General Comments on 4th 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.

==
PROVIDER: Austin State Hospital
THCIC ID: 000100
 QUARTER: 1
    YEAR: 2008

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	2.52%
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
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.
===
PROVIDER: Big Spring State Hospital
THCIC ID: 000101
 QUARTER: 4
    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.

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

of payment, by percent, are:

Standard Source of Payment	Total Percentage (%)
Self-Pay	2.%
Worker's Comp	n/a
Medicare	4.91%
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.
==
PROVIDER: Rio Grande State Center
THCIC ID: 000104
 QUARTER: 4
    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	0.55%
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.
==
PROVIDER: Kerrville State Hospital
THCIC ID: 000106
 QUARTER: 4
    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.
==
PROVIDER: Rusk State Hospital
THCIC ID: 000107
 QUARTER: 4
    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	Total Percentage (%)
Self-Pay	1.65%
Worker's Comp	n/a
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.
==
PROVIDER: San Antonio State Hospital
THCIC ID: 000110
 QUARTER: 4
    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   0.87%
Worker's Comp   n/a
Medicare   8.65%
Medicaid   15.43%
Other Federal Programs   n/a
Commercial   1.46%
Blue Cross   n/a
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

Hospital Comments, 4Q2007.txt
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: Terrell State Hospital
THCIC ID: 000111
 QUARTER: 4
    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

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.
==
PROVIDER: North Texas State Hospital
THCIC ID: 000114

    QUARTER: 4
      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	1.11%
Worker's Comp	n/a
Medicare	0.30%
Medicaid	15.23%
Other Federal Programs	n/a
Commercial	2.16%
Blue Cross	n/a
Champus	0.13%
Other	n/a
Missing/Invalid	n/a

Non Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.05%
Commercial HMO	n/a
Charity	81%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be a danger
to self or others and the severity of illness is determined by an acuity
assessment performed by the hospital. The severity Index on the encounter
record for each patient is assigned based on the patient's APR-DRG (All
Patient Refined-Diagnosis Related Groups), which does not reflect the
severity of mental illness due to reporting methodology.
==
PROVIDER: Waco Center for Youth
THCIC ID: 000117
 QUARTER: 4
     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	95%
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.
==
PROVIDER: El Paso Psychiatric Center
THCIC ID: 000118
 QUARTER: 4
    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.
==
PROVIDER: St Joseph Regional Health Center
THCIC ID: 002001
 QUARTER: 4
    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 2007 was $39,514,330.

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.
==
PROVIDER: Matagorda General Hospital
THCIC ID: 006000
 QUARTER: 4
    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.
==
PROVIDER: Matagorda General Hospital
THCIC ID: 006001
 QUARTER: 4
    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.
===
PROVIDER: Good Shepherd Medical Center-Marshall
THCIC ID: 020000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
===
PROVIDER: Baylor Medical Center-Garland
THCIC ID: 027000
 QUARTER: 4
    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 11% of
the primary payers originally categorized as "Medicaid" were recategorized
as "Managed Care". And 11% 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.

==
PROVIDER: Kindred Hospital-Dallas
THCIC ID: 028000
 QUARTER: 4
    YEAR: 2007

Certified with comments, corrections requested

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: Kindred Hospital-Dallas Walnut Hill
THCIC ID: 028002
 QUARTER: 4
    YEAR: 2007

Certified with comments, corrections requested

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: Madison St Joseph Health Center
THCIC ID: 041000
 QUARTER: 4
    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 2007 was $358,482.

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

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

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

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

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign

the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity
and risk of mortality scores. The assignment is made by evaluation of
the patient's age, sex, diagnosis codes, procedure codes, and discharge
status. This grouper can only use the limited number of procedure and
diagnosis codes available in the data file (nine diagnosis and six procedure
codes). If all the patient's diagnosis codes were available the APR-DRG
assignment may possibly differ from the APR-DRG assigned by THCIC. The
severity grouping assignment performed by the state using the APR-DRG
grouper cannot be replicated by facilities unless they purchase this grouper.
 Additionally, the lack of education regarding how this grouper calculates
the severity adjustments or how it functions can greatly impact the interpretation
of the data.
==
PROVIDER: Trinity Medical Center
THCIC ID: 042000
 QUARTER: 4
    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 n 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 th e Patient, Provider, and Payer and "empowered", educated"
decision-making. Quality improvement is not new; it is an on-going commitment.
==
PROVIDER: Huguley Memorial Medical Center
THCIC ID: 047000
 QUARTER: 4
    YEAR: 2007

Certified with comments

The following comments reflect concerns, errors, or limitations of discharge
data for THCIC mandatory reporting requirements as of August 26, 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 physician with eleven encounters
appeared on the audits due to a missing secondary identifier.

