

=====

THCIC ID: 000100 / Austin State Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

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

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

Admission Source = Because of system constraints, all admission 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 payments, by percent, are:

| Standard Source of Payment: | Total Percentage (%) |
|-----------------------------|----------------------|
| Self-Pay | 2.52% |
| Worker's Comp | n/a |
| Medicare | 10.48% |
| Medicaid | 8.06% |
| Other Federal Program | n/a |
| 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 PPO | 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.

=====

THCIC ID: 000101 / Big Spring State Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

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

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

Admission Source = Because of system constraints, all admission 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 payments, by percent, are:

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

| Non-Standard Source of Payment: | Total Percentage (%) |
|---------------------------------|----------------------|
| State/Local Government | n/a |
| Commercial PPO | 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.

=====
THCIC ID: 000104 / Rio Grande State Center

QUARTER: 1
YEAR: 1999

Certified with comments

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

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

Admission Source = Because of system constraints, all admission 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 payments, by percent, are:

| Standard Source of Payment: | Total Percentage (%) |
|-----------------------------|----------------------|
| Self-Pay | 0.55% |
| Worker's Comp | n/a |
| Medicare | 5.92% |
| Medicaid | 7.32% |
| Other Federal Program | n/a |
| Commercial | 0.87% |
| Blue Cross | n/a |
| Champus | 0.32% |
| Other | n/a |
| Missing/Invalid | n/a |

| Non-Standard Source of Payment: | Total Percentage (%) |
|---------------------------------|----------------------|
| State/Local Government | n/a |
| Commercial PPO | n/a |
| Medicare Managed Care | n/a |
| Medicaid Managed Care | 0.00% |
| Commercial HMO | n/a |
| Charity | 85% |
| Missing/Invalid | n/a |

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

=====
THCIC ID: 000105 / University of Texas M.D. Anderson Cancer Center
QUARTER: 1

YEAR: 1999

Certified with comments

THCIC Intro

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

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

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

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

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

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

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

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

? More than half of M.D. Anderson's patients have received some form of cancer treatment before coming to the institution for subsequent advice and treatment. This proportion is far higher than in general hospitals,

making it difficult to compare M.D. Anderson to community facilities.

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

=====
THCIC ID: 000106 / Kerrville State Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

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

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

Admission Source = Because of system constraints, all admission 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 payments, by percent, are:

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

| Non-Standard Source of Payment: | Total Percentage (%) |
|---------------------------------|----------------------|
| State/Local Government | n/a |
| Commercial PPO | n/a |
| Medicare Managed Care | n/a |
| Medicaid Managed Care | 0.00% |
| 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.

=====
 THCIC ID: 000107 / Rusk State Hospital
 QUARTER: 1
 YEAR: 1999

Certified with comments

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

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

Admission Source = Because of system constraints, all admission 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 payments, by percent, are:

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

=====

THCIC ID: 000110 / San Antonio State Hospital
 QUARTER: 1
 YEAR: 1999

Certified with comments

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

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

Admission Source = Because of system constraints, all admission 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 payments, 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 Program | 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 PPO | n/a |
| Medicare Managed Care | n/a |
| Medicaid Managed Care | 0.12% |
| Commercial HMO | n/a |
| Charity | 73% |
| Missing/Invalid | n/a |

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

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

=====

THCIC ID: 000111 / Terrel State Hospital
 QUARTER: 1
 YEAR: 1999

Certified with comments

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

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

Admission Source = Because of system constraints, all admission 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 payments, 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 Program | n/a |
| Commercial | 0.36% |
| Blue Cross | n/a |
| Champus | 0.00% |
| Other | n/a |
| Missing/Invalid | n/a |

| Non-Standard Source of Payment: | Total Percentage (%) |
|---------------------------------|----------------------|
| State/Local Government | n/a |
| Commercial PPO | 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.

=====

THCIC ID: 000113 / North Texas State Hospital Vernon
 QUARTER: 1
 YEAR: 1999

Certified with comments

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

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

Patient Discharge Status = All patients, are either sent to a civil state hospital (as not manifestly dangerous but still incompetent) or to jail (as competent to stand trial or for a revision of their committment as incompetent to stand trial).

Standard Source of Payment = Because of system constraints, all payment sources on the encounter records are, reported as charity. The sources of payments, 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 Program | n/a |
| Commercial | 2.16% |
| Blue Cross | n/a |
| Champus | 0.13% |
| Other | n/a |
| Missing/Invalid | n/a |

| Non-Standard Source of Payment: | Total Percentage (%) |
|---------------------------------|----------------------|
| State/Local Government | n/a |
| Commercial PPO | 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.

=====

THCIC ID: 000114 / North Texas State Hospital Wichita Falls
QUARTER: 1
YEAR: 1999

Certified with comments

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

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

Admission Source = Because of system constraints, all admission 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 payments, by percent, are:

| Standard Source of Payment: | Total Percentage (%) |
|-----------------------------|----------------------|
| Self-Pay | 1.85% |
| Worker's Comp | n/a |
| Medicare | 5.68% |
| Medicaid | 8.22% |
| Other Federal Program | n/a |
| Commercial | 2.73% |
| Blue Cross | n/a |
| Champus | 0.47% |
| Other | n/a |
| Missing/Invalid | n/a |

| Non-Standard Source of Payment: | Total Percentage (%) |
|---------------------------------|----------------------|
| State/Local Government | n/a |
| Commercial PPO | n/a |
| Medicare Managed Care | n/a |
| Medicaid Managed Care | 0.02% |
| Commercial HMO | n/a |
| Charity | 81% |
| Missing/Invalid | n/a |

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

=====

THCIC ID: 000115 / Harris County Psychiatric
QUARTER: 1
YEAR: 1999

Certified with comments

First Quarter '99 Comments:

1. Patient Discharge Status: Due to computer field default value of "Discharge to home or self care", the majority of discharges for the period were automatically coded to this value. Beginning in August 2000 the computer default was eliminated and data from that time forward will reflect a correct value.
2. Admission source: The code for Correctional Agency (11) was inadvertently added to the code for physicians (1) for the Admission Source field. This caused 11 (eleven) patients to be recorded with the wrong admission source. We have corrected this problem for future data after 2nd quarter of 1999.
3. Standard/Non-Standard sources of payment - Sixty-three of the seventy self-pay patients were placed in the Other category, rather than the Self-Pay category. This has been corrected for future data after 2nd qtr of 1999.
4. Patient Age: The age of one patient was incorrectly recorded as less than one year old.

Signed by Dr. Lois Moore
Administrator, Harris County Psychiatric Center, Houston, Tx.

=====
THCIC ID: 015000 / CHRISTUS St. Joseph Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Qt. 1 1999

St. Joseph certified the data but could not account for 15 patients due to processing the patients after the data was submitted.

During this time period St. Joseph Hospital provided charity care for 450 patients with the total charges over 2 million dollars. The system didn't identify these patients.

St. Joesph data didn't correspond to the newborn admissions, according to our data we had 68 premature infants and 99 sick infants.

=====
THCIC ID: 019000 / Valley Regional Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

Comments not received by THCIC.

=====
THCIC ID: 027000 / Baylor Medical Center at Garland
QUARTER: 1
YEAR: 1999
CERTIFIED WITH COMMENTS

Data Content

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

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

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.

Diagnosis and Procedures

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

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

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

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

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.

Normal Newborns

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. 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 38% of encounters originally categorized across all values have a different value as of today. Upon review an additional data issue was uncovered. All managed care encounters were categorized as "Commercial PPO" instead of separating the encounters into "HMO" versus "PPO".

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

Cost/ Revenue Codes

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

Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough

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

07/21/00

1

=====
THCIC ID: 028000 / Vencor Hospital Dallas
QUARTER: 1
YEAR: 1999

Certified with comments

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

=====
THCIC ID: 035000 / St. Davids Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

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

2.) The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the of the diagnoses and procedures relative to each patient.

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

=====
THCIC ID: 040000 / Providence Health Center
QUARTER: 1
YEAR: 1999

Certified with comments

A. Due to a data mapping error, 43 records from the DePaul Center (THCIC #763000) were submitted under Providence Health Center's THCIC Number. The accounts had the following HCFA DRGs:

| HCFA DRG NO | - | Quantity |
|--------------|---|----------|
| HCFA DRG 425 | - | 1 |
| HCFA DRG 426 | - | 3 |
| HCFA DRG 427 | - | 4 |
| HCFA DRG 428 | - | 5 |
| HCFA DRG 430 | - | 26 |
| HCFA DRG 431 | - | 1 |
| HCFA DRG 434 | - | 1 |
| HCFA DRG 435 | - | 2 |

B. Of the total deaths, 22 (23%) were hospice patients.

C. A clerical error resulted in one record with HCFA DRG 157 being coded with the patient's sex as female when the patient's sex was male.

=====
THCIC ID: 042000 / Trinity Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

DATA Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing

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

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

Diagnosis and Procedures

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

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

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

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

Specialty Services

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

Length of Stay

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

Normal Newborns

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

Race/Ethnicity

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

Cost/Revenue

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

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

Certification Process

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

=====
THCIC ID: 047000 / Huguley Health Systems

QUARTER: 1

YEAR: 1999

Certified with comments

Data Content

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of July 31, 2000. Under the requirements we are unable to alter our comments after today. If any errors are discovered in our data after this point we will be unable to communicate these due to THCIC. This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

Submission Timing

The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this 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 system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but

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

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

Length of Stay

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

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

Race/Ethnicity

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are 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 serviced by the hospital.

Physician Error

One physician is incorrectly reported to have seen a patient. The patient actually saw another physician. When the error was discovered Huguley was unable to submit a correction because the state's deadline had passed.

Certification Process

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

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

=====
THCIC ID: 057000 / Beaumont Medical Surgical Hosp
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 071000 / College Station Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

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

=====
THCIC ID: 072000 / Memorial Medical Center San Augustine
QUARTER: 1
YEAR: 1999

Certified with comments

We are aware statistics and data may be inaccurate due to software conflicts. Vendors have been contacted and every effort is being made to curb this problem

=====
THCIC ID: 073000 / Silsbee Doctors Hospital
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 076000 / Tomball Regional Hospital
QUARTER: 1
YEAR: 1999

Elect not to certify

I elect not to certify the information because:

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 physicians due to the acuity and needs of the patient; (ie) attending physician is General Practice charged with 100% mortality rate in open heart surgery performed by open heart surgeon.

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.

=====
THCIC ID: 095000 / CHRISTUS St. Josephs Health System
QUARTER: 1
YEAR: 1999

Certified with comments

Two encounters were taken by THCIC's version 15 grouper and placed in MDC 14 and reported on the certification summary report as Newborns and OB. These two encounters were not births but were adult patients with obstetrical related cases. We felt this comment was necessary, as our facility does not have an OB department per se.

=====
THCIC ID: 109000 / Covenant Medical Center Lakeside
QUARTER: 1
YEAR: 1999

Certified with comments

1. Data does not accurately reflect the hospital's newborn population.
Mature Newborn 81%

Premature Newborn 19%

2. Data does not accurately reflect the number of charity cases for the time period. This is due to internal process for determination of the source of payment.

Charity Cases 4% of discharges

```
=====
THCIC ID: 111000 / Gulf Coast Medical Center
  QUARTER: 1
  YEAR: 1999
```

Certified with comments

Skilled nursing facility data not included in 1999.

```
=====
THCIC ID: 118000 / St Lukes Episcopal Hospital
  QUARTER: 1
  YEAR: 1999
```

Certified with comments

The data reports for quarter 1, 1999 do not accurately reflect patient volume, severity, or patient origin.

Patient Volume

Data reflects administrative claims data (Uniform Billing data elements) that are a snapshot of claims one month following quarter-end. Even though source payment will not be released for this quarter, a programming issue with these payor sources was identified during the extraction of the data. THCIC's requirement for data submission is a claim be produced. At St. Luke's Episcopal Hospital, a claim is not produced on self-pay patients. As a result, this payor source was inadvertently omitted. Once identified, it was too late to correct for this release.

Severity

Descriptors for newborn admissions are based on nation billing data elements (UB92) and definitions of each element can and do vary from hospital to hospital. Because of the absence of universal definitions for normal delivery, premature delivery, and sick baby, this category cannot be used for comparison across hospitals. The DRG is the only somewhat meaningful description of the infant population born at a facility. More importantly, not all clinically significant conditions can be captured and reflected in the various billing data elements including the ICD-9-CM diagnosis coding system such as ejection fraction. As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

Patient Origin

Because of a mapping issue with resident area in our patient population, the data incorrectly reflects that we had no out of country patients during the quarter. Our out of country patients are in fact counted in the out of state numbers. This was recognized too late to be corrected. Corrected demographics would reveal the following:

Quarter 1 1999
Out of country patients = 178
Out of state patients = 275

=====
THCIC ID: 119000 / Memorial Hospital Southeast
QUARTER: 1
YEAR: 1999

Certified with comments

All discharges with an admit type of newborn have an admission source of normal delivery versus a combination of normal delivery, premature delivery, sick baby, and extramural birth. These admission sources will not appear until June 2000 data. All newborns are, however, represented accurately by diagnoses and procedure codes.

=====
THCIC ID: 129000 / Memorial Medical Center East Texas
QUARTER: 1
YEAR: 1999

Certified with comments

Of the 2,469 encounters reported for 1st quarter 1999, 305 encounters were identified by THCIC as having errors. No corrections were submitted for these errors. The result is a claim accuracy rate of 87.65%.

There were a total of 357 errors and warnings reported for the 305 erred encounters. A summary of reported errors and warnings is as follows:

- 1 Invalid zip code
- 2 Invalid social security number (warning)
- 1 Procedure date must be on or after the 3rd day before admission date and on or before statement thru date
- 268 Occurrence date is after statement through date
- 4 Invalid patient status
- 5 Admitting diagnosis is required (warning)
- 12 First revenue code field is required
- 26 First charge field is required
- 38 Charges required when associated revenue code present

Errors affecting Certification Data represent 20.66% of erred encounters and 2.55% of total reported encounters. Errors affecting Public Use Data represent .33% of erred encounters and .04% of total reported encounters.

Errors affecting Review Only Data represent 79.34% of erred encounters and 9.8% of total reported encounters. No reported errors affected THCIC Data.

Errors reported for invalid zip code, invalid social security number (warning), procedure date, and required admitting diagnosis (warning) total 9. These errors, resulting from clerical entry error, represent .98% of total erred encounters and .12% of total reported encounters

Occurrence date errors are reported for occurrence codes 18-Date of Retirement Patient/Beneficiary and 19-Retirement Date Spouse. Cause of the error is two-fold. If a patient or spouse did not know their retirement date, Admission Staff entered 01/01/01. Our patient accounting system read this date as January 1, 1901. Our data submission agent's software system read any two digit year prior to 34 as a 21st century date and therefore read our 01/01/01 date as January 1, 2001. This error, representing 79.34% of erred encounters and 9.8% of total reported errors, did not affect Certification Data or Public Use Data. Resolutions implemented to eliminate this error include: (1) During 4th quarter 1999, Admission Staff were instructed not to enter retirement data if patient or spouse

do not know their retirement date. (2) Utilization of THCIC 1450 version 5.0 file format as of 1st quarter 2000 resolves the date conversion problem.

