be very different from those used in other specialties. The data is limited in its ability to categorize patient type. Services utilized by patients in specialty units may be very different from those used in acute care. Conditions such as stroke and hip replacement typically require a lower level of care, a longer length of stay, and a different utilization of service.

#### Length of Stay

The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay as long as or longer than 999 days, therefore, it is not anticipated that this limitation will affect this data. The hospital does have an inpatient rehabilitation unit whose patients stay an average of 12 days. This may skew the data when combined with other acute care patient stays.

#### Normal Newborns

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. The hospital's normal hospital registration process defaults "normal delivery" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual



experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

#### Race/Ethnicity

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

#### Cost/Revenue

The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges. Charges also do not reflect the actual costs to deliver the care that each patient needs.

#### Quality

Trending of data over a few years is important to define outcome and quality.

A small sampling of data (i.e. one year) does not explain outcome. We recommend the Patient communicate with the Hospital and the Physician regarding data.

Patient and physician preference contributes to the care rendered to the patient and the data does not always reflect this.

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

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

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PROVIDER: Huguley Memorial Medical Center  
THCIC ID: 047000  
QUARTER: 2  
YEAR: 2007

#### Certified with comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of March 1, 2008.

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 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 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 Clarification

All physician license numbers and names have been validated with the physician and the website recommended by the state.

One encounter with DRG 010 was mapped to an incorrect physician in the submission file as a result of an interface issue not crossing over. Another encounter with an interface issue was incorrectly mapped to DRG 469 but should have crossed over as DRG 373. The following encounters with DRG's 429, 430, 523, and 323 were mapped to incorrect physicians.

The THCIC minimum data set has only (2) physician fields, Attending and Operating Physicians, Mortality rates, case costs and other data calculated in the dataset for physicians can be misrepresented due to the complexity of most inpatient admissions. 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 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 Physician. "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.

#### 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.

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

YEAR: 2007

Elect not to certify

The information reported in the report is misleading to the general public. The attending physician is charged with the procedures requested or performed by the consulting or specialist physiicans due to the acuity and needs of the patient.

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

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

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PROVIDER: Covenant Medical Center-Lakeside  
THCIC ID: 109000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Data does not accurately reflect the number of charity cases for the time period. This is due to internal processing for determination of the source of payment. 4% of total discharges were charity for 2nd Quarter 2007.

Data does not accurately reflect the hospital's newborn population.  
Total Births = 760  
Live = 612  
Premature = 148

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PROVIDER: St Lukes Episcopal Hospital  
THCIC ID: 118000  
QUARTER: 2  
YEAR: 2007

Certified with comments

The data reports for Quarter 2, 2007 do not accurately reflect patient volume or severity.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that are a snapshot of claims one month following quarter-end. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

Descriptors for newborn admissions are based on national billing data elements (UB04) and definitions of each element can and do vary from hospital to hospital. Because of the absence of universal definitions for normal delivery, premature delivery and sick baby, this category cannot be used for comparison across hospitals. The DRG is the only somewhat meaningful description of the infant population born at a facility.

More importantly, not all clinically significant conditions, such as the heart's 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.

Claim Filing Indicator

Due to a format change made by THCIC after the submission of the data, the Claim Filing Indicator Codes (Payer designations) reflect the old format and not the new one.

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PROVIDER: Navarro Regional Hospital  
THCIC ID: 141000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Navarro Regional Hospital is an acute general medical-surgical hospital with the additional services of a Skilled Nursing Facility. The data in the public release file may or may not adequately allow separation of patients in the acute hospital from those in the skilled unit. Admixture of the skilled unit can lead to increases for acute hospitals alone. It is notable that for the 2nd Quarter, 2007, in at least 21 of the 29 deaths, the patients or family members had requested that full efforts to maintain life not be pursued (Advanced Directive, Living Will, or Do Not Resuscitate Orders).

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PROVIDER: Methodist Charlton Medical Center  
THCIC ID: 142000  
QUARTER: 2  
YEAR: 2007

Certified with comments

DATA CONTENT

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

PHYSICIAN REVIEW OF THE DATA

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

SUBMISSION TIMING

The State requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient

encounters not billed by this cut-off date will not be included in the quarterly submission. Claims billed in the subsequent quarter for discharges of a previous quarter will be submitted to the State in the subsequent quarter's submission.

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

#### OMISSION OF OBSERVATION PATIENTS

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

#### DIAGNOSIS AND PROCEDURES

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

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

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

#### NORMAL NEWBORNS

Admission Source or Admission Type codes are not the best way to reflect

the pre-maturity or illness of an infant. Per State data submission regulation, if Admission Type is coded as a "newborn" then Admit Source is a code used to delineate the type of birth as "normal newborn" "premature delivery" "sick baby" and "extra-mural birth." Admission type is a code used to classify a baby as a newborn only if the baby was actually born in the reporting hospital. A very sick baby, transferred from another hospital or facility will be coded as an Admission Type of "Emergency" and Admission Source of "Xfer from Hospital." The actual conditions and experiences of an infant in our facility are captured elsewhere in the data file, namely, in the ICD-9-CM diagnoses and procedures codes.

#### RACE AND ETHNICITY CODES

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

#### STANDARD/NON-STANDARD SOURCE OF PAYMENT

The standard and non-standard source of payment codes are an example of data required by the State that is not contained within the standard UB92 billing record. In order to meet this requirement each payer's identification must be categorized into the appropriate standard and non-standard source of payment value. It is important to note that sometimes, many months after billing and THCIC data submission, a provider may be informed of a retroactive change in a patient's eligibility for a particular payer. This will cause the Source of Payment data to be inaccurate as reported in the quarter's snapshot of the data. The categories most effected are "Self Pay" and "Charity" shifting to "Medicaid" eligible.

#### REVENUE CODE AND CHARGE DATA

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

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

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

#### SEVERITY ADJUSTMENT SCORES

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

DRG contained in the data sets.

PHYSICIAN UPIN NUMBER ERRORS

All physician UPIN numbers and names have been validated with the physician and the UPIN web-site as accurate even though some remain unidentified in the THCIC data tables. This appears to be due to delays in updating the THCIC UPIN data tables.

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PROVIDER: Childrens Medical Center-Dallas  
THCIC ID: 143000  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: University Medical Center  
THCIC ID: 145000  
QUARTER: 2  
YEAR: 2007

Certified with comments

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

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PROVIDER: Covenant Hospital-Plainview  
THCIC ID: 146000  
QUARTER: 2  
YEAR: 2007

Certified with comments

The data reviewed by hospital staff and physicians appears, to the best of our knowledge, to be correct and accurate. It is the practice of the hospital to review all unusual occurrences or length of stay cases via the medical staff's peer review process.

