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THCIC ID: 000100 / Austin State Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

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

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

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

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

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

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

Non-Standard Source of Payment:	Total Percentage (%)
State/Local Government	n/a
Commercial PPO	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.02%
Commercial HMO	n/a
Charity	75%
Missing/Invalid	n/a

Severity Index = All patients admitted have been determined to be danger to self or others and the severity of illness is determined by an acuity assessment performed by the hospital. The Severity Index on the encounter record for each patient is assigned based on the patient's APR-DRG (All

Patient Refined-Diagnosis Related Groups), which does not reflect the severity of mental illness due to reporting methodology.

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THCIC ID: 000101 / Big Spring State Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

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

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

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

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

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

Standard Source of Payment:	Total Percentage (%)
Self-Pay	2%
Worker's Comp	n/a
Medicare	4.91%
Medicaid	9.49%
Other Federal Program	n/a
Commercial	1.49%
Blue Cross	n/a
Champus	1.06%
Other	n/a
Missing / Invalid	n/a
Non-Standard Source of Payment:	Total Percentage (%)
State/Local Government	n/a
Commercial PPO	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.00%
Commercial HMO	n/a
Charity	81%
Missing / Invalid	n/a

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

severity of mental illness due to reporting methodology.

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THCIC ID: 000104 / Rio Grande State Center
QUARTER: 3
YEAR: 1999

Certified with comments

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

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

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

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

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

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

Non Standard Source of Payment:	Total Percentage (%)
State / Local Government	n/a
Commercial PPO	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.0%
Commercial HMO	n/a
Charity	85%
Missing / Invalid	n/a

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

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THCIC ID: 000105 / University of Texas M.D. Anderson Cancer Center
QUARTER: 3
YEAR: 1999

Certified with comments

THCIC Intro

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

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

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

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

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

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

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

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

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

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

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THCIC ID: 000106 / Kerrville State Hospital
 QUARTER: 3
 YEAR: 1999

Certified with comments

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

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

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

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

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

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

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

Charity 77%
 Missing/ Invalid n/a

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

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THCIC ID: 000107 / Rusk State Hospital
 QUARTER: 3
 YEAR: 1999

Certified with comments

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

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

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

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

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

Standard Source of Payment:	Total Percentage
Self-Pay	1.65%
Worker's Comp	n/a
Medicare	9.15%
Medicaid	5.18%
Other Federal Program	n/a
Commercial	1.99%
Blue Cross	n/a
Champus	0%
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	82%
Missing / Invalid	n/a

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

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THCIC ID: 000110 / San Antonio State Hospital
 QUARTER: 3
 YEAR: 1999

Certified with comments

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

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

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

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

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

Standard Source of Payment:	Total Percentage: (%)
Self-Pay	0.87%
Worker's Comp	n/a
Medicare	8.65%
Medicaid	15.43%
Other Federal Program	n/a
Commercial	1.46%
Blue Cross	n/a
Champus	0.44%
Other	n/a
Missing / Invalid	n/a

Non-Standard Source of Payment	Total Percentage:(%)
State/Local Government	n/a
Commercial PPO	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.12%
Commercial HMO	n/a

Charity 73%
 Missing/Invalid n/a

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

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THCIC ID: 000111 / Terrell State Hospital
 QUARTER: 3
 YEAR: 1999

Certified with comments

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

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

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

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

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

Standard Source of Payment:	Total Percentage (%)
Self-Pay	1.29%
Worker's Comp	n/a
Medicare	11.18%
Medicaid	3.10%
Other Federal Program	n/a
Commercial	0.36%
Blue Cross	n/a
Champus	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	84%
Missing / Invalid	n/a

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

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THCIC ID: 000113 / N TX State Hospital Vernon
 QUARTER: 3
 YEAR: 1999

Certified with comments

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

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

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

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

Standard Source of Payment:	Total Percentage (%)
Self-Pay	1.11%
Workers' Comp	n/a
Medicare	0.30%
Medicaid	15.23%
Other Federal Program	n/a
Commercial	2.16%
Blue Cross	n/a
Champus	0.13%
Other	n/a
Missing / Invalid	n/a

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

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

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 THCIC ID: 000114 / N TX State Hosp Wichita Falls
 QUARTER: 3
 YEAR: 1999

Certified with comments

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

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

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

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

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

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

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

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

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THCIC ID: 000115 / Harris County Psychiatric
QUARTER: 3
YEAR: 1999

Certified with comments

Lois Moore, BSN, MED, LHD, FACHE
Administrator
Harris County Psychiatric Center
2800 South MacGregor Way
Houston, Texas 77021

Hospital Discharge Data Certification Letter (3Q99)

Third Quarter '99 Attachment:

1. Patient Discharge Status - Due to a computer field default value of "discharge to home or self care", the majority of discharges for the period were automatically coded to this value. Beginning in August, 2000, the computer default was eliminated and data from that time forward will reflect a correct value.

2. Admission source - The code for Correctional Agency (11) was inadvertently added to the code for physicians (1) for the Admission source field. This caused 4 patients to be recorded with the wrong admission source. We have corrected this problem for future data.

3. Patient Age Breakdown - There is one patient whose date of birth was not made available and hence his/her date of admission was recorded as his/her date of birth. This caused the patient to fall in the 'Less than 1 year old bucket'.

Lois Moore, Administrator Date 11-10-00

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THCIC ID: 006000 / Matagorda General Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Acute inpatient discharge totals are 5 less than actual. These 5 patients were classified as swingbed patients in error.

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THCIC ID: 006001 / Matagorda General Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

A total of 9 "Swingbed" patients were reported when there actually were only 4.

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THCIC ID: 015000 / CHRISTUS St. Joseph Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Qt. 3 1999

St. Joseph certified the data but could not account for 59 patients due to processing the patients after the data was submitted.

During this time period St. Joseph Hospital provided charity care for 298 patients with the total charges over 2 million dollars. The system didn't identify these patients.

St. Joseph data didn't correspond to the newborn admissions, according to our data we had 47 premature infants and 299 sick infants.

DRG's for patients not submitted:

12 - 1	208 - 1
14 - 2	219 - 1
24 - 2	236 - 1
65 - 5	277 - 1
75 - 1	294 - 2
79 - 3	319 - 1
85 - 1	320 - 2
104 - 1	337 - 1
112 - 1	350 - 1
113 - 2	357 - 1
116 - 4	369 - 2
120 - 1	387 - 1
124 - 1	395 - 1
130 - 1	397 - 1
138 - 1	398 - 1
141 - 1	400 - 1
143 - 4	437 - 1

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

Length of Stay

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

Normal Newborns

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 76% of encounters originally categorized across all values have a different value as of today. Upon review an additional data issue was uncovered. All managed care encounters were categorized as "Commercial PPO" instead of separating the encounters into "HMO" versus "PPO".

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

Cost/ Revenue Codes

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

Certification Process

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

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THCIC ID: 028000 / Vencor Hospital - Dallas
QUARTER: 3
YEAR: 1999

Certified with comments

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

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THCIC ID: 028001 / Vencor Hospital - Dallas East
QUARTER: 3
YEAR: 1999

Certified with comments

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

=====
THCIC ID: 035000 / St. David's Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

- 1.) The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes.
- 2.) The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient.
- 3.) The relationship between cost of care, charges and the revenue that a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.

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THCIC ID: 040000 / Providence Health Center
QUARTER: 3
YEAR: 1999

Certified with comments

A. Due to a data mapping error, 19 records from the DePaul Center (THCIC #763000) were inadvertently submitted under Providence Health Center's THCIC Number (THCIC #040000). The accounts had the following HCFA DRGs:

- HCFA DRG NO - Quantity
HCFA DRG 426 - 2
HCFA DRG 426 - 1
HCFA DRG 427 - 2
HCFA DRG 428 - 1
HCFA DRG 430 - 12
HCFA DRG 435 - 1

B. Of total deaths, 13 (18%) were hospice patients.

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THCIC ID: 042000 / Trinity Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

DATA Content

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

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

Submission Timing

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

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

Diagnosis and Procedures

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

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

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

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

Specialty Services

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

Length of Stay

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

Normal Newborns

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

Race/Ethnicity

During the hospital's registration process, the registration clerk does routinely complete patient's race and/or ethnicity field. The race data

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

Cost/Revenue

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

Certification Process

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

=====
THCIC ID: 047000 / Huguley Health Systems
QUARTER: 3
YEAR: 1999

Certified with comments

CERTIFIED WITH COMMENTS.

Data Content

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of November 30, 2000. Under the requirements we are unable to alter our comments after today.

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

Submission Timing

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

Diagnosis and Procedures

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

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

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

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

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

Length of Stay

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

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

Race/Ethnicity

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

does not accurately describe the true population serviced by the hospital.

Certification Process

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

=====
THCIC ID: 057000 / Beaumont Medical Surgical Hospital
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 071000 / College Station Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

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

THCIC ID: 072000 / Memorial Medical Center - San Augustine
QUARTER: 3
YEAR: 1999

Certified with comments

We are aware statistics and data may be inaccurate due to software conflicts. Every effort is being made to correct this error and to eliminate it on future submissions.

=====

THCIC ID: 076000 / Tomball Regional Hospital
QUARTER: 3
YEAR: 1999

Elect not to certify

I elect not to certify the information because:

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

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

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

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

=====

THCIC ID: 081000 / Southeast Baptist Hospital
QUARTER: 3
YEAR: 1999

Certified with comments, corrections requested

Baptist Health System (BHS) has significant concerns regarding the accuracy and reliability of the hospital discharge data. According to the certification data files for the third quarter 1999 there were zero encounters reported for the months of July and August. This, of course, is completely incorrect.

We have confirmation reports from the Texas Hospital Association (THA) showing the required transmissions for the quarter were successfully completed by Baptist Health System. The transmissions were sent to an unauthorized vendor, HCIA, who notified THA that the data had been received by their offices. By agreement and standard practice, HCIA then forwards the data to THCIC on our behalf. Due to the fact that all data is missing for the months of July and August 1999, BHS must expressly state our significant concern regarding the validity of the entire data set. In addition, BHS notes that the discharge data for September indicates that 46% of the encounters had missing or invalid sources of payment and we must disagree with that finding. Further, the discharge data set indicates the existence of normal newborn patients with ages other than under one year of age.

That data is obviously invalid.

=====

THCIC ID: 091000 / Abilene Regional Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

This Certification file is missing 4 claims that were rejected during the THIN claim upload process. Due to our HIS vendor's system restrictions it was not possible to recreate and upload a file for selected claims/accounts. A workaround to this restriction has since been developed but comes too late to submit claims for the reporting period in question.

=====
THCIC ID: 095000 / CHRISTUS St Josephs Health System
QUARTER: 3
YEAR: 1999

Certified with comments

One encounter was taken by THCIC's version 15 grouper and placed in MDC 14 and reported on the certification summary report as Newborn and OB.

This 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 have an OB department per se.

