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General Comments on 3rd Quarter 2000 Data

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

- Data is administrative data, collected for billing purposes, not clinical data.

- Data is submitted in a standard government format, the UB-92 (or HCFA 1450). State specifications require the submission of additional data elements. These data elements include race, ethnicity and non-standard source of payment. Because these data elements are not sent to payers and may not be part of the hospital's standard data collection process, there may be an increase in the error rate for these elements. Data users should not conclude that billing data sent to payers is inaccurate.

- Hospitals are required to submit the patient's race and ethnicity following categories used by the U. S. Bureau of the Census. This information is generally not provided by the patient, rather, it is collected subjectively and may not be accurate.

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

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

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

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

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

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

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PROVIDER: Austin State Hospital
THCIC ID: 000100
QUARTER: 3
YEAR: 2000

Certified with comments

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

Admission Type= 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 percentage, are:

Table with 2 columns: Standard Source of Payment, Total Percentage (%). Rows include Self Pay (2.52%), Medicare (10.48%), Commercial (3.71%), Non-Standard Source of Payment (Charity 75%).

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

Deleted Discharge Data- There was a system mapping problem due to interim claims filed which caused some of the discharge data to be deleted. The true discharge count for the 3rd quarter 2000 is 787.

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PROVIDER: Big Spring State Hospital
THCIC ID: 000101

QUARTER: 3  
YEAR: 2000

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 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 of 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 Programs         | n/a                  |
| Commercial                     | 1.49%                |
| Blue Cross                     | n/a                  |
| Champus                        | 1.06%                |
| Other                          | n/a                  |
| Missing/Invalid                | n/a                  |
| Non-Standard Source of Payment | Total Percentage (%) |
| State/Local Government         | n/a                  |
| Commercial PPO                 | n/a                  |
| Medicare Managed Care          | n/a                  |
| Medicaid Managed Care          | 0.0%                 |
| 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.

Deleted Discharge Data- There was a system mapping problem due to interim claims filed which caused some of the discharge data to be deleted. The true discharge count for the 3rd quarter of 2000 is 282.

As a result of missing discharge data other demographics are incomplete.

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PROVIDER: Rio Grande State Center  
 THCIC ID: 000104  
 QUARTER: 3  
 YEAR: 2000

Certified with comments

Due to system limitations, note, that is just an estimate related 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 record are reported as urgent. The data reported also includes emergency admissions.

Admission Source= Because of system constraints, all admission sources on 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 Programs     | 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          | 0.0%                 |
| Commercial HMO                 | n/a                  |
| Charity                        | 85%                  |
| Missing/Invalid                | n/a                  |

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

Deleted Discharge Data- There was a system mapping problem due to interim claims filed which caused some of the discharge data to be deleted. The true discharge count for the 3rd quarter of 2000 is 359.

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PROVIDER: University of Texas MD Anderson Cancer Center  
THCIC ID: 000105  
QUARTER: 3  
YEAR: 2000

Certified with comments

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.

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PROVIDER: Kerrville State Hospital  
THCIC ID: 000106  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

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

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

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

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

| Standard Source of Payment | Total Percentage (%) |
|----------------------------|----------------------|
| Self-pay                   | 4.90%                |
| Worker's Comp              | n/a                  |
| Medicare                   | 2.92%                |
| Medicaid                   | 2.21%                |
| Other Federal Programs     | n/a                  |
| Commercial                 | 2.95%                |
| Blue Cross                 | n/a                  |
| Champus                    | 0.0%                 |
| 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          | 0.0%                 |
| 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 records 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.

Deleted Discharge Data- There was a system mapping problem due to interim claims filed which caused some of the discharge data to be deleted. The true discharge count for the 3rd quarter of 2000 is 158.

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PROVIDER: Rusk State Hospital  
THCIC ID: 000107  
QUARTER: 3  
YEAR: 2000

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 Sourc= 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 source of payment, 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 Programs         | n/a                  |
| Commercial                     | 1.99%                |
| Blue Cross                     | n/a                  |
| Champus                        | 0.0%                 |
| Other                          | n/a                  |
| Missing/Invalid                | n/a                  |
| Non-Standard Source of Payment | Total Percentage (%) |
| State/Local Government         | n/a                  |
| Commerical PPO                 | n/a                  |
| Medicaid Managed Care          | n/a                  |
| Medicare Managed Care          | 0.12%                |
| Commerical 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 records 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.

Deleted Discharge Data= There was a system mapping problem due to interim claims filed which caused some of the discharge data to be deleted. The true discharge count for the 3rd quarter of 2000 is 484.

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PROVIDER: Texas Center for Infectious Disease
THCIC ID: 000108
QUARTER: 3
YEAR: 2000

Certify with comments, corrections requested

Certification done for 14 claims submitted without errors. Experienced incomplete interim bills due to mapping issues for 14 discharge claims submitted under XX2 type bill with XX4 claims. Processed corrections to complete interim data for patient's confinement through Commonwealth Clinical Systems (CCS).

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PROVIDER: San Antonio State Hospital
THCIC ID: 000110
QUARTER: 3
YEAR: 2000

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.

Admissions 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 source of payments, by percent, are:

Table with 2 columns: Standard Source of Payment, Total Percentage (%). Rows include Self-Pay (0.87%), Worker's Comp (n/a), Medicare (8.65%), Medicaid (15.43%), Other Federal Programs (n/a), Commercial (1.46%), Blue Cross (n/a), Champus (0.44%), Other (n/a), Missing/Invalid (n/a), Non-Standard Source of Payment, Total Percentage (%), State/Local Government (n/a).

|                       |       |
|-----------------------|-------|
| Commercial PPO        | n/a   |
| Medicaid Managed Care | n/a   |
| Medicare 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 records 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.

Deleted Discharge Data- There was a system mapping problem due to interim claims filed which caused some of the discharge data to be deleted. The true discharge count for the 3rd quarter of 2000 is 732.

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PROVIDER: Terrell State Hospital  
 THCIC ID: 000111  
 QUARTER: 3  
 YEAR: 2000

Certified with comments

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

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

Admission Source= Because of system constraints, all admissions 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 percentage, are:

| Standard Source of Payment     | Total Percentage (%) |
|--------------------------------|----------------------|
| Self-Pay                       | 1.29%                |
| Worker's Comp                  | n/a                  |
| Medicare                       | 11.18%               |
| Medicaid                       | 3.10%                |
| Other Federal Programs         | n/a                  |
| Commercial                     | 0.36%                |
| Blue Cross                     | n/a                  |
| Champus                        | 0.0%                 |
| Other                          | n/a                  |
| Missing/Invalid                | n/a                  |
| Non-Standard Source of Payment | Total Percentage (%) |

|                        |      |
|------------------------|------|
| State/Local Government | n/a  |
| Commercial PPO         | n/a  |
| Medicaid Managed Care  | n/a  |
| Medicare Managed Care  | 0.0% |
| 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 records 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.

Deleted Discharge Data= There was a system mapping problem due to interim claims filed which caused some of the discharge data to be deleted. The true discharge count for the 3rd quarter of 2000 is 867.

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PROVIDER: N TX State Hospital Vernon  
 THCIC ID: 000113  
 QUARTER: 3  
 YEAR: 2000

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

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

Deleted Discharge Data= There was a system mapping problem due to interim claims filed which caused some of the discharge data to be deleted. The true discharge count for the 3rd quarter of 2000 is 235.

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PROVIDER: N TX State Hosp Wichita Falls  
 THCIC ID: 000114  
 QUARTER: 3  
 YEAR: 2000

Certified with comments

Due to system limitations, note that this is just an estimate and related to unidentified source of funds, rather than actual collections from the identified sources 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 payment, by percent are:

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

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

Deleted Discharge Data= There was a system mapping problem due to interim claims filed which caused some of the discharge data to be deleted. The true discharge count for the 3rd quarter of 2000 is 399.

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PROVIDER: Harris County Psychiatric  
 THCIC ID: 000115  
 QUARTER: 3  
 YEAR: 2000

Certified with comments

1. Patient Race - Three patient records were modified from a designation of Other to White after the submission of the original file.
2. Patient Ethnicity- One patient record was modified from a designation of White to Hispanic after the submission of the original file.
3. Standard and Non-Standard Sources of Payment- Payor classification was changed from resource designation of Missing/Invalid (11) to Charity (10) and Commercial (1) on 11 patient records after the original file was submitted.
4. Patient Age- One patient record was modified (birth date) after the submission of the original file.

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PROVIDER: Waco Center for Youth  
 THCIC ID: 000117  
 QUARTER: 3  
 YEAR: 2000

Certified with comments

Due to system limitations, note, that this is just an estimate related 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 record are reported as urgent. The data reported also includes emergency admissions.

Admission Source= Because of system constraints, all admission sources on 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 percentage are:

| Standard Source of Payment     | Total Percentages (%) |
|--------------------------------|-----------------------|
| Self-Pay                       | 2.01%                 |
| Worker's Comp                  | n/a                   |
| Medicare                       | n/a                   |
| Medicaid                       | 1.06%                 |
| Other Federal Programs         | n/a                   |
| Commercial                     | 1.91%                 |
| Blue Cross                     | n/a                   |
| Champus                        | n/a                   |
| Other                          | n/a                   |
| Missing/Invalid                | n/a                   |
| Non-Standard Source of Payment | Total Percentages (%) |
| State/Local Government         | n/a                   |
| Commercial PPO                 | n/a                   |
| Medicare Managed Care          | n/a                   |
| Medicaid Managed Care          | 0.0%                  |
| Commercial HMO                 | n/a                   |
| Charity                        | 95.00%                |
| Missing/Invalid                | n/a                   |

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

Deleted Discharge Data- There was a system mapping problem due to interim claims filed which caused some of the discharge data to be deleted. The true discharge count for the 3rd quarter 2000 is 31.