Two encounters with DRG 211 and 317 were mapped to incorrect physicians
in the submission file. Two encounters with DRG 111 and 470 were mismapped
as a result of an interface issue not crossing over. One encounter with
DRG 143 was incorrectly entered as an Inpatient but should have been an

ED visit.

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 the hospital documents 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.
===
PROVIDER: College Station Medical Center
THCIC ID: 071000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
===
PROVIDER: Tomball Regional Hospital
THCIC ID: 076000
 QUARTER: 4
    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.
===
PROVIDER: Covenant Medical Center-Lakeside
THCIC ID: 109000
 QUARTER: 4
    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 4th Quarter 2007.
==
PROVIDER: St Lukes Episcopal Hospital
THCIC ID: 118000
 QUARTER: 4
    YEAR: 2007

Certified with comments

The data reports for Quarter 4, 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.
==
PROVIDER: Angleton Danbury Medical Center
THCIC ID: 126000
 QUARTER: 4
    YEAR: 2007

Elect not to certify

Both the Information Director and Authorized Certifier are no longer employed
by Angleton Danbury Medical Center. The submission of Quarter 4 2007
data was completed by the former Information Director; therefore, we do
not feel confident in certifying the data.
==
PROVIDER: Methodist Charlton Medical Center
THCIC ID: 142000
 QUARTER: 4
    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.
===
PROVIDER: University Medical Center
THCIC ID: 145000
 QUARTER: 4
    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.
===
PROVIDER: Covenant Hospital-Plainview
THCIC ID: 146000
 QUARTER: 4
    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.
==
PROVIDER: Methodist Hospital
THCIC ID: 154000
 QUARTER: 4
    YEAR: 2007

Certified with comments

Top 30 DRGs are not correct because they are not based on the correct
Grouper Version. They are based on version 24 instead of 25.
==
PROVIDER: Methodist Specialty & Transplant Hospital
THCIC ID: 154001
 QUARTER: 4
    YEAR: 2007

Certified with comments

Top 30 DRGs are not correct because they are not based on the correct
Grouper Version. They are based on version 24 instead of 25.
==
PROVIDER: Northeast Methodist Hospital
THCIC ID: 154002
 QUARTER: 4
    YEAR: 2007

Certified with comments

Top 30 DRGs are not correct because they are not based on the correct
Grouper Version. They are based on version 24 instead of 25.
==
PROVIDER: Harris Methodist HEB
THCIC ID: 182000
 QUARTER: 4
    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.
==
PROVIDER: Select Specialty Hospital-Houston West
THCIC ID: 206004
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Oakbend Medical Center
THCIC ID: 230000
 QUARTER: 4
    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 continous.
==
PROVIDER: Harris Methodist-Fort Worth
THCIC ID: 235000
 QUARTER: 4
    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.
==
PROVIDER: Methodist Dallas Medical Center
THCIC ID: 255000
 QUARTER: 4
    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. Medical Center
did not attempt to have
every physician individually review each patient in the actual data set
returned to us by the State.
We matched the State generated reports to internally generated reports
to ensure data submission
accuracy. We then reviewed these reports with Physician leadership who
assisted us in
generating the comments contained herein.

SUBMISSION TIMING
The State requires us to submit a snapshot of billed claims, extracted
from our database

approximately 20 days following the close of the calendar year quarter. Any discharged patient
encounters not billed by this cut-off date will not be included in the quarterly submission. Claims
billed in the subsequent quarter for discharges of a previous quarter will be submitted to the State
in the subsequent quarter's submission.