=====
THCIC ID: 106000 / Northeast Medical Center
QUARTER: Q3
YEAR: 1999

Certified with comments

The number of encounters in the race category are in error. Corrections are as follow:

American Indian/Eskimo/Aleut - 7
Asian or Pacific Islander - 1
Black - 19
White - 271
Other - 1

=====
THCIC ID: 109000 / Covenant Medical Center Lakeside
QUARTER: 3
YEAR: 1999

Certified with comments

Data does not accurately reflect the hospital's newborn population.
Total Births = 212
Live = 189
Premature = 23

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.

0.89% of total discharges were charity for 3 Quarter 1999.

=====
THCIC ID: 111000 / Gulf Coast Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

Skilled nursing facility data not included in 1999.

=====
THCIC ID: 114000 / Baptist Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments, corrections requested

Baptist Health System (BHS) has significant concerns regarding the accuracy and reliability of the hospital discharge data. According to the certification data files for the third quarter 1999 there were zero encounters reported for the months of July and August. This, of course, is completely incorrect.

We have confirmation reports from the Texas Hospital Association (THA) showing the required transmissions for the quarter were successfully completed by Baptist Health System. The transmissions were sent to an authorized vendor, HCIA, who notified THA that the data had been received by their offices. By agreement of standard practice, HCIA then forwards the data to THCIC on our behalf. Due to the fact that all data is missing for the months of July and August 1999, BHS must expressly state our significant concern regarding the validity of the entire data set. In addition, BHS notes tha the discharge data for September indicates that 46% of the encounters had missing or invalid sources of payment and we must disagree with that finding. Further, the discharge data set indicates the existence of normal newborn patients with ages other than under one year of age. That data is obviously invalid.

=====
THCIC ID: 115000 / Rosewood Medical Center
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 118000 / St Lukes Episcopal Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

The data reports for quarter 3, 1999 do not accurately reflect patient volume, severity, or patient orgin.

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.

Even though source of payment will not be released for the quarter, a programming issue with payor sources was identified during the extraction of the data. At St. Luke's Episcopal Hospital, a claim is not produced

on self-pay patients. As a result, this payor source was inadvertently omitted. Once identified, it was too late to correct for this release.

Severity

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

Patient Origin

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

Quarter 3, 1999

Out of country patients = 134

Out of state patients = 187

=====

THCIC ID: 119000 / Memorial Hospital Southeast

QUARTER: 3

YEAR: 1999

Certified with comments

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

=====

THCIC ID: 129000 / Memorial Medical Center East Texas

QUARTER: 3

YEAR: 1999

Certified with comments

We are aware information in this data may be inaccurate. We are making every effort to eliminate these errors on future data.

=====

THCIC ID: 130000 / Providence Memorial Hospital

QUARTER: 3

YEAR: 1999

Certified with comments

Discharge Disposition Clarification

The discharge disposition 06 is inclusive of patients discharged home with home health and those discharged home with hospice. Discharge disposition

50, should have been used for those patients being sent home with hospice.

=====
THCIC ID: 134000 / Northeast Baptist Hospital
QUARTER: 3
YEAR: 1999

Certified with comments, corrections requested

Baptist Health System (BHS) has significant concerns regarding the accuracy the reliability of the hospital discharge data. According to the certification data files for the third quarter 1999 there were zero encounters reported for the months of July and August. This, of course, is completely incorrect. We have confirmation reports from the Texas Hospital Association (THA) showing the required transmissions for the quarter were successfully completed by Baptist Health System. The transmissions were sent to an authorized vendor, HCIA, who notified THA that the data had been received by their offices. By agreement and standard practice, HCIA then forwards the data to THCIC on our behalf. Due to the fact that all data is missing for the months of July and August 1999, BHS must expressly state our significant concern regarding the validity of the entire data set. In addition, BHS notes that the discharge data for September indicates that 46% of the encounters had missing or invalid sources of payment and we must disagree with that finding. Further, the discharge data set indicates the existence of normal newborn patients with ages other than under one year of age. That data is obviously invalid.

=====
THCIC ID: 141000 / Navarro Regional Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Navarro Regional Hospital is an acute, general medical-surgical hospital with the additional services of a Skilled Nursing Facility and an Acute Rehabilitation Unit. The data in the public release file may or may not adequately allow separation of patients in the acute hospital from those in the other two units. Admixture of all three units can lead to increases in length of stay, charges and mortality rates when compared to rates for acute hospitals alone. It is notable that 7 of the 32 deaths in the third quarter of 1999 occurred in the two non-acute units, and that in at least 24 of the deaths, the patient or family members had requested that full efforts to maintain life not be pursued (Advanced Directive, Living Will or Do Not Resuscitate orders).

=====
THCIC ID: 142000 / Margaret Jonsson Charlton Methodist Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

DATA CONTENT

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

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

PHYSICIAN REVIEW OF THE DATA

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

SUBMISSION TIMING

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

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

OMISSION OF OBSERVATION PATIENTS

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

DIAGNOSIS AND PROCEDURES

The state and billing regulations require us to submit diagnoses and procedures in ICD-9-CM standard codes. The hospital can code up to 25 diagnosis codes and 25 procedure codes. The state data submission requirements limit us to the first nine diagnosis codes and the first six

procedure codes. As a result, the data sent by us do meet state requirements but may not reflect all the codes an individual patient's record may have been assigned. Approximately 13% of Charlton Methodist Hospital's patient population have more than nine diagnoses and/or six procedures assigned.

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

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

NORMAL NEWBORNS

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

ADMIT SOURCE

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

RACE AND ETHNICITY CODES

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

STANDARD/NON-STANDARD SOURCE OF PAYMENT

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

REVENUE CODE AND CHARGE DATA

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

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

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

SEVERITY ADJUSTMENT SCORES

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

=====
THCIC ID: 144000 / Wadley Regional Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

Admissions includes SNF patients

=====
THCIC ID: 145000 / University Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

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

=====
THCIC ID: 146000 / Covenant Hospital Plainview
QUARTER: 3
YEAR: 1999

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 by appropriate medical staff.

=====
THCIC ID: 158000 / University Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

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

As part of University Hospital's internal quality control procedures, data was audited to check for accuracy and completeness. After data was submitted to the Texas Health Care Information Council for public release, an error was noted in regard to patient discharge status which impacts six patient records. Six patients in the 3rd Quarter 1999 were given a discharge status classification value of 42 ("Expired - Place Unknown (to be used for Medicare Outpatients)"). In fact, none of the six patients expired.

Please note the following description of the patient discharge status for the six patient records impacted:

Five patients were discharged to home or self care (a routine discharge). One patient had subsequent visits with University Health System.

PLEASE NOTE THIS CORRECTION WHEN PERFORMING ANY CALCULATIONS IN REGARD TO THE HOSPITAL MORTALITY RATE. Please direct any questions you may have regarding this data correction to Kirk Black at (210) 358-2335.

DATA CONTENT

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

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

SUBMISSION TIMING

University Health System estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires submission of billed claims extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this deadline date are not included in the quarterly submission file sent in.

DIAGNOSIS AND PROCEDURES

The data submitted matches the state's reporting requirements but may be incomplete due to a limitation on the number of diagnoses and procedures the state allows us to include for each patient. The state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed. Approximately 15% of University Health System's patient population have more than nine diagnoses and/ or six procedures assigned.

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

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

The state requires submission of ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by University Health System meets state requirements but cannot reflect all the codes an individual patient's record may have been assigned. Accurate total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). Sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format.

LENGTH OF STAY

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

NORMAL NEWBORNS

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

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

RACE/ETHNICITY

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

STANDARD/NON-STANDARD SOURCE OF PAYMENT

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

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

COST/ REVENUE CODES

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

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

CERTIFICATION PROCESS

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not complete and thorough at this time. During the current certification phase, University Health System did not have an efficient mechanism to edit and correct the data.

In addition, due to University Health System's volume, it is not feasible to perform encounter level audits.

=====

THCIC ID: 164000 / The Institute for Rehabilitation & Research

QUARTER: 3

YEAR: 1999

TIRR (The Institute for Rehabilitation and Research)

CERTIFY 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 1999, we discovered that the patient discharge status mapped incorrectly to "Other Institution" instead of "Home or Self Care" in 4 cases. Also, one invalid discharge status should have been "Home or Self Care." This changes our statistics to:

Patient Discharge Status	No. Patients	% of Total Admissions
Discharge to Home or Self Care	138	75.8%
Discharge/Transfer to Gen. Hospital	10	5.5%
Discharge/Transfer to SNF	10	5.5%
Discharge to ICF	5	2.8%
Discharge/Transfer to Other Institution	12	6.6%
Discharge/Transfer to Home Health	7	3.9%
Missing/Invalid	0	0%

=====
 THCIC ID: 168000 / Shannon West Texas Memorial Hospital
 QUARTER: 3
 YEAR: 1999

Certified with comments

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

=====
THCIC ID: 181000 / Medical Center Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

data does not include private pay patients but is less than three percent of total

=====
THCIC ID: 182000 / Harris Methodist H.E.B.
QUARTER: 3
YEAR: 1999

Certified with comments

THR 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 8.4% of THR'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.

Currently, Harris Methodist HEB has classified Workmen's Compensation to be included in "Commercial". This will be modified in the future.

Cost/ Revenue Codes

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

Certification Process

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

=====
THCIC ID: 184000 / Gonzales Warm Springs Rehab Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

The field for acute care facility continues to show a "Y". The field should contain a "N".
The field for Rehab Facility should contain a "Y".
Error code 957 must be a software issue, the UB is correct.

=====
THCIC ID: 191000 / Texoma Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

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

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

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

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

Severity Adjustment. THCIC is using the 3M APR-DRG system to assign the All-Patient Refined (APR) DRG, severity and risk of mortality scores. The scores represent a categorization of patient severity and mortality risk. The assignment is made by evaluation of the patient's age, sex, diagnosis codes, procedure codes, and discharge status.

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

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

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

THCIC ID: 191001 / Reba McEntire Center for Rehabilitation
QUARTER: 3
YEAR: 1999

Certified with comments

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

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

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

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

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

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

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

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

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

=====
THCIC ID: 191002 / Texoma Medical Center Behavioral Health Center
QUARTER: 3
YEAR: 1999

Certified with comments

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

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

- The procedure codes are limited to six (principal plus five secondary).
- The fewer the codes the less information is available to evaluate the patient's outcomes and service utilization.
- The Hospital can only list 4 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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

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

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

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

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

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

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

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THCIC ID: 191004 / Texoma Restorative Care SNF
QUARTER: 3
YEAR: 1999

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Certified with comments

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

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

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

Revenue Codes and Charges. Charges associated with the 1450 data do not

represent actual payments or costs for services.

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

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

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

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

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

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THCIC ID: 206000 / Select Specialty Hospital - Houston Heights
QUARTER: 3
YEAR: 1999

Certified with comments

Discharge Status - there were mapping errors that have been corrected in Healthcare Management Systems (HMS), our billing and medical record abstracting system.