Errors reported for invalid patient status, admitting diagnosis required (warning), first revenue code field is required, and first charge field is required total 47 and represent 26 encounters. These errors result from encounters that should have been excluded from reported encounters due to patient type classification. These errors represent 8.52% of total erred encounters and 1.05% of total reported encounters. Beginning with 2nd quarter 1999 reporting, these encounters will be deleted from submitted data.

The error reported as "charges required when associated revenue code present" resulted from misassignment of a room revenue code to a supply item. This error represents 11.15% of erred encounters and 1.38% of total reported encounters. Correction of the revenue code associated with this charge was implemented during 2nd quarter 2000.

Our review of reported data found 83.68% of reported encounters have missing or invalid payment source codes. Resolution of this data omission issue will be implemented during 3rd quarter 2000.

Primary source payment codes may not be valid. If a claim was issued and denied because the patient was not covered, the encounter is reclassified as self-pay. Because our patient accounting system will not allow an insurance plan to be removed from an encounter once a claim has been issued, encounter and claim data appear to indicate an insurance payer. Secondary source payment codes also may not be valid. If a claim was issued as primary and denied because the patient was not covered, the plan is reclassified

to secondary and the correct plan is added as primary. The claim issued on the correct primary plan goes out with an invalid secondary payer because our patient accounting system will not allow secondary plans to be removed from an encounter once a claim has been issued.

Additional source of payment code inaccuracies may exist. If the wrong insurance plan is assigned during admission or a generic miscellaneous plan is assigned because no recognizable plan exists in our insurance plan table, the claim may have been corrected and issued without changing the insurance plan assigned to the encounter (ex: free text insurance plan information or edit electronic claim in SSI). The result is source of payment codes linked to a wrong or a generic miscellaneous plan may not correctly reflect actual source of payment.

Our patient accounting system does not incorporate utilization of newborn source of admission codes. As a result, no encounters were reported as newborn admissions. No resolution of this data reporting inaccuracy is expected in the near future.

Nine (9) Champus encounters were inadvertently omitted. Correction of this data omission error was implemented during 2nd quarter 2000.

Physician response identified diagnosis coding errors on two encounters. One was resolved prior to the physician's response. The second will be researched for appropriate resolution during 3rd quarter 2000.

The THCIC database incorrectly identifies this hospital as a pediatric facility. Correction of this reporting inaccuracy will be coordinated with THCIC.

=====
THCIC ID: 130000 / Providence Memorial Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Discharge Disposition Clarification

The discharge disposition 06 is inclusive of patients discharged home with home health and those discharged home with hospice. Discharge disposition 50, should have been used for those patients being sent home with hospice.

=====
THCIC ID: 141000 / Navarro Regional Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Navarro Regional Hospital is an acute, general medical-surgical hospital with the additional services of a Skilled Nursing Facility and an Acute Rehabilitation Unit. The data in the public release file may or may not adequately allow separation of patients in the acute hospital from those in the other two units. Admixture of all three units can lead to increases in length of stay, charges and mortality rates when compared to rates for acute hospitals alone. It is notable that 10 of the 37 deaths in the first quarter of 1999 occurred in the two non-acute units, and that in at least 27 of the deaths, the patient or family members had requested that full efforts to maintain life not be pursued (Advanced Directive, Living Will or Do Not Resuscitate orders).

=====
THCIC ID: 142000 / Margaret Jonsson Charlton Methodist Hospital
QUARTER: 1
YEAR: 1999

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. Charlton 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.

ADMIT SOURCE

Charlton Methodist Hospital does not currently use all of the codes that are available in the State data. Specifically we are not actively collecting data that stratifies the type of facility a patient came from in the event of a transfer from another healthcare facility.

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.

=====
THCIC ID: 144000 / Wadley Regional Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

SNF and Hospital admissions are commingled.

=====
THCIC ID: 145000 / University Medical Center
QUARTER: 1
YEAR: 1999

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.

=====
THCIC ID: 146000 / Covenant Hospital Plainview
QUARTER: 1
YEAR: 1999

Certified with comments

The data reviewed by hospital staff and physicians appears, to the best of our knowledge, to be correct with one noticeable exception -- the patient's name is being carried to the provider field on all records. The provider's ID number, however, is correct. This error has been forwarded to Commonwealth for their future review and correction.

It is the practice of the hospital to review all unusual occurrence or length of stay cases via the medical staff's peer review process. Outliers seen in this quarter's data have been reviewed by appropriate medical

staff.

=====

THCIC ID: 158000 / University Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

DATA CORRECTION - PLEASE NOTE BEFORE PERFORMING ANY MORTALITY CALCULATIONS
USING THIS DATA.

As part of University Hospital's internal quality control procedures, data was audited to check for accuracy and completeness. After data was submitted to the Texas Health Care Information Council for public release, an error was noted in regard to patient discharge status which impacts eight patient records. Eight patients in the 1st Quarter 1999 were given a discharge status classification value of 42 ("Expired - Place Unknown" (to be used for Medicare Outpatients)). In fact, all eight patients were discharged to home or self care (a routine discharge). None of the eight patients expired. PLEASE NOTE THIS CORRECTION WHEN PERFORMING ANY CALCULATIONS IN REGARD TO THE HOSPITAL MORTALITY RATE. Please direct any questions you may have regarding this data correction to Kirk Black at (210) 358-2335.

DATA CONTENT

This data is administrative data that hospitals collect for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.

The state requires submission of inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. The state specifications require additional data elements to be included over and above that. Adding these additional data elements places programming burdens on the hospital since it is data not included in the actual hospital billing process. Errors can occur due to this additional programming.

SUBMISSION TIMING

University Health System 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 submission 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 deadline date are not 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. The state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed. Approximately 15% of University Health System's patient population

have more than nine diagnoses and/ or six procedures assigned.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is a code does not exist 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 requires submission of ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by University Health System meets state requirements but cannot reflect all the codes an individual patient's record may have been assigned. Accurate 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). Sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format.

LENGTH OF STAY

The length of stay data element contained in the state's certification file is only three characters long. Thus any patient 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.

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. University Health System'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 not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are 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. Analysis of these two data fields does not accurately describe the true population served by the hospital.

STANDARD/NON-STANDARD SOURCE OF PAYMENT

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

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.

At the time of data submission, a high percentage of discharges categorized as "self-pay" are pending eligibility for another funding source, including Medicare, Medicaid and CareLink (a program supported by the Bexar County Hospital District tax division). By the time the data is released, the status for approximately 90% of "self-pay" discharges have changed to one of these funding sources.

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 each patient needs.

CERTIFICATION PROCESS

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not complete and thorough at this time. During the current certification phase, University Health System did not have an efficient mechanism to edit and correct the data. In addition, due to University Health System's volume, it is not feasible to perform encounter level audits.

=====

THCIC ID: 164000 / The Institute for Rehabilitation & Research

QUARTER: 1

YEAR: 1999

Certified with Comments

TIRR (The Institute for Rehabilitation and Research)

TIRR (The Institute for Rehabilitation and Research) was founded in 1959 in Houston's Texas Medical Center by William A. Spencer, MD. Dr. Spencer articulated a rehabilitation philosophy of maximizing independence and quality of life that continues to guide the development of our programs. This guiding philosophy includes providing appropriate medical intervention, helping the patient establish realistic goals and objectives, and supporting the patient to maintain personal integrity and family and social ties. TIRR is an internationally known, fully accredited teaching hospital that specializes in medical care, education and research in the field of catastrophic injury. It has been recognized every year in a nationwide survey of physicians by U.S. News & World Report as one of the best hospitals in America.

The hospital's research into developing improved treatment procedures has substantially reduced secondary complications of catastrophic injuries as well as average lengths of stay. TIRR is one of only three hospitals in the country that has Model Systems designation for both its spinal cord and brain injury programs.

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

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

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

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

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

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

In reviewing the THCIC data for 1st quarter 1999, we discovered that the patient discharge status mapped incorrectly to "Other Institution" instead of "Home or Self Care" in 9 cases. This changes our statistics to:

Patient Discharge Status
No. Patients
% of Total Admissions
Discharge to Home or Self Care
145
77.54%
Discharge/Transfer to Gen. Hospital
10
5.35%
Discharge/Transfer to SNF
14
7.49%
Discharge to ICF
4
2.14%
Discharge/Transfer to Other Institution
4
2.14%
Discharge/Transfer to Home Health
9
4.81%
Left AMA
1
.53%
Expired
0
0.00%

=====
THCIC ID: 168000 / Shannon West Texas Memorial Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Our facility historically has used the ICD9 codes to define normal or premature delivery, sick baby or extramural births. This data does not include the newborn admission codes designating any of the above.

Physician names are incorrect in some instances but they do have the correct Texas license number.

Physicians and the hospital are concerned that the data only reflects inpatient information, is not reflective of the services provided by the hospital and/or physician.

=====
THCIC ID: 178000 / Sweeny Community Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

The data is primarily financial in nature and should not, by itself, be

used to judge the quality of healthcare services provided. Charges do not reflect actual reimbursement received, nor do they reflect the actual cost of providing the services.

=====
THCIC ID: 181000 / Medical Center Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

The data reported is correct but there are 290 missing claims for the reporting period that did not get reported because of mapping problems of accounts admitted in 1998 and a few claims that were over the 250,000 limit.

=====
THCIC ID: 182000 / Harris Methodist H.E.B.
QUARTER: 1
YEAR: 1999

Certified with comments

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

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

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 10.3% of Harris Methodist HEB's patient population have more than nine diagnoses and/ or six procedures assigned.

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

When the Admit type is equal to "newborn", the admit source should indicate whether the baby was a normal newborn, premature delivery, sick baby, extramural birth, or information not available. The best way to focus

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

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

Based on the ICD9 codes for newborns for Harris Methodist HEB hospital:

265 Normal Newborns
13 Premature
38 Sick Babies
1 Extramural

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and as

thorough as all parties would like to see in the future. Within the constraints of the current THCIC process the data is certified to the best of our knowledge as accurate.

=====
THCIC ID: 184000 / Gonzales Warm Springs Rehab Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

We have numerous account with error code "970" (Upin). Also due to a vendor error, the Acute Care Facility has a "Y" in it, it should read Rehab Facility equal "Y".

=====
THCIC ID: 188000 / Bellaire Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

- 1) The length of stay information is affected by our skilled nursing unit population. Our length of stay for the first quarter of 1999 is 4.6 excluding the skilled nursing patients.
- 2) The relationship between the cost of care, charges and the revenue that a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.
- 3) The data is administrative/claims data, not clinical. This carries inherent limitations to using it to compare outcomes.

=====
THCIC ID: 191000 / Texoma Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

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

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

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

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

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

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

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

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

- Not all claims may have been billed at this time.
- Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

=====
THCIC ID: 191001 / Reba McEntire Center for Rehabilitation
QUARTER: 1
YEAR: 1999

Certified with comments

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

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

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

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

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

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

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

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

- Not all claims may have been billed at this time.
- Internal data may be updated later and appear different than the data

on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

=====
THCIC ID: 191002 / Texoma Medical Center Behavioral Health Center
QUARTER: 1
YEAR: 1999

Certified with comments

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

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

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

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

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

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

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

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

- Not all claims may have been billed at this time.
- Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

=====
THCIC ID: 191004 / Texoma Restorative Care SNU
QUARTER: 1
YEAR: 1999

Certified with comments

Data Source. The source of this data, the electronic 1450, is administrative

in nature, and was collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality.

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

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

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

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

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

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

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

- Not all claims may have been billed at this time.
- Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

=====
THCIC ID: 200000 / Parmer County Community Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

The only difference was in the patient ethnicity.
The report shows 1 Hispanic and 69 not of Hispanic.
The true totals should be 17 Hispanic and 53 not of Hispanic.

Peggy Cabrera
Business Office Director

=====
THCIC ID: 206000 / Select Specialty Hospital - Houston Heights
QUARTER: 1
YEAR: 1999

Certified with comments

Comments not received by THCIC.

=====
THCIC ID: 206001 / Select Specialty Hospital Houston West
QUARTER: 1
YEAR: 1999

Certified with comments

Comments not received by THCIC.

=====
THCIC ID: 206002 / Select Specialty Hospital Houston Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

Comments not received by THCIC.

=====
THCIC ID: 214000 / Medical Center of Plano
QUARTER: 1
YEAR: 1999

Certified with comments

Data Content:

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

Timing of Data Collection:

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

Diagnosis and Procedures:

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures that the state allows us to include for each patient. The 1450 data file limits the diagnosis codes to nine, and procedure codes are limited to six. The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization. In other words the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 35% of patients treated by Medical Center of Plano have more than nine diagnoses codes and/or six procedures assigned.

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification

of Disease, or ICD-9-CM. The federal government mandates this and all hospitals must comply. The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes.

The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. Due to the limit set by the state of nine diagnoses codes and six procedure codes, the data sent by us meets their criteria but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals which treat sicker patients are likewise less accurately reflected.

Normal Newborns:

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

Race/Ethnicity:

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

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

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

Cost/Revenue Codes:

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

Specialty Services:

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

Services used by and outcomes expected of patients on hospice units, rehabilitation units and skilled nursing facility beds are very different

from hospital acute care services. The state is currently working to categorize patient type. Inclusion of these specialty services can significantly impact outcome and resource consumption analysis. (e.g. lengths of stay mortality and cost comparisons) Medical Center of Plano has a skilled nursing facility whose patients are included in the data.

Payer Codes:

The payer codes utilized in the state database were defined by the state. These definitions are not standardized. Each hospital may map differently. Charity and self-pay patients are difficult to assign in the data submitted to the state. Hospitals are often not able to determine whether or not a patient's charges will be considered "charity" until long after discharge (after the claim has been generated) and when other potential payment sources have been exhausted. This will not be reflected in the state data submission due to the timing involved.

=====
THCIC ID: 225000 / BayCoast Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

Several data fields from first quarter, 1999 discharge Data are not accurate.

By the time the State of Texas returned data to be corrected, the old system could not be accessed to make corrections because the computer system was discontinued in May, 1999. The following fields are blank or contain incorrect information.

Race
Ethnicity
Total Charges
New Born Admission Source

By second quarter, 1999, the problem was fixed.

=====
THCIC ID: 228000 / Southwest General Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

the 2 warnings are being reviewed by the billing office.

=====
THCIC ID: 229000 / Houston Northwest Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

Comments not received by THCIC.

=====
THCIC ID: 235000 / Harris Methodist Fort Worth
QUARTER: 1
YEAR: 1999

Certified with comments

Clinical Data:

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

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

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

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

The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization. When the patient has more codes in the medical record than allowed in the 1450 file, the hospital must select only nine diagnosis codes and six procedure codes. Hospitals populate these code fields differently.

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

Admit Type and Source:

Problems have been identified with newborn source codes. The data collection source for the THCIC newborn baby (i.e. normal delivery, premature, sick baby or extramural birth) is an admission code assigned by an admission clerk. This does not give an accurate description of the severity of illness in the newborn and the more precise area to collect this information would be in the infant's diagnoses codes assigned on discharge.