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

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

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

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

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

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

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

STANDARD/NON-STANDARD SOURCE OF PAYMENT
The standard and non-standard source of payment codes are an example of data required by the
State that is not contained within the standard UB92 billing record. In order to meet this
requirement each payer's identification must be categorized into the appropriate standard and
non-standard source of payment value. It is important to note that sometimes, many months after
billing and 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.
==
PROVIDER: Harris Methodist-Erath County
THCIC ID: 256000
 QUARTER: 4
    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.
==
PROVIDER: R E Thomason General Hospital
THCIC ID: 263000
 QUARTER: 4
    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.

Corrections to reported newborn statistics are as follows:

Born inside the hospital: 1248
Born outside the hospital: 1
Total: 1249

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.
==
PROVIDER: Metropolitan Methodist Hospital
THCIC ID: 283000
 QUARTER: 4
    YEAR: 2007

Certified with comments

Top 30 DRGs are not correct because they are not based on the correct
Grouper Version. They are based on version 24 instead of 25.

==
PROVIDER: Baylor Medical Center-Waxahachie
THCIC ID: 285000
 QUARTER: 4
    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 15% of
the primary payers originally categorized as "Medicaid" were recategorized
as "Managed Care". And approximately 7% of the secondary payers originally
as "Indemnity" were recategorized as "Self-Pay", 50% originally categorized
as "Missing/Invalid" were recategorized as "Managed Care", and 25% 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.
==
PROVIDER: Mother Frances Hospital
THCIC ID: 286000
 QUARTER: 4
    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.
==
PROVIDER: Baylor Medical Center-Irving
THCIC ID: 300000
 QUARTER: 4
    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 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
25% of the primary payers originally categorized as "Medicaid" were recategorized
as "Indemnity", 31% originally categorized as "Managed Care" were recategorized
as "Indemnity" and 6% originally categorized as "Managed Care" were recategorized
as"Champus". And approximately 9% 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.
==
PROVIDER: Presbyterian Hospital-Kaufman
THCIC ID: 303000
 QUARTER: 4
    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.

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.
==
PROVIDER: Walls Regional Hospital
THCIC ID: 323000
 QUARTER: 4
    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. 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.
==
PROVIDER: Baylor University Medical Center
THCIC ID: 331000
 QUARTER: 4
    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 42% of the
primary payers originally categorized as "Missing/Invalid" were recategorized
as "Managed Care", 29% originally categorized as "Missing/Invalid" were
recategorized as "Medicare", 9% originally categorized as "Indemnity"
were recategorized as "Self-Pay". Approximately 9% 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.
==
PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
 QUARTER: 4
    YEAR: 2007

Certified with comments

Cook Children's Medical Center has submitted and certified fourth 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
fourth 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.
==
PROVIDER: Brackenridge Hospital
THCIC ID: 335000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: West Houston Medical Center
THCIC ID: 337001
 QUARTER: 4
    YEAR: 2007

Certified with comments

Included in the discharge encounter data are discharges from our Rehabilitation
Nursing Unit, Geropsychiatric Unit, and Hospice which may skew lenght
of stay, deaths, and charge data.
==
PROVIDER: Vista Hospital-Dallas
THCIC ID: 359002
 QUARTER: 4
    YEAR: 2007

Certified with comments

HCFA DRG #'s shown are from the 2007 version and not 2008. On one HCFA
DRG 288 a dx code left off. Under 1 acct. for HCFA DRG 155 a disgnosis
is missing and under 2 accounts some proc. codes are missing. Under HCFA
DRG 579, the princ. PX adn Otr. PX codes should be switched on one account.
 Under HCFA DRG 288 for 1 account the operating phy. is incorrect. Should
be the same as the attending. Total admits should be 194 (8 emergencies
and 186 elective admission types. Admission source should be 185 for
#1, 2 for #4, and 7 for #7. The number of patients discharged should be
198 with 186 for #1, 1 for #9, 1 for #20, and 1 for #63. For claims filing
Indicator code - 23 for BL, 81 for CI, 1 for HM, 8 for MA, 2 # 12 and
1-ZZ. Pt. Gender(male 52, Female 142). Race (1-#1,1-#2,46-#3, 122-#4,