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PROVIDER: St Joseph Reg Health Center  
THCIC ID: 002001  
QUARTER: 3  
YEAR: 2000

Certified with comments

St. Joseph Regional Health Center

Data Correction - The attending physician for an expired patient within the DRG 431 population is incorrect. The physician did not see the patient and therefore should not be responsible for the mortality.

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

health care quality and compare outcomes.

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for St. Joseph Regional Health Center charity care, based on established rates during the calendar year of 2000 was \$8,152,011.

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

Our Skilled Nursing and Rehabilitation units are long-term care units. Because of this Mortality and Length of Stay may be skewed. This will prohibit any meaningful comparisons between St. Joseph Regional Health Center and any "acute care only" facilities.

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

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

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

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

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PROVIDER: Matagorda General Hospital  
THCIC ID: 006000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

Due to computer issues there were 17 claims that were duplicated.

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PROVIDER: Matagorda General Hospital
THCIC ID: 006001
QUARTER: 3
YEAR: 2000

Certified with comments

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

These discharges reflect special units (Rehab and Geropsych) within the acute care hospital. Length of stay and charges will be higher when compared to acute care facilities

=====
PROVIDER: Highland Medical Center
THCIC ID: 013000
QUARTER: 3
YEAR: 2000

Certified with comments

Source of Payment breakdown for Blue Cross is not accurate as it was being combined into commercial due to error in cross reference coding. Error 970 number of Type 22 and Type 30 records do not match. Type 30 records are correct.

=====
PROVIDER: CHRISTUS St. Joseph Hospital
THCIC ID: 015000
QUARTER: 3
YEAR: 2000

Certified with comments

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

During this time period St. Joseph Hospital provided charity care for 273 patients with the total charges (-\$1,776,201.00) dollars. The system didn't identify these patients.

St. Joseph data didn't correspond to the newborn admission, according to our data we had 40 premature infants and 264 sick infants.

=====
PROVIDER: Baylor Med Ctr at Garland
THCIC ID: 027000
QUARTER: 3
YEAR: 2000

Certified with comments

Submission Timing

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

#### Physician Identification

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

#### Diagnosis and Procedures

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

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

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

#### Normal Newborns

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

#### Race/Ethnicity

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

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

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

must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 2% of the encounters originally categorized as "Other" and 2% categorized as "Medicaid" were recategorized as "Self Pay".

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

#### Cost/ Revenue Codes

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

#### Certification Process

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

=====

PROVIDER: Vencor Hospital - Dallas  
THCIC ID: 028000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

=====

PROVIDER: Vencor Hospital - Dallas East  
THCIC ID: 028001  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

=====

PROVIDER: Good Shepherd Medical Center  
THCIC ID: 029000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Two claims rejected because of TOB 117 for a total of \$53,578.65. We also show a discrepancy in total charges from the THIN report (4933 claims for \$59,978,064.35) and the Certification Summary (4931 claims \$60,026,862.43).

We are researching to see why the two reports show different amounts for the same amount of claims.

=====
PROVIDER: CHRISTUS Jasper Memorial Hospital
THCIC ID: 038000
QUARTER: 3
YEAR: 2000

Certified with comments

Patient Location, Missing/Invalid information: Patient comatose and information could not be obtained.
Length of stay, Over 100 days: Two patients were admitted in error as an inpatient and should have been admitted as Series patients for Outpatient Physical Therapy.
Diagnosis/Procedure Codes Summary, Discharges with no Principle code: Two admissions were admitted in error and the accounts were discharged with no diagnosis since no patient existed.

=====
PROVIDER: Providence Health Center
THCIC ID: 040000
QUARTER: 3
YEAR: 2000

Certified with comments

- A. Of total deaths, 17 (23%) were hospice patients.
B. Errors were identified in the physician license numbers on 85 records (4%). These errors will be fixed starting with the 1st Quarter 2001 data.

=====
PROVIDER: Madison St. Joseph Health Center
THCIC ID: 041000
QUARTER: 3
YEAR: 2000

Certified with comments

Madison St. Joseph Health Center

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

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Madison St. Joseph Health Center charity care, based on established rates during the calendar year of 2000 was \$211,408.

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

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

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

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

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

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

=====

PROVIDER: Trinity Medical Center  
THCIC ID: 042000  
QUARTER: 3  
YEAR: 2000

Certified with comments

DATA Content

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

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

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

#### Submission Timing

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

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

#### Diagnosis and Procedures

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

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

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

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

#### Specialty Services

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

#### Length of Stay

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

#### Normal Newborns

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

#### Race/Ethnicity

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

#### Cost/Revenue

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

#### Certification Process

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

=====  
PROVIDER: Huguley Health Systems  
THCIC ID: 047000  
QUARTER: 3  
YEAR: 2000

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, 2001. Under the requirement we are unable to alter our comments after today. If any errors are discovered in our data after this point we will be unable to communicate these due to THCIC. This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgements about patient care.

#### Submission Timing

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

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 and individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (I.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected. Also, the state's reporting system does not allow for severity adjustment at this time.

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

#### Physician Clarification

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

#### Length of Stay

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

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

differentiates these two classifications.

#### Race/Ethnicity

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

#### Certification Process

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

=====

PROVIDER: College Station Medical Center  
THCIC ID: 071000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

=====

PROVIDER: Memorial Medical Center - San Augustine  
THCIC ID: 072000  
QUARTER: 3  
YEAR: 2000

Certify with comments

One doctor mapped to wrong doctor number

=====

PROVIDER: Tomball Regional Hospital  
THCIC ID: 076000  
QUARTER: 3  
YEAR: 2000

Elect not to certify

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

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

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

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

=====

PROVIDER: CHRISTUS St Josephs Health System  
THCIC ID: 095000  
QUARTER: 3  
YEAR: 2000

Certified with comments

One encounter was taken by THCIC's version of the grouper, and place in MDC 14, and reported on the certification summary report as Newborns and OB. This one encounter was not a birth but was an adult patient with an obstetrical related case. We felt this comment was necessary, as our facility does not currently have an OB department.

=====

PROVIDER: Northeast Medical Center  
THCIC ID: 106000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Patient Race: Corrections as follow:  
American Indian/Eskimo/Aleut: 2  
Asian or Pacific Islander: 0  
Black: 12  
White: 305  
Other: 0  
Missing/Invalid: 0

=====

PROVIDER: Covenant Medical Center Lakeside  
THCIC ID: 109000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Starting 3rd quarter 2000 birthing for Covenant Lakeside was moved to Covenant Medical Center.

Data does not accurately reflect the number of charity cases for the time period.

This is due to internal processing for determination of the source of payment.

4% of total discharges were charity for 3rd Quarter 2000.

=====  
PROVIDER: St Lukes Episcopal Hospital  
THCIC ID: 118000  
QUARTER: 3  
YEAR: 2000

Certified with comments

The data reports for quarter 3, 2000 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

Descriptors for newborn admissions are based on nation billing data elements (UB92) and definitions of each element can and do vary from hospital to hospital. Because of the absence of universal definitions for normal delivery, premature delivery and sick baby, this category cannot be used for comparison across hospitals. The DRG is the only somewhat meaningful description of the infant population born at a facility.

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

=====  
PROVIDER: Memorial Hermann Baptist Orange Hospital  
THCIC ID: 121000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Memorial Hermann Baptist Orange Hospital requests the following comments be included with the data submission for the 3rd quarter, 2000 data set.

A discrepancy has been noted within the Patient Discharge Status Section. The Hospital Certification Committee does not agree that there were no discharges to Home Health noted during this quarter.

The data for newborn admissions does not provide the specifics associated with the type of birth, i.e., normal delivery or prematurity. The certification states "Info not available".

The final comment is noted within the Standard Source of Payment Section. The

Hospital Certification Committee does not agree that there were no self pay payments during this quarter.

The information above did not appear as an error during the data correction timeframe. Subsequent review reveals this discrepancy to be associated with the conversion codes submitted by our third party vendor which we are currently unable to correct or modify. Memorial Hermann Baptist Orange underwent a complete Information System conversion on April 1, 2001. Data submissions prior to the third quarter of 2001 will be submitted with similar comments.

=====

PROVIDER: The Methodist Hospital  
THCIC ID: 124000  
QUARTER: 3  
YEAR: 2000

Certified with comments

TMH is not missing any accounts. TMH has some physician UPIN numbers that are unidentified on the State's file, but according to websites, they are correct.

=====

PROVIDER: Providence Memorial Hospital  
THCIC ID: 130000  
QUARTER: 3  
YEAR: 2000

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.