Errors relating to missing social security numbers have been corrected in HMS.

We do not use the non standard source of payment codes in Healthcare Management Systems (HMS).

=====
THCIC ID: 206002 / Select Specialty Hospital Houston West
QUARTER: 3
YEAR: 1999

Certified with comments

Error Record Message 871E, Source Pay Code, F, will be changed in Healthcare Management System, Inc. network software to the letter C. These patients were covered by Medicare Plans that were managed by for profit insurance companies, such as, Nylcare 65 and Prudential Senior Care.

Error Record Message 863 W, Social Security Number and Error Record Message 804E, Zip Code: When a patient is admitted, we sometimes are unable to obtain the correct SSN and Zip Code from the patient or transferring hospital. Therefore, the errors identified cannot be corrected.

Error Record Message 855E, Patient Status OS, We use OS to identify patients transferred to other SNF Beds in Health Management Systems, Inc. These patients should have the patient status of 03. HS is for a host SNF Bed and should also represent 03 in the THCIC Hospital Discharge Data File.

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THCIC ID: 214000 / Medical Center of Plano
QUARTER: 3
YEAR: 1999

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.

=====
THCIC ID: 225000 / BayCoast Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

Due to system mapping - inpatient and newborns were included in the data submission. Hospice and OB/GYNs were not included in the data submission. The problem was fixed after the deadline to resubmit.

=====
THCIC ID: 228000 / Southwest General Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

the warning is being reviewed by the billing office.

=====
THCIC ID: 229000 / Houston Northwest Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

1. Admit Type for 3rd Quarter 1999 true value is Emergency 2,080; Urgent 134; Elective 2,179; Newborn 885.

2. Admit Source for 3rd Quarter 1999 true value is Clinical Referral 4; Emergency Room 2,075; Physician Referral 3,106; Transfer from Nursing Home 2; Transfer from Rehab/Substance Abuse 6; Transfer from SNF 10; Transfer other Acute Hospital 75.

3. Newborn code for 3rd Quarter 1999 true value is Normal Delivery 704; Premature Delivery 77; Sick Babies 104.

=====
THCIC ID: 235000 / Harris Methodist Fort Worth
QUARTER: 3
YEAR: 1999

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 coded to nine (principal plus eight secondary diagnosis codes); the admission diagnosis and E-code field.

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

The procedure codes are limited to six (principal plus five secondary). The fewer the codes, the less information is available to evaluate the patient's 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 code fields differently.

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

ADMIT TYPE AND SOURCE:

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

The collection, documentation and coding of race and ethnicity vary considerably

across hospitals. Some hospitals do not ask the patient, rather and admission clerk makes a subjective decision. Each hospital may designate a patient's race/ethnicity differently.

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

SPECIALTY SERVICE:

The 1450 data does not have any specific data field to capture unit of service or to expand on the specialty services.

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 my not be captured.

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

CERTIFICATION PROCESS:

Harris Methodist Fort Worth does not have policies and procedures in place to validate and assure the accuracy of the discharge data and corrections submitted. To the best of our knowledge, all errors and omissions known to the hospital have been corrected and data is accurate and complete.

=====
THCIC ID: 245000 / Dolly Vinsant Memorial Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

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

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

=====
THCIC ID: 255000 / Methodist Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

DATA CONTENT

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

PHYSICIAN REVIEW OF THE DATA

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

SUBMISSION TIMING

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

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

OMISSION OF OBSERVATION PATIENTS

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

DIAGNOSIS AND PROCEDURES

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

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

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

NORMAL NEWBORNS

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

ADMIT SOURCE

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

RACE AND ETHNICITY CODES

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

STANDARD/NON-STANDARD SOURCE OF PAYMENT

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

REVENUE CODE AND CHARGE DATA

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

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

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

SEVERITY ADJUSTMENT SCORES

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

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THCIC ID: 256000 / Harris Methodist Erath County

QUARTER: 3
YEAR: 1999

Certified with comments

HARRIS METHODIST ERATH COUNTY CERTIFIED WITH COMMENTS

Data Content

This data is administrative data, which hospitals collect for billing purposes. Administrative data may not accurately represent 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.

Diagnoses and Procedures

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

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

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

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

The data submitted matches the state's reporting requirements but may be incomplete due to 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 Harris Methodist Erath County's patient population have more than

nine diagnoses and/or six procedures assigned.

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

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedure codes. As a result, the data sent by us 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. Harris Methodist Erath County recommends use of ICD-9-CM coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

these two data fields does not accurately describe the true population served by the hospital.

Standard/Non-Standard Source of Payment

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

Cost/Revenue Codes

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

Certification Process

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

=====
THCIC ID: 258000 / Pecos County General Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

3RD Quarter, 1999 - 63 papered claims

General noted errors:

1 Account entered: not our patient or doctor.

=====
THCIC ID: 263000 / R. E. Thomason General Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

NEWBORN ADMISSIONS

Errors in Newborn admissions were identified. Based on coding information the following are corrected figures.

Normal deliveries = 1030
Premature Deliveries = 131

Sick Babies = 270
Extramural = data not available

Total Newborns for 3Q99 = 1431

PAYOR MIX

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

CHARITY = 459
COMMERCIAL = 388
MEDICAID = 2531
MEDICARE = 301
SELF PAY = 859

Total Encounters = 4538

=====
THCIC ID: 266000 / Sierra Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

1. Admission Type: Elective
Elective admission category was previously not being captured. Data will be captured and reflective beginning 11/1/00.
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 will be captured and reflective beginning 11/1/00.
4. Newborn Admissions
Newborn Admissions data reflects 558 encounters under category, "Information Not Available", which should be reflected under category, "Normal Delivery". This has been identified to be a mapping issue and is currently being addressed. Resolution is pending.
5. Patient Discharge Status
All Patient Discharge Status data that is available to Hospital was not being captured. Additional data was and is now being captured beginning 7/1/00.
6. 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.

=====
THCIC ID: 285000 / Baylor Med Ctr Ellis County
QUARTER: 3
YEAR: 1999

Certified with comments

Data Content

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

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

Submission Timing

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

Diagnosis and Procedures

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

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

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

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

format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Normal Newborns

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 31% of encounters originally categorized across all values have a different value as of today. Upon review an additional data issue was uncovered. All managed care encounters were categorized as "Commercial PPO" instead of separating the encounters into "HMO" versus "PPO".

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

Cost/ Revenue Codes

The state requires that hospitals submit revenue information including charges. It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service. Typically actual payments are much less than charges due to managed

care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost to deliver the care that each patient needs.

Certification Process

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

=====
THCIC ID: 300000 / Baylor Medical Center at Irving
QUARTER: 3
YEAR: 1999

Certified with comments

Data Content

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

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

Submission Timing

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

Diagnosis and Procedures

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as

many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

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

Length of Stay

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

Normal Newborns

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

Race/Ethnicity

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

Upon review, a mapping issue was uncovered regarding the categorization of "Hispanic" and "White" encounters. Approximately 14% of the "Hispanic" encounters were categorized under the state defined "Black" race code instead of the state defined "Other" race code. Approximately 71% of the "White" encounters were categorized under the state defined "Black" race code instead of the state defined "White" 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 3.8% of encounters originally categorized as "Charity" have been re-categorized as "Medicare" or "Commercial".

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

Admission Source

Upon review of the certification data, a mapping error from the source system values to the state defined values was uncovered. Approximately 39% of patient encounter records categorized with an Admission Source Code of "Xfer from Psych, Sub Abuse, Rehab Hosp" should have been categorized with an Admission Source code of "Emergency Room".

Cost/ Revenue Codes

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

Certification Process

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

=====
THCIC ID: 303000 / Presbyterian Hospital of Kaufman
QUARTER: 3
YEAR: 1999

Certified with comments

PRESBYTERIAN HOSPITAL OF KAUFMAN CERTIFIED WITH COMMENTS

Data Content

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

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

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

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

Diagnosis and Procedures

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

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

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

which makes it difficult to obtain an accurate comparison of hospital or physician performance.

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

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

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

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

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

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

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

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

Length of Stay

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

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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THCIC ID: 307000 / Covenant Hospital Levelland
QUARTER: 3
YEAR: 1999

Certified with comments

Please note all physician data is incorrect due to mapping problems. We understand that the physician data file will not be used this quarter for the public use file.

=====
THCIC ID: 315000 / Mesquite Community Hospital
QUARTER: 3
YEAR: 1999

Elect not to certify

December 1, 2000

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

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

Dear Mr., Loyd,

I, Raymond P. De Blasi, Chief Executive Officer at Mesquite Community Hospital, elect not to certify the returned data due to the reasons stated below and as stated previously in our first and second quarter 1999 certification letters.

Errors in coding such as Admission Type, Newborn Admissions, Patient Race and Operating Physician have been identified. We now have mechanisms for correction being developed and in place for all identified errors on current quarterly submissions.

If you have questions, please call me at (972) 698-2523.

Sincerely,

Raymond P. De Blasi
Chief Executive Officer

=====
THCIC ID: 319000 / Del Sol Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

The data is correct, but when printing in batch the physician data seems to be incorrect when comparing Dr. to patient. See below details.
Comments from R. Vanhouton Systems Analyst-

I have reviewed those parts of the THCIC software I can get access to, and have determined that the data in the system correctly identifies the attending physician. There is no join problem in the queries. They pull the correct patients and attending physician. The problem, therefore, has to be with the report specification being used.

I am not able to see the report design, but comparison between the printed reports and the results of the query make it clear that the report is sorting and grouping on the physicians name rather than the physician number or license. When the all physician option is used to print the "Patients for Attending Physician" report, this sorting and grouping results in all patients for physicians with a single last name being printed together. Each page of the resulting report has the physician number for the first patient printed on the page.

We have apparently been advised that re-naming the physicians in the master file will resolve this issue. I agree that doing this will greatly reduce the problem for future reports, but it will not eliminate it and it will do nothing for the reports that already exist. If two physicians have the same last name, and the same first and middle initials, their patients will still group together after the master file has been changed. Long term, our experience is that rigid formatting of input that cannot be enforced by the computer will not be consistently applied so what we fix today will get broken again in the future.

The ultimate fix for this problem is for THCIC to fix the design flaw in their software. In the mean time, the only method we have that is certain to result in the reports to the physicians having only their patients on them is for us to print the reports one physician at a time. For the third quarter data, that means requesting 250 individual reports.

=====
THCIC ID: 323000 / Walls Regional Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Data Content

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

Diagnosis and Procedures

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The data submitted matches the state's 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 volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e., mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Race/Ethnicity

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's race and/or ethnicity. The race and 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 are 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 new program to Walls and the state, therefore the certification process is not as complete and as thorough as all parties expect it will be in the future. With this understanding of the current THCIC process, the data is certified to the best of our knowledge as accurate.