Payor Codes/Costs:

The payor codes utilized in the THCIC database were defined by the state and are not using the standard payor information from the claim.

The mapping process of specific payors to the THCIC payor codes was not a standardized by THCIC. Therefore, each hospital may map differently which can create variances in coding.

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

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

Race and Ethnicity:

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

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

Many hospitals do not collect ethnicity as a separate category. They may collect race, e.g., Hispanic, which defaults to ethnicity and then to whatever the hospital has mapped for that category. The lack of standardization may result in apparently significant differences among hospital's reported racial mix, which are not valid or accurate.

Specialty Service:

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

THCIC is using codes from the bill type and accommodation revenue codes in an attempt to distinguish specialty services.

Services used by and outcomes expected of patient on the hospice units, in rehab, in skilled nursing areas and other specialty areas are very different. The administrative data has inherent limitations and will impact the evaluation of health care services provided at Harris Methodist Fort Worth.

Timing of Data Collection:

Hospitals are required to submit data to THCIC no later than 60 days after the close of the quarter.

Not all claims may have been billed in this time period. Depending on how the data is collected and the timing of the billing cycle all hospital discharges may not be captured.

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

Certification Process:

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

=====
THCIC ID: 243000 / Campbell Health System
QUARTER: 1
YEAR: 1999

Certified with comments

We are trying to include field 22 with our data. We understand we have a 100% error rate on field 22 and we will correct this. Thank you.

=====
THCIC ID: 245000 / Dolly Vinsant Memorial Hospital
QUARTER: 1

YEAR: 1999

Certified with comments

We certify that the patient data contained within these records are correct to the best of our knowledge with the exceptions noted below.

The physician data is incorrect. This was caused by a system reporting error that has since been corrected and physician data for future quarters will be correct.

The result of the physician data error is the patient's name is in the attending physician's name field. The correct physician's name is then in the operating physician field. If there is an operating physician the name appears in the consulting physician field and so on.

One other error was noticed. One of our records lists an HCFA MDC 14 (Newborn class). That was culled from an incorrect DRG from the same patient. It has since been corrected. At this time, we do not have perform maternity cases.

=====
THCIC ID: 251000 / Northeast Medical Center Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

The physicians have been asked to certify the Comparative Data Report Quarter Ending 03/30/99. We wish to make the statement that we cannot certify that this information accurately reflects the individual physician's practice patterns/profiles.

=====
THCIC ID: 255000 / Methodist Medical Center
QUARTER: 1
YEAR: 1999

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.

ADMIT SOURCE

Methodist Medical Center does not currently use all of the codes that are available in the State data. Specifically we are not actively collecting data that stratifies the type of facility a patient came from in the event of a transfer from another healthcare facility.

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.

=====
THCIC ID: 256000 / Harris Methodist Erath County
QUARTER: 1
YEAR: 1999

Certified with comments

HARRIS METHODIST ERATH COUNTY CERTIFIED WITH COMMENTS

Data Content

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

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

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

Diagnoses and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification

of Disease, or ICD-9-CM. 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 limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 4% of Harris Methodist Erath County's patient population have more than nine diagnoses and/or six procedures assigned.

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

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us to 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 or illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients,

are likewise less accurately reflected.

Length of Stay

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

Admit Source Data for Normal Newborn

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Harris Methodist Erath County recommends use of ICD-9-CM coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The standard and non-standard sources of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identification must be categorized into the appropriate standard and non-standard source of payment value. These values might not accurately reflect the hospital payer information, because those payers identified contractually as both "HMO, and PPO" are categorized as "Commercial PPO". Thus any true managed care comparison 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 no not reflect the actual cost to deliver the care that each patient needs.

Certification Process

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

=====
THCIC ID: 258000 / Pecos County General Hospital
QUARTER: 1
YEAR: 1999

Certified with comments
1ST Quarter, 1999 - 64 papered claims

General noted errors:

Entered into software incorrectly:
Admit/Discharge hours - 25 claims
Doctor name incorrect - 38 claims
Address incorrect - 3 / 1 out of state
Charges incorrect total - 1 claim

53 substance abuse claims showed as transfers/ patients were actually discharged into the care of the company that referred them to this hospital. Correct code should have been Home.

=====
THCIC ID: 263000 / R.E. Thomason General Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Errors in Newborn admissions were identified. Based on coding information the following information was extracted:

Normal Newborns = 736
Premature = 112
Sick Baby = 291
Extramural = ???

Total Newborns for 1Q99 = 1,139

Mapping problems were identified in primary payer source. The following is the correct information.

Self Pay = 589
Medicare = 320
Medicaid = 2189
Commercial = 412
Charity = 542

The total accounts for 1Q99 was 4052.

=====
THCIC ID: 266000 / Sierra Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

Comments Calendar Quarter 1/1999:

1. Newborn Admissions data reflects 466 encounters under category, "Information Not Available", which should be reflected under category, "Normal Delivery". This has been identified to be a mapping issue that is currently being addressed.
2. Admission Type data under category, "Elective" reflects 'zero' encounters, which is currently being addressed and will correctly be represented with 1st Quarter 2001 data.

=====
THCIC ID: 285000 / Baylor Medical Center Ellis County
QUARTER: 1
YEAR: 1999
CERTIFIED WITH COMMENTS

Data Content

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

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

Submission Timing

Baylor estimates that our data volumes for the calendar year time period submitted may include 94% 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 a patient's hospitalization, sometimes significantly.

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

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

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

Length of Stay

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

Normal Newborns

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

Race/Ethnicity

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are 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.

Upon review, a mapping issue was uncovered regarding the Race code and Ethnicity code categorization of all patient encounters. Approximately 95% of the encounters were incorrectly categorized under the state defined "Other" race code.

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 35% of encounters originally categorized across all values have a different value as of today. Upon review an additional data issue was uncovered. All managed care encounters were categorized as "Commercial PPO" instead of separating the encounters into "HMO" versus "PPO".

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

Cost/ Revenue Codes

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

Certification Process

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

07/21/00

1

```
=====
THCIC ID: 300000 / Baylor Medical Center at Irving
QUARTER: 1
YEAR: 1999
CERTIFIED WITH COMMENTS
```

Data Content

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

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

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.

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Normal Newborns

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

Race/Ethnicity

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are 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.

Upon review, a mapping issue was uncovered regarding the categorization of "Hispanic" encounters. Approximately 12% of the "Hispanic" encounters were categorized under the state defined "Black" race code instead of the state defined "Other" race code.

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 2.2% of encounters originally categorized as "Charity" have been re-categorized as "Medicare" or "Commercial".

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

Admission Source

Upon review of the certification data, a mapping error from the source system values to the state defined values was uncovered. Approximately 50% of patient encounter records categorized with an Admission Source Code of "Xfer from Psych, Sub Abuse, Rehab Hosp" should have been categorized with an Admission Source code of "Emergency Room".

Patient Discharge Status

Upon review of the certification data, a mapping error from the source system values to the state defined values was uncovered. Approximately 10% of patient encounters were categorized into an incorrect patient discharge status code.

Cost/ Revenue Codes

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

Certification Process

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

current certification phase, Baylor did not have an efficient mechanism to edit and correct the data. In addition, due to the volume at Baylor, it is not feasible to perform encounter level audits.

07/21/00
1

```
=====
THCIC ID:  TH303000 / Presbyterian Hospital of Kaufman
QUARTER:    1
YEAR:       1999
PRESBYTERIAN HOSPITAL OF KAUFMAN CERTIFIED WITH COMMENTS
```

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 6% of PRESBYTERIAN HOSPITAL OF KAUFMAN's patient population have more than nine diagnoses assigned.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Certification Process

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

07/24/00

3

=====
THCIC ID: 314000 / Brownsville Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

The State's Software errors edits do not match to the HCIA software's errors edits.

=====
THCIC ID: 315000 / Mesquite Community Hospital
QUARTER: 1
YEAR: 1999

Elect not to certify

July 26, 2000

Jim Loyd
Texas Health Care Information Council
4900 North Lamar Boulevard, Suite 3407
Austin, Texas 78751-2399

Re: Hospital Discharge Data Certification Letter
Quarter Ending: March 1999

Dear Mr. Loyd:

I, Raymond P. De Blasi, Chief Executive Officer at Mesquite Community Hospital, elect not to certify the returned data due to the reasons stated below:

1. Admission Type: The encounters under the heading of "Admission Type" on the Certification Summary reflect a minimal number of urgent admissions.

We believe there are more urgent admissions than reflected and less emergency admissions than reflected.

Mechanism for Correction: The definitions for the types of admission codes have been obtained and provided to the appropriate departments whose staffs are involved in assigning the admission code. The key processes in assigning the admission code upon admission and making necessary adjustments at discharge have been reviewed with the Registration and Medical Information Services Department staffs.

2. Newborn Admissions: The encounters under the heading of "Newborn Admission" on Certification Summary reflect all newborn admissions as a normal delivery.

In reviewing our internal data, we discovered that approximately 2-5% of the newborn admissions represented premature deliveries.

Mechanism for Correction: The definitions for the types of newborn admission codes have been obtained and provided to the appropriate departments whose staffs are involved in assigning the newborn admission code. The definitions have also been forwarded to the physicians in the Department of OB/GYN with emphasis on concise documentation which will assist the coders in the Medical Information Services Department in assigning the appropriate code at discharge, if deemed appropriate. The key processes in assigning the newborn admission code upon admission and making necessary adjustments at discharge have been reviewed with the Registration staff and coders.

3. Patient Race: The encounters under the heading of "Patient Race" on the Certification Summary reflect a percent of "Others" encounters which is higher than anticipated.

Mechanism for Correction: We have met with the Registration staff on scripting the staff for obtaining patient race at the time of admission.

4. Operating Physician: In the report designated as "Operating Physician," we discovered a few cases whereby the attending physician was incorrectly assigned as the operating physician.

Mechanism for Correction: The Director of Medical Information Services

and coders have were notified of the aforementioned problem in an effort to assure that the correct physician is assigned to the procedure.

=====
THCIC ID: 319000 / Del Sol Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

REASON: Del Sol's master files are set up with "MD" placed between the physician's last and first name. When the reports were batch printed using the "*" option for all, the data did not appear under the heading of the correct physician. This problem has been corrected by reprinting the reports individually by physician. Del sol is working on placing the patient's first name in the correct field. I spoke to Dee Shaw, Hospital Coordinator, who recommended that we certify 1st and 2nd Quarter 1999 data because no physician identifying information will be released for 1999 and the data is correct for each patient.

Thanks
Debra Mora

=====
THCIC ID: 323000 / Walls Regional Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

WALLS REGIONAL HOSPITAL CERTIFIED WITH COMMENTS

Data Content

Walls Regional Hospital collects this data for billing purposes therefore, it is limited in describing a complete clinical encounter.

Diagnosis and Procedures

Walls Regional Hospital patients are coded by diagnoses and procedures for a particular hospital stay 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 data submitted matches the state's reporting requirement, which is limited to 9 diagnoses treated by the hospital or all procedures performed, because of the limitation on diagnosis and procedures. This can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 10% of Walls patient population have more than nine diagnoses and/or six procedures assigned. 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.

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.

Race/Ethnicity

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race and thnicity data elements are subjectively capture. 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. Therefore, until that occurs the epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment

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

Due to mapping limitations, Workers' Compensation and Blue Cross claims are understated and it is hoped this will be corrected in the future.

Walls Regional Hospital grants Charity based on approved cirteria. However, that decision is made after discharge and is not reflected in the Standard Source of Payment. For example, Self-pay will often eventually be granted Charity but this report is mapped on discharge data prior to that determination hence, Charity on this report is not accurate.

Cost/Revenue Codes

The state required 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 cost for performing the services.

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

This is a new program to Walls and the state therefore, the certification process is not as complete and as thorough as all parties expect it will be in the future. With this understanding of the current THCIC process, the data is certified to the best of our knowledge as accurate.

=====
THCIC ID: 331000 / Baylor University Medical Center
QUARTER: 1
YEAR: 1999
CERTIFIED WITH COMMENTS

Data Content

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

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

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.

Diagnosis and Procedures

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 20 % of Baylor's patient population have more than nine diagnoses and/ or six procedures assigned.

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

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

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

Length of Stay

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

Normal Newborns

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. Upon review approximately 3.25% of Baylor encounters categorized as "Commercial or Other" should have been categorized as "Managed Care", and .12% of Baylor encounters categorized as "Other" should have been categorized as "Commercial", and .07% of Baylor encounters categorized as "other" should have been categorized as "Medicare".

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

Cost/ Revenue Codes

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

Certification Process

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

=====
THCIC ID: 332000 / Cook Children's Medical Center
Quarter: 1
Year: 1999
Elects to not certify

We have elected to not certify the first quarter 1999 discharge encounter data as returned by the Texas Health Care Information Council for the following reasons:

Upon review of the data, we discovered that THCIC has systematically excluded certain types of patients from the database. Hence, we know that the data are not complete and cannot attest to the completeness or accuracy of the data. Specifically, every patient who was ever 'interim billed' was systematically excluded. Since these patients represent the most severely ill and lengthy cases, their exclusion has a strong potential to distort any analysis.

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.

=====
THCIC ID: 335000 / Brackenridge Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

335000: Daughters of Charity-Brackenridge Quarter One 1999

As the public teaching hospital in Austin and Travis County, Brackenridge serves patients who are often unable to access primary care. It is more likely that these patients will present in the later more complex stage of their disease. Brackenridge has a perinatal program that serves a population that includes mothers with late or no prenatal care. Brackenridge is also a regional referral center, receiving patient transfers from hospitals not able to serve a complex mix of patients. Treatment of these very complex, seriously ill patients increases the hospital's costs of care, lengths of stay and mortality rates.

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

Admission Source - Newborn Data

Brackenridge Hospital experienced a data collection problem affecting the admit source field when the admit type is 4 (Newborn). As a result of this collection problem, 729 of the 733 newborn admissions to Brackenridge were reported as normal delivery, and no premature newborns were reported. The hospital is correcting the data collection problem prospectively, but corrections will not affect data previously submitted.

Race and ethnicity data are self-reported by patients and are not independently verified by the hospital.

=====
THCIC ID: 335001 / Childrens Hospital of Austin
QUARTER: 1
YEAR: 1999

Certified with comments

335001: Children's Hospital of Austin Quarter One 1999

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

Admission Source - Newborn Data

Children's Hospital of Austin Center experienced a data collection problem affecting the admit source field when the admit type is 4 (Newborn). As a result of this collection problem, 22 of the 56 newborn admissions to Children's were reported as normal delivery, and no premature newborns were reported. The hospital is correcting the data collection problem prospectively, but corrections will not affect data previously submitted.

Race and ethnicity data are self-reported by patients and are not independently verified by the hospital.

=====
THCIC ID: 336001 / Denton Regional Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

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

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

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

All statistics for Denton Regional include Skilled Nursing, Rehabilitation, and Geriatric Psychiatry, which are long-term care units, in addition to acute care services. This will preclude any meaningful comparisons between Denton Regional Medical Center and an "acute care services only"

provider.

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

Newborn statistics should be amended to reflect five premature deliveries and five sick babies.

Length of stay statistics are higher, as a result of patient stays on our long-term care units.