21-#5, and 3 - missing/invalid). Pt. Ethnicity(13-#1, 181-#2). Pat. Age
Breakdown correction on age 18-44 (should be 111) and 45-64(should be
83).
==
PROVIDER: Baylor All Saints Medical Center-Fort Worth
THCIC ID: 363000
 QUARTER: 4
    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 "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 11% of the primary
payers originally categorized as "Medicaid" were recategorized as "Managed
Care". Also, approximately 6% of the secondary payers originally categorized
as "Missing/Invalid" were recategorized as "Self-Pay", 4% originally categorized
as "Indemnity" were recategorized as "Champus", and 7% originally categorized
as "Managed Care" 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.
==
PROVIDER: Baylor Medical Center-Southwest Fort Worth
THCIC ID: 363001
 QUARTER: 4
    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 19% of the primary
payers originally categorized as "Medicaid" were recategorized as "Managed
Care". Approximately 5% of the secondary payers originally categorized
as "Missing/Invalid" were recategorized as "Self-Pay", and 3% 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.
==
PROVIDER: Smithville Regional Hospital
THCIC ID: 385000
 QUARTER: 4
    YEAR: 2007

Certified with comments

More errors than usual due to POA indicators as well as facility administrative
personnel indicators of "No Name" on billing data. Data is extracted
based on data entered.
==
PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
 QUARTER: 4
    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 fourth 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.
==
PROVIDER: Arlington Memorial Hospital
THCIC ID: 422000
 QUARTER: 4
    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 $2,502,833 in charity care during this time period.

Certification Process

Due to the infancy of the state reporting process and the state's computer
system development, the certification process is not as complete and as
thorough as all parties would like to see in the future. Within the constraints
of the current THCIC process, the data is certified to the best of our
knowledge as accurate.
==
PROVIDER: Lake Granbury Medical Center
THCIC ID: 424000
 QUARTER: 4
    YEAR: 2007

Certified with comments

Due to the UB04 data change we had a problem with Newborn Admission Type.
Please note all babies for 4q2007 were born in the hospital.
==
PROVIDER: El Campo Memorial Hospital
THCIC ID: 426000
 QUARTER: 4
    YEAR: 2007

Certified with comments

For the fourth quarter of 2007, El Campo Memorial Hospital submitted 178
claims. Error rate of these claims were 055% therefore we are certifying
our fourth quarter of 2007 with these comments.
==
PROVIDER: Presbyterian Hospital-Dallas
THCIC ID: 431000
 QUARTER: 4
    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.

==
PROVIDER: Connally Memorial Medical Center
THCIC ID: 433000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Presbyterian Hospital-Winnsboro
THCIC ID: 446000
 QUARTER: 4
    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.
==
PROVIDER: DeTar Hospital-Navarro
THCIC ID: 453000
 QUARTER: 4
    YEAR: 2007

Certified with comments

The DeTar Healthcare System includes two hospital campuses: the recently
renovated DeTar Hospital Navarro located at 506 E. San Antonio Street
and DeTar Hospital North, also named Women & 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 III Trauma Designation at DeTar Navarro and Level IV Trauma Designation
at DeTar North, DeTar Health & Wellness Center, DeTar Medworks Ocupational
Medicine Center, DeTar Outpatient Rehabilitation Center, DeTar Inpatient
Rehabilitation Center, DeTar SeniorCare Center, Senior Circle, 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.
==
PROVIDER: Covenant Medical Center
THCIC ID: 465000
 QUARTER: 4
    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 4th Quarter 2007.
==
PROVIDER: Harris Methodist-Northwest
THCIC ID: 469000
 QUARTER: 4
    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 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.
===

PROVIDER: Parkland Memorial Hospital
THCIC ID: 474000
 QUARTER: 4
    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. 14,196 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.
==
PROVIDER: Knapp Medical Center
THCIC ID: 480000
 QUARTER: 4
    YEAR: 2007

Certified with comments

KNAPP MEDICAL CENTER THCIC DISCLAIMER STATEMENT AND COMMENTS FOR FOURTH QUARTER 2007

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 Fourth Quarter 2007 was $2,790,133.80 for 104 patients.
==
PROVIDER: Driscoll Childrens Hospital
THCIC ID: 488000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Seton Medical Center
THCIC ID: 497000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Baylor Regional Medical Center-Grapevine
THCIC ID: 513000
 QUARTER: 4
    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 7% of
the primary payers originally categorized as "Other" were recategorized
as "Managed Care". And approximately 8% 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.
==
PROVIDER: Seton Highland Lakes
THCIC ID: 559000
 QUARTER: 4
    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
==
PROVIDER: Baylor Specialty Hospital
THCIC ID: 586000
 QUARTER: 4
    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.