=====
THCIC ID: 331000 / Baylor University Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

Data Content

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

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

Submission Timing

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

Diagnosis and Procedures

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

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

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

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

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

Length of Stay

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

Normal Newborns

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

Race/Ethnicity

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

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. Upon review approximately 6% of 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. During the current certification phase, Baylor did not have an efficient mechanism to edit and correct the data. In addition, due to Baylor's volume, it is not feasible to perform encounter level audits.

=====
THCIC ID: 332000 / Cook Children's Medical Center
QUARTER: 3
YEAR: 1999

Elect not to certify

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

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

The data structure allowed by THCIC erroneously assigns surgeons to surgical procedures they did not perform. The data structure provided by THCIC allows for one attending and one operating physician assignment.

However, patients frequently undergo multiple surgeries where different physicians perform multiple procedures. Assigning all of those procedures to a single 'operating physician' will frequently attribute surgeries to the wrong physician. THCIC chooses to only assign one surgeon to a patient encounter, not to each procedure.

=====
THCIC ID: 335000 / Ascension Health - Brackenridge Hospital
QUARTER: 3
YEAR: 1999

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.

Admission Source - Newborn Data

Brackenridge Hospital experienced a data collection problem affecting the admit source field when the admit type is 4 (Newborn). As a result of this collection problem, 614 of the 618 newborn admissions to Brackenridge were reported as normal delivery, and no premature newborns were reported. The hospital is correcting the data collection problem prospectively, but corrections will not affect data previously submitted.

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

=====
THCIC ID: 335001 / Childrens Hospital of Austin
QUARTER: 3
YEAR: 1999

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.

Admission Source - Newborn Data

Children's Hospital of Austin Center experienced a data collection problem affecting the admit source field when the admit type is 4 (Newborn).

As a result of this collection problem, 25 of the 54 newborn admissions to Children's were reported as normal delivery, and no premature newborns were reported. The hospital is correcting the data collection problem prospectively, but corrections will not affect data previously submitted.

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

=====
THCIC ID: 336001 / Denton Regional Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

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

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

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

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

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

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 patient age breakdown.

Under the Standard Source 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.

=====
THCIC ID: 337000 / West Houston Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

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

=====
THCIC ID: 340000 / Medical City Dallas Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

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

=====
THCIC ID: 345000 / Doctors Memorial Hospital
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 363000 / All Saints Episcopal Hosp Ft Worth
QUARTER: 3
YEAR: 1999

Certified with comments

The Newborn admissions shows all normal deliveries with no premature deliveries or sick babies. This is incorrect. I have been told this is because THCIC does not take this information from the ICD 9 codes but uses the admit source and type. All Saints is working to try to address this but feels 2000 data will be incorrect and needs to be suppressed.

=====
THCIC ID: 390000 / Park Plaza Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

The data included in the third quarter 1999 submission to the State is considered administrative data collected by Park Plaza Hospital for billing purposes and not used to make judgements about patient care. On a quarterly basis we submit only inpatient UB 92 data to the State. The UB 92 is a standard billing form that all hospitals use to submit claims to payors. The information is submitted in a standard government format called HCFA 1450 EDI electronic claim format. The data must be submitted by the 20th day following the close of the quarter. Any accounts in the quarter not billed by the deadline will not be reflected in this data. In addition, it is important to note that the UB 92 claim form only allows nine diagnoses and six procedure codes to be submitted. In addition only three physicians can be identified; attending physician, and two other physicians. Anyone evaluating this data should understand that our diagnoses/procedure data collection system allows us to enter twelve diagnoses codes, ten procedures

codes and identify up to ten physicians. The additional diagnoses and procedures may have an impact on the severity level and APR/DRG assigned to the admission. Therefore the physician data, severity level and APR/DRG assignments reported for some of these admissions may not be accurate.

=====

THCIC ID: 392000 / Nacogdoches Medical Center

QUARTER: 3

YEAR: 1999

CERTIFIED WITH COMMENTS

DATA Content

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

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

Submission Timing

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

Diagnosis and Procedures

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and

procedure due to the continued evolution of medicine; new codes are added yearly as coding manuals are updated.

The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses codes and the first six procedures codes. As a result, the data sent by us do not meet state requirements but cannot reflect all the codes in an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness). 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 payers. Charges also do not reflect the actual costs to deliver the care that each patient needs.

Certification Process

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

=====
THCIC ID: 394000 / Medical Center of Lewisville
QUARTER: 3
YEAR: 1999

Certified with comments

1. This data is administrative and claims data only. It is not clinical research data. There may be inherent limitations in using this data to compare clinical outcomes.
2. This data only contains a subset of the diagnoses and procedure codes. This limits the ability to access all of the diagnoses and procedures relative to each patient.
3. The relationship between the cost of patient care, charges, and the payment that a facility receives is very complex. Inferences made in comparing the cost of patient care, charges and payments from one hospital to another may result in unreliable results.
4. The severity grouping assignments performed by the state using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Also, the lack of knowledge regarding how this grouper calculates the severity adjustments can greatly impact the interpretation of the data.
5. There is great uncertainty about how the physician linkages will

be done across hospitals.

6. Race and ethnicity classification is not done systematically within, or between facilities. Caution should be used when analyzing this data within one facility and when comparing one facility to another,

7. This data includes skilled nursing patients. The average length of stay for a skilled nursing patient is normally higher than that of an acute care patient.

=====
THCIC ID: 396000 / Nix Health Care System
QUARTER: 3
YEAR: 1999

Certified with comments

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

=====
THCIC ID: 398000 / CHRISTUS Spohn Memorial Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

CHRISTUS Spohn Hospital Memorial
Corpus Christi, Texas

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/1999 represents the patient population of CHRISTUS Spohn Hospital Memorial with an accuracy rate of 98%.

=====
THCIC ID: 407000 / Memorial Hermann Southwest Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

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

accurately by diagnoses and procedure codes.

=====
THCIC ID: 409000 / John Peter Smith Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

JPS Health Network
Comments on THCIC Data Submission
for
Quarter 3 1999

Introduction

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

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

JPSH is a major teaching hospital offering or providing through co-operative arrangements 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 1999 inpatient hospital discharge data.

The data used by Texas Health Care Information Council (THCIC) is administrative and collected for billing purposes. It is not clinical data and should be cautiously used to evaluate health care quality. Also, the use of only one quarter's data to infer statistical meaning can lead to misinterpretation.

Payer Source

The treatment of many JPS patients is financed from County taxes and most patients who qualify for our tax-supported services are responsible for a nominal co-payment. This nominal co-payment causes patients to be moved

into the self-pay category when, in actuality, they should be reported as charity. The payer codes utilized by THCIC were defined by the State and sometimes mapping conflicts occur, but cases like those above should be charity not self-pay. Our payer sources are typically as follows:

Charity/Indigent care	37%
Medicaid	34%
Medicare	15%
Commercial	9%
Self-Pay	5%

Physician Master File

Attending, operating, first other, and second other physician fields are defined differently across multiple hospitals systems. 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. This results in patients being categorized as follows:

Home Health with I.V.	>	Home Health
Non-Skilled Nursing Home	>	Other Facility
Hospice Care	>	Other Facility

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.

Newborns

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

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 the foregoing reservations) as accurate.

Physician Comments

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

- Charts under this report relate to the third calendar quarter of 1999. Due to the extended time elapsing between the delivery of care and the submission of this report it is difficult to recall if all patients are correctly listed under the appropriate treating or attending physician.
- JPSH cares for an indigent population, which often has limited resources to transfer care to home care agencies, skilled nursing units or nursing homes. This may produce an increase in the reported length of stay while outpatient resources are developed to which care can be transferred.
- JPSH functions as a regional receiving facility for trauma. 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.
- JPSH is a teaching facility. As such, the attending physicians rotate among the established services. This rotation may result in some inpatients not having a single attending staff for the duration of the hospital episode.
- Some physicians noted that they believed they had more admissions during the reporting period than that listed on the report. Other physicians in the same practice group may have been listed as the attending physician for more patients than they actually attended.
- Some physicians noted being incorrectly identified as the attending physician on some cases.

=====
THCIC ID: 417000 / United Regional Health Care System - 8th St Cmps
QUARTER: 3
YEAR: 1999

Certified with comments

This data is incomplete in that approximately 17% of our patient records are not included. Many of the missing records have a Source of Payment marked Self-Pay or Special Handling (Charity, Indigent, etc). Since records in the state data file are captured during the billing process and records

marked Self-Pay or Special Handling do not go through the billing process they were not included in the file. There are some records which were not included because they had not been billed (and therefore had not gone through the billing process) prior to the cut-off date for data submission to the state.

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

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

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

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

=====
THCIC ID: 421000 / Columbia Spring Branch Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

Data is reasonable with some variations. Financial class data has some irregularities,

=====
THCIC ID: 422000 / Arlington Memorial Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

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

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

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

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

Race/Ethnicity

During the hospital's registration process, the registration clerk does not routinely inquire as to a patient's ethnicity. In fact, there is not a field for ethnicity in the hospital's computer system. Therefore,

all patients are being reported in the "Other" ethnicity category.

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

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

Any assumptions based on race or ethnicity will be inaccurate.

Standard/Non-Standard Source of Payment

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

Revenue

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

Charity Care

THCIC assumes charity patients are identified in advance and reports charges in a charity financial class as the amount of charity care provided in a given period. In actuality, charity patients are usually not identified until after care has been provided and in the hospital's computer system charity care is recorded as an adjustment to the patient account, not in a separate financial class. Therefore, the THCIC database shows no charity care provided by the hospital for the quarter when in fact the hospital provided over \$1,091,000 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.

=====

THCIC ID: 423000 / Memorial Hospital of Center

QUARTER: 3

YEAR: 1999

Certified with comments

Claims in error: 1

Fields in error: 1

1. Error 877: - The first Revenue Code field is required.
1 error - Due to mapping error, Revenue Code did not
did not transmit.

=====
THCIC ID: 426000 / El Campo Memorial Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

For the third quarter of 1999 there were 216 claims submitted. Of these 216 only 1 claim was denied with error code 989. This computes to a less than 1% error rate which is considered acceptable by the THCIC help desk therefore ECMH has elected to not correct this claim. With this in mind we are certifying our third quarter of 1999 data with the above comments.

=====
THCIC ID: 429000 / CHRISTUS Spohn Hospital Beeville
QUARTER: 3
YEAR: 1999

Certified with comments

Accurate within a 98% confidence level.

=====
THCIC ID: 431000 / Presbyterian Hospital of Dallas
QUARTER: 3
YEAR: 1999

Certified with comments

PRESBYTERIAN HOSPITAL OF DALLAS CERTIFIED WITH COMMENTS

Data Content

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

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

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

Diagnosis and Procedures

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

The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria

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

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

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

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

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

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

Length of Stay

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

a length of stay greater than 999 days will not be accurately stored within the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

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.