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

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

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

=====
THCIC ID: 337000 / West Houston Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

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

=====
THCIC ID: 340000 / Medical City Dallas Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

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

=====
THCIC ID: 367000 / Reeves County Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Comments not received by THCIC.

=====
THCIC ID: 383000 / Hill Regional Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Comments not received by THCIC.

=====

THCIC ID: 394000 / Medical Center of Lewisville
QUARTER: 1
YEAR: 1999

Certified with comments

1. This data is administrative and claims data only. It is not clinical research data. There may be inherent limitations in using this data to compare clinical outcomes.
2. This data only contains a subset of the diagnoses and procedure codes. This limits the ability to access all of the diagnoses and procedures relative to each patient.
3. The relationship between the cost of patient care, charges, and the payment that a facility receives is very complex. Inferences made in comparing the cost of patient care, charges and payments from one hospital to another may result in unreliable results.
4. The severity grouping assignments performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Also, the lack of knowledge regarding how this grouper calculates the severity adjustments can greatly impact the interpretation of the data.
5. There is great uncertainty about how the physician linkages will be done across hospitals.
6. Race and ethnicity classification is not done systematically within, or between facilities. Caution should be used when analyzing this data within one facility and when comparing one facility to another,
7. This data includes skilled nursing patients. The average length of stay for a skilled nursing patient is normally higher than that of an acute care patient.

=====

THCIC ID: 396000 / Nix Health Care System
QUARTER: 1
YEAR: 1999

Certified with comments

Due to computer software mapping and logic problems, incorrect values are documented in the following three categories: Admission Source, Newborn Admissions, and Patient Race. Solutions are being investigated and implemented in order to provide correct information for future data submission.

There was a total of two physicians/four patients where the admit type and admit source were inappropriately assigned.

=====

THCIC ID: 398000 / CHRISTUS Spohn Memorial Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

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

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

We believe that the discharge encounter data as returned by the Texas Health Care Information Council for calendar quarter one/1999 represents the patient population of CHRISTUS Spohn Hospital Memorial with an accuracy rate of 98%.

=====
THCIC ID: 407000 / Memorial Hermann Southwest Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

All discharges with an admit type of newborn have an admission source of normal delivery versus a combination of normal delivery, premature delivery, sick baby, and extramural birth. These admission sources will not appear until June 2000 data. All newborns are, however, represented accurately by diagnoses and procedure codes.

=====
THCIC ID: 409000 / John Peter Smith Hospital
QUARTER: 1
YEAR: 1999

Elect not to certify

JPS Hospital
Comments on THCIC Data Submission
for
Quarter 1 1999

Introduction

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

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

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

In addition to JPSH, the JPS Health Network operates community-based health centers located in medically underserved areas of Tarrant County, a home

health agency, school-based health centers, special outpatient programs for substance abusing pregnant women and a wide range of wellness education programs. A free medical information service, InfoNurse?, is staffed 24 hours a day, seven days a week by licensed nurses.

Supportive Data Comments

This inpatient data was submitted to meet requirements of the State of Texas for reporting first quarter 1999 inpatient hospital discharge data.

The data used by THCIC is administrative and collected for billing purposes.

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.

JPSH created the file provided to THCIC directly from the billing system, which only included information provided on an UB-92. Therefore, some data elements, such as ethnicity and race were added to the 1450 file to meet the data requirements of THCIC. Program errors were not known until all data was returned to the hospital in the certification encounter file. In addition, since the data was compiled directly from the billing system, discharge statistics include only those patients for whom a bill was issued by JPSH. This excluded all patients that were pending assigned payer sources.

Newborns

Currently, all newborns are defaulted as "normal" in the admissions source fields for the JPSH system as designated by mapping. The standard method used to review ill and premature infants uses ICD-9 and DRG coding. JPSH is operationally addressing the admission source mapping to more accurately report the statistics of normal, premature, and sick, newborns. On average, our NICU admissions represent approximately 8% of all newborn admissions.

Ethnicity

There is no universally accepted set of codes for race and ethnicity designations.

At JPSH, ethnicity is a default field after race is entered. The details surrounding this data are complex and JPSH will continue to address this issue to provide a more accurate picture of our population mix.

Length of Stay

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

? JPSH is a major trauma center, many patients have suffered multiple system trauma.

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

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

? Many of our patients have limited financial resources. This, in turn, often limits their discharge options.

Payer Source

Texas Health Care Information Council (THCIC) has not standardized this process and each health care facility may map their data differently. New edits that address these issues will be implemented with third quarter 2000 data. The payer codes utilized by THCIC were defined by the State.

They are not utilizing the standard payer information from the claim,

which may result in internal mapping issues that are currently being addressed by JPSH.

Mortalities

Due to insurance payer requirements, organ donor patients are readmitted into our billing system to address the issue of separate payers. This may increase the number of mortalities reported and not accurately reflect the actual number of mortalities. Also, in our trauma center, DOA's are listed as mortalities to allow for monitoring on behalf of JPSH trauma services and for LifeGift organ donor reporting.

Diagnoses and Procedures

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

Physician Master File

Attending, operating, first other, and second other physician fields are defined differently across multiple hospitals systems. At JPSH, the attending physician is the final attending on a case. In reality, a patient may have additional attending physicians throughout their 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.

System Mappings

Due to the newly identified mapping discrepancies, additional data fields may not accurately reflect activity. For example:

- ? Discharge disposition
- ? Patient Status
- ? Response for no social security number
- ? Patient relationship to insured
- ? Insurance Company Name

All known errors were corrected or accounted for to the best of our ability, consistent with the limited window of opportunity afforded by the extremely short time span allotted to all hospitals for the process. As we progress through the process of State filing and certification, JPSH is addressing the operational and mapping issues to improve the accuracy of the data reported to THCIC. JPSH will continue in its endeavor of continual quality improvement.

We are not certifying the State data file as accurate at this time.

Physician Comments

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

? Charts under this report relate to the first calendar quarter of 1999.

Due to the extended time elapsing between the delivery of care and the submission of this report it is difficult to recall if all patients are

correctly listed under the appropriate treating or attending physician.
? JPSH cares for an indigent population, which often has limited resources to transfer care to home care agencies, skilled nursing units or nursing homes. This may produce an increase in the reported length of stay while outpatient resources are developed to which care can be transferred.
? JPSH functions as a regional receiving facility for trauma. This results in admission of complicated multi-system injured patients which increases hospital costs and hospitalization needs beyond that which may be seen with facilities that do not function as regional trauma referral sites.
? During the period of this report oncology services were in a state of transition. This transition may have produced a skew effect on the number of oncology patients, their severity and may have had an impact on reported inpatient mortality rates.
? JPSH is a teaching facility. As such, the attending physicians rotate from time to time among the established services. This rotation may result in some inpatients not having a single attending staff for the duration of the hospital episode.
? Some physicians noted that they believed they had more admissions during the reporting period than that listed on the report. Other physicians in the practice group may have been listed as the attending physician for some patients.
? Some physicians noted being incorrectly identified as the attending physician on some cases.

JPSH is reviewing its operational and mapping pathways to assure more accurate assignment of attending physician to cases.

=====
THCIC ID: 415000 / McKenna Memorial Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Comment #1

During this initial analysis and certification of the inpatient discharge data required by THCIC, the Medical Staff governing structure was utilized to provide physician review and oversight of the data. The Hospital continues to improve its internal communications with its Medical Staff in order to feel confident that all interested physicians and other health professionals have ample opportunity to individually analyze the data.

Comment #2

During this initial certification process, it was discovered that not all inpatient discharge data was being collected through the THCIC hospital discharge data file process. Specifically, those discharges that were not reduced to a UB92 (Charity Care, Private Pay, etc.) were not captured for the hospital discharge data file. It is believed that this data represents an additional 20-25% of hospital discharge data. The Hospital has undertaken measures to capture this data moving forward, but concludes that the administrative, personnel, and financial burden to retrospectively capture this data is too large to justify the investment in today's healthcare environment.

=====
THCIC ID: 417000 / United Regional Health Care System
QUARTER: 1

YEAR: 1999

Certified with comments

This data is incomplete in that approximately 9% of our patient records are not included. Many of the missing records have a Source of Payment marked Self-Pay or Special Handling (Charity, Indigent, etc). Since records in the state data file are captured during the billing process and records marked Self-Pay or Special Handling do not go through the billing process they were not included in the file. There are some records which were not included because they had not been billed (and therefore had not gone through the billing process) prior to the cut-off date for data submission to the state.

The Source of Payment was broken down into the Standard Source of Payment. The Non-Standard Source of Payment, which includes a breakdown by Managed Care, PPO, and HMO information, was not captured.

The state pulls newborn admission statistics from the admission source code rather the final diagnosis code. The final diagnosis code provides a more appropriate reflection of the newborn's condition as the admission source is entered at registration when the status of the newborn is unknown.

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

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

=====
THCIC ID: 422000 / Arlington Memorial Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Data Content -

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

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

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

Diagnosis and Procedures -

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification

of Disease, or ICD-9-CM. This is mandated by the federal government.

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

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

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

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

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

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

Race/Ethnicity -

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

Race is an element the hospital does attempt to collect at admission.

However, many patients refuse to answer this question and therefore, the registration clerks are forced to use their best judgment or answer "Unknown" to this question.

Any assumptions based on race or ethnicity will be inaccurate.

Standard/Non-Standard Source of Payment -

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

Revenue -

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

Charity Care -

THCIC assumes charity patients are identified in advance and reports charges in a charity financial class as the amount of charity care provided in a given period. In actuality, charity patients are usually not identified until after care has been provided and in the hospital's computer system charity care is recorded as an adjustment to the patient account, not in a separate financial class. Therefore, the THCIC database shows no charity care provided by the hospital for the quarter when in fact the hospital provided over \$1,845,000 in charity care during this time period.

Physician Comments -

THCIC regulations require that all caregivers have the opportunity to review and comment on the data submitted by the hospital. Two physicians requested that their comments be attached in the public use data file.

One physician wanted it known that, while his name was associated with patients as the attending physician, surgeons and other specialists also provide care for these patients. He believes it would be inaccurate to use this data to make any assumptions about his practice patterns since it is not possible to separately identify in the state data file, the care he provided from the care provided by others. He also wanted it known that he is not a surgeon even though his name was associated with patients with surgical DRGs. He believes the use of DRG data would not provide accurate information about his practice.

The other comment was from an oncology (cancer) physician regarding the hospital reported mortality rate. He wanted it known that "In an oncology practice, whether or not a patient dies in the hospital or outside the hospital has more to do with the availability and use of hospice care, patient preference, treatments being received elsewhere and many other complicating factors than it does with the quality of healthcare delivery."

He does not believe the data is useful in assessing practice trends, competency or quality of care provided.

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.

=====
THCIC ID: 423000 / Memorial Hospital of Center
QUARTER: 1
YEAR: 1999

Certified with comments

Error Code 907 - Procedure Date must be on or after the 3rd day before Admission Date and on or before Statement Thru Date:

5 errors - due to maping error, procedure date did not roll over.

Error Code 804 - Invalid Zip Code due to data entry keying error:

1 Error - Due to data entry keying error.

=====
THCIC ID: 426000 / El Campo Memorial Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Of 221 claims submitted, there were 10 claims which appeared on the incomplete encounters and deleted claims report. These claims were submitted with xx7 bill type. This produced a 5% error rate which is acceptable per THCIC HELP desk. Therefore these errors will not be corrected and the first quarter findings for 1999 are considered certified with these comments.

=====
THCIC ID: 429000 / CHRISTUS Spohn Hospital Beeville
QUARTER: 1
YEAR: 1999

Certified with comments

Report submitted is accurate within a 97% confidence level.

=====
THCIC ID: TH431000 / Presbyterian Hospital of Dallas
QUARTER: 1
YEAR: 1999

PRESBYTERIAN HOSPITAL OF DALLAS CERTIFIED WITH COMMENTS

Data Content

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

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

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

Diagnosis and Procedures

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

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

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 11% of PRESBYTERIAN HOSPITAL OF DALLAS's patient population have more than nine diagnoses.

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 up to 99 diagnoses and 99 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

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

Standard/Non-Standard Source of Payment

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

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

Cost/ Revenue Codes

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

Certification Process

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

Physician Comments to the data set:

Under the present system the length of stay, morbidity, and/or mortality may be incorrectly attributed to provider "A" when in fact the length of stay, morbidity, and/or mortality are related to procedure "B" or unrelated to any procedure.

Bassett B. Kilgore, M.D.

Mortality and length of stay may be attributed to a diagnostic procedure physician when grouping the data by primary procedure physician, when in fact the major reason for the admission was unrelated, or a minor event in the admission. In this case scenario the procedure was diagnostic and not therapeutic.

Pat Fulgham, M.D.

Comments from Magella Healthcare Corporation-a Neonatology Group Practice:

Magella wishes to express their concern regarding data collection methodology being employed to fulfill the Texas State Mandate of 1997 for creation of a health care data warehouse. As Megella understands it, this process is being undertaken to gain useful information regarding health resource utilization and patient outcomes. Megella is a large group practice specializing in neonatology and perinatology services. The practice of neonatology is very much a team endeavor and we believe that the current data collection and collation methodology will not accurately reflect the true performance of the individual neonatologist of of the team of neonatology health care providers.

For neonatologists that work in group practices, the way this data is assigned to specific physicians for attending and admitting physicians may not accurately reflect the physician that was responsible for the majority of the patient's care. In neonatology, patients tend to be shared by the group of neonatologists, often on some kind of rotational basis. The admitting doctor may never care for a patient after admission, several doctors might provide

weekend or night-time support, or a small subset of doctors might provide most of the day-time care while a different subset of doctors do the night-time piece. Additionally, the term, "Operating Physician" is an inappropriate designation for a neonatologist (though neonatologist do perform minor procedures). This is of particular concern should the "Operating Physician" reports be compared to the more traditional "Attending Physician" reports. The comparison has very little if any value.

Ian M. Ratner, M.D. Chairman of the MAGELLA Healthcare Corporation

07/24/00

3

=====
THCIC ID: 434000 / Westwood Medical Center

QUARTER: 1

YEAR: 1999

Certified with comments

January 1999 discharge data is not available. We were converting to a new computer system and could not pull the information.

=====
THCIC ID: 436000 / Brazosport Memorial Hospital

QUARTER: 1

YEAR: 1999

Certified with comments

General Comments for THCIC data:

Notes/Comments:

1. Brazosport Memorial Hospital's length of stay statistics include its physical rehabilitation and skilled nursing units, which appropriately have longer lengths of stay. In 1999, the ALOS for acute med/surg patients was 3.5 days.

2. Some average charges may be skewed by one or two very high charge patients and the inclusion of physical rehabilitation and skilled nursing patients.

3. Psych/CD services were closed September 30, 1999. Charges for those services during the first two quarters of 1999 may include charges for treatment of physical diagnoses in conjunction with their psych/CD treatment.

4. Number of expired patients may be somewhat increased over expected due to inclusion of skilled nursing unit statistics.