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

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

Certification Process
Given the current certification software, there is not an efficient mechanism
to
edit and correct the data. In addition, due to hospital volumes, it is
not feasible to perform encounter level audits and edits. Within the
constraints of the current THCIC process, the data is certified to the
best of our knowledge as accurate and complete given the above comments.
==
PROVIDER: Baylor Specialty Hospital
THCIC ID: 586001
 QUARTER: 4
    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 20% of the
secondary payers originally categorized as "Managed Care" were recategorized
as "Self-Pay", 7% originally categorized as "Indemnity" were recategorized
as "Self-Pay", 5% originally categorized as "Indemnity" were recategorized
as "Medicare", and 3% originally categorized as "Indemnity" were recategorized
as "Missing/Invalid".

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

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

Certification Process
Given the current certification software, there is not an efficient mechanism
to
edit and correct the data. In addition, due to hospital volumes, it is
not feasible to perform encounter level audits and edits. Within the
constraints of the current THCIC process, the data is certified to the
best of our knowledge as accurate and complete given the above comments.
==
PROVIDER: Baylor Specialty Hospital-Irving
THCIC ID: 586002
 QUARTER: 4
    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, 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. With this in mind, approximately
2.94% of the primary payers originally categorized as "Indemnity" were
recategorized as "Medicare". Also 3% of the secondary payers originally
categorized as "Indemnity" were recategorized as "Champus", and 3% 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.
==
PROVIDER: Seton Edgar B Davis
THCIC ID: 597000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: CHRISTUS St John Hospital
THCIC ID: 600001
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Round Rock Medical Center
THCIC ID: 608000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Harris Methodist-Southwest
THCIC ID: 627000
 QUARTER: 4
    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 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.
==
PROVIDER: Baylor Institute for Rehab-Gaston Episcopal Hosp
THCIC ID: 642000
 QUARTER: 4
    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 10% of the secondary payers originally categorized
as "Missing/Invalid" were recategorized as "Self-Pay", and 3% 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.
==
PROVIDER: Baylor Institute for Rehabilitation
THCIC ID: 642001
 QUARTER: 4
    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 4% of the secondary payers originally categorized
as "Managed Care" were recategorized as "Medicare", 3% originally categorized
as "Indemnity" were recategorized as "Self-Pay", and 2% 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.
==
PROVIDER: Harris Continued Care Hospital
THCIC ID: 652000
 QUARTER: 4
    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.
===
PROVIDER: Kindred Hospital-Mansfield
THCIC ID: 657000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
===
PROVIDER: Presbyterian Hospital-Plano
THCIC ID: 664000
 QUARTER: 4
    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.
===
PROVIDER: HEALTHSOUTH Plano Rehab Hospital
THCIC ID: 670000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Kindred Hospital-Houston
THCIC ID: 676000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Burleson St Joseph Health Center-Caldwell
THCIC ID: 679000
 QUARTER: 4
    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
Burleson St. Joseph Health Center charity care, based on established rates
for 2007 was $487,517.

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

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

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

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

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign
the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity

and risk of mortality scores. The assignment is made by evaluation of
the patient's age, sex, diagnosis codes, procedure codes, and discharge
status. This grouper can only use the limited number of procedure and
diagnosis codes available in the data file (nine diagnosis and six procedure
codes). If all the patient's diagnosis codes were available the APR-DRG
assignment may possibly differ from the APR-DRG assigned by THCIC. The
severity grouping assignment performed by the state using the APR-DRG
grouper cannot be replicated by facilities unless they purchase this grouper.
 Additionally, the lack of education regarding how this grouper calculates
the severity adjustments or how it functions can greatly impact the interpretation
of the data.
==
PROVIDER: Covenant Childrens Hospital
THCIC ID: 686000
 QUARTER: 4
    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 4th Quarter 2007.

==
PROVIDER: Kindred Hospital-Tarrant County
THCIC ID: 690000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Trinity Mother Frances Rehab Hospital
THCIC ID: 692000
 QUARTER: 4
    YEAR: 2007

Certified with comments

Results may not be 100% accurate.
==
PROVIDER: The Corpus Christi Medical Center-Doctor's Regional
THCIC ID: 703002
 QUARTER: 4
    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.