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

Please consider this un-audited data. As accounts move through the billing and collection cycle, financial classification may change based on additional information obtained.

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

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PROVIDER: Methodist Hospital  
THCIC ID: 154000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Facility shows 66 Missing/Invalid accounts. This is due to 66 accounts with Admission Source D. Admission Source D is a valid admission source.

Commonwealth is looking into possibility of them needing to update their system.

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PROVIDER: Methodist Specialty & Transplant Hospital  
THCIC ID: 154001  
QUARTER: 2  
YEAR: 2007

Certified with comments

Facility shows 54 Missing/Invalid accounts. This is due to 54 accounts with Admission Source D. Admission Source D is a valid admission source. Commonwealth is looking into possibility of them needing to update their system.

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PROVIDER: Northeast Methodist Hospital  
THCIC ID: 154002  
QUARTER: 2  
YEAR: 2007

Certified with comments

Facility shows 27 Missing/Invalid accounts. This is due to 27 accounts with Admission Source D. Admission Source D is a valid admission source. Commonwealth is looking into possibility of them needing to update their system.

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PROVIDER: Harris Methodist HEB  
THCIC ID: 182000  
QUARTER: 2  
YEAR: 2007

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

#### Admit Source data for Normal Newborn

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Harris Methodist 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 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 (Seimens) 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: Medical Center-Plano  
THCIC ID: 214000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Since 1975 Medical Center of Plano has maintained a reputation for superior health care as the largest and most sophisticated medical facility in Collin County. The Medical Center is a 427 bed, JCAHO Accredited Hospital which offers a broad base of quality patient services.

Medical Center of Plano's mission is to be a health care organization founded on the values of excellence, leadership, integrity and compassion. We exist to provide the highest quality services for the individuals and families we serve.

General Comments:

Medical Center of Plano supports the effort of the THCIC to provide publicly released hospital data.

Medical Center of Plano is committed to continuous Performance Improvement efforts.

The public data file does not contain all the diagnosis and procedure codes. It contains only 9 diagnosis codes and 6 procedure codes. This

may affect the volume of procedures, the severity adjustment and the mortality rate.

Data Comments:

Inpatient discharge data has been collected from information that is used for billing purposes and, is not clinical data. Due to the differences in health care organizations and data collecting practices throughout Texas, there can be limitations with comparing outcomes.

THCIC has excluded data when five or fewer patients had a procedure and did not perform statistical analysis when there were fewer than 30 patients.

Although the risk-adjusting software helps in making the data more comparable among facilities, it too is an approximation that may not truly represent the mix of patients. This is particularly true for mortalities in patients admitted for end of life care.

"Medical Center of Plano provides quality care to our women/children patient population. Our 23 bed Labor and Delivery suite, 10 bed antepartum unit, 41 bed level II Neonatal Intensive Care Unit and 40 basinet nursery; is staffed with highly competent nursing personnel. The decision to perform a cesarean section is most often a decision between the patient and her physician. We believe that the right C-section rate is determined by a healthy baby and healthy mom.

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PROVIDER: Oakbend Medical Center  
THCIC ID: 230000  
QUARTER: 2  
YEAR: 2007

Certified with comments

OakBend Medical Center is an acute, general medical-surgical hospital with the additional services of a Skilled Nursing Facility. The way the PDUF mortality information is presented does not accurately reflect our case mix of patients or numbers of cases per physician. Several physicians have 70-80% nursing home patients with higher numbers of co-morbidities.

Since the state limits the number of diagnoses and procedures, the data cannot reflect all the codes an individual patient's records may have been assigned. This also means that true total volumes may not be represented by the State's data file therefore making percentage calculations skewed.

Also not reflected accurately is the number of patients cared for by consulting physicians. Many consultants seldom admit patients to the inpatient setting but consult on hundreds. This causes inaccurate mortality rates. Since this data is taken from administrative data, it cannot accurately represent the patient's clinical picture. OakBend Medical center urges caution in using this information to evaluate quality of care. We encourage patients to talk with the primary care physician or the hospital about this data. Our commitment to quality is strong and continuous.

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PROVIDER: Harris Methodist-Fort Worth  
THCIC ID: 235000  
QUARTER: 2  
YEAR: 2007

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 state's certification

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

#### Admit Source data for Normal Newborn

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Harris Methodist 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 (Seimens) 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.

THCIC ID: 255000  
QUARTER: 2  
YEAR: 2007

Certified with comments

#### DATA CONTENT

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

#### PHYSICIAN REVIEW OF THE DATA

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

#### SUBMISSION TIMING

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

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

#### OMISSION OF OBSERVATION PATIENTS

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

#### DIAGNOSIS AND PROCEDURES

The state and billing regulations require us to submit diagnoses and procedures in ICD-9-CM

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

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

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

#### NORMAL NEWBORNS

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

#### RACE AND ETHNICITY CODES

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

STANDARD/NON-STANDARD SOURCE OF PAYMENT

The standard and non-standard source of payment codes are an example of data required by the State that is not contained within the standard UB92 billing record. In order to meet this requirement each payer's identification must be categorized into the appropriate standard and non-standard source of payment value. It is important to note that sometimes, many months after billing and THCIC data submission, a provider may be informed of a retroactive change in a patient's eligibility for a particular payer. This will cause the Source of Payment data to be inaccurate as reported in the quarter's snapshot of the data. The categories most effected are "Self Pay" and "Charity" shifting to "Medicaid" eligible.

REVENUE CODE AND CHARGE DATA

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

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

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

SEVERITY ADJUSTMENT SCORES

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

PHYSICIAN UPIN NUMBER ERRORS

All physician UPIN numbers and names have been validated with the physician and the UPIN web-site as accurate even though some remain unidentified in the THCIC data tables. This appears to be due to delays in updating the THCIC UPIN data tables.

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PROVIDER: Harris Methodist-Erath County
THCIC ID: 256000
QUARTER: 2
YEAR: 2007

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

this data.

#### Admit Source data for Normal Newborn

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Harris Methodist Erath County 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 (Seimens) 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: R E Thomason General Hospital  
THCIC ID: 263000  
QUARTER: 2  
YEAR: 2007

Certified with comments

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

Mapping for the payer source indicates differences. In the THCIC information, Charity appears to be included in the self pay lines and the commercial insurances are itemized separately. On the THCIC report the payer source fields have increased to include CHIP, other not federal programs, Missing/Invalid and HMOs.