=====
THCIC ID: 444000 / CHRISTUS St Elizabeth Hospital

QUARTER:

YEAR:

Certified with comments

Procedural changes are currently underway to enable reporting of the following elements:

Newborn Admissions - currently admission source for premature and sick babies are coded as normal

Standard Source of Payment - currently classification of accounts adjusted

to charity care are not changed from self pay to "charity care"
Attending Physician - procedural changes are underway to enable accurate
reporting as defined by THCIC

=====
THCIC ID: 445000 / Shannon Medical Center St Johns Campus
QUARTER: 1
YEAR: 1999

Certified with comments

Physician names are incorrect in some instances but they do have the correct
Texas license number.

=====
THCIC ID: TH446000 / Presbyterian Hospital of Winnsboro
QUARTER: 1
YEAR: 1999

Certified with comments

PRESBYTERIAN HOSPITAL OF WINNSBORO CERTIFIED WITH COMMENTS

Data Content

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

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

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

Patient Population Characteristics

Presbyterian Hospital of Winnsboro's patient population is an older patient
population with a large percentage of Medicare patients. This will impact the
acuity of our patient population and our mortality rates. As noted earlier,
administrative data does not always accurately represent all clinical
characteristics and may be deficient in representing the true acuity level of
our patients.

Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by
the hospital using a universal standard called the International Classification
of Disease, or ICD-9-CM. This is mandated by the federal government. The
hospital complies with the guidelines for assigning these diagnosis codes,
however, this is often driven by physician's subjective criteria for defining
a diagnosis. For example, while one physician may diagnose a patient with

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

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

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 5% of PRESBYTERIAN HOSPITAL OF WINNSBORO's patient population have more than nine diagnoses assigned.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

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

Length of Stay

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Certification Process

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

07/24/00

2

=====
THCIC ID: 000448000 / St Paul Medical Center
QUARTER: 1
YEAR: 1999

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 a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. In addition, the state specifications require additional data elements to be included over and above that. Adding these additional elements places programming burdens on the hospital since it is

"over and above" the actual 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.

Submission Timing

The state requires us to submit a snapshot of billed claims extracted from our database approximately 40 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. This represents a rare event and is approximately 1% of the encounter volume.

Specialty Services

The 1450 data does not have any specific data field to capture unit of service or to expand on the specialty services provided to a patient. St. Paul's hospital characteristics are provided by using codes from bill type and accommodation revenue codes in an attempt to distinguish, at the patient level, use of specialty services. Services used by and outcomes expected of patients in our hospice, NICU, rehab, transplant, psychiatric and skilled nursing facility beds are very different and the administrative data has inherent limitations.

Diagnosis and Procedures

The data submitted matches the state's reporting requirements but may be incomplete due to the limited number of diagnosis and procedure codes the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 14% of St. Paul's patient population have more than nine diagnosis and/or six procedures assigned.

The state requires us to submit ICD-9-CM data on each patient but has limited the number of diagnosis and procedures to the first nine diagnosis codes and the first six procedure codes. 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 diagnoses or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, that the sicker patients are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Patient diagnosis and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD-9-CM. The federal government mandates this and all hospitals must comply. The codes are assigned based on documentation in the patient's medical record and are used by hospitals for billing purposes. St. Paul complies with the guidelines for assigning these diagnosis codes; however, this is often driven by a physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their 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 that 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.

Race/Ethnicity

The race and ethnicity data elements are subjectively captured and the ethnicity element is derived from the race designation. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by this hospital.

There are no national standards regarding patient race categorization, 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 and this mapping may not be consistent across hospitals.

Standard/Non-Standard Source of Payment

The standard and non-standard sources of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. Each hospital must independently map their specific codes to the state's payer information categories (there are no standards for this process) thus the mapping may be inconsistent across hospitals. Also, 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.

Certification Process

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

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

=====
THCIC ID: 449000 / RHD Memorial Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

DATA Content

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

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

untried use of this data as far as hospitals are concerned.

Submission Timing

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

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

Diagnosis and Procedures

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

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

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

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

Specialty Services

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

Length of Stay

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

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

Normal Newborns

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

Race/Ethnicity

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

Cost/Revenue

The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to negotiated discounts with 3rd party payors. Charges also do not reflect the actual costs to deliver the care that each patient needs.

Certification Process

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

=====
THCIC ID: 453000 / DeTar Hospital
QUARTER: 1 and 2
YEAR: 1999

Certified with comments

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

DeTar Hospital also maintains a Rehabilitation Unit.

DeTar Hospital had a Geriatric-Psychiatry Unit in operation, but was closed in the latter part of 1999.

=====
THCIC ID: 465000 / Covenant Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

1. Data does not accurately reflect the hospital's newborn population.
Mature Newborn 77%
Premature Newborn 23%

2. Data does not accurately reflect the number of charity cases for the time period. This is due to internal process for determination of the source of payment.
Charity Cases 281

=====
THCIC ID: 466000 / Memorial Medical Center Livingston
QUARTER: 1
YEAR: 1999

Certified with comments

Due to mechanical problems with this quarter's data and due to a mapping problem with our vender, we certify this data with exceptions. The race is not correct due to mapping problem. There are TX initials on some of the doctor's numbers and some doctor fees (Revenue Code 981) that should not be included in this process.

=====
THCIC ID: 469000 / Harris Methodist Northwest
QUARTER: 1
YEAR: 1999

Certified with comments

Data Content

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

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

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

Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded

by the hospital using a universal standard called the International Classification

of Disease, or ICD-9-CM. This is mandated by the federal government.

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

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

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

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification

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

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

Length of Stay

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

Race/Ethnicity

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

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Certification Process

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

```
=====
THCIC ID:  474000 / Parkland Memorial Hospital
  QUARTER:  1
    YEAR:  1999
```

Certified with comments

Comments not received by THCIC.

```
=====
THCIC ID:  478000 / Memorial Hospital
  QUARTER:  1
    YEAR:  1999
```

Certified with comments

In general, the summary data is acceptable; however, a number of data quality errors are unresolved: facility records indicate 125 more births than shown on the report and mapping errors or timing differences were identified causing inaccurate reporting of discharge status and race.

```
=====
THCIC ID:  480000 / Knapp Medical Center
  QUARTER:  1
    YEAR:  1999
```

Certified with comments

KNAPP MEDICAL CENTER THCIC DISCLAIMER STATEMENT AND COMMENTS FOR FIRST QUARTER 1999

DISCLAIMER STATEMENT

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

ETHNICITY COMMENT FOR FIRST QUARTER 1999

Ethnicity data for the first quarter of 1999 does not reflect the diversity of the population served by Knapp Medical Center. The data indicates that in a region with a high population of Hispanics, of 3772 discharges none were of Hispanic origin. Our analysis indicated a data-mapping problem in regards to the initial admission input for all patients, inherent in the system we use. This is not correctable for prior periods, however changes in the admitting tables correcting this mapping problem have been implemented.

CHARITY COMMENT

Knapp Medical Center has a long tradition of providing charity care for the population it serves. Prior to designation as charity, program qualification attempts are exhausted. This results in designation of charity being made after the patient is discharged, sometimes many months. Patient specific charity amounts are not available, therefore, at the time of submission of data to THCIC. Due to the impracticality at this time of identifying specific patients designated as charity and submitting corrections, the aggregate amount of charity provided during the first quarter 1999 was \$1,007,102.90 for 64 patients.

=====
THCIC ID: 481000 / Woodland Heights Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

*The data presented includes Skilled Nursing Inpatient Admission. There is nothing to distinguish the difference between Inpatient and skilled patients. This will reflect an inaccurate length of stay on our Acute Inpatient 's due to the fact Skilled Nursing Facilities run longer lengths of stay.

*We are a major cardiovascular hospital within a 100 mile radius.
=====

THCIC ID: 488000 / Driscoll Childrens Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Quarter ending: March 1999

Data Content:

This data is informational in nature and may be used to develop a hospital's strategic plan or to identify potential areas of opportunities for improvement, either clinical or financial. The data should not be used exclusively to determine the quality of care rendered by a health care provider.

Submission Timing:

The Hospital has calculated that 93% of the total discharges for the first quarter are included in this quarter's release. The remaining 7% of the total discharges were processed for billing according to hospital guidelines, but were not processed prior to the state's submission deadline.

Charges Summary:

The state requires that hospitals submit data that includes patient charges. It would be important to note that charges are normally much higher than the reimbursements received and do not reflect the cost associated with the services performed. Hospitals are required by Federal programs, and managed care contracts to offer substantial discounts on charges, thus reducing the amounts of reimbursements. In many cases, those reimbursements do not cover the actual costs.

Admission Type:

The three newborn admission encounters were reported in error. Only emergency and urgent admission types are to be used at the time of hospital admission. Driscoll Children's Hospital is not a birthing center.

Length of stay/Severity Index

Driscoll Children's Hospital is a regional referral hospital for South Texas servicing 33 counties. Typically, the hospital will receive transfers of critically ill children. The severity of their illness, multiple complications and need for surgery will impact the child's length of stay.

Diagnosis/Procedure Codes Summary:

The data submitted corresponds with the state's reporting requirements. The assignments of these codes are established using a universal standard called the International Classification of Disease, 9th modification, ICD-9-CM. The federal government mandates this coding classification system. The codes are assigned based upon physician documentation in the patient's medical record and are used by the hospital for statistical and billing purposes.

The hospital can code up to 30 diagnoses and 30 procedures for each patient: however, the state is only requiring the submission of the first 9 diagnoses and 6 procedure codes. This lack of additional data could create an inaccurate representation of all of the types of diagnoses

treated at the hospital and procedures performed. Approximately 7% of the patients treated at the hospital had either more than 9 diagnoses or 6 procedure codes.

=====
THCIC ID: 497000 / Seton Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

Daughters of Charity-Seton Medical Center Quarter One 1999

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

Admission Source - Newborn Data

Seton Medical Center experienced a data collection problem affecting the admit source field when the admit type is 4 (Newborn). As a result of this collection problem, 1046 of 1049 newborn admissions at Seton were reported as "information not available", and no premature or normal newborns were reported. The hospital is correcting the data collection problem prospectively, but corrections will not affect data previously submitted.

Race and ethnicity data are self-reported by patients and are not independently verified by the hospital.

=====
THCIC ID: 497002 / Seton Northwest Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

497002: Seton Northwest Hospital Quarter One 1999

Admission Source - Newborn Data

Seton Northwest Hospital experienced a data collection problem affecting the admit source field when the admit type is 4 (Newborn). As a result of this collection problem, 100% of the newborn admissions at Seton Northwest were reported as "information not available". The hospital is correcting the data collection problem prospectively, but corrections will not affect data previously submitted.

Race and ethnicity data are self-reported by patients and are not independently verified by the hospital.

=====
THCIC ID: 501000 / Dallas Fort Worth Medical Center Grand Prairie
QUARTER: 1
YEAR: 1999

Elect not to certify

Data Content

The state has requested that we submit our UB92 data. This data is used for administrative, billing, and collection purposes. This data is not used for clinical purposes and therefore does not make it an accurate picture of the patient care that our facility offers.

The state specifications require us to submit our data in the HCFA 1450 format, which is used for electronic claims or EDI. Then the state also requested additional data elements that are not included in this format.

Our facility does not support a programmer on staff and our I.T. department is very small compared to larger networked facilities. This required us to out source this project to our HIS (Health Information Systems) provider. Outsourcing the programming has put our facility at the mercy of a third party to meet the state requirements and has caused us an undue amount of stress trying to meet state deadlines. Also, due to the lack of staff and resources we have been unable to dedicate the time required to correct the data in an efficient manner. The additional data elements requested has required more programming and has left a wider margin for errors to occur.

Submission Timing

Dallas/Fort Worth Medical Center estimates that our data volume for the first quarter of 1999 is 99% to 100% accurate. The state requires a snapshot of the billed claims for all patients discharged during this period. We have approximately 20 days to submit our data after the close of a quarter during the calendar year. Any discharged patient encounters not billed by the time the data was submitted to the state will not be included in the quarterly submission file.

Diagnosis and Procedures

Data submitted to the state matches their requirements but may be incomplete for some patients due to the limitation on the number of diagnosis and procedures the state allows to be included for each patient. Patient diagnosis and procedures for a hospital stay are coded by a universal standard called the International Classification of Disease, or ICD-9-CM. The codes are assigned based on the documentation in the patient's chart. The state has limited us to the first nine diagnoses codes and the first six procedure codes. Our system allows us to code above what is currently required and therefore may not reflect all the individual codes assigned to a patient. Approximately 16% of DFW Medical Center's patient population have more than nine diagnoses and/or six procedures assigned. Therefore, patients that are sicker and require more coding may not be accurately reflected. The hospital does recognize that the DRG and HCFA diagnosis that is reflected for this facility is 99% accurate.

Newborns

The best way to focus on the severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Dallas/Fort Worth Medical Center defaults all new babies as newborn and we do not currently differentiate between sick or premature babies upon admission. The actual experience of a newborn is captured elsewhere in the medical record file where the proper ICD-9-CM is assigned.

Race/Ethnicity

It is not the policy of Dallas/Fort Worth Medical Center to routinely inquire about a person's race and/or ethnicity upon registration. Our

goal is to make the patients feel comfortable and we do not wish to offend any patients. There is no national standards regarding patient race categorization, and therefore hospitals may designate a patient's race differently. Due to state's categorization, our programmer has to map our codes to match their codes. We have discovered there is an error occurring in this program that inaccurately reflects the patient race/ethnicity. Therefore, analysis of these two data elements is not accurately reflected by the numbers the state has issued and does not describe the true population served by the hospital. Our encounters fall in these percentages: 82% White, 14% Black, 3% Asian/Oriental, and 1% Indian. Of these numbers, 25% are of Hispanic origin, and 75% are not of Hispanic origin.

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes is an another example of data elements required by the state, but not contained within a standard UB92 bill. Again the hospital has to make changes to our system to meet their requirements. Changes such as these take time and planning and we have yet to meet this requirement as is reflected in the state's data for Dallas/Fort Worth Medical Center. Currently the analysis states that 100% of our accounts are invalid/missing. We did submit the source of payment on all patients, but as stated earlier we have encountered programming difficulties. Our encounters fall in these percentages: 14% Self Pay, 2% Worker's Comp, 29% Medicare, 20% Medicaid, 20% Commercial, 1% Champus, 1% Other, 1% Commercial PPO/HMO, 4% Medicare Managed Care, and 8% Medicaid Managed Care.

Patient Discharge Status

The discharge status is used by the hospital to dictate to whom and where the patient was released when discharged from the facility. This information is found on the UB92 in record field number twenty-two. Discharge status is a required field for billing insurance companies. Upon the release of this certification information we have discovered that our data file transfer shows all 1134 patients being discharged to home with self-care.

This information is inaccurate and we are working with our third party programmer to resolve the issue. The correct encounters are as follows:

839 Discharged to Home/Self Care, 49 Discharge/Transfer to another Hospital, 84 Discharge/Transfer to SNF, 2 Discharge/Transfer to ICF, 57 Discharge/Transfer to Other Institution, 65 Discharge/Transfer to Home Health, 5 Left AMA, 33 Expired.

Patient Location

Dallas/Fort Worth Medical Center is located in Grand Prairie, Texas.