==
PROVIDER: The Corpus Christi Medical Center-Heart Hospital
THCIC ID: 703003
 QUARTER: 4
    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".
==
PROVIDER: Dubuis Hospital-Beaumont
THCIC ID: 708000
 QUARTER: 4
    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.
==
PROVIDER: Dubuis Hospital-Port Arthur
THCIC ID: 708001
 QUARTER: 4
    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.
==
PROVIDER: Our Childrens House Baylor
THCIC ID: 710000
 QUARTER: 4
    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, 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
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 24%
of the primary payers originally categorized as "Medicaid" were recategorized
as "Managed Care". Approximately 12% of secondary payors categorized
as "Missing/Invalid" were recategorized as "Medicare", 5% originally categorized
as "Medicaid" were recategorized as "Medicare", and 7% originally categorized
as "Medicaid" 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.
===
PROVIDER: CHRISTUS St Catherine Hospital
THCIC ID: 715901
 QUARTER: 4
    YEAR: 2007

Certified with comments

CHRISTUS St. Catherine Hospital provided $1,896,212 charity care during
the 4th quarter of 2007.
===
PROVIDER: Padre Behavioral Hospital
THCIC ID: 716500
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
===
PROVIDER: Kindred Hospital-White Rock
THCIC ID: 719400
 QUARTER: 4
    YEAR: 2007

Certified with comments, corrections requested

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: 4
    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.
==
PROVIDER: Presbyterian Hospital-Allen
THCIC ID: 724200
 QUARTER: 4
    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.
===
PROVIDER: Mother Frances Hospital-Jacksonville
THCIC ID: 725400
 QUARTER: 4
    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.
===

PROVIDER: Grimes St Joseph Health Center
THCIC ID: 728800
 QUARTER: 4
    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 2007 was $466,602.

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
procedures codes allowed. The data is limited to nine diagnoses codes
and six procedure codes per patient visit.

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

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign
the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity
and risk of mortality scores. The assignment is made by evaluation of
the patient's age, sex, diagnosis codes, procedure codes, and discharge
status. This grouper can only use the limited number of procedure and
diagnosis codes available in the data file (nine diagnosis and six procedure
codes). If all the patient's diagnosis codes were available the APR-DRG
assignment may possibly differ from the APR-DRG assigned by THCIC. The
severity grouping assignment performed by the state using the APR-DRG
grouper cannot be replicated by facilities unless they purchase this grouper.
 Additionally, the lack of education regarding how this grouper calculates
the severity adjustments or how it functions can greatly impact the interpretation
of the data.
==
PROVIDER: Harris Methodist-Springwood
THCIC ID: 778000

QUARTER: 4
    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 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.
==
PROVIDER: Baylor Heart & Vascular Center
THCIC ID: 784400
 QUARTER: 4
    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 20% of the primary
payers originally categorized as "Indemnity" were recategorized as "Managed
Care". Also approximately 10% of the secondary payers originally categorized
as "Indemnity", 8% categorized as "Managed Care", and 3% 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.
==
PROVIDER: Baylor Medical Center-Frisco
THCIC ID: 787400
 QUARTER: 4
    YEAR: 2007

Certified with comments

The Texas Health Care Information Council (THCIC) has been charged with
collecting data on each inpatient discharge. The state of Texas has given
hospitals the responsibility
of reporting this data in a timely manner expecting accuracy of information
using billing information which could use to compare clinical outcomes.
Baylor Medical Center at Frisco would like the following comments submitted
with their 2007 fourth quarter data.

Data Content:
Due to system limitations, note, that this is just an estimate and relates

to identified sources of funds, rather than actual collections from identified
sources. This data is administrative data, which hospitals collect for
billing and reimbursement purposes, and not clinical data in the medical
records from which judgments concerning medical care
can be made. The state requires us to submit inpatient claims by quarter
end; our data is gathered using the hospital's Meditech system and downloaded
to a 1450 file flat file. This file is submitted to Thomson by an electronic
transfer via web browser. This information is submitted to Thomson's
secure site where it is formatted to an 837 file as required by the state
of Texas THCIC. Before submitting the data to the Texas Health Care Information
Council (THCIC), it is reviewed by data quality checks and verified for
content using the error threshold established by the Texas Hospital Association.