The separation of the discharge disposition 06 and 50 was implemented during the 3rd Quarter of 2000

=====

PROVIDER: Navarro Regional Hospital  
THCIC ID: 141000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Navarro Regional Hospital is an acute, general medical-surgical hospital with the additional services of a Skilled Nursing Facility and an Acute Rehabilitation Unit. The data in the public release file may or may not adequately allow separation of patients in the acute hospital from those in the other two units. Admixture of all three units can lead to increases for acute hospitals alone. It is notable that 17 of the 43 deaths in the third quarter of 2000 occurred in the two non-acute units, and that in at least 30 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).

=====

PROVIDER: Margaret Jonsson Charlton Methodist Hospital  
THCIC ID: 142000  
QUARTER: 3  
YEAR: 2000

Certified with comments

#### DATA CONTENT

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

#### PHYSICIAN REVIEW OF THE DATA

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

#### SUBMISSION TIMING

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

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

#### OMISSION OF OBSERVATION PATIENTS

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

#### DIAGNOSIS AND PROCEDURES

The state and billing regulations require us to submit diagnoses and procedures in ICD-9-CM standard codes. The hospital can code up to 25 diagnosis codes and 25 procedure

codes. The state data submission requirements limit us to the first nine diagnosis codes and the first six procedure codes. As a result, the data sent by us do not 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 prematurity 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.

PHYSICIAN LICENSE NUMBER ERRORS

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

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PROVIDER: University Medical Center  
THCIC ID: 145000  
QUARTER: 3  
YEAR: 2000

Certified with comments

This data represents accurate information at the time of certification.

Subsequent changes may continue to occur that will not be reflected in this published dataset.

=====
PROVIDER: Covenant Hospital Plainview
THCIC ID: 146000
QUARTER: 3
YEAR: 2000

Certified with comments

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

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

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

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

Financial data does not necessarily correlate to quality outcomes data. It is the practice of the facility to provide the highest quality care possible given the resources available.

=====
PROVIDER: University Hospital
THCIC ID: 158000
QUARTER: 3
YEAR: 2000

Certified with comments

Beginning with September 2000 discharges, University Hospital implemented a new patient accounting system for all administrative functions (registration, discharges, billing, etc). After auditing third quarter discharge data, some information could not be verified as accurate. Overall, the data is representative of the inpatient activity at University Hospital during July through September 2000. The number of patient discharges, patient diagnoses and procedure codes are accurate. Information that could not be verified or inaccurate information is noted below.

PLEASE CONSIDER THE FOLLOWING BEFORE ANY ANALYSIS OF THIS DATA:

PATIENT DISCHARGE STATUS

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SEPTEMBER 2000 PATIENT DISCHARGE STATUS COULD NOT BE VERIFIED WITH DATA THAT CURRENTLY RESIDES ON UNIVERSITY HOSPITAL INFORMATION SYSTEMS.

ATTENDING AND OPERATING PHYSICIAN ID

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JULY AND AUGUST PHYSICIAN NAMES AND LICENSE NUMBERS WERE SUBMITTED FROM A DIFFERENT PATIENT ACCOUNTING SYSTEM THAN SEPTEMBER 2000 NAMES AND LICENSE NUMBERS. EACH PHYSICIAN MAY NOT HAVE BEEN ASSIGNED THE SAME UNIQUE IDENTIFICATION NUMBER BY THE STATE. THEREFORE, PHYSICIAN SPECIFIC ANALYSIS OF THIS DATA WILL LIKELY BE INCOMPLETE AND INACCURATE.

OTHER PHYSICIAN 1 PHYSICIAN ID

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THIS INFORMATION IS INCORRECT AND SHOULD NOT BE USED IN ANALYSIS OF THIS DATA.

PATIENT RACE

-----  
PATIENT RACE IS INCORRECT AND SHOULD NOT BE USED IN ANALYSIS OF THIS DATA.

ADMISSION SOURCE

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SEPTEMBER 2000 ADMISSION SOURCES COULD NOT BE VERIFIED WITH DATA THAT CURRENTLY RESIDES ON UNIVERSITY HOSPITAL INFORMATION SYSTEMS.

STANDARD SOURCE OF PAYMENT

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SEPTEMBER 2000 STANDARD SOURCES OF PAYMENT COULD NOT BE VERIFIED WITH DATA THAT CURRENTLY RESIDES ON UNIVERSITY HOSPITAL INFORMATION SYSTEMS.

ADDITIONAL NOTES RELATED TO PAYMENT SOURCES

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University Hospital provides care to many patients that do not have healthcare insurance. Efforts are made to determine patient eligibility for County, State and Federal financial assistance such as Medicare and Medicaid. Self-pay patients comprise 30% of discharges in this public use data file (PUDF).

THIS DOES NOT ACCURATELY REFLECT THE TRUE PAYER MIX. For Medicare and Medicaid funding, there is an approximate 120-day window when patients are placed in a "pending" category while they provide the needed documentation to be properly categorized. In reality, only 5% of University Hospital inpatients are self-pay while the remaining 25% (totaling 30% in the (PUDF)) are funded through Bexar County's CareLink program, other county tax assistance programs or state or federal programs.

University Health System offers Bexar County residents the opportunity to become members of CareLink. Over 50,000 residents annually are offered a monthly payment plan that is based on income and family size. CareLink assists families in accessing quality care and members select PCPs and schedule office visits just as any insured patient would.

-----  
PROVIDER: The Institute for Rehabilitation & Research  
THCIC ID: 164000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

The hospital's research into developing improved treatment procedures has substantially reduced secondary complications of catastrophic injuries

as well as average lengths of stay. TIRR is one of only three hospitals in the country that has Model Systems designation for both its spinal cord and brain injury programs.

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

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

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

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

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

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

In reviewing the THCIC data for 3rd quarter 2000, we discovered that the patient discharge status mapped incorrectly to "Other Institution" instead of "Home or Self Care" in 25 cases. This changes our statistics to:

**Patient Discharge Status**

No. Patients

% of Total Admissions

Discharge to Home or Self Care:

190

83.3%

Discharge/Transfer to Gen. Hospital:

12

5.26%

Discharge/Transfer to SNF:

3

1.32%

Discharge to ICF:

1

0.44%

Discharge/Transfer to Other Institution:

15

6.6%

Discharge/Transfer to Home Health:

5

2.19%

Left AMA:

1

0.44%

Hospice/Medical Facility:

1

0.44%

=====

PROVIDER: Medical Center Hospital

THCIC ID: 181000

QUARTER: 3

YEAR: 2000

Certified with comments

Does not reflect self-pay patients.

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PROVIDER: Harris Methodist H.E.B.

THCIC ID: 182000

QUARTER: 3

YEAR: 2000

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 14% 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.

#### Race/Ethnicity

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

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

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

#### Cost/ Revenue Codes

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

#### Certification Process

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

=====

PROVIDER: Texoma Medical Center  
THCIC ID: 191000  
QUARTER: 3  
YEAR: 2000

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.

\* We found 149 claims that had not been included in this submission initially and were submitted in a subsequent quarter.

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

=====  
PROVIDER: Reba McEntire Center for Rehabilitation  
THCIC ID: 191001  
QUARTER: 3  
YEAR: 2000

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.

\* We found 14 claims that had not been included in this submission initially and were submitted in a subsequent quarter.

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

=====

PROVIDER: Texoma Medical Center Behavioral Health Center

THCIC ID: 191002

QUARTER: 3

YEAR: 2000

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.
- \* We found 8 claims that had not been included in this submission initially and were submitted in a subsequent quarter.
- \* Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

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PROVIDER: Texoma Restorative Care SNU  
THCIC ID: 191004  
QUARTER: 3  
YEAR: 2000

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.
- \* We found 11 claims that had not been included in this submission initially and were submitted in a subsequent quarter.
- \* Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences

between internal systems and the snapshot of data that was taken at the end of the quarter.

=====

PROVIDER: Select Specialty Hospital - Houston Heights  
THCIC ID: 206000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Patient Status Error 855:  
This is a mapping error being addressed by software vendor HMS

Source Payment Code Error 871 and 927:  
Source Payment Code F, Commercial on THCIC Claims does not match Select's HMS, Financial Class, 7, Medicare HMO, e.g., Methodist Care 65, etc. These errors need to be edited on the THCIC Claim Corrections Software to Source Payment Code of C, Medicare.

Attending Physician Error 915, 916, 918, and 919:  
Texas State Board of Medical Examiners (512) 305-7010 needs to be called to verify Physician License Numbers.

Accom Revenue Codes Error 877, 881, 923, 924, 827, and 926 need to be addressed with our Patient Accounting Department.

=====

PROVIDER: Select Specialty Hospital Houston Medical Center  
THCIC ID: 206002  
QUARTER: 3  
YEAR: 2000

Certified with comments

Patient Status Error 855: Patient Statuses OS, OD, RC, OR, H1 on THCIC Claims does not match Select's HMS 3, 2, 3, 5, and 2 respectively. These errors need to be edited on the THCIC Claim Correction Software.

Source Payment Code Error 871 and 927: Source Payment Code F, Commercial on THCIC Claims does not match Select's HMS, Financial Class, 7, Medicare HMO, e.g., Methodist Care 65, etc. These errors need to be edited on the THCIC Claim Corrections Software to Source Payment Code of C, Medicare.

Attending Physician Error 915, 916, 918, and 919 Texas State Board of Medical Examiners (512) 305-7010 needs to be called to verify Physician License Numbers.

Accom Revenue Codes Error 877, 881, 923, 924, 827, and 926 need to be addressed with Patient Accounting Department.