This is the heart of the entire metroplex area. We service patients in Grand Prairie and the surrounding areas, such as Arlington and Dallas.

Unfortunately, the state reflects that this information is missing or invalid. We have submitted the address of all patients discharged during this period to the state and at this time cannot comment as to why they do not show patient location. This will require further investigation by the I.T. department of the hospital.

Severity Index

This statistical information regarding the level of the patients we treat

is not available through our current Health Information System, and is not information we collect or report. The current UB92 does not require a severity level and does not provide a place for it on the form. Due to this fact, we cannot comment as to the accuracy of these numbers and appeal to the state to provide information on how they are using the UB92 to calculate the severity level for patients.

Physician Information

Dallas/Fort Worth Medical Center currently cannot comment as to the accuracy of the physician statistics gathered by the state due to all the other inaccuracies of the data previously discussed in these comments. Due to all the inaccuracies, we feel confident that the physician information is inaccurate and will not present this information to our current staff physicians for certification until we are confident all the problems have been resolved.

Certification Process

Due to the infancy of this process for the hospitals and state, it is not as complete, organized, or thorough as all parties would like to see it in the future. Dallas/Fort Worth Medical Center did not have an efficient mechanism for editing and correcting this data in conjunction with the programming problems and lack of resources to dedicate to this process.

Hopefully in the future both entities will be able to streamline the process to make it more efficient.

=====
THCIC ID: 502000 / Medical Center of Arlington
QUARTER: 1
YEAR: 1999

Certified with comments

Per one of the physicians on staff, if the data is submitted based on attending rather than actual patient contacts of consultants particularly pulmonary consultants, it is very likely the numbers are grossly underestimated.

In single speciality groups, the data may not be physician specific due to rotation of group.

=====
THCIC ID: 508000 / Conroe Regional Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

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

The public data will only contain a subset of the diagnosis and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient.

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

Race/Ethnicity classification is not done systematically within or between

facilities. Caution should be used when analyzing this data within one facility and between facilities.

=====

THCIC ID: 511000 / Doctors Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Data Content

This data is administrative data, collected by hospitals for billing purposes, and not clinical data, from which judgements about patient care can be made. The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 1450 EDI electronic claim format. The state specifications then require additional data elements to be included over and above that. Adding those additional data elements places programming burdens on the hospital since it is "over and above" the actual hospital billing process.

Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing

Doctors Hospital estimates that our data volumes for the calendar year time period submitted include 90% 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. As a result, the state submitted 2,190 encounters while Doctors Hospital's database reflects 2,345 encounters.

Diagnosis and Procedures

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 25% of the patient population serviced at Doctors Hospital has more than nine diagnosis and 15% have more than six procedures assigned to them.

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

There is no limit to the number of diagnoses and procedure codes that can be assigned to a patient record. The codes are assigned based on the physician's documentation in the patient's record and are used by hospitals for billing purposes. 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. However, new codes have not been provided to hospitals since October 1998 due to Y2K preparation.

The state is required to submit ICD-9-CM data on each patient but has limited the number of diagnosis and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us does not meet requirements but does not 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 (ie. 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 diagnosis and procedures) are less accurately reflected by the 1450 format. Many of the patients treated at Doctors Hospital are Do Not Resuscitate (DNR) patients or Living Wills.

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. Doctors normal hospital registration process only allows for "newborn" 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.

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. Upon review of the data, the THCIC report shows twice as many cases as were reported by the Doctors Hospital Charge Breakout And Summary Report for Quarter 1, 1999. The greatest occurrence of error is with the Primary Commercial Pay category. The hospital database reflects 57 cases. The state data reflects 686 cases. This is also the case in the Primary Non-Standard Source of Payment category. The state recognizes 283 cases whereas Doctors Hospital reflects 339. Another area of concern is the Missing/Invalid Source of Payment under the Non-Standard Source of Payment field. The state recognizes 1346 cases. Doctors Hospital database indicates that there are no cases in this category. THCIC has recognized that there is a problem with the way this data is captured and will not be publishing it for Quarter 1, 1999-Quarter 2, 2000. However, we would like to include in our comments that this data is invalid and therefore can not be considered accurate in any way.

Cost/Revenue Codes

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

Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process does not completely and accurately reflect all of the data that has been submitted. It also should

be noted that due to high turnover in key areas of the hospital, we spent a great deal of time learning and relearning the process involved in submitting the THCIC data as well as preparing the data for submission.

=====
THCIC ID: 513000 / Baylor Medical Center Grapevine
QUARTER: 1
YEAR: 1999
CERTIFIED WITH COMMENTS

Data Content

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

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

Submission Timing

Baylor estimates that our data volumes for the calendar year time period submitted may include 95% 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 a patient's hospitalization, sometimes significantly.

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

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

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us do meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make

percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

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.

Normal Newborns

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. 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 47% of encounters originally categorized across all values have a different value as of today. Upon review an additional data issue was uncovered. All managed care encounters were categorized as "Commercial PPO" instead of separating the encounters into "HMO" versus "PPO".

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

Cost/ Revenue Codes

The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received

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

Certification Process

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

07/21/00
1

=====
THCIC ID: 515000 / Doctors Hospital
QUARTER: 1
YEAR: 1999

Certified without comments

=====
THCIC ID: 524000 / East Texas Medical Center Rusk
QUARTER: 1
YEAR: 1999

Certify with comments

This facility stopped providing Inpatient Care on June 1, 1999.

=====
THCIC ID: 525000 / Longview Regional Medical Center
QUARTER: 1
YEAR: 1999

Certified without comments, corrections requested

Need correction of physician numbers:

| FROM | NAME | TO |
|--------|--------------------|-------|
| G9325 | BLOW, ALTON | J3050 |
| H25927 | MCDONALD, DEWARD M | C5174 |
| G7451 | SCOTT, RONALD A | G5587 |

=====
THCIC ID: 534000 / Katy Medical Center
QUARTER: 1
YEAR: 1999

Did not participation in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 537000 / Scott & White Memorial Hospital

QUARTER: 1
YEAR: 1999

Certified with comments

Data Content

To the best of our knowledge and ability with the configuration of our data systems, and the fact the data has gone through edits by other entities, the encounter data returned accurately represents the hospital inpatient and skilled nursing facility data from the UB92 billing claim form and data required by the state. The information being certified does not indicate or address the quality of services that were provided and is not provided for that purpose. Instead, this information is extracted from a billing file that is solely used for administrative purposes. Certain medical disciplines are responsible for the treatment of severely ill patients and physicians within those disciplines may experience a higher mortality rate due to the nature of their clinical practice. In addition, tertiary care facilities, such as ours often accept in transfer critically ill patients whose outcomes may adversely affect accepting institutions' performance profile. The data being submitted and certified is not meant to measure clinical quality.

Certification Process

It is possible that some cases discharged during this quarter were not included in the file submitted to the state due to the timing of submission required by the state. This may have occurred in instances when a case had not been billed before the tape was submitted, or when a correction of a billing error was made after the tape was submitted. Due to the volume of encounters for this certification period, time constraints and the resources needed for this process, the facility did not have an efficient method for verifying, auditing and correcting data at the encounter level.

Organization of Data

We are a teaching facility and the structure of our inpatient care is such that multiple physicians are involved in the patient's care in a serial fashion over the total duration of the patient's episode of care. Therefore, based solely on the billing file data, we cannot accurately assign a single physician as being largely responsible for the care of a patient when there may have been more than one attending physician involved in the care

of the patient. For internal data analysis, the discharging physician has long been used as the responsible physician when assigning DRG's (Diagnosis Related Groups) or computing mortality statistics. The attending physician reported in this data submission to THCIC might not be consistent with our assessment of the discharging physician.

Diagnosis/Procedure Code Summary

Being a teaching facility, we do assign more diagnoses and procedures than are captured on the UB92 billing claim form. The average number of diagnoses per encounter should read 6.5 and the average number of procedure codes assigned should be 2.0. These numbers are under-represented by THCIC methodology.

Standard/Non-Standard Source of Payment

This level of specificity is not required on the UB92 claim, therefore additional programming was done that may need additional attention to accurately capture the specified categories under Non-Standard Source of Payment.

=====
THCIC ID: 547000 / Fort Duncan Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments:

Data is accurate and complete to a great degree, however the following is noted:

1. Pay source needs clarification: all of the self-pay encounters are included with the commercial encounters: Commercial = 7% and Self-pay = 13%.
2. There were 9 patient encounters omitted from the data files. Information for these are as follows:
 - a. DRG's: 127, 184, 098, 378, 494, 132, 018, 391, and 132.
 - b. Primary Dx: 414.01, V30.0, 250.62, 414.01, 574.0, 633.1, 466.19, 536.2, and 428.0
 - c. There were 5 males and 4 females.

=====
THCIC ID: 549000 / Baylor Richardson Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

BAYLOR / RICHARDSON MEDICAL CENTER
TEXAS HEALTH CARE INFORMATION COUNCIL
STATE DATE REPORTING COMMENTS

Source of Data

The state requires each hospital to submit claims data, also called billing data, in an industry standard format called the UB92. The UB92 format is how information is sent to insurance companies (i.e. Medicare, Medicaid, HMOs, PPOs, Commercial, Etc) in order for the hospital to receive payment. This data is considered administrative data and not clinical data.

Diagnosis and Procedures

Patient diagnoses and procedures for each individual hospital stay are coded according to pre-set criteria using an industry standard called the International Classification of Diseases (ICD-9). The codes are assigned based on the documentation within the patient's chart. The federal government mandates the use of the ICD-9 code books and all hospitals must comply with coding guidelines.

A patient may have 25 diagnoses and 25 procedure codes assigned for their stay. Unfortunately, a limitation of these codes is that there is not a code for every possible diagnosis and procedure due to the continual evolution of medicine. Annually, new codes are added and current codes are updated to reflect current changes in medicine.

The UB92 claims data format which the state is requiring hospitals to submit, only accepts the first 9 diagnosis codes and the first 6 procedure codes. As a result, these records will not reflect every code from an individual patient record that was assigned. Thus the state's data file may not fully represent all diagnoses treated at the hospital, or all procedures performed by the hospital. Therefore true total volumes may not be accurately represented by the state's data file, making percentage calculations inaccurate (% of patients in each severity of illness categories).

Normal Newborns

For each patient record there is an admission type. This tells the status of the patient at the time of registration (i.e. Emergency, Urgent, or Newborn). For newborn admit types, there is a subset that also tells the status of the newborn. They may be classified as Normal, Premature, Sick, or Information Not Available.

Race/Ethnicity

When patients are admitted, the hospital does not routinely inquire as to their race and/or ethnicity. Thus analysis of these two data fields will not accurately describe the true population served by the hospital. The hospital does not discriminate based on race, color, ethnicity, gender or national origin.

Cost/ Revenue Codes

The state data files will include charge information. It is important to understand that charges do not equal payments received by the hospital. Payments 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 for care that each patient receives.

Quality and Validity of the process

Process are in place to verify the integrity and validity of the claims data. Steps are taken to ensure that the information sent to the state matches what is in the hospitals system. Occasionally, due to timing issues not all patient claims are submitted. If a case was not billed prior to data submission, that patient will not be included in the current submission, nor will it be included in any future data submissions. An example of why this would occur, is the patient is discharged on the last day of the calendar quarter, and not allowing adequate time to issue a bill or

the case was extremely complex requiring extra time for coding.

=====
THCIC ID: 555000 / Pampa Regional Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

Data includes information from the Skilled Nursing Unit.

Procedure code 3722 incorrectly identifies one patient in the wrong age category. Patient's birth date typed same as admission date.

=====
THCIC ID: 559000 / Seton Highland Lakes Medical Center
QUARTER: 1
YEAR: 1999

Certified without comments

=====
THCIC ID: 586000 / Baylor Specialty Hospital
QUARTER: 1
YEAR: 1999
CERTIFIED WITH COMMENTS

Data Content

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

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

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.

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 an acute care hospital. They are admitted to BSH to continue their recovery and focus on improving their medical condition and/or functional ability in order to improve their quality of life to the fullest extent possible.

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

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

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

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

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

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.

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

Race/Ethnicity

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are no national standards regarding patient race categorization, and thus each hospital may designate a patient's race

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. 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 20% of encounters originally categorized as self-pay have been re-categorized as Medicare or Commercial.

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

Cost/ Revenue Codes

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

Certification Process

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

07/21/00

1

=====
THCIC ID: 597000 / Seton Edgar B. Davis
QUARTER: 1
YEAR: 1999

Certified with comments

597000: Daughters of Charity - Seton Edgar B. Davis Quarter One 1999

Seton Edgar B. Davis is a community hospital that serves the Caldwell County and surrounding rural areas as a medical/surgical facility. The transfer of the seriously ill and injured is reflected in the lengths of stay and mortality rate.

Admission Source and Type:

Seton Edgar B. Davis experienced a data collection problem which affected admission and type. The hospital is correcting the problem prospectively, but corrections will not affect data previously submitted by the hospital.

=====
THCIC ID: 600000 / CHRISTUS St John Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

St. John certified the data, but could not account for 238 patients whose accounts were processed after the date of the original data submission.

During this interval, St. John Hospital provided charity care for 25 patients with charges of \$118,699.23. The system did not identify these patients as recipients of charity care.

=====
THCIC ID: 602000 / South Austin Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

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

The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes. Race / Ethnicity classification is not done systematically within or between facilities.

Caution should be used when analyzing this data within one facility and between facilities. The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient. The relationship between cost of care, charges and the revenue that a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.

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.

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

=====
THCIC ID: 603000 / Medical Center at Lancaster
QUARTER: 1
YEAR: 1999

Certified with comments

We had slight variation on the top 30 HCFA- DRG's and procedure codes.

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

2. The public data only contains a subset of diagnosis and procedure codes.
3. The relationship between cost of care, charges and the revenue that a facility receives is extremely complex. Inferences to comparing charges from one hospital to the next may give unreliable results.
4. The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase the grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.
5. Race/ethnicity classification is not done systematically at each hospital.
6. Our hospital does not capture charity data at the time of billing.
7. The designation of attending physician is usually assigned to the physician that discharges the patient. In some cases this does not reflect the physician that provides most of the patient's care.
8. We identified a mapping problem with physician middle initials not always being accurate.
9. We identified an error in the patient status upon discharge. The wrong code was entered.

=====

THCIC ID: 608000 / Round Rock Medical Center
 QUARTER: 1
 YEAR: 1999

Certify with Comments

Charity cases are a subset of the self-pay category.

=====

THCIC ID: 611000 / Regional Medical Center
 QUARTER: 1
 YEAR: 1999

Certified with comments

C:\programfiles\certview611000.text
 Until February 2000, a portion of the Regional North Building was used for inpatient psychiatric services. Effective February 2000, the pschiatric unit was relocated within Regional Medical Center Building.