=====
THCIC ID: 436000 / Brazosport Memorial Hospital
Quarter: 3
Year: 1999

Certify With Comment

Notes/Comments:

1. Brazosport Memorial Hospital's length of stay statistics include its physical rehabilitation and skilled nursing units, which appropriately have longer lengths of stay. In 1999, the ALOS for acute med/surg patients was 3.5 days.
2. Some average charges may be skewed by one or two very high charge patients and the inclusion of physical rehabilitation and skilled nursing patients.
3. Psych/CD services were closed September 30, 1999. Charges for those services during the first two quarters of 1999 may include charges for treatment of physical diagnoses in conjunction with their psych/CD treatment.
4. Number of expired patients may be somewhat increased over expected due to inclusion of skilled nursing unit statistics.

=====
THCIC ID: 438000 / East Texas Medical Center - Pittsburg
QUARTER: 3
YEAR: 1999

Certify with Comments

The data for those Medicare patients that had a Skill Nursing hospital stay in the hospital's "Swing Bed" immediately after the Acute care hospital stay, is combined with the Acute Care hospital stay data. Therefore, the total length of the hospital stay will be longer than those Medicare patients who did not have a Skill Nursing hospital stay in a "Swing Bed".

=====
THCIC ID: 445000 / Shannon Medical Center St Johns Campus
QUARTER: 3
YEAR: 1999

Certified with comments

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

=====
THCIC ID: 446000 / Presbyterian Hospital of Winnsboro
QUARTER: 3
YEAR: 1999

Certified with comments

PRESBYTERIAN HOSPITAL OF WINNSBORO CERTIFIED WITH COMMENTS

Data Content

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

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

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

Patient Population Characteristics

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

Diagnosis and Procedures

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

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

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

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

The data submitted matches the state's reporting requirements but may

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

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

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

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

Length of Stay

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

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.

=====
THCIC ID: 448000 / St Paul Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

CERTIFIED WITH COMMENTS

Data Content

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

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

Submission Timing

The state requires us to submit a snapshot of billed claims extracted from our database approximately 40 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in. This represents a rare event and is approximately 1% of the encounter volume.

Specialty Services

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

Diagnosis and Procedures

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

The state requires us to submit ICD-9-CM data on each patient but has limited the number of diagnosis and procedures to the first nine diagnosis codes and the first six procedure codes. This means also that true total volumes may not be represented by the state's data file which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnoses or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, that the sicker patients are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

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

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

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

The codes also do not distinguish between conditions present at the time of the patient's admission to the hospital and that occurring during hospitalization.

For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

Race/Ethnicity

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

There are no national standards regarding patient race categorization, thus each hospital may designate a patient's race differently. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories and this mapping may not be consistent across hospitals.

Standard/Non-Standard Source of Payment

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

Also, these values might not accurately reflect the hospital payer information because those payers identified contractually as both "HMO and "PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Certification Process

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

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

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

=====
THCIC ID: 449000 / RHD Memorial Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

DATA Content

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

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

Submission Timing

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

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

Diagnosis and Procedures

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

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

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

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

Specialty Services

The data submitted does not have any specific data field to capture unit of service or expand in the specialty service (such as rehab) provided to a patient. Services used by patients in rehab may be very different

from those used in other specialties. The data is limited in its ability to categorize patient type.

Length of Stay

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

Normal Newborns

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

Race/Ethnicity

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

Cost/Revenue

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

Certification Process

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

=====
THCIC ID: 453000 / DeTar Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

DeTar Hospital has a Skilled Nursing Unit which has been in operation since 1988.

DeTar Hospital also maintains a Rehabilitation Unit which has been in operation since 1991.

DeTar Hospital had a Geriatric-Psychiatry Unit in operation, but was closed effective September 20, 1999.

=====
THCIC ID: 459000 / Ben Taub General Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

The physicians or other health care providers involved in the treatment of the patients have not reviewed the attached data. The District understands that the physician data will not be released to the public for the 3rd quarter of 1999.

=====
THCIC ID: 465000 / Covenant Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

Data does not accurately reflect the hospital's newborn population.
Total Births = 468
Live = 378
Premature = 90

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.
2.8% of total discharges were charity for 3 Quarter 1999.

3rd quarter 1999 data is currently being corrected and resubmitted to Common Wealth because of UB92 versioning issues with the 90 record. This is being done with the approval of THCIC.

=====
THCIC ID: 469000 / Harris Methodist Northwest
QUARTER: 3
YEAR: 1999

Certified with comments

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

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

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

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

Diagnosis and Procedures

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

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

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

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

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

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

Length of Stay

The length of stay data element contained in the state's certification

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Certification Process

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

=====
THCIC ID: 474000 / Parkland Memorial Hospital
QUARTER: 3
YEAR: 1999

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 1984 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 \$6760 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

For the third quarter 1999 data, Parkland Health & Hospital System shows a payer mix with close to 40% categorized as "self pay." This does not accurately reflect the true payer mix. Parkland has a significant number of patients who qualify for Medicaid, Medicare or another type of third-party reimbursement. However, 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, Parkland's self pay patients total approximately 30 percent.

There is also 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.

=====
THCIC ID: 478000 / Memorial Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

In general the summary data is acceptable; however, a number of data quality errors are unresolved: facility records indicate 174 more births than shown on the report and mapping errors continue to be identified causing inaccurate

reporting of discharge status, race, attending physician and omission of "other" physician information.

=====
THCIC ID: 480000 / Knapp Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

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

DISCLAIMER STATEMENT

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

ETHNICITY COMMENT FOR THIRD QUARTER 1999

Ethnicity data for the third quarter of 1999 does not reflect the diversity of the population served by Knapp Medical Center. The data indicates that in a region with a high population of Hispanics, of 3182 discharges none were of Hispanic origin. Our analysis indicated a data-mapping problem in regards to the initial admission input for all patients, inherent in the system we use. This is not correctable for prior periods, however changes in the admitting tables correcting this mapping problem have been implemented.

CHARITY COMMENT

Knapp Medical Center has a long tradition of providing charity care for the population it serves. Prior to designation as charity, program qualification

attempts are exhausted. This results in designation of charity being made after the patient is discharged, sometimes many months. Patient specific charity amounts are not available, therefore, at the time of submission of data to THCIC. Due to the impracticality at this time of identifying specific patients designated as charity and submitting corrections, the aggregate amount of charity provided during the third quarter 1999 was \$1,584,897.90 for 47 patients.

=====
THCIC ID: 481000 / Woodland Heights Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

The data presented includes Skilled Nursing Admissions. Skilled Nursing patients usually have a long length of stay, therefore the average length of stay may not be truly reflected for Acute Care Facility. Data presented in DRG 116 is being investigated through Performance Improvement to ensure we are in line with hospital standards. We are the only major cardiovascular hospital within a 100 mile radius.

=====
THCIC ID: 497000 / Ascension Health - Seton Medical Center
QUARTER: 3
YEAR: 1999

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.

Admission Source - Newborn Data

Seton Medical Center experienced a data collection problem affecting the admit source field when the admit type is 4 (Newborn). As a result of this collection problem, 1081 of 1084 newborn admissions at Seton were reported as "information not available", and no premature or normal newborns were reported. The hospital is correcting the data collection problem prospectively, but corrections will not affect data previously submitted.

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

=====
THCIC ID: 497002 / Ascension Health - Seton Northwest Hospital
QUARTER: 3

YEAR: 1999

Certified with comments

Admission Source - Newborn Data

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

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

=====
THCIC ID: 501000 / Dallas/Fort Worth Medical Center-Grand Prairie
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 503000 / St Luke's Baptist Hospital
QUARTER: 3
YEAR: 1999

Certified with comments, corrections requested

Baptist Health System (BHS) has significant concerns regarding the accuracy and reliability of the hospital discharge data. According to the certification data files for the third quarter 1999 there were zero encounters reported for the months of July and August. This of course, is completely incorrect.

We have confirmation reports from the Texas Health Association (THA) showing the required transmissions for the quarter successfully completed by Baptist Health System. The transmissions were sent to an authorized vendor, HCIA, who notified THA that the data had been received by their offices. By agreement and standard practice, HCIA then forwards the data to THCIC on our behalf. Due to the fact that all data is missing for the months of July and August 1999, BHS must expressly state our significant concern regarding the validity of the entire data set. In addition, BHS notes that the discharge data for September indicates that 46% of the encounters had missing or invalid sources of payment and we must disagree with that finding. Further, the discharge data set indicates the existence of normal newborn patients with ages other than under one year of age. That data is obviously invalid.

=====
THCIC ID: 508000 / Conroe Regional Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

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

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

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

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

=====
THCIC ID: 511000 / Doctors Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Data Content

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

Adding those additional data elements places programming burdens on the hospital since it is "over and above" the actual hospital billing process.

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

Submission Timing

Doctors Hospital estimates that our data volumes for the calendar year time period submitted include 95% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in. As a result, the state submitted data recognizes 2,085 encounters while Doctors Hospital's database reflects 2,199 encounters.

Diagnosis and Procedures

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

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

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

There is no limit to the number of diagnoses and procedure codes that can be assigned to a patient record. The codes are assigned based on the physician's documentation in the patient's record and are used by hospitals for billing purposes. One limitation of using the ICD-9-CM system is that there does not exist a code for every possible diagnosis and procedure due to the continued evolution of medicine. New codes are added yearly as coding manuals are updated.

The state is required to submit ICD-9-CM data on each patient but has limited the number of diagnosis and procedures to the first nine diagnosis codes and the first six procedure codes. As a result, the data sent by us does not meet state requirements but does not reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (ie mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious, therefore, those sicker patients (more diagnosis and procedures) are less accurately reflected by the 1450 format. Many of the patients treated at Doctors Hospital are Do Not Resuscitate (DNR) patients or have Living Wills.

Normal Newborns

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. Doctors normal hospital registration process only allows for "newborn" as the admission source. Other options are premature delivery, sick baby, extramural birth, or information not available. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture. As of 10/1/00, this information will be captured by the coders. A change in the data will not be seen until Q4 2000.

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement, each payer identification must be categorized into the appropriate standard and non-standard source of payment value. Upon review of the data, the THCIC report shows almost twice as many cases as were reported by the Doctors Hospital charge breakout and summary report for Quarter 3, 1999. The greatest occurrence of error is with the Primary Commercial Pay category. The hospital database reflects 57 cases. The state data reflects 727 cases. Another area of concern is the Missing/Invalid Source of Payment under the Non-Standard Source of Payment field. The state recognizes 1,184 cases. Doctors Hospital database indicates that there are no cases in this category. THCIC has recognized that there is a problem with the way this data is captured and will not be publishing it for Quarter 1, 1999 - Quarter 2, 2000. However, we would like to include in our comments that this data is invalid and therefore can not be considered in any way accurate.

Cost/Revenue Codes

The state requires that hospital submit revenue information including charges.

It is important to note that charges are not equal to actual payments received by the hospital or hospital cost for performing the service.

Typically, actual payments are much less than charges due to managed care-negotiated discounts and denial of payment by insurance companies.