=====

PROVIDER: Medical Center of Plano  
THCIC ID: 214000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Patient Confidentiality:  
The current data submission format does not identify individual patients, therefore, in theory protecting patient confidentiality. However, if the sample size used for analysis is small, individual patients might

be identifiable. In many hospitals, the number of patients discharged in a quarter in a race category of Black, Asian or American Indian, for example; could be < 5. With such a small cell size, there may be only one black male in the community--thereby making the individual identifiable violating his right to have his medical information confidential.

#### Data Content:

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

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 to 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.

=====  
PROVIDER: Houston Northwest Medical Center  
THCIC ID: 229000  
QUARTER: 3  
YEAR: 2000

Certified with comments

1. Admit Type true value is 2,196 Emergency; 1,015 Urgent; 1,422 Elective; 860 Newborn for 3rd Quarter 2000.
2. Admit Source 3rd Quarter 2000 true value is 3,029 Physician Referral; 0 Clinical Referral; 248 Transfer from Hospital; 6 Transfer from Skilled

Nursing Facility; 11 Transfer from Other Health Care Facility; 2,190 Emergency Room; 0 Court/Law Enforcement and 9 Transfer from Psyche,Sub Abuse,Rehab Hospital.

3. Newborn Code 3rd Quarter 2000 true value is 647 Normal Delivery; 79 Premature Delivery and 134 Sick Babies.

=====

PROVIDER: Harris Methodist Fort Worth  
THCIC ID: 235000  
QUARTER: 3  
YEAR: 2000

Certified with comments

CLINICAL DATA:

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

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

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

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

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

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

ADMIT TYPE AND SOURCE:

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

#### PAYOR CODES/COSTS:

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

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

It is important to note that charges do not reflect actual payments to the hospital to deliver care. Actual payments are substantially reduced by managed care 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 category.

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

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

#### SPECIALTY SERVICE:

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

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

Internally the data may be updated after submission, then it will be different from the data submitted to THCIC. This makes it difficult to evaluate the accuracy and completeness of the THCIC data file against internal systems.

PHYSICIAN DATA:

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

CERTIFICATION PROCESS:

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

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PROVIDER: Henderson Memorial Hospital
THCIC ID: 248000
QUARTER: 3
YEAR: 2000

Elect not to certify

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PROVIDER: Methodist Medical Center
THCIC ID: 255000
QUARTER: 3
YEAR: 2000

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 comorbidity and a complication.

#### NORMAL NEWBORNS

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

PHYSICIAN LICENSE NUMBER ERRORS

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

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PROVIDER: Northside General Hospital  
THCIC ID: 261000  
QUARTER: 3  
YEAR: 2000

Elect not to certify

Due to flooding in Houston and severe damage to this facility.

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PROVIDER: R. E. Thomason General Hospital  
THCIC ID: 263000  
QUARTER: 3  
YEAR: 2000

Certified with comments

NEWBORN ADMISSIONS

Errors in Newborn Admissions were identified. Based on coding information the following is the correct information:

Normal Deliveries - 1035  
Premature Deliveries - 138  
Sick Babies - 302  
Extramural - Data Not Available

Total Newborns for 3Q2000 - 1475

PAYOR MIX

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

Charity - 358

Commercial - 444  
Medicaid - 2549  
Medicare - 326  
Self Pay - 965

Total Encounters - 4642

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PROVIDER: Sierra Medical Center  
THCIC ID: 266000  
QUARTER: 3  
YEAR: 2000

Certified with comments

1. Admission Type: Elective  
Elective admission category was previously not being captured. Data is being captured as of 11/1/00 and will be reflected with 4th Quarter 2000 data.
2. Admission Type: Unknown  
Hospital data captured is not compatible with THCIC who currently utilizes UB92 definitions and format. Resolution is pending.
3. Admission Source  
All Admission Source available data for Hospital was not being captured. Data is being captured as of 11/1/00 and will be reflected with 4th Quarter 2000 data.
4. Newborn Admissions  
Newborn Admissions data reflects 579 encounters under category, "Information Not Available", which should be reflected under category, "Normal Delivery". This has been identified to be a mapping issue and currently is being addressed and resolution is scheduled to be in place for submission of 2001 Quarter 1 data.
5. Non-standard Source of Payment  
Non-standard Source of Payment codes for Hospital do not match THCIC codes. Many of the Source Payment Codes have been classified by THCIC as Missing or Invalid. This has been identified to be mapping issue and is currently being addressed. Resolution is pending.

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PROVIDER: Diagnostic Center Hospital  
THCIC ID: 267000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Two physicians UPIN #'s have been verified as correct after being checked by our system.

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PROVIDER: Baylor Med Ctr Ellis County  
THCIC ID: 285000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

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

#### Physician Identification

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

#### Diagnosis and Procedures

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

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

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

#### Normal Newborns

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

#### Race/Ethnicity

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

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

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

of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 5% of the encounters originally categorized as "Self Pay" were recategorized as "Commercial".

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

#### Cost/ Revenue Codes

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

#### Certification Process

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

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PROVIDER: Baylor Medical Center at Irving  
THCIC ID: 300000  
QUARTER: 3  
YEAR: 2000

Certified with comments

#### Submission Timing

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

#### Physician Identification

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

#### Diagnosis and Procedures

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

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

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

#### Normal Newborns

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

#### Race/Ethnicity

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

Upon review, a mapping issue was uncovered regarding the categorization of "Hispanic" and "White" encounters. Approximately 16% of the "Hispanic" encounters were categorized under the state defined "White" 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 4% of the encounters originally categorized as "Blue Cross" were recategorized as "Commercial" and 2% categorized as "Other" were recategorized as "Self Pay".

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

It should be noted that only the primary payer information was submitted.

#### Cost/ Revenue Codes

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

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

#### Certification Process

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

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PROVIDER: Presbyterian Hospital of Kaufman  
THCIC ID: 303000  
QUARTER: 3  
YEAR: 2000

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.

#### Bill Types

Due to data export considerations, all inpatient's are designated as bill type 111. This includes all skilled nursing admissions should be designated as bill type 211 and 221. The result is an overall LOS that is slightly increased.

#### Certification Process

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

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PROVIDER: Mesquite Community Hospital
THCIC ID: 315001
  QUARTER: 3
    YEAR: 2000
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#### Elect not to certify

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PROVIDER: Walls Regional Hospital
THCIC ID: 323000
  QUARTER: 3
    YEAR: 2000
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#### 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 and 6 procedures. In other words, the state's data file may not fully represent all 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 may 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 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. 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 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.

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

Walls Regional Hospital grants Charity based on approved criteria. 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.

### Certification Process

This is a fairly new program to Walls and the state therefore, the certification process may not be 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.

08/01/2001

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PROVIDER: Baylor University Medical Center  
THCIC ID: 331000  
QUARTER: 3  
YEAR: 2000

Certified with comments

### Submission Timing

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

### Physician Identification

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

### Diagnosis and Procedures

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

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

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

### Normal Newborns

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Baylor's normal hospital registration process defaults "normal delivery"

as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

Mortalities

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. Upon review approximately 5% of Baylor encounters originally categorized as "Medicare" have been recategorized as "Commercial".

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

Cost/ Revenue Codes

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

Certification Process

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

=====

PROVIDER: Cook Children's Medical Center  
THCIC ID: 332000  
QUARTER: 3  
YEAR: 2000

Elect not to certify

Cook Children's Medical Center has elected to not certify the third quarter 2000 discharge encounter data as returned by the Texas Health Care Information Council for the following reasons:

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

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

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

=====

PROVIDER: Ascension Health - Brackenridge Hospital  
THCIC ID: 335000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

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

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

=====

PROVIDER: Childrens Hospital of Austin  
THCIC ID: 335001  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

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

=====

PROVIDER: Denton Regional Medical Center  
THCIC ID: 336001  
QUARTER: 3  
YEAR: 2000

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 only" facility.

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

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

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

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

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

=====

PROVIDER: West Houston Medical Center  
THCIC ID: 337000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Included in the discharge encounter data are discharges from our

Skilled Nursing Unit, Rehabilitation Unit, Geropsychiatric Unit, and medical Hospice service which may skew length of stay, deaths, and charge data.

=====
PROVIDER: Medical City Dallas Hospital
THCIC ID: 340000
QUARTER: 3
YEAR: 2000

Certified with comments

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

=====
PROVIDER: Memorial Hermann Baptist Beaumont Hospital
THCIC ID: 389000
QUARTER: 3
YEAR: 2000

Certified with comments

Memorial Hermann Baptist Beaumont Hospital requests the following comments be included with the data submission for the 3rd quarter, 2000 data set.

A discrepancy has been noted within the Patient Discharge Status Section. The Hospital Certification Committee does not agree that there were no discharges to Home Health noted during this quarter.

The data for newborn admissions does not provide the specifics associated with the type of birth, i.e., normal delivery or prematurity. The certification states "Info not available".

The final comment is noted within the Standard Source of Payment Section. The Hospital Certification Committee does not agree that there were no self pay payments during this quarter.

The information above did not appear as an error during the data correction timeframe. Subsequent review reveals this discrepancy to be associated with the conversion codes submitted by our third party vendor which we are currently unable to correct or modify. Memorial Hermann Baptist Beaumont underwent a complete Information System conversion on April 1, 2001. Data submissions prior to the third quarter of 2001 will be submitted with similar comments.