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

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PROVIDER: Metropolitan Methodist Hospital
THCIC ID: 283000
QUARTER: 2
YEAR: 2007

Certified with comments

Facility shows 40 Missing/Invalid accounts. This is due to 40 accounts with Admission Source D. Admission Source D is a valid admission source. Commonwealth is looking into possibility of them needing to update their system.

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PROVIDER: Baylor Medical Center-waxahachie
THCIC ID: 285000
QUARTER: 2
YEAR: 2007

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, THIC 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. With this in mind, approximately 16% of the primary payers originally categorized as "Medicaid" were recategorized as "Managed Care". And approximately 8% of the secondary payers originally as "Missing/Invalid" were recategorized as "Self-Pay".

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.

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PROVIDER: Mother Frances Hospital  
THCIC ID: 286000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Our billing system does not have a payer classification for "PPO" insurance plans. The "PPO" plan activity has been mapped, erroneously, to "HMO". We are working to correct this issue in future data submissions.

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PROVIDER: Baylor Medical Center-Irving  
THCIC ID: 300000  
QUARTER: 2  
YEAR: 2007

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.

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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 and non-standard source of payment value.

It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 16% of the primary payers originally categorized as "Medicaid" were recategorized as "Managed Care". And approximately 10% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self Pay".

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.

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

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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 THIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

QUARTER: 2  
YEAR: 2007

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

#### Admit Source data for Normal Newborn

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

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

#### Race/Ethnicity

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

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



Discharge Disposition

THR has identified a problem with a vendor (Seimens) 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: Walls Regional Hospital  
THCIC ID: 323000  
QUARTER: 2  
YEAR: 2007

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.

#### Hospital Comments, 2q2007.txt

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

#### Length of Stay

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

#### Admit Source data for Normal Newborn

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Walls Regional 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 (Seimens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Baylor University Medical Center  
THCIC ID: 331000  
QUARTER: 2  
YEAR: 2007

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. Upon review, approximately 3% of the primary payers originally categorized as "Medicaid" were recategorized as "Managed Care". Approximately 8% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self-Pay", and approximately 2% originally categorized as "Missing/Invalid" were recategorized as "Medicare".

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

#### Cost/ Revenue Codes

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

Certification Process

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

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PROVIDER: Cook Childrens Medical Center  
THCIC ID: 332000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Cook Children's Medical Center has submitted and certified second quarter 2007 discharge 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:

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 second quarter of 2007.

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: Brackenridge Hospital  
THCIC ID: 335000  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Childrens Hospital-Austin  
THCIC ID: 335001  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: West Houston Medical Center  
THCIC ID: 337001  
QUARTER: 2  
YEAR: 2007

Certified with comments

Included in the discharge encounter data are discharges from our Rehabilitation Unit, Geropsychiatric Unit, and Hospice which may skew length of stay, deaths, and charge data.

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PROVIDER: Vista Hospital-Dallas  
THCIC ID: 359002  
QUARTER: 2  
YEAR: 2007

Certified with comments

Duplicate accounts - DRG 183 should have been combined with DRG 155.

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PROVIDER: Baylor All Saints Medical Center-Fort Worth  
THCIC ID: 363000  
QUARTER: 2  
YEAR: 2007

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, THIC 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.

#### Medical Record Number

Due to a new system implementation, the Medical Record format was changed from alphanumeric to numeric. Starting 4QTR2004 forward, the leading digit of "M" was dropped leaving the remaining number as the Medical Record number. This change in format will need to be considered when calculating any readmission rates or the rates will be erroneously lower.

#### 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 might change over time. Upon review, approximately 2% of the primary payers originally categorized as "Indemnity" were recategorized as "Managed Care" 2% originally categorized as "Indemnity" were recategorized as "Medicare", and 8% originally categorized as "Medicaid" were recategorized as "Managed Care". Also, approximately 3% of the secondary payers originally categorized as "Indemnity" were recategorized as "Champus", and 7% originally categorized as "Missing/Invalid" recategorized as "self-Pay".

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.

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PROVIDER: Baylor Medical Center-Southwest Fort Worth  
THCIC ID: 363001  
QUARTER: 2  
YEAR: 2007

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.

#### Medical Record Number

Due to a new system implementation, the Medical Record format was changed from alphanumeric to numeric. Starting 4QTR2004 forward, the leading digit of "N" was dropped leaving the remaining number as the Medical Record number. This change in format will need to be considered when calculating any readmission rates or the rates will be erroneously lower.

#### 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 might change over time. Upon review, approximately 14% of the primary payers originally categorized as "Medicaid" were recategorized as "Managed Care". Approximately 7% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self-Pay", 2% originally categorized as "Missing/Invalid" were recategorized as "Champus" and 2% originally categorized as "Indemnity" were recategorized as "Champus".

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.

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PROVIDER: Smithville Regional Hospital  
THCIC ID: 385000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Discharge data is generated by computer and is not closely reviewed. Reports are generated to compare total claims in THCIC discharge report to total inpatient discharges for specified quarter to verify that total discharges correlate.

For 2nd quarter, 2007, it was noted one claim was not extracted into THCIC discharge data. Facility IT personnel & software company personnel failed to resolve problem.

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PROVIDER: Medical Center-Lewisville  
THCIC ID: 394000  
QUARTER: 2  
YEAR: 2007

Certified with comments

When reviewing the data for the Medical Center of Lewisville, please consider the following:

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

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

Admission source data is not collected and grouped at the Medical Center of Lewisville in the same manner as displayed.

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

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

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PROVIDER: CHRISTUS Spohn Hospital Corpus Christi-Shoreline  
THCIC ID: 398001  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: John Peter Smith Hospital  
THCIC ID: 409000  
QUARTER: 2  
YEAR: 2007

Certified with comments

#### Introduction

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

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

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

#### Data Comments

This inpatient data was submitted to meet requirements of the State of Texas for reporting second quarter 2007 inpatient hospital discharge data.

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

#### Charges

Because of changes in payor categories, information about insurance or patient type may not be accurate. Specifically, charity care may not be accurately reflected in the new reporting categories.

#### Maximum Charge Calculation

There is an inherent limitation in our Siemens billing system. At the point during a specific patient stay that the system's maximum number of entries is reached, a certain number of defined charges are captured at a summary level and then deleted from the system to make room for additional charges. At JPS, this would impact the charges for a very limited number of patients for whom we will attempt a manual adjustment. Because of this deficiency, charge information may be understated.