=====

THCIC ID: 616000 / HEALTHSOUTH Rehab Hospital
 QUARTER: 1
 YEAR: 1999

Certified with comments

Patient Discharge Status information should read as follows:

| | | |
|------------------------------------|----|-----|
| Discharge to Home or Self Care | 77 | 48% |
| Discharge/Transfer to Gen Hospital | 32 | 20% |

| | | |
|-----------------------------------|----|-----|
| Discharge/Transfer to SNF | 19 | 12% |
| Discharge/Transfer to Home Health | 30 | 19% |
| Left AMA | 2 | 1% |

=====
 THCIC ID: 624000 / Denton Community Hospital
 QUARTER: 1
 YEAR: 1999

Certified with comments

Comments regarding 1st Quarter, 1999 Data

1. Discrepancy in total number of encounters. THCIC has 1579 and hospital system shows 1613. Gender count is also incorrect.

Some 1st quarter claims received late by THCIC.

Hospital process and systems being reviewed and modified to prevent future occurrence.

2. Variance in Admission type numbers regarding Newborns--- THCIC: 191 Our System: 198.

Did not have any extramural births. Registration process incorrectly registered Newborns as "Elective" type rather than "Newborn".

Data was corrected through THCIC to reflect the appropriate number of newborns, but changing the admit type caused the error of erroneous counting of Extramural Births. Audits in place to monitor and correct.

3. Admission Source identifies 3 patients from "Clinic". We do not have a hospital based clinic.

Local Physician office is called "The Clinic". Misunderstanding at Registration.

Clarified in meeting with Registration clerks. Admission source info can't be captured at this point in our source data, so unable to correct this quarter.

4. Data shows 86 pts as "Black"

Unable to ascertain race if patient does not come through registration. Clerks are using "best observed guess"

Efforts will continue to ensure accuracy.

=====
 THCIC ID: 627000 / Harris Methodist Southwest
 QUARTER: 1
 YEAR: 1999

Certified with comments

Data Content

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

The State requires us to submit inpatient claims, by quarter/year, gathered from a billing form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Adding those additional data places programming burdens on the Hospital since it is "over and above" the actual hospital billing process. The billing data submitted to our payers is accurate; however, errors can occur due to this additional programming.

These errors have been corrected to the best of our knowledge.

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

Diagnoses and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the Hospital using a universal standard called the International Classification of Disease, or ICD-9-CM. The Hospital complies with the guidelines for assigning these diagnosis codes; however, this is often driven by physicians' subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level is 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 hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

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

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

Admit Source data for Normal Newborn

Currently the State uses Admit Source to determine the status of a 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. Many hospital information systems and registration processes default to "normal delivery" as the Admission Source. Therefore, Admission Source does not always give an accurate picture. 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. If Admission Source is used to examine length of stay or mortality of normal neonates, the data will reflect premature and sick babies mixed in with the normal newborn data.

Harris Methodist Southwest Hospital recommends use of ICD-9-CM coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The standard and non-standard Source of Payment codes are an example of data required by the State that are not contained within the standard UB92 billing record. In order to meet this requirement, each payer identification must be categorized into the appropriate standard and non-standard Source of Payment value. These values might not accurately reflect the hospital payer information. For example, 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. Of equal concern to Harris Methodist Southwest is that, because of these "mapping" problems, our numbers of Charity patients are not accurately represented in the State's data.

Cost/Revenue Codes

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

Certification Process

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

=====
THCIC ID: 636000 / HEALTHSOUTH Rehab Institute of San Antonio
QUARTER: 1
YEAR: 1999

Certified with comments

1st quarter, 1999 data is incomplete due to technical problems with data submission. The data does not reflect 100% of the encounters for 1st

quarter, 1999.

=====
THCIC ID: 639000 / Rehabilitation Hospital of South Texas
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 642000 / Baylor Institute for Rehab at Gaston
QUARTER: 1
YEAR: 1999
CERTIFIED WITH COMMENTS

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form call a UB92, in a standard government format called HCFA 150 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing

Baylor Institute for Rehabilitation (BIR) estimates that our data volumes for the calendar year time period submitted may include 91% 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.

Diagnosis and Procedures

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

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

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

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

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

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

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.

Medical rehabilitation 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

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race data element is subjectively captured and the ethnicity data element is derived from the race designation. There are 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.

Upon review, a mapping issue was uncovered regarding the Race code and Ethnicity code categorization of all patient encounters. Approximately 33% of the encounters were incorrectly categorized under the state defined "Other" race code.

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identification must be categorized into the appropriate standard and non-standard source of payment value. With this in mind, approximately 75% of encounters originally categorized across all values have a different value as of today. Upon review an additional data issue was uncovered. All managed care encounters were categorized as "Commercial PPO" instead of separating the encounters into "HMO" versus "PPO".

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

Cost/Revenue Codes

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

Certification Process

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

07/27/00

1

=====
THCIC ID: 646000 / HEALTHSOUTH Houston Rehabilitation Institute
QUARTER: 1
YEAR: 1999

Certified with comments

On my discharge data report I have a seventy-four (74) year old patient listed as a newborn, sick baby.

=====
THCIC ID: 649000 / St Davids Rehabilitation Center
QUARTER: 1
YEAR: 1999

Certified with comments

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

2.) The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the of the diagnoses and procedures relative to each patient.

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

=====
THCIC ID: 652000 / Harris Continued Care Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Some "Admission Types" were listed as Urgent, Emergency, or Unknown categories. All admissions to Harris Continued Care Hospital are elective. The Admissions Office will be reminded about choosing "Elective" for all Harris Continued Care Hospital Admissions in the future.

=====
THCIC ID: 653000 / Zale Lipshy University Hospital
QUARTER: 1
YEAR: 1999

Certified with comments, corrections requested

CERTIFICATION WITH COMMENTS
TEXAS HEALTHCARE INFORMATION COUNCIL
FIRST QUARTER 1999 DATA

DATE: July 25, 2000

RE: ZALE LIPSHY UNIVERSITY HOSPITAL
5151 HARRY HINES BLVD.
DALLAS, TEXAS 75235-7786

1. Zale Lipshy University Hospital is an academic teaching hospital.
2. Zale Lipshy University Hospital is a private, adult referral hospital located on the campus of UT Southwestern Medical Center.
3. Zale Lipshy University Hospital does not provide for the following types of medical services: pediatrics and obstetrics.
4. Our charity cases are determined after final billing; therefore, they are not quantified in this report.
5. The file definition for self-pay does not adequately display billing for secondary and tertiary billing specifications.
6. Admission Source: physician and clinic are used interchangeably at our institution.
7. Admission Source: correctional facility code and court ordered admission code are used as one code.
8. Total Patient Volume: information on 3 patient discharges is missing from the data file.
9. The corrected data has been accepted by Commonwealth.

=====

THCIC ID: 659000 / HEALTHSOUTH Rehabilitation Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

AS ADVISED BY COMMONWEALTH AND THCIC, WE RECOGNIZE THAT SEVERAL 0001 FIELD IN FIRST QTR ARE BLANK , HOWEVER ALL ROOM & ANCILLARY CHARGES HAVE BEEN SUBMITTED AND ARE ACCURATE. FUTHER IT IS OUR UNDERSTANDING FIELD 0001 WILL BE SUPRESSED AT THIS TIME.

SECONDLY, WE ACKNOWLEDGE THAT ALL ADMISSIONS TO THIS HOSPITAL ARE ELECTIVE AND CONFIRMED THAT 2 RECORDS ARE ERRONEOUSLY LISTED AS EMERGENCY. WE WILL CONTINUE TO AUDIT AND ELEMIMATE THIS ERROR IN FUTURE QUARTERS.

=====
THCIC ID: 660000 / HEALTHSOUTH Rehab Hospital of Arlington
QUARTER: 1
YEAR: 1999

Certified with comments

It became necessary to submit certification data for Quarter 1 1999 in two separate batches, one for 26 discharges, the other for the balance of 311. You are receiving comments and certification letters for both of these batches. Combined figures accurately reflect discharges for the quarter. We acknowledge that the total revenues figure derived from UB92 0001 are undercounted in the THCIC database, and that this figure will not be in the public record for the first six quarters.

=====
THCIC ID: 662000 / HEALTHSOUTH City View Rehab Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

We discovered a discrepancy in total charges for Q1, 1999. Summary statistics list charges of 3.7million while our records show \$4.1million. Per consultation with THCIC and Commonwealth we re-state that the 0001 field is suppressed for the first six quarters due to software issues. Also, we find three records - 119990470427, 119990470394, 119990470451 - showing room charges without ancillaries. The total revenues missing are not statistically significant enough to warrant correction in this quarter.

=====
THCIC ID: 664000 /Presbyterian Hospital of Plano
QUARTER: 1
YEAR: 1999
PRESBYTERIAN HOSPITAL OF PLANO CERTIFIED WITH COMMENTS

Data Content

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

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

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

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

Patient Population Characteristics:

Low volume in the overall cardiac surgery program is due to a start up program that began in February, 1999.

Diagnosis and Procedures

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

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

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately 5% of PRESBYTERIAN HOSPITAL OF PLANO's patient population have more than nine diagnoses assigned.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

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

Standard/Non-Standard Source of Payment

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

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

Cost/ Revenue Codes

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

Certification Process

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

07/24/00

3

=====
THCIC ID: 665000 / Central Texas Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Due to hardware limitations and personnel changes, 1999 data has all diagnosis codes listed with a leading blank. The code shown on the certification data is correct when viewed, but will not necessarily match a computer search.

=====
THCIC # 670000 / HEALTHSOUTH Plano Rehabilitation Hospital
Quarter: 1
Year: 1999

Certified with Comments

Due to system problems, HealthSouth Plano Rehab Hospital was unable to make changes to the ethnic groups.

=====
THCIC ID: 672000 / Select Specialty Hospital Dallas
QUARTER: 1
YEAR: 1999

Certified with comments

Upon discussion with the IS Department, it is noted that there are mapping errors involving Non-Standard Payment Source Codes that will be addressed. Potential mapping errors involving Revenue Codes found to be out-of-sequence will also be addressed.

=====
THCIC ID: 675000 / Columbia Kingwood Medical Center

QUARTER: 0
YEAR: 0

Certified with comments

Comments for first quarter 1999 data:

The data for Kingwood Medical Center includes acute, skilled, rehabilitation and hospice patients which impacts our clinical and financial outcomes and summary data.

=====
THCIC ID: 676000 / Vencor Hospital - Houston
QUARTER: 1
YEAR: 1999

Certified with comments

Comments not received by THCIC.

=====
THCIC ID: 681400 / Kell West Regional Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Error due to vendor mapping

=====
THCIC ID: 684000 / HEALTHSOUTH Rehab Hospital of Texarkana
QUARTER: 1
YEAR: 1999

Certified with comments

Due to a system error, all patient discharges for the first quarter of 1999 were erroneously coded as 01 (patient discharged to home). The actual patient discharge status break-out is as follows:

| Discharge location code: | Number of Patients: |
|---|---------------------|
| 01 Home, NO Home Health | 26 |
| 02 Board & Care | 1 |
| 04 Intermediate Care | 1 |
| 05 Skilled Nursing | 27 |
| 07 Acute Unit @ Other Med Facility | 22 |
| 10 AMA | 1 |
| 11 Died | 3 |
| 12 Alternate Level of Care (SNF unit @ other hospital) | 1 |
| 50 Home with Home Health | 141 |

Total patients discharged = 223

=====
THCIC ID: 686000 / Covenant Childrens Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

1. Data does not accurately reflect the number of charity cases for the time period. This is due to internal process for determination of the source of payment.

Charity Cases 28

=====
THCIC ID: 691000 / Memorial Specialty Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

We are aware that the physician listed was considered the original admitting physician for Memorial Health System and may not have been updated when transferred on our computer system.

=====
THCIC ID: 694000 / Surgicare Specialty Hospital of Corpus Christi
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 695000 / HEALTHSOUTH Rehab Hospital North Houston
QUARTER: 1
YEAR: 1999

Certified with comments

Patient Discharge Status should read as follows:

| | | |
|---------------------------------------|-----|--------|
| Discharge to Home or Self Care | 111 | 70.25% |
| Discharge/Transfer to Gen Hosp | 24 | 15.19% |
| Discharge/Transfer to SNF | 11 | 6.96% |
| Discharge/Transfer to Oth Institution | 1 | .63% |
| Discharge/Transfer to Home Hlth | 7 | 4.43% |
| Left AMA | 3 | 1.90% |
| Expired | 1 | .63 % |

=====
THCIC ID: 698000 / The Specialty Hospital of Houston
QUARTER: 1
YEAR: 1999

Certified with comments

Comments:

1. Due to technical issues with Information Systems the discharge data for the quarter is not accurate. The Technical issues are related to vendor and patient account numbers. Please note that these issues are said to be resolved as of this date.
2. The admissions type for all admissions are coded as "urgent". This information is incorrect and should be "elective" admissions.
3. The admission source for all the patients is coded as "physician" This information is incorrect. Not all of the admissions are from physicians,

other sources include transfers from hospitals and Skilled Nursing facilities.
4. Physicians and other health care professionals were not provided an opportunity to review the data for accuracy secondary to time constraints.
5. Please note that this data is half of the total data for the Specialty Hospital of Houston. There are two campuses to one hospital (698000 & 698001) . Due to the inability to merge the data to reflect one hospital; the data is submitted by campus. So, please consider both campuses when reviewing data for Specialty Hospital of Houston.

=====
THCIC ID: 698001 / Specialty Hospital Houston Clear Lake Campus
QUARTER: 1
YEAR: 1999

Certified with comments

Comments:

1. Due to technical issues with Information Systems the discharge data for the first quarter is not accurate. The Technical issues are related to vendor and patient account numbers. Please note that these issues are said to be resolved as of this date.
2. The admissions type for all admissions are coded as "urgent". This information is incorrect and should be "elective" admissions.
3. The admission source for all the patients is coded as "physician" This information is incorrect. Not all of the admissions are from physicians, other sources include transfers from hospitals and Skilled Nursing facilities.
4. Physicians and other health care professionals were not provided an opportunity to review the data for accuracy secondary to time constraints.
5. Please note that this data is half of the total data for the Specialty Hospital of Houston. There are two campuses to one hospital (698000 & 698001) . Due to the inability to merge the data to reflect one hospital; the data is submitted by campus. So, please consider both campuses when reviewing data for Specialty Hospital of Houston.

=====
THCIC ID: 699000 / IHS Hospital at Corpus Christi
Quarter: 1
Year: 1999

Certify with comments

Please note that our facility is a Long Term Acute Care Hospital.

=====
THCIC ID: 700000 / The Specialty Hospital of Austin
QUARTER: 1
YEAR: 1999

Certified with comments

Due to technical issues and other various time constraints, physicians and other individuals were not given adequate time to view the data. Due to system missing key claim componets, patient interim bill numbers do not match the patient control numbers (pcn). In additon, some patients admitted in 1998 but discharged in 1999, therefore being excluded from this data.

=====
THCIC ID: 703002 / The Corpus Christi Medical Center
QUARTER: 1

YEAR: 1999

Certified with comments

The summary numbers under the caption "Standard Source of Payment" and "Non-standard Source of Payment" do not accurately reflect the payor sources identified in the Corpus Christi Medical Center's billing records.

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the Corpus Christi Medical Center is unable to verify the accuracy of these numbers.