=====
PROVIDER: Nacogdoches Medical Center
THCIC ID: 392000
QUARTER: 3
YEAR: 2000

Certified with comments

DATA Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called a UB92, in a standard government format called HCFA 1450 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing

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

#### Submission Timing

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

#### Diagnosis and Procedures

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

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

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

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

#### Specialty Services

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

#### Length of Stay

The length of stay data element contained in the state's certification file is only three characters long. Thus any patients discharged with a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay as long as or longer than 999 days, therefore, it is not anticipated that this limitation will affect this data. The hospital does provide oncology services. The length of stay for this patient population is generally longer compared to other acute care patients. This may skew the data when combined with other acute care patient stays.

#### Normal Newborns

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

#### Race/Ethnicity

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

#### Cost/Revenue

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

#### Certification Process

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

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PROVIDER: Medical Center of Lewisville  
THCIC ID: 394000  
QUARTER: 3  
YEAR: 2000

#### 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.

=====

PROVIDER: Nix Health Care System  
THCIC ID: 396000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Due to computer software mapping and logic problems, incorrect values are documented in the following three categories: Admission Souce, 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.

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PROVIDER: CHRISTUS Spohn Memorial Hospital  
THCIC ID: 398000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Hospital Discharge Data Certification  
Comment Attachment for 398000: CHRISTUS Spohn Hospital Memorial

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.

The discharge encounter data returned to the Texas Health Care Information Council for calendar quarter three/2000 represents the patient population of CHRISTUS Spohn Hospital Memorial with an accuracy rate of 98%.

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PROVIDER: John Peter Smith Hospital  
THCIC ID: 409000  
QUARTER: 3  
YEAR: 2000

Certified without comments

Introduction

John Peter Smith Hospital (JPSH) is operated by the JPS Health Network under the auspices of the Tarrant County Hospital District. The JPS Health

Network is accredited by the Joint Commission on Accreditation of Health Care Organizations as an integrated health network. In addition, JPSH holds JCAHO accreditation as a hospital.

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

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

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

#### Data Comments

This inpatient data was submitted to meet requirements of the State of Texas for reporting third quarter 2000 inpatient hospital discharge data.

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

#### Payor Source

The care of many JPS indigent patients is financed from county taxes.

These patients are added to the field "non-standard source of payment".

Until patients have an identified payor, they are categorized as charity.

#### Discharge Disposition

An SMS computer system limitation causes organ donors to have their mortality counted twice. JPS manually corrects all such errors found and is working on a more permanent solution to the problem.

#### Patient Relationship to Insured

This field can be incorrectly reported whenever the patient's payor classification changes after discharge. Our current computer system automatically changes the relationship to "self" whenever a payor classification changes after discharge. The volume of patients at JPS, whose payor classification change after discharge, is 40-60%. JPS is addressing this limitation of the system and new expanded name and address fields are planned for installation in 2002.

#### Country

The data entry fields within the JPS registration system are limited, preventing any country designation to be entered. All patients for JPS have USA listed as their country. This limitation will be addressed and

corrected with the new expanded name and address fields that are planned for installation in 2002.

#### Physician Master File

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

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

#### System Mappings

Within our current mainframe information system, we are unable to map certain discharge dispositions. These include patient discharges to non-skilled nursing homes, home health with I.V., and hospice care.

#### Diagnoses and Procedures

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

#### Length of Stay

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

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

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

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

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

#### AMA (Against Medical Advice)

Under most circumstances, patients have the right to discontinue treatment, including hospitalization, when he/she chooses. Sometimes, even after the physician has explained the benefits of the proposed treatment, a patient may still decide to leave the hospital. Research is currently being conducted to better understand the demographics of those patients who decide to leave before being officially dismissed.

#### Summary

All known errors were corrected or accounted for to the best of our ability, consistent with the limited time span allotted to all hospitals for the process. As we progress through the process of quarterly 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 certifying the State data file, with comments.

#### Physician Comments

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

? Charts under this report relate to the third calendar quarter of 2000.

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. The admission of patients with complicated multi-system injuries increases hospital costs and hospitalization needs beyond that which may be seen with facilities that do not function as regional trauma referral sites.  
? Some physicians noted that they believed they had more admissions during the reporting period than that listed on the report. Other physicians in the same practice group may have been listed as the attending physician for more patients than they actually attended.

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PROVIDER: United Regional Health Care System - 8th St Camps  
THCIC ID: 417000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Data Content:

Source of Payment

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.

Newborn Admissions

The state pulls newborn admission statistics from the admission source code rather than 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.

Diagnosis/Procedure Codes

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

Certification Process

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

=====

PROVIDER: Arlington Memorial Hospital  
THCIC ID: 422000  
QUARTER: 3  
YEAR: 2000

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 \$1,803,376 in charity care during this time period.

Certification Process

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

=====

PROVIDER: Memorial Hospital of Center  
THCIC ID: 423000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Errors were due to a mapping issue with our HMS software package that have since been resolved. It was the position of the physician that had the issue.

On December 1, 2000 a letter was faxed to Dee Shaw explaining that Memorial of Center ceased to exist on 9/30/00 at midnight. The final quarter for Memorial Hospital of Center is the 3rd quarter 2000 and was sent as THCIC ID# 423000. Therefore it should be reported as such and not Shelby Regional Medical Center(THCIC ID#423001)

In addition, Memorial Hospital of Center no longer has a representative (CEO) to execute certification letter. Noting the above and per the phone conversation with Dee Shaw on 9/19/00 we certify this 3rd quarter data 2000 per your request.

=====
PROVIDER: El Campo Memorial Hospital
THCIC ID: 426000
QUARTER: 3
YEAR: 2000

Certified with comments

For the third quarter of 2000 there were 199 claims submitted. Of these 199, no claims were denied with error codes. Only two claims were included on this report due to info code 992. This computes to a .01% error rate which requires no corrections. With this in mind we are certifying our third quarter of 2000 data with the above comments.

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PROVIDER: CHRISTUS Spohn Hospital Beeville
THCIC ID: 429000
QUARTER: 3
YEAR: 2000

Certified with comments

within a 97 percent confidence level.

=====
PROVIDER: Presbyterian Hospital of Dallas
THCIC ID: 431000
QUARTER: 3
YEAR: 2000

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.

#### Bill Types

Due to data export considerations, all inpatient's are designated as bill type 111. This includes all skilled nursing admissions should be designated as bill type 211 and 221. The result is an overall LOS that is slightly increased.

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

My concern is that a common procedure may be performed for different indications. The mortality for an ethmoidectomy is very low when performed for chronic sinusitis, however, when performed for mucormycosis it is very high. This is not related to surgical technique/care but the underlying disease mortality rate which is very high for mucormycosis. If the database does not reflect underlying pathology accurately then data will be worthless.

John R. Gilmore, M.D.

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PROVIDER: Brazosport Memorial Hospital
THCIC ID: 436000

QUARTER: 3  
YEAR: 2000

Certified with comments

NOTES/COMMENTS:

1. BRAZOSPORT MEMORIAL HOSPITAL'S LENGTH OF STAY STATISTICS INCLUDE ITS PHYSICAL REHABILITATION AND SKILLED NURSING UNITS, WHICH APPROPRIATELY HAVE LONGER LENGTHS OF STAY. IN 1999, THE ALOS FOR ACUTE MED/SURG PATIENTS WAS 3.5 DAYS.
2. SOME AVERAGE CHARGES MAY BE SKEWED BY ONE OR TWO VERY HIGH CHARGE PATIENTS AND THE INCLUSION OF PHYSICAL REHABILITATION AND SKILLED NURSING PATIENTS.
3. PSYCH/CD SERVICES WERE CLOSED SEPTEMBER 30, 1999. CHARGES FOR THOSE SERVICES DURING THE FIRST TWO QUARTERS OF 1999 MAY INCLUDE CHARGES FOR TREATMENT OF PHYSICAL DIAGNOSES IN CONJUNCTION WITH THEIR PSYCH/CD TREATMENT.
4. NUMBER OF EXPIRED PATIENTS MAY BE SOMEWHAT INCREASED OVER EXPECTED DUE TO INCLUSION OF SKILLED NURSING UNIT STATISTICS.

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PROVIDER: CHRISTUS St. Elizabeth Hospital  
THCIC ID: 444000  
QUARTER: 3  
YEAR: 2000

Certified with comments

NORMAL NEWBORNS

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

|   |     |
|---|-----|
| DRG 385 Neonates, died or transferred to another facility   | 15  |
| DRG 386 Extreme Immaturity or Respiratory Distress Syndrome | 30  |
| DRG 387 Prematurity with major problems                     | 4   |
| DRG 388 Prematurity without major problems                  | 10  |
| DRG 389 Full Term Neonate with major problems               | 55  |
| DRG 390 Neonate with other significant problems             | 40  |
| DRG 391 Normal newborn                                      | 477 |

STANDARD/NON-STANDARD SOURCE OF PAYMENT

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

During this time period St. Elizabeth Hospital provided charity to 402 patients for a total of over 5 million dollars.

DIAGNOSIS AND PROCEDURES

The data submission matches the state's reporting requirements but may be incomplete due to a limitation of the number of diagnosis and procedures the state allows us to include for each patient. In other words, the state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the hospital's or physician's severity level.