#### Physician Master File

A patient may have several attending physicians throughout his/her course of stay due to the rotation of physicians to accommodate teaching responsibilities. This rotation may result in an under-representation of true attending physicians.

#### Length of Stay

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

" JPSH is a major trauma center, many patients have suffered multiple

system trauma.

" JPSH operates a SNF (skilled nursing facility) unit.

" JPSH operates a Level III neonatal intensive care unit which has an impact on overall length-of-stay.

" JPSH operates an inpatient psychiatric unit in which many patients are court-committed and length of stay is determined by the legal system.

" Diagnosis of cancer has increased significantly and a large number of our patients do not have resources to access hospice and/or palliative care, thereby impacting length of stay.

" Many of our patients have limited financial resources making it impossible for them to secure intermediate care. This, in turn, often limits their discharge options and they remain at JPSH longer than would otherwise be the case.

We are certifying the State data file, with comments.

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PROVIDER: Arlington Memorial Hospital  
THCIC ID: 422000  
QUARTER: 2  
YEAR: 2007

Certified with comments

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

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. The federal government mandates this.

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

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

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is assigned, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates. One patient was incorrectly coded with a diagnosis of accidental operative laceration. This coding error has since been corrected.

Race/Ethnicity

During the hospital's registration process, many patients refuse to answer these questions and therefore, the registration clerks are forced to use their best judgment or answer unknown to these questions.

Any assumptions based on race or ethnicity will be inaccurate.

Standard/Non-Standard Source of Payment

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

Revenue

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

Charity Care

THCIC assumes charity patients are identified in advance and reports charges in a charity financial class as the amount of charity care provided in a given period. In actuality, charity patients are usually not identified until after care has been provided and in the hospital's computer system charity care is recorded as an adjustment to the patient account, not in a separate financial class. Therefore, the THCIC database shows no charity care provided by the hospital for the quarter when in fact the hospital provided \$4,356,208 in charity care during this time period.

Certification Process

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

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PROVIDER: El Campo Memorial Hospital  
THCIC ID: 426000  
QUARTER: 2  
YEAR: 2007

Certified with comments

For the second quarter of 2007, El Campo Memorial Hospital submitted 177 claims. Error rate of these claims were 0% therefore we are certifying our second quarter of 2007 with these comments.

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PROVIDER: Presbyterian Hospital-Dallas  
THCIC ID: 431000

QUARTER: 2  
YEAR: 2007

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

#### Admit Source data for Normal Newborn

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

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

#### Race/Ethnicity

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

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

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer 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 (Seimens) 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: Connally Memorial Medical Center  
THCIC ID: 433000  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Presbyterian Hospital-Winnsboro  
THCIC ID: 446000  
QUARTER: 2  
YEAR: 2007

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

#### Admit Source data for Normal Newborn

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

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

#### Race/Ethnicity

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

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

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer 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 (Seimens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: DeTar Hospital-Navarro  
THCIC ID: 453000  
QUARTER: 2  
YEAR: 2007

Certified with comments

The DeTar Healthcare System includes two hospital campuses: the recently renovated DeTar Hospital Navarro at 506 E. San Antonio Street and DeTar Hospital North also named Women and Children's Center which opened 12/17/03 located at 101 Medical Drive, both in Victoria, Texas. In addition to services provided by full service acute care hospitals, the system also includes: a Skilled Nursing Unit, two Emergency Departments with Level 3 Trauma Designation ER at DeTar Navarro, DeTar Health & Wellness Center, DeTar Medworks Occupational Medicine Center, DeTar Outpatient Rehabilitation Center, DeTar Inpatient Rehabilitation Center, DeTar SeniorCare Center, Active Advantage, Community Mother & Child Health Clinic, Day Surgery services at both DeTar Hospital Navarro and DeTar Hospital North, and a free Physician Referral Service by dialing (361) 788-6113. To find out more, please visit DeTar Healthcare System's website at [www.detar.com](http://www.detar.com).

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PROVIDER: Covenant Medical Center  
THCIC ID: 465000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Data does not accurately reflect the number of charity cases for the time period. This is due to internal processing for determination of the source of payment. 4% of total discharges were charity for 2nd Quarter 2007.

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PROVIDER: Harris Methodist-Northwest  
THCIC ID: 469000

QUARTER: 2  
YEAR: 2007

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

#### Hospital Comments, 2q2007.txt

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

#### Length of Stay

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

#### Admit Source data for Normal Newborn

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Harris Methodist Northwest 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 (Seimens) 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: Parkland Memorial Hospital  
THCIC ID: 474000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Parkland Health & Hospital System comprises a network of neighborhood-based health centers and Parkland Memorial Hospital, which was established in 1894. The Parkland System is a \$995 million enterprise that is licensed for 968 beds and employs approximately 8,048 staff. 14,227 patients received inpatient care this quarter.

Specific Data Concerns

1. 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.
2. Parkland Hospital transitioned to a new system-wide registration and accounting information system in September, 2005. In this transition, updates to several clinical information systems were also accomplished, with improved integration of patient clinical and administrative data. Data validation processes during and after the transition identified errors in the race, ethnicity, admission source and payor data. Limitations in the replaced administrative system prevented implementing a valid data correction for race and ethnicity without destroying historical data therefore no correction was performed. The race categories of white and black with Hispanic ethnicity were affected with discharges between September 2005 and October 2006. Admission source data was affected with discharges from September 2005. Corrections are ongoing.

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PROVIDER: Llano Memorial Hospital  
THCIC ID: 476000  
QUARTER: 2  
YEAR: 2007

Elect not to certify

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PROVIDER: Knapp Medical Center  
THCIC ID: 480000  
QUARTER: 2  
YEAR: 2007

Certified with comments

DISCLAIMER STATEMENT

Knapp Medical Center has compiled the information set forth above in compliance with the procedures for THCIC certification process. All information that is being submitted has been obtained from Knapp Medical Center's records. The information being provided by Knapp Medical Center is believed to be true and accurate at the time of this submission. The information being submitted has been taken from other records kept by Knapp Medical Center and the codes typically used in those records do not precisely conform to the codes required in THCIC certification process. Knapp Medical Center has used its best efforts and submits this information in good faith compliance with THCIC certification process. Any variances or discrepancies in the information provided is the result of Knapp Medical Center's good faith effort to conform to the information regularly compiled with the information sought by THCIC.

CHARITY COMMENT

Knapp Medical Center has a long tradition of providing charity care for the population it serves. Prior to designation as charity, program qualification attempts are exhausted. This results in designation of charity being made after the patient is discharged, sometimes after many months. The aggregate amount of charity provided during the Second Quarter 2007 was \$3,261,175.00 for 113 patients.