=====
THCIC ID: 705000 / Texoma Medical Center Restorative Care Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

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

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

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

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

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

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

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

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

- Not all claims may have been billed at this time.
- Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill

when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

=====
THCIC ID: 706000 / Vencor Hospital- Houston Northwest
QUARTER: 1
YEAR: 1999

Certify with Comments

Vencor Hospital Houston Northwest is a long term acute care hospital

=====
THCIC ID: 708000 / Dubuis Hospital for Continuing Care Beaumont
QUARTER: 1
YEAR: 1999

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. 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.

=====
THCIC ID: 709000 / Red River Hospital
QUARTER: 1
YEAR: 1999

Data from this reporting quarter includes 4 patient discharges representing 504 patient days for care rendered to adolescents enrolled in long term substance abuse treatment in conjunction with the Texas Commission on Alcohol and Drug Abuse.

=====
THCIC ID: 710000 / Our Childrens House at Baylor
QUARTER: 1
YEAR: 1999

CERTIFIED WITH COMMENTS

Data Content

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

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

payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

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.

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 an acute care hospital. They are admitted to OCH to continue their recovery and focus on improving their medical condition and/or functional ability in order to improve their quality of life to the fullest extent possible.

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

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

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

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

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

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.

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. 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 5% of encounters originally categorized as self-pay have been re-categorized as Medicare or Commercial.

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

Cost/ Revenue Codes

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

Certification Process

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

07/21/00

1

=====
THCIC ID: 713000 / CHRISTUS St Michael Rehab Hospital
QUARTER: 1st Q
YEAR: 1999

Certified with comments

This is the first attempt in this process. We are making every effort to assure data quality and timeliness.

=====
THCIC ID: 723000 / Laurel Ridge A Brown Schools Psych Hospital
QUARTER: 1
YEAR: 1999

CERTIFIED WITH COMMENTS

"Both the accomm. charge and the ancillary charge, do not reflect physician compensation; These are hospital and clinical charges that have relatively little bearing on currently reduced and discounted psychiatrist's fees and hourly rates."

=====
THCIC ID: 727000 / The Oaks Treatment Center
QUARTER: 1
YEAR: 1999

Certified with comments

Please add the following comments to the 1st Q'99 encounter file for The Oaks Treatment Center.

"The Oaks Treatment Center provides long-term residential treatment to adolescents with severe emotional disturbances. No hospital programs are in operation.

Please note the THCIC software is not equipped to store lengths of stay over 999 days. For patient stays which exceed 999 days, the THCIC system automatically rounds the actual length of stay down to a maximum of 999 days. The system does not round down the actual charges for these stays, but reports the actual charges for the entire stay. This should be taken into consideration when interpreting LOS and charge data for this facility as some patient stays may exceed 999 days."

=====
THCIC ID: 733000 / Charter Behavioral Health System of Kingwood
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====

THCIC ID: 735000 / TIRR LifeBridge
QUARTER: 1
YEAR: 1999

Certified with Comments

TIRR LifeBridge
Subacute Medical Transitional and General Rehabilitation

TIRR LifeBridge is a fully accredited teaching specialty hospital that provides subacute medical transitional and general rehabilitation. The philosophy of LifeBridge is to assist patients in attaining the highest level of function possible within the resources available to them. LifeBridge works closely with the patient and his/her family and the External Case Manager to provide care effectively at an appropriate level. Patient care is offered in general clinical services including:

- * Stroke
- * Cancer Recovery
- * Wound and Skin Care Management
- * Post Surgical Care
- * General Rehabilitation
- * Neuromuscular Complications of Diseases or Injuries
- * Ventilator and Other Respiratory Care
- * Brain Injury Recovery, Including Coma
- * Complex Diabetes
- * Orthopedics

Types of Services

Subacute general rehabilitation services are provided for patients who have limited tolerance for participation or benefit from a comprehensive acute rehabilitation program. Medical transitional services are designed for patients who need specialized care for medical issues that do not require an acute care hospital setting. The types of services include:

- * Pulmonary/Ventilator
- * Strength/Endurance Exercises
- * Complex Wound Care
- * Speech/Language Intervention
- * Bowel/Bladder Training
- * Alternative Communication Techniques
- * Positioning
- * ADL Training
- * Patient/Family/Attendant Training
- * Mobility Training
- * Gait Training

THCIC data show TIRR LifeBridge as a "SNF Facility". TIRR LifeBridge operated a SNF unit until December 1998, when the unit was converted back to long term acute care.

=====

THCIC ID: 736000 / DePaul Center - Div of Providence Health Center
QUARTER: 1
YEAR: 1999

Certified with comments

Due to a data mapping error, 43 records from the DePaul Center were accidentally submitted under Providence Health Center's THCIC Number (THCIC #040000). The accounts had the following HCFA DRGs:

HCFA DRG NO - Quantity
HCFA DRG 425 - 1
HCFA DRG 426 - 3
HCFA DRG 427 - 4
HCFA DRG 428 - 5
HCFA DRG 430 - 26
HCFA DRG 431 - 1
HCFA DRG 434 - 1
HCFA DRG 435 - 2

=====
THCIC ID: 737000 / Southwest Mental Health Center
QUARTER: 1
YEAR: 1999

Certified with comments

1. Fifty-four patients are missing from the data set due to bill type errors.
2. The admission type data is skewed due to data entry errors; this problem has been corrected. Most of the patients admitted should have been considered urgent.
3. Standard source of payment is incorrect. Our vendor inadvertently mapped Champus patients to the other category. Steps have been taken to correct this matter.
4. We have many physicians caring for patients. There was a data mapping problem that caused one physician to become the attending physician on all patients submitted.

=====
THCIC ID: 742000 / COMPASS Hospital of Dallas
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 745000 / Charter Haven Behavioral Health System
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 753000 / San Marcos Treatment Center

QUARTER: 1
YEAR: 1999

Certified with comments

San Marcos Treatment Center provides long- term residential treatment to adolescents with severe emotional disturbances. No hospital programs are in operation.

Please note the THCIC software is not equipped to store length of stays over 999 days. For patient stays which exceed 999 days, the THCIC system automatically rounds the actual length of stay down to a maximum of 999 days. The system, however, does not round down the actual charges for these stays, but reports the actual charges for the entire treatment stay.

This should be taken into consideration when interpreting average LOS and charge data for this facility as some patient stays do exceed 999 days.

=====
THCIC ID: 756000 / Charter Real Behavioral Health System
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 757000 / Charter Palms Behavioral Health System
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 758000 / HEALTHSOUTH Hospital for Specialized Surgery
QUARTER: 1
YEAR: 1999

Certified with comments

I certify our data with the following comments:

1. Data on charges are not reported due to software programming problems and assistance needed with programmers at software vendor.
2. Reporting of duplicate diagnosis codes is an internal issue. Although a diagnosis is reported twice, it should have been reported only one.
3. No zip code on two encounters is because the patients were from a foreign country.

=====
THCIC ID: 760000 / Charter Behavioral Health System of Corpus Christi
QUARTER: 1

YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 764000 / Charter Behavioral Health System of Austin
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 768000 / Pinelands Hospital
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 771000 / St Davids Pavilion
QUARTER: 1
YEAR: 1999

Certified with comments

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

2.) The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the of the diagnoses and procedures relative to each patient.

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

=====
THCIC ID: 778000 / Harris Methodist Springwood
QUARTER: 1
YEAR: 1999

Certified with comments

Data Content

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

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

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

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

Diagnosis and Procedures

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

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

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

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

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly. Approximately .95% of Harris Methodist Springwood's patient population have more than nine diagnoses and/ or six procedures assigned.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 25 diagnoses and 25 procedures for each patient record. One limitation

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Certification Process

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

=====
THCIC ID: 780000 / Harris Continued Care Hospital H.E.B.
QUARTER: 1
YEAR: 1999

Certified with comments

Some "Admission Types" were listed as Urgent, Emergency, or Unknown categories. All admissions to Harris Continued Care Hospital are elective. The Admissions Office will be reminded about choosing "Elective" for all Harris Continued Care Hospital Admissions in the future.

=====
THCIC ID: 784000 / Charter Behavioral Health System of Dallas
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 785000 / Panhandle Surgical Hospital
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did

not identify any material errors.

=====
THCIC ID: 787000 / Charter Grapevine Behavioral Health System
QUARTER: 1
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 1st Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 788000 / CHRISTUS St Michael Health System
QUARTER: 1st Q
YEAR: 1999

Certified with comments

This is the first attempt in this process. We are making every effort to assure data quality and timeliness.

=====
THCIC ID: 793000 / Mainland Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

Pt born in the ambulance prior to admissoio.

Pt a skilled patient and was billed correctly.

=====
THCIC ID: 796000 / IHS Hospital of Amarillo
QUARTER: 1
YEAR: 1999

Certified with comments

Due to a computer system conversion, discharge encounter data for calendar quarter one/1999 includes only February 99 and March 99 data.

Due to limited computer options, admission source reflects 100% direct physician admits.

=====
THCIC ID: 797000 / North Austin Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

The data is administrative data that was collected for billing purposes and was not designed to allow judgements about patient care.

The public data set includes only a subset of diagnoses and procedure codes and will not accurately represent the sickest or most complicated patients.

The relationship between cost of care, charges, and revenue is complex. Inferences drawn from comparing different facilities' charges may be unreliable.

Charity care is not accurately reflected in the source of payment data. Patients who have no insurance are initially identified as 'Self-Pay,' but frequently become 'Charity' after it is determined that they are unable to pay.

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.

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

The data does not accurately reflect the number of PPO patients at North Austin Medical Center because of a computer mapping problem. PPO patients are currently included in the HMO classification.

DRG 112 represents 20 patients in 1st and 2nd quarters of 1999. Two of these were extremely high-risk patients who underwent cardiac catheterization procedures as a last resort and who subsequently died during the hospital stay. North Austin Medical Center has high volumes in the cardiac cath lab and most patients are in DRG's other than 112.

=====
THCIC ID: 798000 / Summit Hospital of Central Texas
QUARTER: 1
YEAR: 1999

Certified with comments

Due to technical issues and other various time constraints, physicians and other individuals were not given adequate time to view the data.

=====
THCIC ID: 801000 / Vencor Hospital Bay Area Houston
QUARTER: 1
YEAR: 1999

Certified with comments

Vencor Hospital - Bay Area Houston is a Long Term Acute Care Facility

=====
THCIC ID: 802000 / McAllen Heart Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Recent changes within our Hospital information systems has caused data mapping errors. Errors listed do not affect the overall services provided to our patients.

=====
THCIC ID: 806000 / Cedar Crest Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

We are aware that all of our Non-Standard Sources of Payment are listed as "Missing/Invalid". We are currently working to correct this problem.

=====
THCIC ID: 807000 / Dubuis Hospital for Continuing Care Houston
QUARTER: 1
YEAR: 1999

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. 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.

=====
THCIC ID: 810000 / Harris Continued Care Hospital
QUARTER: 1
YEAR: 1999

Certified with comments

Some "Admission Types" were listed as Urgent, Emergency, or Unknown categories. All admissions to Harris Continued Care Hospital are elective. The Admissions Office will be reminded about choosing "Elective" for all Harris Continued Care Hospital Admissions in the future.

=====
THCIC ID: 814000 / Las Colinas Medical Center
QUARTER: 1
YEAR: 1999

Certified with comments

Mapping issues exist regarding patient race and ethnicity.

Las Colinas Medical Center's patient RACE data reflects 26 "American/Indian/Eskimo/Aleut" ; THCIC data 0; LCMC "Asian or Pacific Islander" 25; THCIC 120; LCMC "Black" 63; THCIC data 0; LCMC "White" 417; THCIC data 432 and finally, LCMC "Other" 186; THCIC data 165.

Las Colinas Medical Center's patient ETHNICITY data reflects "hispanic origin" 122; THCIC data 149; LCMC "not of hispanic origin" 595; THCIC 568.

=====
THCIC ID: 817000 / Renaissance Womens Center of Austin
QUARTER: 1

YEAR: 1999

Certified with comments

Renaissance Women's Center is certifying the first quarter 1999 data with the exception of the patient demographic information. We are aware that all patient addresses only contain the first seven digits of the street address. Due to computer problems and the time frame allowed, we are unable to correct the patient demographic data for this quarter.

=====
THCIC ID: 818000 / SCCI Hospital of Amarillo
QUARTER: 1
YEAR: 1999

Certified with comments

For the 1st Quarter of 1999, there were 8 patients who were admitted in 1998 but discharged in 1999. These patients show up as incomplete encounters due to this fact. The data on these patients are as follows. (per Lorna)

| PT # | TOB | DX | Charges | Payor | Race | |
|------|-----|--------|-------------|----------|------|--------|
| 1 | 111 | 730.28 | \$121824.15 | Medicare | W | |
| 2 | 111 | 424.90 | \$93293.73 | Comm | W | |
| 3 | 111 | 436 | \$126135.33 | Medicare | W | 1/8/99 |
| 4 | 111 | 486 | \$124337.34 | Medicare | W | |
| 5 | 111 | 038.9 | \$80779.82 | Medicare | W | |
| 6 | 111 | 996.77 | \$28801.97 | Medicare | W | |
| 7 | 111 | 444.3 | \$155742.78 | Medicare | W | |
| 8 | 111 | 518.81 | \$243214.74 | Medicare | W | |

3 Patients showing up on the incomplete encounter list had incorrect admit hours.
Change admit hour to 00.

Comments on Patient Discharge Status are as follows:

| | |
|--|----|
| Discharge/Transfer to Home | 9 |
| Discharge/Transfer to General Hospital | 5 |
| Discharge/Transfer to SNF | 10 |
| Expired | 7 |
| Discharge/Transfer to Hospice | 1 |

=====
THCIC ID: 819000 / SCCI Hospital San Angelo
QUARTER: 1
YEAR: 1999

Certified with comments

There were 8 patients whose data did not come across certification because of being admitted in 1998 but discharged in 1999. I have compiled some information on these patient's and have listed below. The format of the information will be sex; length of stay; principal diagnosis; and total charges billed.

Female, LOS 16 days, principal diagnosis 73026, total charges billed \$14734.54

Female, LOS 37 days, principal diagnosis 486, total charges billed \$37881.73

Male, LOS 15 days, principal diagnosis 0381, total charges billed \$94827.92

Male, LOS 4 days, principal diagnosis 3570, total charges billed \$23334.70

Male, LOS 42 days, principal diagnosis 73025, total charges billed \$47659.53

Male, LOS 45 days, principal diagnosis 59080, total charges billed \$57966.36

Male, LOS 43days, principal diagnosis 7078, total charges billed \$32697.49

Male, LOS 36 days, principal diagnosis 25082, total charges billed \$26632.19

=====
THCIC ID: 822000 / The Dubuis Hospital for Continuing Care Texarkana
QUARTER: 1
YEAR: 1999

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. 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.

=====
THCIC ID: 826000 / CHRISTUS Spohn Hospital South
QUARTER: 1
YEAR: 1999

Certified with comments

Due to software incompatibilities, data contains some mapping errors that were not able to be corrected prior to deadline. Meditech, the hospital's information system vendor, is researching the problem.

=====

THCIC ID: 831000 / Victoria Warm Springs Rehabilitation Hospital
QUARTER: 1
YEAR: 1999

Certified without comments