ATTENDING PHYSICIANS

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

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PROVIDER: Presbyterian Hospital of Winnsboro

THCIC ID: 446000

QUARTER: 3

YEAR: 2000

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.

#### Bill Types

Due to data export considerations, all inpatient's are designated as bill type 111. This includes all skilled nursing admissions should be designated as bill type 211 and 221. The result is an overall LOS that is slightly increased.

#### Certification Process

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

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PROVIDER: St Paul Medical Center
THCIC ID: 448000
  QUARTER: 3
    YEAR: 2000
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Certified with comments

#### Operating Physician

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

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

The payer codes utilized in the THCIC database were defined by the state and are not using standard payer information from the claim. The mapping process of specific payers to the THCIC payer codes was not standardized by THCIC, therefore, each hospital may map differently which can create variances in coding. These values might not accurately reflect the hospital payer information because those payers identified contractually as both "HMO and "PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Charity patients are not identified until after discharge when other potential payment sources have been processed. The THCIC database shows no charity care provided by St. Paul Medical Center when the hospital provided over \$1.9 million dollars in charity care for inpatients for this quarter.

This will not be reflected in the state data submission due to the timing.

#### Certification Process

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

To the best of our knowledge the data submitted is accurate and complete.

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PROVIDER: RHD Memorial Medical Center  
THCIC ID: 449000  
QUARTER: 3  
YEAR: 2000

Certified with comments

#### DATA Content

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

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

#### Submission Timing

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

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

#### Diagnosis and Procedures

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

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

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

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

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

#### Specialty Services

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

#### Length of Stay

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

#### Normal Newborns

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

#### Race/Ethnicity

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

#### Cost/Revenue

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

#### Certification Process

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

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PROVIDER: Midland Memorial Hospital  
THCIC ID: 452000  
QUARTER: 3  
YEAR: 2000

Elect not to certify

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PROVIDER: DeTar Hospital Navarro  
THCIC ID: 453000  
QUARTER: 3  
YEAR: 2000

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.

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PROVIDER: Ben Taub General Hospital  
THCIC ID: 459000  
QUARTER: 3  
YEAR: 2000

Certified with comments

We are a teaching facility, though the THCIC profile for this quarter does not reflect it. This oversight is being corrected.

PHYSICIAN COMMENT:

The paradigm used by teaching hospitals is a "care team" approach, rather than a private practitioner, so getting an accurate picture of any one physician's admitting practices from UB-92 data is very difficult.

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PROVIDER: Covenant Medical Center  
THCIC ID: 465000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Data does not accurately reflect the hospital's newborn population.  
Total Births = 624  
Live = 513  
Premature = 111

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

4% of total discharges were charity for 3rd Quarter 2000.

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PROVIDER: Memorial Medical Center - Livingston  
THCIC ID: 466000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

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PROVIDER: Harris Methodist Northwest  
THCIC ID: 469000  
QUARTER: 3  
YEAR: 2000

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 hosptal 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.

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PROVIDER: Parkland Memorial Hospital

THCIC ID: 474000

QUARTER: 3

YEAR: 2000

Certified with comments

#### General Information

Parkland Health & Hospital System comprises a network of neighborhood-based health centers and Parkland Memorial Hospital, which was established in 1894 to care for the city's poor. Today, the hospital is often ranked among the 25 best hospitals in the United States - public or private.

Due to Parkland's affiliation with the University of Texas Southwestern Medical Center, the finest in medical care is now available to all Dallas County residents.

The Parkland system is a \$675.9 million enterprise that is licensed for 990 beds and employs about 5,500 staff. It's Trauma Center is internationally renowned for excellence and many other medical services are equally state of the art including: burn treatment, epilepsy, kidney/pancreas transplants, cardiovascular services, diabetes treatment, gastroenterology, radiology, neonatal intensive care, and high risk pregnancy. The hospital delivers more babies than any other hospital in the United States - 15,181 babies in fiscal year 2000. The hospital's Burn Center was established in 1962, and since then has treated more burn patients than any other civilian burn center in the world. In 1964, the hospital performed the first kidney transplant in Texas. Since then, it's transplant success among African-Americans is the nation's best.

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

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

#### Specific Concerns

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

reflect the hospital's demographics.

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

=====
PROVIDER: Memorial Hospital
THCIC ID: 478000
QUARTER: 3
YEAR: 2000

Certified with comments

In general, the data is acceptable. Either program glitches or mapping errors continue to impact total charges, attending physician identification with multiple names/ID numbers for a single physician, race and the Hospital had a total of 248 newborn admissions for this quarter.

=====
PROVIDER: Knapp Medical Center
THCIC ID: 480000
QUARTER: 3
YEAR: 2000

Certified with comments

KNAPP MEDICAL CENTER THCIC DISCLAIMER STATEMENT AND COMMENTS FOR THIRD QUARTER 2000

DISCLAIMER STATEMENT

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

CHARITY COMMENT

Knapp Medical Center has a long tradition of providing charity care for the population it serves. Prior to designation as charity, program qualification attempts are exhausted. This results in designation of charity being made after the patient is discharged, sometimes many months. Patient specific charity amounts are not available, therefore, at the time of submission of data to THCIC. Due to the impracticality at this time of identifying specific patients designated as charity and submitting corrections, the aggregate amount of charity provided during the third quarter 2000 was \$ 894,985.17 for 79 patients.

=====
PROVIDER: Ascension Health - Seton Medical Center

THCIC ID: 497000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

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

=====

PROVIDER: Ascension Health - Seton Northwest Hospital  
THCIC ID: 497002  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

=====

PROVIDER: Parkview Regional Hospital  
THCIC ID: 505000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Certain physician data is generalized due to mapping issues with physician name cell.

=====

PROVIDER: Conroe Regional Medical Center  
THCIC ID: 508000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

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

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

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

=====

PROVIDER: Doctors Hospital  
THCIC ID: 511000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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 cutoff date will not be included in the quarterly submission file sent in. As a result, the state submitted data recognizes 2159 encounters while Doctors Hospital's database reflects 2368 encounters for a difference of 209 encounters.

The state data continues to reflect that the majority of the babies born at Doctors Hospital are admitted as "Information Not Available." Tenet has identified this as a problem and has developed a crosswalk with HCIA based on the principal diagnosis code to better identify the type of delivery, ie normal delivery, premature delivery, sick baby, or extramural birth. However, this change was not effective until February 2001. Therefore, all data prior to this time will continue to be reflected as not available.

We continue to identify issues with the Standard and Non-Standard Source of Payment fields. The state data reflects 652 Commercial accounts; while Doctors Hospital data lists 32 commercial accounts for the quarter. Doctors Hospital also recognizes 41 accounts for Blue Cross; while the state recognizes six accounts.

In the Non-Standard Source of Payment fields, the state data lists 1324 as missing/invalid. However, the hospital data has zero accounts in this field.

During this quarter, our length of stay was a little higher than it has been in previous quarter. This is due in part to the age of the patients seen during this quarter. There were ten patients who were 97 years old and nine patients who were older than 100 years of age. Overall, we serviced almost 800 patients who were over 74 years of age. Also during this quarter, we had one patient who was inhouse for four months and one patient who was inhouse approximately three months.

=====

PROVIDER: Baylor Medical Center Grapevine  
THCIC ID: 513000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

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

#### Physician Identification

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

#### Diagnosis and Procedures

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

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

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

#### Normal Newborns

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

#### Race/Ethnicity

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

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

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

Additionally, those payers identified contractually as both "HMO and PPO"

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

Cost/ Revenue Codes

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

Certification Process

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

=====
PROVIDER: Memorial Hermann Katy Hospital
THCIC ID: 534001
QUARTER: 3
YEAR: 2000

Certified with comments

78 Medicaid Managed Care patients are appearing under 'Medicaid' source of payment. 25 Medicare Managed Care patients are appearing under 'Commercial HMO' source of payment.

=====
PROVIDER: Scott & White Memorial Hospital
THCIC ID: 537000
QUARTER: 3
YEAR: 2000

Elect not to certify

We are currently working on a method for internal validation of physician assignment which will provide a better comfort level for our medical staff in the release of this data to the public. A mapping issue has been discovered in which charity care is underrepresented for our facility. We chose not to certify this data until these issues are resolved.

=====
PROVIDER: Fort Duncan Medical Center
THCIC ID: 547000
QUARTER: 3
YEAR: 2000

Certified with comments

FORT DUNCAN MEDICAL CENTER
547000
3RD QTR 2000 DATA

Data indicates "no" patients expired during 3rd qtr 2000; hospital had 12 patients expire.

=====

PROVIDER: Baylor/Richardson Medical Center  
THCIC ID: 549000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Diagnosis and Procedures

The UB92 claims data format which the state is requiring hospitals to submit, only accepts the first 9 diagnosis codes and the first 6 procedure codes. As a result, 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 and severity of illness may not be accurately represented by the state's data file, making percentage calculations inaccurate.

Race/Ethnicity

The hospital does sometimes encounter difficulties in obtaining race/ethnicity information. Thus analysis of these two data fields may 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

Processes 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.

Insurance - Source of Payment Data

There was an error in mapping Self Pay Data during the conversion from UB92 version 5 to version 6. Standard Source of Payment for Self Pay data reflects a total of 2 self pays. However Self Pays for 3rd Qtr 2000 were actually 98 % higher than that reflected in the final reports.