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PROVIDER: Driscoll Childrens Hospital  
THCIC ID: 488000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Driscoll Children's Hospital continually strives to analyze the clinic processes used in an effort to improve patient care. Our goal is to provide the best care we can for the children of South Texas.

Driscoll Children's Hospital is a tertiary care regional referral center offering the most complex and comprehensive medical and surgical care for children. The hospital's medical staff is comprised of pediatric board-certified specialists in more than 30 medical and 10 surgical specialties. Working with the Medical Staff is over 1,500 employees including more than 450 nurses.

Every year more than 6,500 children are admitted for inpatient care, 6,000 patients for day surgery, and 65,000 children for outpatient primary and specialty care. Driscoll was the first hospital in South Texas to provide emergency services exclusively for children and today we provide emergency care to more than 40,000 children a year. Driscoll was also the first hospital in south Texas to perform an organ transplant.

All of Driscoll's patient care units offer state-of-the-art services and the latest technology for the treatment of newborns, infants, and children with life threatening illnesses and injuries.

The administrative data used by THCIC for reporting is a condensed subset of the entire clinical information collected on a given case and may not fully reflect the complete picture of a patient's health status or stage of illness, as well as hospital and physician performance. These can be important limitations to the study. We would be glad to talk with patients and families further about the data and any concerns they may have. It is important that the consumer of the THCIC Provider Reports realize that there are parameters with regard to the THCIC data.

It is the mission of Driscoll Children's Hospital to offer hope and healing in an environment of trust, compassion, and care.

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PROVIDER: Seton Medical Center  
THCIC ID: 497000  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Baylor Regional Medical Center-Grapevine  
THCIC ID: 513000  
QUARTER: 2  
YEAR: 2007

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.

Hospital Comments, 2q2007.txt

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. With this in mind, approximately 7% of the primary payers originally categorized as "Other" were recategorized as "Managed Care". And approximately 10% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self-Pay".

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.

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PROVIDER: Seton Highland Lakes  
THCIC ID: 559000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Seton Highland Lakes, a member of the Seton Family of Hospitals, is a 25-bed acute care facility located between Burnet and Marble Falls on Highway 281. The hospital offers 24-hour Emergency services, plus comprehensive diagnostic and treatment services for residents in the surrounding area. Seton Highland Lakes also offers home health and hospice services. For primary and preventive care, Seton Highland Lakes offers a clinic in Burnet, a clinic in Marble Falls, a clinic in Bertram and a pediatric mobile clinic



in the county.

This facility is designated by the Center for Medicare & Medicaid Services as a Critical Access Hospital and is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations under its Critical Access program.

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PROVIDER: Baylor Specialty Hospital  
THCIC ID: 586000  
QUARTER: 2  
YEAR: 2007

Certified with comments

#### Submission Timing

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

#### Physician Identification

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

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

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

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

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

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

#### Length of Stay

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

#### Admission Source

The majority of entries for "Admission Source" were coded incorrectly (erroneously reflecting that our main source of admission was "Physician Referral"). The majority of admission sources are "Transfer from Hospital". This was due to a procedural error which has now been corrected.

#### 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. Upon review, approximately 4% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self-Pay", and 4% originally categorized as "Missing/Invalid" were recategorized as "Campus".

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.

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PROVIDER: Baylor Specialty Hospital  
THCIC ID: 586001  
QUARTER: 2  
YEAR: 2007

Certified with comments

#### Submission Timing

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

#### Physician Identification

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

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

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

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

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

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

#### Length of Stay

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

#### Admission Source

The majority of entries for "Admission Source" were coded incorrectly (erroneously reflecting that our main source of admission was "Physician Referral"). The majority of admission sources are "Transfer from Hospital". This was due to a procedural error which has now been corrected.

#### 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. Upon review, approximately 7% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self-Pay", 2% originally categorized as "Commercial" were recategorized as "Medicare", and 2% originally categorized as "Managed Care" were recategorized as "Champus".

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.

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PROVIDER: Baylor Specialty Hospital-Irving  
THCIC ID: 586002  
QUARTER: 2  
YEAR: 2007

Certified with comments

#### Submission Timing

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

#### Physician Identification

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

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, THIC 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

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

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

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

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

#### Length of Stay

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

#### Admission Source

The majority of entries for "Admission Source" were coded incorrectly (erroneously reflecting that our main source of admission was "Physician Referral"). The majority of admission sources are "Transfer from Hospital". This was due to a procedural error which has now been corrected.

#### 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. With this in mind, approximately 2.5% of the primary payers originally categorized as "Indemnity" were recategorized as "Managed Care". Also, approximately 2.5% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self-Pay", 6% originally categorized as "Managed Care" were recategorized as "champus", and 7% originally categorized as "Indemnity" were recategorized as "Medicare".

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

Cost/ Revenue Codes

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

Certification Process

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

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PROVIDER: Seton Edgar B Davis  
THCIC ID: 597000  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: CHRISTUS St John Hospital  
THCIC ID: 600001  
QUARTER: 2  
YEAR: 2007

Certified with comments

During this time period Christus St. John Hospital provided charity care with total charges (-\$5,666,766.00)dollars.

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PROVIDER: South Austin Hospital  
THCIC ID: 602000  
QUARTER: 2

YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Round Rock Medical Center
THCIC ID: 608000
QUARTER: 2
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Harris Methodist-Southwest
THCIC ID: 627000
QUARTER: 2
YEAR: 2007

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.



## Hospital Comments, 2q2007.txt

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

### Length of Stay

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

### Admit Source data for Normal Newborn

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Harris Methodist 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.

Additionally, there continues to be mapping issues between the State's source of payment values and that used by Texas Health Resources (THR) and Harris Methodists Southwest Hospital (HMSW). In March 2006, the State requested a change in assignment of source of payment values and THR/HMSW complied with that request. However, the State has not yet converted to this new mapping criteria thus causing a discrepancy in the data generated for HMSW's payers. We have been assured that by the 3rd Quarter 2006 Certification time period, the State's source of payment values will be updated and there will no longer be this discrepancy.

#### Cost/ Revenue Codes

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

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PROVIDER: Palestine Regional Medical Center  
THCIC ID: 629001  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Baylor Institute for Rehab-Gaston Episcopal Hosp  
THCIC ID: 642000  
QUARTER: 2  
YEAR: 2007

Certified with comments

#### Submission Timing

Baylor Institute for Rehabilitation (BIR) 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. BIR has a 10-day billing cycle; therefore we will have a higher percentage of incomplete encounters than hospitals with a 30-day billing cycle.