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

Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process does not completely and accurately reflect all of the data that has been submitted. It also should be noted that due to high turnover in key areas of the hospital, we spent a great deal of time learning and relearning the process involved in submitting the THCIC data as well as preparing the data for submission. While we have grasped many of the steps involved in certifying the data, we continue to learn the requirements of reporting.

=====
THCIC ID: 513000 / Baylor Medical Center Grapevine
QUARTER: 3
YEAR: 1999

Certified with comments

Data Content

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

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

Submission Timing

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

Diagnosis and Procedures

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

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

The codes are assigned based on documentation in the patient's chart and

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

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

Length of Stay

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

Normal Newborns

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

to the patient's encounter record may change over time. With this in mind, approximately 57% of encounters originally categorized across all values have a different value as of today. Upon review an additional data issue was uncovered. All managed care encounters were categorized as "Commercial PPO" instead of separating the encounters into "HMO" versus "PPO".

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

Cost/ Revenue Codes

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

Certification Process

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

=====
THCIC ID: 537000 / Scott & White Memorial Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Data Content

To the best of our knowledge and ability with the configuration of our data systems, and the fact the data has gone through edits by other entities, the encounter data returned accurately represents the hospital inpatient and skilled nursing facility data from the UB92 billing claim form and data required by the state.

The information being certified does not indicate or address the quality of services that were provided and is not provided for that purpose. Instead, this information is extracted from a billing file that is solely used for administrative purposes. Certain medical disciplines are responsible for the treatment of severely ill patients and physicians within those disciplines may experience a higher mortality rate due to the nature of their clinical practice. In addition, tertiary care facilities, such as ours often accept in transfer critically ill patients whose outcomes may adversely affect accepting institutions' performance profile. The data being submitted and certified is not meant to measure clinical quality.

Certification Process

It is possible that some cases discharged during this quarter were not included in the file submitted to the state due to the timing of submission required by the state. This may have occurred in instances when a case had not been billed before the tape was submitted, or when a correction of a billing error was made

after the tape was submitted. Due to the volume of encounters for this certification period, time constraints and the resources needed for this process, the facility did not have an efficient method for verifying, auditing and correcting data at the encounter level.

Organization of Data

We are a teaching facility and the structure of our inpatient care is such that multiple physicians are involved in the patient's care in a serial fashion over the total duration of the patient's episode of care. Therefore, based solely on the billing file data, we cannot accurately assign a single physician as being largely responsible for the care of a patient when there may have been more than one attending physician involved in the care of the patient. For internal data analysis, the discharging physician has long been used as the responsible physician when assigning DRG's (Diagnosis Related Groups) or computing mortality statistics. The attending physician reported in this data submission to THCIC might not be consistent with our assessment of the discharging physician.

Diagnosis/Procedure Code Summary

Being a teaching facility, we do assign more diagnoses and procedures than are captured on the UB92 billing claim form. The average number of diagnoses per encounter should read 6.0 and the average number of procedure codes assigned should be 2.0. These numbers are under-represented by THCIC methodology.

Standard/Non-Standard Source of Payment

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

=====
THCIC ID: 547000 / Fort Duncan Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

Data is complete to a great degree; the following is noted for this quarter:

1. Pay source needs clarification--all self-pay encounters are included with the commercial accounts. Distribution is as follows: Commercial = 8% and Self-pay=12%; charity care is included within the self-pay but data is not available to identify it.

2. There were 5 encounters not captured, they included: 4 females and one male; ages were 31, 26, 30, 51, & 60. Primary Diagnosis included: 654.21, 661.21, 669.51, 618.5, & 823.32; with DRG's # 219, 356, 373, and two with 371.

=====
THCIC ID: 549000 / Baylor/Richardson Medical Center
QUARTER: 3
YEAR: 1999

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

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

Cost/ Revenue Codes

The state data files will include charge information. It is important to understand that charges do not equal payments received by the hospital. Payments are much less than charges, due to managed care-negotiated discounts and denial of payment by insurance companies. Charges also do not reflect the actual cost for care that each patient receives.

Quality and Validity of the process

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

Standard Source of Payment data reflects 80.47% missing/invalid, and Non-Standard Source of Payment reflects 100% missing/invalid. This data is a result of the editing software utilized during 1999. The software utilized by the hospital was updated to meet THCIC specifications. However, the DFW Hospital Council software had not been updated, therefore a discrepancy exists, and data does not accurately reflect Source of Payment information.

=====
THCIC ID: 555000 / Pampa Regional Medical Center
QUARTER: 3

YEAR: 1999

Certified with comments

This data contains information from patients in the skilled nursing unit.

=====
THCIC ID: 574000 / Wagner General Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Wagner General Hospital has very low volumes which will make quality statistics invalid.

=====
THCIC ID: 586000 / Baylor Specialty Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Data Content

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

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

Submission Timing

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

Diagnosis and Procedures

BSH is different from most hospitals submitting data to the state. We provide complex medical services to patients who have experienced a catastrophic illness and/or complex body system failure that requires coordinated, intensive treatment and care. Many of the patients have received emergency care and stabilizing treatment at 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.

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

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

Length of Stay

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

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

Race/Ethnicity

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

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. With this in mind, approximately 6% of encounters originally categorized as Medicare have been re-categorized 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. During the current certification phase, Baylor did not have an efficient mechanism to edit and correct the data. In addition, due to the volume at BSH, it is not feasible to perform encounter level audits.

=====

THCIC ID: 597000 / Ascension Health - Seton Edgar B. Davis
QUARTER: 3
YEAR: 1999

Certified with comments

597000: Daughters of Charity - Seton Edgar B. Davis Quarter Three
1999

Seton Edgar B. Davis is a community hospital that serves the Caldwell County and surrounding rural areas as a medical and surgical facility.

The transfer of the seriously ill and injured is reflected in the lengths of stay and the mortality rates.

Admission Source and Type:

Seton Edgar B. Davis experienced a data collection problem which affected admission source and type. The hospital is correcting the problem prospectively, but corrections will not affect the data previously submitted by hospital.

=====
THCIC ID: 600000 / CHRISTUS St John Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

St. John Hospital certified the third quarter, 1999 data but could not account for 11 patients whose accounts were processed after the date of the original data submission.

During this interval, St. John provided charity care for 44 patients with charges of \$393,622.65. The system did not identify these patients as recipients of charity care.

=====
THCIC ID: 601000 / Rio Grande Regional Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Many of our physicians are concerned with errors they discovered in their mortality rates as well as diagnosis and treatment data. One of our gastroenterologist found a procedure done that could only be done by a cardiologist in his data. Our physicians are aware that their 1999 data will be suppressed but are not satisfied with that. They have concerns because the accuracy of the data is so poor and want to know what THCIC plans to do with the suppressed 1999 data and all its errors.

=====
THCIC ID: 602000 / South Austin Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

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

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

The severity grouping assignment performed by the State using the APR-DRG grouper cannot be replicated by facilities unless they purchase this grouper. Additionally, the lack of education regarding how this grouper

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

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

=====
THCIC ID: 603000 / Medical Center at Lancaster
QUARTER: 3
YEAR: 1999

Elect not to certify

Texas Health Care Information Council (THCIC)
3rd Quarter 1999 - Certification Summary
December, 2000

Elect not to certify:

Due to the fact the data was received late. The data has been sent to physicians but not all physicians have had an opportunity to review their data for this quarter.

Other Comments:

We had slight variation on the top 30 HCFA DRG's and procedure codes.

? This is claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes.
? The public data only contains a subset of diagnosis and procedure codes.

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

? Race/ethnicity classification is not done systematically at each hospital.
? Our hospital does not capture charity data at the time of billing.
? The designation of attending physician is usually assigned to the physician that discharges the patient. In some cases this does not reflect the physician that provided most of the patient's care.
? We identified a mapping problem with physician middle initials not always being accurate.

Dec. 1, 2000

Dear Doctor,

Attached is your latest Texas Health Care Information Council report (3rd Quarter 1999). I have done a preliminary review of the data and it appears accurate.

If you have any questions regarding your data please give me a call. I can pull more detailed information or the patient chart.

Thanks,

Susan Adair
(972)274-7358

=====
THCIC ID: 608000 / Round Rock Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

Charity cases are a subset of the self-pay category.

=====
THCIC ID: 609000 / Fort Bend Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

Twenty newborn admissions appear with an admission source of Physician vs. Newborn.

=====
THCIC ID: 611000 / Regional Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

Regional Medical Center maintains a Psychiatric Unit.

=====
THCIC ID: 616000 / HEALTHSOUTH Rehab Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

The Patient Discharge Status should read as follows:

Discharge to Home or Self Care	96
Discharge/Transfer to Gen. Hospital	19
Discharge to ICF	12
Discharge/Transfer to Home Health	19

Expired

1

=====
THCIC ID: 622000 / The Brown Schools Rehab Center
QUARTER: 3
YEAR: 1999

Certified with comments

The Administrator advised on comments that "he was a new administrator and was not employed at time that data was compiled."

=====
THCIC ID: 624000 / Denton Community Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Comments:

1. There is some difference in the total number of encounters for this quarter. THCIC indicates 1638 discharges. Our internal system counts 1659 discharges.
2. THCIC data shows 85 patients as "Black" and 195 as "Other". Unable to accurately ascertain Race if patient does not personally come through registration. Clerks are using "best observed guess". Efforts will continue to ensure accuracy.
3. THCIC data shows 215 newborns. Our internal system shows 244.

=====
THCIC ID: 627000 / Harris Methodist Southwest
QUARTER: 3
YEAR: 1999

Certified with comments

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. 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 your payers is inaccurate; this was a unique, untried use of this data as far as the hospitals are concerned.

Several issues might affect the accuracy of any data gathered in this manner:

1. 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 sent in.
2. 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 HMSW patient population have more than nine diagnoses and/or six procedures assigned.

The State is requiring us to submit ICD9 data on each patient but has limited the number of diagnoses and procedures to the first nine diagnoses 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.

3. 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.

4. 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. HMSW's normal hospital registration process defaults to "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 ICD9 diagnoses. Admission source does not give an accurate picture. The current summary of HMSW data shows 100% normal newborns which has been the case at all THR facilities.

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

6. The standard and non-standard sources of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. Several problems with Harris entity "mapping" have been identified. Blue Shield has been mapped incorrectly so that HMSW appears to have an unreasonably low number of Blue Cross patients. Workmen's compensation and Charity must be mapped differently. The current summary incorrectly states that HMSW had no Charity cases during this time frame.

7. 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.

=====
THCIC ID: 628000 / All Saints Episcopal Hosp Cityview
QUARTER: 3
YEAR: 1999

Certified with comments

The Newborn admissions shows all normal deliveries with no premature deliveries or sick babies. This is incorrect. I have been told this is because THCIC does not take this information from the ICD 9 codes but uses the admit source and type. All Saints is working to try to address this but feels 2000 data will be incorrect and needs to be suppressed.