=====

PROVIDER: Baylor Specialty Hospital  
THCIC ID: 586000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Submission Timing

Baylor Specialty Hospital (BSH) estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters

not billed by this cut-off date will not be included in the quarterly submission file sent in.

#### Physician Identification

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

#### Diagnosis and Procedures

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

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

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

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

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

#### Length of Stay

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

#### Race/Ethnicity

There are no national standards regarding patient race categorization so hospitals may not have the same designations from which patients can

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

Upon review, it was discovered that 3% of the "White" encounters were mapped to "Other".

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

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. Upon review approximately 8% of the BSH encounters originally categorized as "Medicare" have been recategorized as "Commercial".

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

#### Cost/ Revenue Codes

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

#### Certification Process

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

=====

PROVIDER: CHRISTUS St John Hospital  
THCIC ID: 600000  
QUARTER: 3  
YEAR: 2000

Certified with comments

St. John Hospital certified the 3 quarter 2000 data, but could not account for 18 patients whose accounts were processed after the date of the original data submission.

During this interval, St. John provided charity for 25 patients with charges of ( -\$233,098.38). The system did not identify these patients as recipients of charity care.

=====

PROVIDER: South Austin Hospital

THCIC ID: 602000  
QUARTER: 3  
YEAR: 2000

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

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

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

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

=====

PROVIDER: Memorial Hermann Fort Bend Hospital  
THCIC ID: 609001  
QUARTER: 3  
YEAR: 2000

Certified with comments

Fort Bend's Managed Medicaid patients are included in the regular 'Medicaid' payment source. Fort Bend's Managed Medicare patients are included in the 'Commercial HMO' payment source.

=====

PROVIDER: Regional Medical Center  
THCIC ID: 611000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Regional Medical Center (DeTar Hospital North) has a Psychiatric Unit in operation.

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PROVIDER: HEALTHSOUTH Rehab Hospital  
THCIC ID: 616000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Patient Discharge Status should read as follows:

|   |    |
|---|----|
| Discharge to Home or Self Care          | 83 |
| Discharge/Transfer to Gen. Hospital     | 22 |
| Discharge/Transfer to SNF               | 16 |
| Discharge to ICF                        | 1  |
| Discharge/Transfer to Other Institution | 2  |

Discharge/Transfer to Home Health 31  
Left AMA 1

=====

PROVIDER: Harris Methodist Southwest  
THCIC ID: 627000  
QUARTER: 3  
YEAR: 2000

Certification 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.

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PROVIDER: North Dallas Rehabilitation Hospital  
THCIC ID: 635000  
QUARTER: 3  
YEAR: 2000

Elect not to certify

Continued mapping issues with Texas Ace software. Correctly entered data shows up with wrong information on data report.

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PROVIDER: Rio Vista Rehabilitation Hospital  
THCIC ID: 638000  
QUARTER: 3  
YEAR: 2000

Certified with comments

#### Patient Ethnicity:

All Patient Ethnicity available data for Hospital was not being captured. Data is being captured as of 10/01/00 and will be reflected with 4th Quarter 2000 data.

=====

PROVIDER: Baylor Institute for Rehab at Gaston  
THCIC ID: 642000  
QUARTER: 3  
YEAR: 2000

Certified with comments

#### Submission Timing

Baylor Institute for Rehabilitation (BIR) estimates that our data volumes for the calendar year time period submitted may include 93% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in. BIR has a 10-day billing cycle; therefore we will have a higher percentage of incomplete encounters than hospitals with a 30-day billing cycle.

#### Physician Identification

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

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

#### Diagnosis and Procedures

BIR is different from most hospitals submitting data to the state. We provide comprehensive medical rehabilitation services to patients who have lost physical or mental functioning as a result of illness or injury.

Many of these patients have already received emergency care and stabilizing treatment at an acute care hospital. They are admitted to BIR to continue their recovery and focus on improving their functional ability in order to improve their quality of life to the fullest extent possible.

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

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

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

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

#### Length of Stay

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

#### Race/Ethnicity

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

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

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

must be categorized into the appropriate standard and non-standard source of payment value. With this in mind, approximately 5% of the encounters originally categorized as "Other" were recategorized as " Self Pay".

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

#### Cost/Revenue Codes

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

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

#### Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments. THCIC ID: 642000 (Baylor Institute for Rehabilitation)

=====

PROVIDER: Zale Lipshy University Hospital  
THCIC ID: 653000  
QUARTER: 3  
YEAR: 2000

#### Certification with Comments

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

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

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PROVIDER: Presbyterian Hospital of Plano  
THCIC ID: 664000  
QUARTER: 3  
YEAR: 2000

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.

Bill Types

Due to data export considerations, all inpatient's are designated as bill type 111. This includes all skilled nursing admissions should be designated as bill type 211 and 221. The result is an overall LOS that is slightly increased.

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:

The neonatal ICU began treating infants at 32-34 weeks gestation in August of 1999, which may increase the acuity and complication rate for newborns.

Erik W. Gunderson, MD

=====
PROVIDER: Central Texas Hospital
THCIC ID: 665000
QUARTER: 3
YEAR: 2000

Certified with comments

Report C01 page 3 shows all patient race as othe and all ethnicity as not of hispanic origin. Due to a possible software problem, this figures are incorrect.

=====
PROVIDER: Columbia Kingwood Medical Center
THCIC ID: 675000
QUARTER: 3
YEAR: 2000

Certified with comments

The data for Kingwood Medical Center includes acute, skilled, rehabilitation, and hospice patients.

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PROVIDER: Burlleson St. Joseph Health Center of Caldwell  
THCIC ID: 679000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Burlleson St. Joseph Health Center charity care, based on established rates during the calendar year of 2000 was \$178,443.

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

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

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

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

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

grouper cannot be replicated by facilities unless they purchase this grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.

=====

PROVIDER: Kell West Regional Hospital  
THCIC ID: 681400  
QUARTER: 3  
YEAR: 2000

Certified with comments

Working with Vendor to resolve minor issues.

=====

PROVIDER: HEALTHSOUTH Rehab Hospital of Texarkana  
THCIC ID: 684000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Due to a system error, all patient discharges for the third quarter of 2000 were erroneously coded as 01 (patient discharged to home). The actual patient discharge status break-out is as follows:

Discharge Location Code:

|                   |     |
|-------------------|-----|
| D/C HOME          | 126 |
| D/C GEN HOSP      | 19  |
| D/C SNF           | 30  |
| D/C ICF           | 3   |
| D/C OTHER         | 2   |
| D/C HOME HEALTH   | 64  |
| LEFT AMA          |     |
| D/C TX HOMES W/IV |     |
| ADMITTED INP/RPH  |     |
| EXPIRED           | 5   |
| HOSPICE/ HOME     |     |
| HOSPICE/MED FAC   |     |
| MISSING           |     |

Total patients reflected - 249

Certification letter for 3rd quarter 2000 was not filed in a timely manner as a result of layoffs which included the Data Processing employee who handled this report for this facility.

=====

PROVIDER: Covenant Children's Hospital  
THCIC ID: 686000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Data does not accurately reflect the number of charity cases for the time period. This is due to internal processing for determination of the source of payment.  
4% of total discharges were charity for 3rd Quarter 2000.

=====

PROVIDER: LifeCare Hospital of Fort Worth  
THCIC ID: 690600  
QUARTER: 3  
YEAR: 2000

Certified with comments

Five areas need restatement:

1. Source of Payment: Medicare=123, Commercial=9, and Blue Cross=3.
2. Discharge Status: Home/SelfCare=27, Discharge/Transfer to Gen hospital=16, Discharge to ICF=48, Discharge/Transfer to Other Institution=6, Discharge/Transfer to Home Health=20, Left AMA=4, Expired=13, and Hospice/Home=2.
3. Length of stay is as follows: 2-9 days=15, 10-29 days=52, 30-59 days=47, 60-99 days=16, and over 100 days=5.
4. Patient Race: Black =7, White=122, and Other=6.
5. Patient Ethnicity: Hispanic Origin=6, and Not of Hispanic Origin=129

=====

PROVIDER: HEALTHSOUTH Rehab Hospital of Tyler  
THCIC ID: 692000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Results do not accurately reflect discharge disposition status.

=====

PROVIDER: Vista Medical Center Hospital  
THCIC ID: 694100  
QUARTER: 3  
YEAR: 2000

Certified with comments

Two DRG's 497 have a secondary diagnosis code displayed which should be deleted, as this was incidental to the procedure.

=====

PROVIDER: HEALTHSOUTH Rehab Hospital North Houston  
THCIC ID: 695000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Patient Discharge Status should read as follows:

|   |     |
|---|-----|
| Discharge to Home or Self Care          | 129 |
| Discharge/Transfer to Gen. Hospital     | 34  |
| Discharge/Transfer to SNF               | 16  |
| Discharge/Transfer to Other Institution | 1   |
| Discharge/Transfer to Home Health       | 16  |
| Left AMA                                | 1   |
| Expired                                 | 1   |
| Missing/Invalid                         | 0   |

=====

PROVIDER: The Specialty Hospital of Houston  
THCIC ID: 698000  
QUARTER: 3  
YEAR: 2000

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.

=====

PROVIDER: Specialty Hospital Houston - Clear Lake Campus  
THCIC ID: 698001  
QUARTER: 3  
YEAR: 2000

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.