#### Physician Identification

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

information, some physicians may remain unidentified in the THCIC Practitioner Reference Files.

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

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

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

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

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

#### Length of Stay

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

#### Race/Ethnicity

There are no national standards regarding patient race categorization

so hospitals may not have the same designations from which patients can choose. The state has recently attempted to standardize a valid set of race codes for this project, but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

#### Standard 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. With this in mind, approximately 9% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self-Pay", 8% originally categorized as "Other" were recategorized as "Managed Care", and 3% originally categorized as "Other" were recategorized as "Medicare".

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

#### Cost/Revenue Codes

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

#### Certification Process

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.

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PROVIDER: Baylor Institute for Rehabilitation  
THCIC ID: 642001  
QUARTER: 2  
YEAR: 2007

Certified with comments

#### Submission Timing

Baylor Institute for Rehabilitation (BIR-BUMC) 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. BIR has a 10-day billing cycle; therefore we will have a higher percentage of incomplete encounters than hospitals with a 30-day billing cycle.

#### Physician Identification

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

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

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

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

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

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

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

#### Length of Stay

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

or injury.

Race/Ethnicity

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

Standard 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. With this in mind, approximately 8% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self-Pay", 4% originally categorized as "Indemnity" were recategorized as "Medicare", and 4% originally categorized as "Managed Care" were recategorized as "Champus".

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.

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PROVIDER: Harris Continued Care Hospital
THCIC ID: 652000
QUARTER: 2
YEAR: 2007

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

Admit Source data for Normal Newborn

Harris Methodist Continued Care 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 (Seimens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Kindred Hospital-Mansfield
THCIC ID: 657000
QUARTER: 2
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Presbyterian Hospital-Plano
THCIC ID: 664000
QUARTER: 2
YEAR: 2007

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 state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than

999 days, therefore, it is not anticipated that this limitation will affect this data.

#### Admit Source data for Normal Newborn

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

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

#### Race/Ethnicity

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

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

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer 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 (Seimens) 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: HEALTHSOUTH Plano Rehab Hospital  
THCIC ID: 670000  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Burluson St Joseph Health Center-Caldwell  
THCIC ID: 679000  
QUARTER: 2  
YEAR: 2007

Certified with comments

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

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Burluson St. Joseph Health Center charity care, based on established rates for the first two quarters of 2007 was \$314,574.

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

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

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

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

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

the severity adjustments or how it functions can greatly impact the interpretation of the data.

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PROVIDER: Covenant Childrens Hospital  
THCIC ID: 686000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Data does not accurately reflect the number of charity cases for the time period.  
This is due to internal processing for determination of the source of payment.  
4% of total discharges were charity for 2nd Quarter 2007.

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PROVIDER: Kindred Hospital-Tarrant County  
THCIC ID: 690000  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Trinity Mother Frances Rehab Hospital  
THCIC ID: 692000  
QUARTER: 2  
YEAR: 2007

Certified with comments

All results may or may not be 100% accurate.

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PROVIDER: Surgery Specialty Hospitals of America-Southeast Houston  
THCIC ID: 694100  
QUARTER: 2  
YEAR: 2007

Certified with comments

One cervical refusion included an additional cervical fusion code 81.02 that should be removed. No change in the DRG.

One anterior lumbar fusion was actually a posterior approach.

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PROVIDER: The Corpus Christi Medical Center-Bay Area  
THCIC ID: 703000  
QUARTER: 2  
YEAR: 2007

Certified with comments

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the accuracy of these numbers cannot be verified.

Corpus Christi Medical Center maintains that under Non-Standard source of payment, accounts that are summarized as missing/invalid are neither missing nor invalid, but are accounts that are not required to be additionally

Hospital Comments, 2q2007.txt  
categorized and should be listed as "blank" or "not-applicable".

Consolidation efforts for all women's and OB services to be located at Corpus Christi Medical Center's Women's Center at Bay Area were completed in May 2005.

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PROVIDER: The Corpus Christi Medical Center-Doctor's Regional  
THCIC ID: 703002  
QUARTER: 2  
YEAR: 2007

Certified with comments

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the accuracy of these numbers cannot be verified.

Corpus Christi Medical Center maintains that under Non-Standard source of payment, accounts that are summarized as missing/invalid are neither missing nor invalid, but are accounts that are not required to be additionally categorized and should be listed as "blank" or "not-applicable".

Consolidation efforts for all women's and OB services to be located at Corpus Christi Medical Center's Women's Center at Bay Area were completed in May 2005.

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PROVIDER: The Corpus Christi Medical Center-Heart Hospital  
THCIC ID: 703003  
QUARTER: 2  
YEAR: 2007

Certified with comments

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the accuracy of these numbers cannot be verified.

Corpus Christi Medical Center maintains that under Non-Standard source of payment, accounts that are summarized as missing/invalid are neither missing nor invalid, but are accounts that are not required to be additionally categorized and should be listed as "blank" or "not-applicable".

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PROVIDER: Dubuis Hospital-Beaumont  
THCIC ID: 708000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital.

In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently

they require a longer hospital stay than the younger population.

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PROVIDER: Dubuis Hospital-Port Arthur  
THCIC ID: 708001  
QUARTER: 2  
YEAR: 2007

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital.

In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

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PROVIDER: Our Childrens House Baylor  
THCIC ID: 710000  
QUARTER: 2  
YEAR: 2007

Certified with comments

**Submission Timing**

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

**Physician Identification**

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

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, THIC 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

OCH is different from most hospitals submitting data to the state. We provide complex medical services to patients who have experienced a catastrophic illness, congenital anomalies and/or complex body system failure that requires coordinated, intensive treatment and care. Many of the patients have received emergency care and stabilizing treatment at another acute care hospital or another children's acute care hospital. They are admitted to OCH to continue their recovery and focus on improving their medical condition.

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

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

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

#### Length of Stay

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

#### Admission Source

The majority of entries for "Admission Source" were coded incorrectly (erroneously reflecting that our main source of admission was "Physician Referral"). The majority of admission sources are "Transfer from Hospital". This was due to a procedural error which has now been corrected.

#### 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 and non-standard source of payment value.

It should also be noted that the primary payer associated to the patient's encounter record might change over time. Upon review, approximately 29% of the primary payers originally categorized as "Medicaid" were recategorized as "Managed Care", 21% originally categorized as "Medicaid" were recategorized as "Medicare", and 7% originally categorized as "Commercial" were recategorized as "Medicare". Approximately 11% of secondary payors categorized as "Missing/Invalid"

were recategorized as "Medicare", 5% originally categorized as "Medicaid" were recategorized as "Managed Care", and 4% originally categorized as "Medicaid" were recategorized as "Self-Pay".