Submission Timing:
The hospital estimates that our data volumes for the calendar year time
period submitted may be less than the total % of all cases for that period.
 The state requires us to submit a snapshot of billed claims, extracted
from our discharge database following the close of the calendar year quarter.
 Any discharged patient encounter not billed by the cut off date will
not be included in the quarterly submission file. Baylor Medical Center
at Frisco has submitted its fourth quarter data for the year 2007. We
had approximately 981 inpatient discharges during this quarter, of which
981 claims were submitted. This gives Baylor Medical Center at Frisco
a 100% submittal rate.

Cost and Charges:
The state requires that the hospital submit revenue information including
charges. It is important to note that charges do not reflect the actual
cost of providing the service, and typically actual payments received
are much less than the charges due to managed care contracts, negotiated
discounts, and even denial of claims by insurance companies. The hospital
has also done charity work as well as un-collectable accounts, which were
not included in the data. Baylor Medical Center at Frisco supports it
community in several areas not included in this data.

Physicians:
All physicians on staff at Baylor Medical Center at Frisco go thru the
credentialing process where their license number and names are validated
as accurate. The THCIC practitioner reference files are not updated timely
enough to capture all the new physicians. As a result of this, some of
our physicians are unidentified in the data, or consulting physicians
may be credited with assisting in these procedures. THCIC has provided
a UPIN lookup for physician identification numbers which has been helpful
in correcting this problem. Some physician data is not submitted or unavailable
because their UPIN number did not match the state database. Unfortunately
the THCIC software did not allow changes to the fields, so this data was
not submitted. There are also discrepancies in the spelling of physician's
names in the Attending Physician report and Operating Practitioner Report
due to clerical errors, when typing in the data in the Key Claim software.
 This process has been improved, by electronically submitting our data
from the hospital's billing system.

Diagnosis and Procedures:
The data submitted matches the states reporting requirements but may be
incomplete due to limitations of software compatibilities between 3M Coding
software and Meditech the hospital's information system. We have made
great improvements in our data capturing by utilizing electronic submission.
The data submitted might not fully represent all diagnosis or procedures
performed at our facility, which could alter the true picture of a patient's
hospitalization. Baylor Medical Center at Frisco utilizes the 3M Coding
Software to assign a universal standard set of codes recognized by the
World Health Organization called the ICD-9CM or International Classification
of Disease Index. We receive quarterly updates of new codes, reference

material and HCFA regulation changes. We also utilize Precyse Solutions
a Health Information Services firm to verify the accuracy of our coding,
which has consistently fallen within the 95 to 100% accuracy rating.

Race and Ethnicity:
The hospital admission staff is responsible for capturing demographic
data on all our patients during the registration process. Race and ethnicity
are sensitive topics; we utilize discretion when gathering this information
from the patient's in the registration area. To assist in gathering this
data we have included an ethnicity question in our registration procedure,
we believe our data has improved as a result of this effort.

William Keaton CEO
Baylor Medical Center at Frisco
==
PROVIDER: Dubuis Hospital-Paris
THCIC ID: 787500
 QUARTER: 4
    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.
==
PROVIDER: CHRISTUS St Michael Health System
THCIC ID: 788001
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Texas Orthopedic Hospital
THCIC ID: 792000
 QUARTER: 4
    YEAR: 2007

Elect not to certify

I, Alice Adams, CEO elect not to certify fourth quarter 2007 data for
Texas Orthopedic Hospital due to the fact Texas Orthopedic Hospital is
licensed as a 49 bed acute care hospital. 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 impatient 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.
==
PROVIDER: St Lukes Community Medical Center-The Woodlands
THCIC ID: 793100
 QUARTER: 4
    YEAR: 2007