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PROVIDER: The Corpus Christi Medical Center - Doctors Regional  
THCIC ID: 703002  
QUARTER: 3  
YEAR: 2000

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 record.

The summary numbers under the caption "Severity Index" are not calculated

using the same system used by the Corpus Christi Medical Center, therefore, the accuracy of these numbers.

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PROVIDER: Texoma Medical Center Restorative Care Hospital  
THCIC ID: 705000  
QUARTER: 3  
YEAR: 2000

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.
- \* We found 3 claims that had not been included in this submission initially and were submitted in a subsequent quarter.
- \* Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

=====

PROVIDER: Kindred Hospital Houston Northwest  
THCIC ID: 706000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Kindred Hospital Houston NW is a long term acute care facility.

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PROVIDER: Dubuis Hospital of Beaumont  
THCIC ID: 708000  
QUARTER: 3  
YEAR: 2000

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

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital. In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

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PROVIDER: Dubuis Hospital of Port Arthur  
THCIC ID: 708001  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

Only acutely ill patients requiring an average length of stay of approximately 25 days are admitted to Dubuis Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital. In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

=====

PROVIDER: Red River Hospital  
THCIC ID: 709000  
QUARTER: 3  
YEAR: 2000

Certified with comments

We had a total of 27 Champus discharges for the Third quarter of 2000.

=====

PROVIDER: Our Children's House at Baylor  
THCIC ID: 710000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Submission Timing

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

#### Physician Identification

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

#### Diagnosis and Procedures

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

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

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

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

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

#### Admission Type

Upon review, it was determined that the "Urgent" encounters were erroneously categorized. That group should have been categorized as "Elective" admission types.

#### Length of Stay

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

#### Race/Ethnicity

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

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

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. Upon review approximately 7% of the OCH encounters originally categorized as "Medicaid" have been recategorized as "Commercial".

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

#### Cost/ Revenue Codes

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

#### Certification Process

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

=====

PROVIDER: CHRISTUS St Michael Rehab Hospital  
THCIC ID: 713000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Accurate to the best of my knowledge.  
Chris Karam C.O.O.

=====

PROVIDER: CHRISTUS St Catherine Health & Wellness Center  
THCIC ID: 715900  
QUARTER: 3  
YEAR: 2000

Certified with comments

Christus St. Catherine Hospital treated 76 patients who qualified for

charity care during this quarter. Their charges totalled \$242,245.56.

The actual number of births during this quarter was 129.

The actual number of deaths during this quarter was 5.

The actual number of discharges during this quarter was 657.

=====
PROVIDER: LifeCare Specialty Hosps of Dallas
THCIC ID: 717000
QUARTER: 3
YEAR: 2000

Certified with comments

Based on hospital data reports run in July 2001, for 3rd quarter 2001, the following is correct: Payment source: Mediare 102/58%, Commercial 26/15%, Self Pay 48/27%, and Workers comp 1/1%. Race: White 48%, Black 44%, Other 7%, and Missing or invalid 1%. Top 5 procedures: 9338 Combined pt NOS=69, 9383 Occupational Therapy=63, 9301 Functional PT Eval=59, 8744 Routine Chest X-Ray =54, and 3893 Venous Cath NBC=45.

=====
PROVIDER: The Physicians Centre
THCIC ID: 717500
QUARTER: 3
YEAR: 2000

Elect not to certify

=====
PROVIDER: Select Specialty Hospital - San Antonio
THCIC ID: 719300
QUARTER: 3
YEAR: 2000

Certified with comments

Comments for 3q00 not received by THCIC.

=====
PROVIDER: The Oaks Treatment Center
THCIC ID: 727000
QUARTER: 3
YEAR: 2000

Certified with comments

The Oaks Treatment Center provides long-term residential treatment to adolescents with severe psychiatric disturbances. No hospital services are provided. This should be taken into consideration when comparing this facility's discharge data with other facilities who provide acute hospital care.

Please note the THCIC software is not equipped to store length of stay data exceeding 999 days. For treatment stays exceeding 999 days, the THCIC system rounds down the actual LOS to a maximum of 999 days. The system does, however, report the actual charges for the entire stay. This should be taken into consideration when interpreting ALOS and charge data for this facility as some patient stays exceed 999 days.

=====
PROVIDER: TIRR LifeBridge

THCIC ID: 735000  
QUARTER: 3  
YEAR: 2000

Certified with comments

TIRR LifeBridge is a fully accredited teaching specialty hospital that provides transitional 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

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.

In reviewing the THCIC data for 3rd quarter 2000, we discovered that the patient discharge status mapped incorrectly to "Other Institution" instead of "Home or Self Care" in 5 cases. This changes our statistics to:

#### Patient Discharge Status

No. Patients

% of Total Admissions

Discharge to Home or Self Care:

23

23%

Discharge/Transfer to Gen. Hospital:

31

31%

Discharge/Transfer to SNF:

13  
13%  
Discharge to ICF:  
2  
2%  
Discharge/Transfer to Other Institution:  
9  
9%  
Discharge/Transfer to Home Health:  
20  
20%  
Expired:  
1  
1%  
Hospice/Medical Facility:  
1  
1%

=====

PROVIDER: Southwest Mental Health Center  
THCIC ID: 737000  
QUARTER: 3  
YEAR: 2000

Certified with comments

The non-standard payment source reported as missing or invalid is incorrect as a result of a vendor submission error.

=====

PROVIDER: Millwood Hospital  
THCIC ID: 765001  
QUARTER: 3  
YEAR: 2000

Certified with comments

Problem with revenue data. Data not accurate.

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PROVIDER: Harris Methodist Springwood  
THCIC ID: 778000  
QUARTER: 3  
YEAR: 2000

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 1% 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.

=====
PROVIDER: The Cedars Hospital
THCIC ID: 779000
QUARTER: 3
YEAR: 2000

Certified with comments

The physician UPIN numbers and corresponding Physician First Name, Middle Initial, and Last Name we had on file at that time did not match the Texas state records. We have since corrected the problem so that Physician First Name, Middle Initial and Last Name match the UPIN Number that is registered with the State of Texas. We should be in full compliance in the future.

=====
PROVIDER: CHRISTUS St Michael Health System
THCIC ID: 788000
QUARTER: 3
YEAR: 2000

Certified with comments

Accurate to the best of my knowledge.
Chris Karam C.O.O.

=====
PROVIDER: Texas Orthopedic Hospital
THCIC ID: 792000
QUARTER: 3
YEAR: 2000

Elect not to certify

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PROVIDER: IHS Hospital of Amarillo
THCIC ID: 796000
QUARTER: 3
YEAR: 2000

Certified with comments

Due to computer issues, Admission type is inaccurate. Changes have been made and correnct information will be reflected in the future.

Due to difficulty with Commonwealth software, some physician names were unable to be entered into the correct fields, causing a high error rate for the physician identifier field. All physician names and license / UPIN numbers entered were correct, but rejected by Commonwealth software.

=====
PROVIDER: North Austin Medical Center
THCIC ID: 797000
QUARTER: 3
YEAR: 2000

Certified with comments

1. The relationship between cost of care, charges, and revenue is complex. Inferences drawn from comparing different facilities' charges may be unreliable.
2. Charity care is not accurately reflected in the source of payment data. Patients who have no insurance are initially identified as "Self-Pay", but frequently become "Charity" after it is determined that they are unable to pay.
3. The severity grouping assignment performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.
4. 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.

=====

PROVIDER: Vencor Hospital - Bay Area - Houston  
 THCIC ID: 801000  
 QUARTER: 3  
 YEAR: 2000

Certified with comments

Kindred Hosptial Bay Area is a Long Term Acute Care Facility. Kindred Hospital Bay Area is formerly known as Vencor Hospital - Bay Area Houston.

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PROVIDER: Dubuis Hospital of Houston  
 THCIC ID: 807000  
 QUARTER: 3  
 YEAR: 2000

Certified with comments

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

=====

PROVIDER: Harris Continued Care Hospital  
 THCIC ID: 810000  
 QUARTER: 3  
 YEAR: 2000

Certified with comments

All Admission Types should be "elective".  
 All Admission Sources should be "transfer from hospital".

=====

PROVIDER: Las Colinas Medical Center  
 THCIC ID: 814000  
 QUARTER: 3  
 YEAR: 2000

Certified with comments

LAS COLINAS MEDICAL CENTER Newborn Statistics should indicate 0 (zero) extramural births, not 16 (sixteen).

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PROVIDER: SCCI Hospital - San Angelo  
THCIC ID: 819000  
QUARTER: 3  
YEAR: 2000

Certified with comments

There were four patients whose information did not come across for certification.

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PROVIDER: IHS Hospital of Wichita Falls  
THCIC ID: 820000  
QUARTER: 3  
YEAR: 2000

Elect not to certify

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PROVIDER: LifeCare Hospital of South Texas  
THCIC ID: 821000  
QUARTER: 3  
YEAR: 2000

Certified with comments

Admission source should be 95% transfer from another facility.

=====

PROVIDER: Dubuis Hospital of Texarkana  
THCIC ID: 822000  
QUARTER: 3  
YEAR: 2000

Certified with comments

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

=====

PROVIDER: Methodist Health Center - Sugar Land  
THCIC ID: 823000  
QUARTER: 3  
YEAR: 2000

Certified with comments

8 accounts missing.

We verify the UPIN numbers are correct.

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