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.

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PROVIDER: CHRISTUS St Catherine Hospital  
THCIC ID: 715901  
QUARTER: 2  
YEAR: 2007

Certified with comments

CHRISTUS St.Catherine Hospital provided \$3,045,066 of charity care during the 2nd quarter 2007.

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PROVIDER: Kindred Hospital-White Rock  
THCIC ID: 719400  
QUARTER: 2  
YEAR: 2007

Certified with comments

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



PROVIDER: Seay Behavioral Health Center  
THCIC ID: 720000  
QUARTER: 2  
YEAR: 2007

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

#### Admit Source data for Normal Newborn

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. 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 (Seimens) 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: Presbyterian Hospital-Allen  
THCIC ID: 724200  
QUARTER: 2  
YEAR: 2007

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

#### Admit Source data for Normal Newborn

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

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

#### Race/Ethnicity

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

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

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer 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 (Seimens) 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: Mother Frances Hospital-Jacksonville  
THCIC ID: 725400  
QUARTER: 2  
YEAR: 2007

Certified with comments

Our billing system does not have a payer classification for "PPO" insurance plans. The "PPO" plan activity has been mapped, erroneously, to "HMO". We are working to correct this issue in future data submissions.

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PROVIDER: Grimes St Joseph Health Center  
THCIC ID: 728800  
QUARTER: 2  
YEAR: 2007

Certified with comments

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

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Grimes St. Joseph Health Center charity care, based on established rates for the first two quarters of 2007 was \$270,450.

Patient Mix - Grimes St. Joseph Health Center is a "Critical Access Hospital". Because of this Mortality and Length of Stay may be skewed. This will prohibit any meaningful comparisons between Grimes St. Joseph Health Center and any "acute care only" facilities.

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

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

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

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

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PROVIDER: Harris Methodist-Springwood  
THCIC ID: 778000  
QUARTER: 2  
YEAR: 2007

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

#### Length of Stay

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

#### Admit Source data for Normal Newborn

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Harris Methodist 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 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 (Seimens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Baylor Heart & Vascular Center  
THCIC ID: 784400  
QUARTER: 2  
YEAR: 2007

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 might change over time. Upon review approximately 21% of the primary payers originally categorized as "Indemnity" were recategorized as "Managed Care". Also approximately 7% of the secondary payers originally categorized as "Indemnity" were recategorized as "Managed Care".

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.

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PROVIDER: Baylor Medical Center-Frisco  
THCIC ID: 787400  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Dubuis Hospital-Paris  
THCIC ID: 787500  
QUARTER: 2  
YEAR: 2007

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital.

In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

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PROVIDER: Texas Orthopedic Hospital  
THCIC ID: 792000  
QUARTER: 2  
YEAR: 2007

Elect not to certify

I, Alice Adams, CEO, elect not to certify second quarter 2007 data for Texas Orthopedic Hospital due to the fact Texas Orthopedic Hospital is licensed as a 49 bed acute care hospital which operates as an ambulatory specialty orthopedic facility. Approximately 80% of all surgical procedures are performed on an outpatient basis. Because of the specialty nature and the high percentage of outpatient surgeries, Texas Orthopedic Hospital has a uniqueness that would limit the general population's ability to form an accurate opinion or decision on the quality of services provided.

The data enclosed does not reflect the actual practice of the individual surgeons and the care given to the inpatient population. Texas Orthopedic Hospital, as a top 100 orthopedic hospital ranked by HCIA, is a referral center and the individual physicians accept referrals from other physicians for patient's that may have had a malfunction of an internal orthopedic device or an infection, which needs to be surgically corrected. It is imperative that individuals looking at the data be aware of these facts so that frequently listed diagnoses of 996.4 and/or 996.66 be interpreted as a result of the patient's primary surgery, as performed by the treating physician. These may well be referred cases for which the original treating physician is not comfortable correcting through surgical means. They do not reflect the practice of the individual Texas Orthopedic Hospital surgeon, i.e., complication of his work. Therefore, the data presented by THCIC to the public could be misinterpreted and not truly reflect the high quality outcomes and superb care our patients receive.

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PROVIDER: St Lukes Community Medical Center-The Woodlands  
THCIC ID: 793100  
QUARTER: 2  
YEAR: 2007

Certified with comments

The data reports for Quarter 2, 2007 do not accurately reflect patient volume or severity.

#### Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that are a snapshot of claims one month following quarter-end. If the encounter has not yet been billed, data will not be reflected in this quarter.

#### Severity

Descriptors for newborn admissions are based on national billing data elements (UB04) and definitions of each element can and do vary from hospital to hospital. Because of the absence of universal definitions for normal delivery, premature delivery and sick baby, this category cannot be used for comparison across hospitals. The DRG is the only somewhat meaningful description of the infant population born at a facility.

More importantly, not all clinically significant conditions, such as the heart's 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.

#### Claim Filing Indicator

Due to a format change made by THCIC after the submission of the data, the Claim Filing Indicator Codes (Payer designations) reflect the old format and not the new one.

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PROVIDER: Dubuis Hospital-Corpus Christi  
THCIC ID: 797001  
QUARTER: 2  
YEAR: 2007

Certified with comments

Hospital Comments, 2q2007.txt

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital.

In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

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PROVIDER: Seton Southwest Hospital  
THCIC ID: 797500  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Seton Northwest Hospital  
THCIC ID: 797600  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Kindred Hospital-Tarrant County  
THCIC ID: 800000  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Kindred Hospital-Fort Worth  
THCIC ID: 800700  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Kindred Hospital  
THCIC ID: 801000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Kindred Hospital Bay Area is a Long Term Acute Care Facility

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PROVIDER: Lubbock Heart Hospital

THCIC ID: 801500  
QUARTER: 2  
YEAR: 2007

Elect not to certify

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PROVIDER: Dubuis Hospital-Houston  
THCIC ID: 807000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital.

In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

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PROVIDER: Harris Methodist Southlake Center-Diagnostics & Surgery  
THCIC ID: 812800  
QUARTER: 2  
YEAR: 2007

Certified with comments

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PROVIDER: Baylor Regional Medical Center-Plano  
THCIC ID: 814001  
QUARTER: 2  
YEAR: 2007

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, THIC 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. With this in mind, approximately 6% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self-Pay" and 2% originally categorized as "Missing/Invalid" were recategorized as "Champus".