Certified with comments

The data reports for Quarter 4, 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.
==
PROVIDER: Dubuis Hospital-Corpus Christi
THCIC ID: 797001
 QUARTER: 4
    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.
==
PROVIDER: Seton Southwest Hospital
THCIC ID: 797500
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Seton Northwest Hospital
THCIC ID: 797600
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Kindred Hospital-Tarrant County
THCIC ID: 800000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Kindred Hospital-Fort Worth
THCIC ID: 800700
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Kindred Hospital
THCIC ID: 801000
 QUARTER: 4
    YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Dubuis Hospital-Houston
THCIC ID: 807000
 QUARTER: 4
    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.
==
PROVIDER: Baylor Regional Medical Center-Plano
THCIC ID: 814001
 QUARTER: 4
    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 5% of the
secondary payers originally categorized as "Missing/Invalid" were recategorized
as "Self-Pay", 5% originally categorized as "Indemnity" were recategorized
as "Self-Pay", and 11% originally categorized as "Managed Care" 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.
==
PROVIDER: Pine Creek Medical Center
THCIC ID: 818200
 QUARTER: 4
    YEAR: 2007

Certified with comments

PINE CREEK MEDICAL CENTER HAD 62 CASES OF WC AND THE CLAIM FILLING INDICATOR
CODE FILE SHOWS "0" CASES
IT SEEMS THAT MEDITECH DOESN'T DIFFERENTIATE BETWEEN COMMERCIAL INSURANCE
COMPANIES AND WC.
WE INFORMED THE IT DEPARTMENT AND THEY WILL INVESTIGATE THE ISSUE
==
PROVIDER: Presbyterian Hospital-Denton
THCIC ID: 820800
 QUARTER: 4

      YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: Dubuis Hospital-Texarkana
THCIC ID: 822000
 QUARTER: 4
     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.
==
PROVIDER: Houston Physicians Hospital
THCIC ID: 822001
 QUARTER: 4
     YEAR: 2007

Certified with comments

Under the Patient Discharge Status, the data shows that 60 patients were
discharged home or self care, 24 patients were discharged/transferred
to short term General Hospital, and 11 patients were discharged/transferred
to Inpatient Rehab Facility, for a total of 95. That data is incorrect.
The correct data is as follows. 89 were discharged home or self care 93.68%
of total admissions, 0 were discharged/transferred to short term General
Hospital, and 6 were discharged/transferred to Inpatient Rehab Facility
6.32% of total admissions. Total of 95.
==
PROVIDER: North Austin Medical Center
THCIC ID: 829900
 QUARTER: 4
     YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: St Davids Georgetown Hospital
THCIC ID: 835700
 QUARTER: 4
     YEAR: 2007

Certified with comments

*Comments not received by THCIC
==
PROVIDER: St Joseph Medical Center
THCIC ID: 838600
 QUARTER: 4
     YEAR: 2007

Certified with comments

St. Joseph Medical Center certified the data, but could not account
for 26 patients due to processing the patients after the data was submitted.

During this time period St. Joseph Medical Center provided charity
care for 6 patients with total charges (-$17,967.27) 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 62 premature newborn, 193 sick newborns
and 1231 normal newborns.
==
PROVIDER: Methodist Mansfield Medical Center
THCIC ID: 842800
 QUARTER: 4
    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. Medical Center
did not attempt to have
every physician individually review each patient in the actual data set
returned to us by the State.
We matched the State generated reports to internally generated reports
to ensure data submission
accuracy. We then reviewed these reports with Physician leadership who
assisted us in
generating the comments contained herein.

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

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

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

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

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

Methodist 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.
==
PROVIDER: The Heart Hospital Baylor Plano
THCIC ID: 844000
 QUARTER: 4
    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.

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 5% 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.
==
PROVIDER: Texoma Medical Center Restorative Care Hospital
THCIC ID: 846900
 QUARTER: 4
    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.
* Not all claims may have been billed at this time.
* Internal data may be updated later and appear different than the data
on the claim. Unless the payment is impacted, the hospitals does not rebill
when a data field is changed internally. This results in differences
between internal systems and the snapshot of data that was taken at the
end of the quarter.
==
PROVIDER: Texoma Medical Center
THCIC ID: 847000
 QUARTER: 4
    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.
* Not all claims may have been billed at this time.
* Internal data may be updated later and appear different than the data
on the claim. Unless the payment is impacted, the hospitals does not rebill
when a data field is changed internally. This results in differences
between internal systems and the snapshot of data that was taken at the
end of the quarter.
==
PROVIDER: Dell Childrens Medical Center
THCIC ID: 852000

QUARTER: 4
YEAR: 2007

Certified with comments

*Comments not received by THCIC
==