=====
THCIC ID: 635000 / North Dallas Rehabilitation Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Blanks in report that were completed and appropriate diagnostic codes (C05 report). When questioned, we were told that this was a problem with the Commonwealth software(3m Grouper), which was not picked up by their editor. Additional problems noted secondary to the data being obtained for patients admitted over a year ago.

=====
THCIC ID: 639000 / Rehabilitation Hospital of South Texas
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 642000 / Baylor Institute for Rehab at Gaston
QUARTER: 3
YEAR: 1999

Certified with comments

Data Content

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

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

EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is "over and above" the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate; this was a unique, untried use of this data as far as hospitals are concerned.

Submission Timing

Baylor Institute for Rehabilitation (BIR) estimates that our data volumes for the calendar year time period submitted may include 88% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in. BIR has a 10-day billing cycle; therefore we will have a higher percentage of incomplete encounters than hospitals with a 30-day billing cycle.

Diagnosis and Procedures

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

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

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

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

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

(more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

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

Length of Stay

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

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

Race/Ethnicity

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

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 31% of encounters originally categorized across all values have a different value as of today. Upon review an additional data issue was uncovered. All managed care encounters were categorized as "Commercial PPO" instead of separating the encounters into "HMO" versus "PPO".

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

Cost/Revenue Codes

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

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

Certification Process

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

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THCIC ID: 643000 / San Antonio Warm Springs Rehabilitation Hospital
QUARTER: 3
YEAR: 1999

Certified without comments

=====
THCIC ID: 649000 / St. David's Rehabilitation Center
QUARTER: 3
YEAR: 1999

Certified with comments

- 1.) The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes.
- 2.) The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient.
- 3.) The relationship between cost of care, charges and the revenue that a facility receives is extremely complex. Inferences to comparing costs of care from one hospital to the next may result in unreliable results.

=====
THCIC ID: 652000 / Harris Continued Care Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Some "Admission Types" were listed as Urgent. All admissions are elective.

=====
THCIC ID: 653000 / Zale Lipshy University Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Certification with Comments
Quarter 3 1999
Zale Lipshy University Hospital
5151 Harry Hines Blvd.
Dallas, TX 75235-7786

1. Zale Lipshy University Hospital is an academic teaching hospital at the University of Texas Southwestern Medical School.
2. Zale Lipshy University Hospital is a private adult referral hospital.
3. Zale Lipshy University Hospital does not provide the following types of medical services: Emergency Room, Obstetrics, and Pediatrics.
4. We do not have the APR-DRG codes to check our risk stratification at this time.
5. Our 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. Admission Source: physician and clinic are used interchangeably at our institution.
8. Admission source: correctional facility code (UC) and court ordered admission code (TB) are used as one code (8).
9. The corrected data has been accepted by Commonwealth.

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THCIC ID: 660000 / HEALTHSOUTH Rehab Hospital of Arlington
  QUARTER: 3
    YEAR: 1999

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Certified with comments

Quarter 2 revenues actual are higher than indicated in THCIC statistics. Discrepancies in all counts are not statistically significant.

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THCIC ID: 664000 / Presbyterian Hospital of Plano
  QUARTER: 3
    YEAR: 1999

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Certified with comments

PRESBYTERIAN HOSPITAL OF PLANO CERTIFIED WITH COMMENTS

Data Content

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

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

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

Patient Population Characteristics:

Low volume in the overall cardiac surgery program is due to a start up program that began in February, 1999.

Diagnosis and Procedures

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

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

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

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

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

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

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

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

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

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

(more diagnoses and procedures) are less accurately reflected by the 1450 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

The state requires that hospitals submit revenue information including

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

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

=====
THCIC ID: 672000 / Select Specialty Hospital Dallas
QUARTER: 3
YEAR: 1999

Certified with comments

Certain errors were determined as mapping errors and have been addressed within Healthcare Management Systems software. Errors involving SSN and procedure codes have been corrected at the facility level.

=====
THCIC ID: 675000 / Columbia Kingwood Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

The data for Kingwood Medical Center includes acute, skilled, rehabilitation and hospice patients. Therefore, this data may appear skewed and our clinical and financial outcomes and summary data are affected. The population of our patients must also be taken into consideration when making comparisons among healthcare institutions.

The method for identifying and correcting of any physician data errors was not implemented until 2000 so there may be errors with the physician data for 1999 claims.

=====
THCIC ID: 677000 / North Central Baptist Hospital
QUARTER: 3
YEAR: 1999

Certified with comments, corrections requested

Baptist Health System (BHS) has significant concerns regarding the accuracy and reliability of the hospital discharge data. According to the certification data files for the third quarter 1999 there were zero encounters reported for the months of July and August. This, of course, is completely incorrect.

We have confirmation reports from the Texas Hospital Association (THA) showing the required transmissions for the quarter were successfully completed by Baptist Health System. The transmissions were sent to an authorized vendor, HCIA, who notified THA that the data had been received by their offices. By agreement and standard practice, HCIA then forwards the data to THCIC on our behalf. Due to the fact that all data is missing for the months of July and August 1999, BHS must expressly state our significant concern regarding the validity of the entire data set. In addition, BHS notes that the discharge data for September indicates that 46% of the encounters had missing or invalid sources of payment and we must disagree with that finding. Further, the discharge set indicates the existence of normal newborn patients with ages other than under one year of age.

That data is obviously invalid.

=====
THCIC ID: 681400 / Kell West Regional Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Mapping issue with Vendor. Errors should be resolved by next Certification.

=====
THCIC ID: 684000 / HEALTHSOUTH Rehab Hospital of Texarkana
QUARTER: 3
YEAR: 1999

Certified with comments

Data Certification for Quarter 3, 1999 has been completed and letter of certification submitted to THCIC. The Certification Data Set CD received from THCIC and labeled "Quarter Q399" contained only partial and incomplete records for the period. Only 15 encounters were identified for the quarter in that set. In actuality, there were 226 patient records submitted to THIN and the Claim Acceptance Response letter from THIN (Blue Cross) confirmed such. It is not known what became of the remaining 211 encounters after the information was received at that office.

From conversations with THCIC key staff, i. e. Dee Shaw and Diana McClenny, we understand that the under-reported data for our facility for this quarter will be pooled with other facilities that had insufficient data. Moreover, we will review a data history file from Commonwealth to determine if any subsequent UB92 reports lack data and will move to correct if such is the case.

=====
THCIC ID: 686000 / Covenant Children's Hospital
QUARTER: 3
YEAR: 1999

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.
0.18% of total discharges were charity for 3 Quarter 1999.

3rd quarter 1999 data is currently being corrected and resubmitted to Common Wealth because of UB92 versioning issues with the 90 record. This is being done with the approval of THCIC.

=====
THCIC ID: 687000 / Warm Springs Rehabilitation Hospital Corpus Christi
QUARTER: 3
YEAR: 1999

Certified with comments

Error code 957 must be a software issue, the the UB is correct.

=====
THCIC ID: 690600 / LifeCare Hospital of Fort Worth
QUARTER: 3
YEAR: 1999

Certified with comments

This data appears correct given margin of human error except in the following areas.

1. Patient Race breakdown was as follows:
2 black, 72 white, 14 other.
2. Standard Source of Payment - 80 Medicare and 8 Commercial.

=====
THCIC ID: 691000 / Memorial Specialty Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

We are aware that a few physicians lists were considered the original admitting physician for Memorial Health System and may not have been updated when the patient was transferred on our computer system.

=====
THCIC ID: 692000 / HEALTHSOUTH Rehab Hospital of Tyler
QUARTER: 3
YEAR: 1999

Certified with comments

We were unable to access information for 2nd Quarter 1999.

=====
THCIC ID: 694100 / Vista Medical Center Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Two lumbar fusion patients should be changed from DRG 497 to DRG 498 as the secondary diagnosis driving the DRG change was incidental to the procedure, and should be deleted.

=====
THCIC ID: 695000 / HEALTHSOUTH Rehab Hospital North Houston

QUARTER: 3
YEAR: 1999

Certified with comments

The Patient Discharge Status should read as follows:

Discharge to Home or Self Care	89
Discharge/Transfer to Gen. Hospital	27
Discharge/Transfer to SNF	1
Discharge to ICF	9
Discharge/Transfer to Other Institution	1
Discharge/Transfer to Home Health	28
Left AMA	3
Discharge/Transfer Home IV	2
Expired	1
Hospice/Home	2

=====
THCIC ID: 698000 / The Specialty Hospital of Houston
QUARTER: 3
YEAR: 1999

Certified with 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 admissions source for all the patients is coded as "physicians". This information is incorrect. Not all 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 The Specialty Hospital of Houston.

=====
THCIC ID: 698001 / Specialty Hospital Houston - Clear Lake Campus
QUARTER: 3
YEAR: 1999

Certified with 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 admissions source for all the patients is coded as "physicians". This information is incorrect. Not all 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 The Specialty Hospital of Houston.

=====
THCIC ID: 700000 / The Specialty Hospital of Austin
QUARTER: 3
YEAR: 1999

Certified with comments

Due to technical issues and various other time constraints physicians and other individuals were not given adequate time to view this data. The data contained herein is not an exact representation of the actual discharge data for this specified quarter.

=====
THCIC ID: 700001 / The Specialty Hospital of Austin at North Austin Medical Ctr
QUARTER: 3
YEAR: 1999

Certified with comments

Due to technical issues and various other time constraints physicians and other individuals were not given adequate time to view this data. The data contained herein is not an exact representation of the actual discharge data for this specified quarter.

=====
THCIC ID: 700002 / The Specialty Hospital of Austin at St Davids Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

Due to technical issues and various other time constraints physicians and other individuals were not given adequate time to view this data. The data contained herein is not an exact representation of the actual discharge data for this specified quarter.

=====
THCIC ID: 703002 / The Corpus Christi Medical Center - Doctors Regional
QUARTER: 3
YEAR: 1999

Certified with comments

The summary numbers under the caption "Standard Source of Payment" and "Non-standard Source of Payment" do not accurately reflect the payor sources identified in the Corpus Christi Medical Center's billing records.

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore, the Corpus Christi Medical Center is unable to verify the accuracy of these numbers.

=====
THCIC ID: 705000 / Texoma Medical Center Restorative Care Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

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

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

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

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

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

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

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

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

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

=====
THCIC ID: 706000 / Vencor Hospital- Houston Northwest
QUARTER: 3rd
YEAR: 1999

Certified with comments

Vencor Hospital Houston Northwest is a long-term acute care facility

=====
THCIC ID: 707000 / Quest Hospital
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 708000 / Dubuis Hospital for Continuing Care-Beaumont
QUARTER: 3
YEAR: 1999

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. 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.

=====
THCIC ID: 710000 / Our Children's House at Baylor
QUARTER: 3
YEAR: 1999

Certified with comments

Data Content

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

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

Submission Timing

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

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

Diagnosis and Procedures

OCH is different from most hospitals submitting data to the state. We provide complex medical services to patients who have experienced a catastrophic illness, congenital anomalies and/or complex body system failure that requires coordinated, intensive treatment and care. Many of the patients have received emergency care and stabilizing treatment at 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.