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.

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PROVIDER: Pine Creek Medical Center  
THCIC ID: 818200  
QUARTER: 2  
YEAR: 2007

Certified with comments

The data files for the 2nd quarter is incorrect. PCMC had 172 discharges and only 131 were included in the report. Our IT department investigated the problem and it was resolved. Future submitted data files should reflect the correct number of discharges.

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PROVIDER: Presbyterian Hospital-Denton  
THCIC ID: 820800  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: South Texas Rehab Hospital  
THCIC ID: 821100  
QUARTER: 2  
YEAR: 2007

Certified with comments

Due to software errors the discharge data is inaccurate. The total discharges are 168 and the total revenue is \$4037112.48.

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PROVIDER: Dubuis Hospital-Texarkana  
THCIC ID: 822000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals.

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital.

In addition, our patient mix is predominately elderly as they most often

have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

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PROVIDER: Houston Physicians Hospital  
THCIC ID: 822001  
QUARTER: 2  
YEAR: 2007

Certified with comments

Under the Patient Discharge Status, the data shows that all 107 patients were discharged home. That data is incorrect. The correct data is as follows. 100 patients were discharged to home or self care, 2 were discharge/transfers to short term general hospital, and 5 were discharge/transfers to rehab facility. These numbers total the original 107 patients. Under the claim filing indicator code, it shows a primary count of 31 and secondary count of 3 listed as Other Non-Federal Programs. That data is incorrect. The 31 and 3 listed above should be counted as Medicare Part A. All other data is correct.

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PROVIDER: North Austin Medical Center  
THCIC ID: 829900  
QUARTER: 2  
YEAR: 2007

Certified with comments

Data Comments:

- \* Inpatient discharge data have been collected from claims data. The data are used for billing purposes and are not clinical data. Due to the diversity of healthcare organizations and data collecting practices throughout Texas, there are inherent limitations on comparing outcomes.
- \* The public data file does not contain all the diagnosis and procedure codes. It contains only 9 diagnosis codes and 6 procedure codes per encounter. This will affect the volume of procedures, the severity adjustment and mortality rates.
- \* The data reflect only those patients admitted to a hospital during the year and are aggregated, not trended. Data over time are needed for a more accurate assessment of the health care facilities' performance.
- \* THCIC has excluded data when five or fewer patients had a procedure and did not perform statistical analysis when there were fewer than 30 patients.
- \* Race / Ethnicity classification is not done systematically within or between facilities. Caution should be used when analyzing this data within one facility and between facilities.

General Comments:

1. North Austin Medical Center is a member of the St. David's Healthcare Partnership and supports the effort of the THCIC to provide publically released hospital data as an integral part of our ongoing organizational quality improvement process. We have been tracking similar data and developing improvement measures as applicable over the past three years.

2. Although the risk-adjusting software helps in making the data more comparable among facilities, it too is an approximation that may not truly represent the mix of patients. This is particularly true for mortalities in patients admitted for terminal care. Terminal care has a very high expected mortality, and this is not accounted for in the methodology.

3. Since medical mortalities are relatively infrequent events and occur at irregular intervals, the data can and do vary considerably over time. We have noticed considerable fluctuation and variation in all of our



facilities over the past three years, depending upon the time period that the data were measured.

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PROVIDER: Laredo Specialty Hospital  
THCIC ID: 836300  
QUARTER: 2  
YEAR: 2007

Certified with comments

Due to software errors the discharge data is inaccurate. The total discharges are 119 and the total revenue is \$6237593.56.

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PROVIDER: St Joseph Medical Center  
THCIC ID: 838600  
QUARTER: 2  
YEAR: 2007

Certified with comments

St. Joseph Medical Center certified the data, but could not account for 66 patients due to processing the patients after the data was submitted.

During this time period St. Joseph Medical Center provided chaity care 150 patients with total charges (-\$484,331.06) dollars. The system didn't identify these patients.

St. Joseph Medical Center data didn't correspond to the newborn admission according to our data there were 89 premature newborns, 206 sick newborns and 824 normal newborns.

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PROVIDER: Mesquite Specialty Hospital  
THCIC ID: 840000  
QUARTER: 2  
YEAR: 2007

Certified with comments

Due to software errors the discharge data is inaccurate. The total discharges are 47 and the total revenue is \$2687567.31.

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PROVIDER: El Paso LTAC Hospital  
THCIC ID: 841300  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: Methodist Mansfield Medical Center  
THCIC ID: 842800  
QUARTER: 2  
YEAR: 2007

Certified with comments

DATA CONTENT  
This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care. The data submitted are certified

to be accurate representations of the billing data recorded, to the best of our knowledge. The data is not certified to represent the complete set of data available on all inpatients but rather that data which was reported to a particular payer as required by that payer.

#### PHYSICIAN REVIEW OF THE DATA

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

#### SUBMISSION TIMING

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

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

#### OMISSION OF OBSERVATION PATIENTS

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

#### DIAGNOSIS AND PROCEDURES

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

nine diagnoses  
and/or six  
procedures assigned.

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

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

#### NORMAL NEWBORNS

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

#### RACE AND ETHNICITY CODES

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

#### STANDARD/NON-STANDARD SOURCE OF PAYMENT

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

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

REVENUE CODE AND CHARGE DATA

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

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

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

SEVERITY ADJUSTMENT SCORES

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

PHYSICIAN UPIN NUMBER ERRORS

All physician UPIN numbers and names have been validated with the physician and the UPIN web-site as accurate even though some remain unidentified in the THCIC data tables. This appears to be due to delays in updating the THCIC UPIN data tables.

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PROVIDER: North Cypress Medical Center  
THCIC ID: 843200  
QUARTER: 2  
YEAR: 2007

Certified with comments

\*Comments not received by THCIC

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PROVIDER: The Heart Hospital Baylor Plano  
THCIC ID: 844000  
QUARTER: 2  
YEAR: 2007

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.

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#### 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 might change over time. Upon review approximately 6% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self-Pay", and 3% "Missing/Invalid" were recategorized as "Champus".

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.

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PROVIDER: Texoma Medical Center Restorative Care Hospital  
THCIC ID: 846900  
QUARTER: 2  
YEAR: 2007

Certified with comments

Data Source. The source of this data, the electronic 1450, is administrative in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.  
\* The Hospital can only list 4 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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

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

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

Hospital Comments, 2q2007.txt

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

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

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

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PROVIDER: Texoma Medical Center

THCIC ID: 847000

QUARTER: 2

YEAR: 2007

Certified with comments

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

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

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

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

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

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

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

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

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