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

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

Length of Stay

The length of stay data element contained in the state's certification

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

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

Cost/ Revenue Codes

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

Certification Process

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

=====
THCIC ID: 713000 / CHRISTUS St Michael Rehab Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

data is accurate to the best of our knowledge

=====
THCIC ID: 717000 / LifeCare Specialty Hosps of Dallas
QUARTER: 3
YEAR: 1999

Certified with comments

1. Admission source: Most of our patients are admitted from another hospital.
2. payment source: commercial payers approximated 10-12%.
3. patient race: approximate % by racial group for 1999 was 10% Asian, 45% Black, 35% White, and 10% Hispanic.
4. Discharge codes: all patients receive a principle diagnosis at discharge.

=====
THCIC ID: 727000 / The Oaks Treatment Center
QUARTER: 3
YEAR: 1999

Certified with comments

The Oaks Treatment Center provides long-term residential treatment to adolescents with severe emotional disturbances. No hospital programs are in operation. This should be taken into consideration when comparing this facility's data to other hospitals providing acute care services.

Please note the THCIC software is not equipped to store length of stays over 999 days. For patient stays which exceed 999 days, the THCIC system automatically rounds down the actual LOS to a maximum of 999 days. The system, however, does not round down the actual charges, but reports the actual charges for the entire LOS. This should be taken into consideration when interpreting average LOS data and charge data for this facility as some patient stays may exceed 999 days.

=====
THCIC ID: 733000 / Charter Behavioral Health System of Kingwood
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 735000 / TIRR LifeBridge
QUARTER: 3
YEAR: 1999

TIRR LifeBridge
Subacute Medical Transitional and General Rehabilitation

CERTIFY WITH COMMENTS

TIRR LifeBridge is a fully accredited teaching specialty hospital that provides subacute medical transitional and general rehabilitation. The philosophy of LifeBridge is to assist patients in attaining the highest level of function possible within the resources available to them. LifeBridge works closely with the patient and his/her family and the External Case Manager to provide care effectively at an appropriate level. Patient care is offered in general clinical services including:

- Stroke
- Cancer Recovery
- Wound and Skin Care Management
- Post Surgical Care
- General Rehabilitation
- Neuromuscular Complications of Diseases or Injuries
- Ventilator and Other Respiratory Care
- Brain Injury Recovery, Including Coma
- Complex Diabetes
- Orthopedics

Types of Services

Subacute general rehabilitation services are provided for patients who have limited tolerance for participation or benefit from a comprehensive acute rehabilitation program. Medical transitional services are designed for patients who need specialized care for medical issues that do not require an acute care hospital setting. The types of services include:

- Pulmonary/Ventilator
- Strength/Endurance Exercises
- Complex Wound Care
- Speech/Language Intervention
- Bowel/Bladder Training
- Alternative Communication Techniques
- Positioning
- ADL Training
- Patient/Family/Attendant Training
- Mobility Training
- Gait Training

THCIC data show TIRR LifeBridge as a "SNF Facility". TIRR LifeBridge operated a SNF unit until December 1998, when the unit was converted back to long term acute care.

=====
THCIC ID: 736000 / DePaul Center - Div of Providence Health Center
QUARTER: 3
YEAR: 1999

Certified with comments

Due to a data mapping error, 19 records from the DePaul Center (THCIC #763000) were inadvertently submitted under Providence Health Center's THCIC Number (THCIC #040000). The accounts had the following HCFA DRGs:

HCFA DRG NO	-	Quantity
HCFA DRG 426	-	2
HCFA DRG 426	-	1
HCFA DRG 427	-	2
HCFA DRG 428	-	1
HCFA DRG 430	-	12

=====

THCIC ID: 737000 / Southwest Mental Health Center
QUARTER: 3
YEAR: 1999

Certified with comments

1. 80 patients are missing from our data set due to database errors.

=====

THCIC ID: 739000 / Healthcare Rehabilitation Center
QUARTER: 3
YEAR: 1999

Certified with comments

The only reservation as to the certification of this data is that I (Chuck Webb) was not on site when this data was recorded.

=====

THCIC ID: 742000 / COMPASS Hospital of Dallas
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====

THCIC ID: 745000 / Charter Haven Behavioral Health System
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====

THCIC ID: 752000 / Timberlawn Mental Health System
QUARTER: 3
YEAR: 1999

Certified with comments

We found discharge hour missing, State of Texas sometimes appears as "AS" and the patient middle initial is omitted. Our corporate IS staff is still working to correct these errors.

=====

THCIC ID: 753000 / San Marcos Treatment Center
QUARTER: 3
YEAR: 1999

Certified with comments

San Marcos Treatment Center provides long-term residential treatment to

adolescents with severe emotional disturbances. No hospital programs are in operation. This should be taken into consideration when comparing this facility's discharge data with other hospitals providing acute care services.

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

=====
THCIC ID: 754000 / Glen Oaks Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

All references to Jane Harmon, APN, as the attending physician are incorrect.

=====
THCIC ID: 756001 / Covenant Behavioral Health
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 757000 / Charter Palms Behavioral Health System
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 760000 / Charter Behavioral Health System of Corpus Christi
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 761000 / Charter Plains Behavioral Health System
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 763000 / Plaza Specialty Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

The data included in the third quarter 1999 submission to the State is considered administrative data collected by Plaza Specialty Hospital for billing purposes and not used to make judgements about patient care.

On a quarterly basis we submit only inpatient UB 92 data to the State.

The UB 92 is a standard billing form that all hospitals use to submit claims to payors. The information is submitted in a standard government format called HCFA 1450 EDI electronic claim format. The data must be submitted by the 20th day following the close of the quarter. Any accounts in the quarter not billed by the deadline will not be reflected in this data. In addition, it is important to note that the UB 92 claim form only allows nine diagnoses and six procedure codes to be submitted. In addition only three physicians can be identified; attending physician, and two other physicians. Anyone evaluating this data should understand that our diagnoses/procedure data collection system allows us to enter twelve diagnoses codes, ten procedures codes and identify up to ten physicians.

The additional diagnoses and procedures may have an impact on the severity level and APR/DRG assigned to the admission. Therefore the physician data, severity level and APR/DRG assignments reported for some of these admissions may not be accurate. A review of the admission source data shows 100% of our admissions were from physicians. This information is the result of a clerical error. The source of our admissions is primarily transfers from other hospitals.

=====
THCIC ID: 764000 / Charter Behavioral Health System of Austin
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 771000 / St. David's Pavilion
QUARTER: 3
YEAR: 1999

Certified with comments

- 1.) The data is administrative/claims data, not clinical research data. There may be inherent limitations to using it to compare outcomes.
- 2.) The public data will only contain a subset of the diagnoses and procedure codes, thus limiting the ability to access all of the diagnoses and procedures relative to each patient.
- 3.) The relationship between cost of care, charges and revenue that a facility receives is extremely complex. Inferences to comparing costs

of care from one hospital to the next may result in unreliable results.

=====
THCIC ID: 778000 / Harris Methodist Springwood
QUARTER: 3
YEAR: 1999

Certified with comments

THR 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 0% of THR'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.

Currently, Harris Methodist HEB has classified Workmen's Compensation to be included in "Commercial". This will be modified in the future.

Cost/ Revenue Codes

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

Certification Process

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

=====
THCIC ID: 779000 / The Cedars Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Continued mapping problems with physician Identification number, race, sex and ethnicity.

=====
THCIC ID: 780000 / Harris Continued Care Hospital - H.E.B.
QUARTER: 3

YEAR: 1999

Certified with comments

Some "Admission Types" were listed as Urgent. All admissions are elective.

=====
THCIC ID: 784000 / Charter Behavioral Health System of Dallas
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 785000 / Panhandle Surgical Hospital
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 787000 / Charter Grapevine Behavioral Health System
QUARTER: 3
YEAR: 1999

Did not participate in certification

This hospital did not participate in the certification process for 3rd Quarter 1999. Review of the certification reports and data by THCIC did not identify any material errors.

=====
THCIC ID: 788000 / CHRISTUS St Michael Health System
QUARTER: 3
YEAR: 1999

Certified with comments

Data is accurate to the best of our knowledge

=====
THCIC ID: 794000 / HEALTHSOUTH Surgical Hospital of Austin
QUARTER: 3
YEAR: 1999

Certified with comments

THE INFORMATION IN THE PAST QUARTERS WAS INCORRECT. IT HAS BEEN CORRECTED ON THE 4th QUARTER THCIC DISCHARGE INFORMATION. I WAS INFORMED THAT THE RACE AND SOME OTHER THINGS WERE INCORRECT.

=====
THCIC ID: 796000 / IHS Hospital of Amarillo

QUARTER: 3
YEAR: 1999

Certified with comments

Due to limited computer options, admission type reflects 100% elective admissions. The majority of admissions are urgent admissions. Computer changes have been made, and urgent type will be reflected beginning in the 3rd Quarter 2000 data.

=====
THCIC ID: 797000 / North Austin Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

The data is administrative data that was collected for billing purposes and was not designed to allow judgements about patient care.

The public data set includes only a subset of diagnoses and procedure codes and will not accurately represent the sickest or most complicated patients.

The relationship between cost of care, charges, and revenue is complex. Inferences drawn from comparing different facilities' charges may be unreliable.

Charity care is not accurately reflected in the source of payment data. Patients who have no insurance are initially identified as "Self-Pay," but frequently become "Charity" after it is determined that they are unable to pay.

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

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

The data does not accurately reflect the number of PPO patients at North Austin Medical Center because of a computer mapping problem. PPO patients are currently included in the HMO classification.

=====
THCIC ID: 798000 / Summit Hospital of Central Texas
QUARTER: 3
YEAR: 1999

Certified with comments

Due to technical issues and various other time constraints physicians and other individuals were not given adequate time to view the data. The data contained herein is not an exact representation of the actual discharge data for this specified quarter.

=====
THCIC ID: 801000 / Vencor Hospital - Bay Area - Houston
QUARTER: 3
YEAR: 1999

Certified with comments

Vencor Hospital Bay Area - Houston is a Long Term Acute Care Hospital.

=====
THCIC ID: 802000 / McAllen Heart Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Patient Race- listed 622 patients as other. It should be noted that those patients were comprised of Mexican American population.

Ethnicity- Those patients listed as not hispanic origin should be listed as hispanic origin.

=====
THCIC ID: 804000 / Sunrise Canyon
QUARTER: 3
YEAR: 1999

Certified with comments

A mapping issue was discovered creating admission source data and admission type data that is unreliable or incorrect. All admission type data should be recorded as urgent. All other data were not affected.

=====
THCIC ID: 805000 / IHS Hospital at Plano
QUARTER: 3
YEAR: 1999

Certified with comments

Due to computer/software problems the actual total of patient encounters should be 57. The following patients were not included in the encounter files:

1. White female 92 yrs. Old.
Diagnosis: decubitus ulcer
2. White female 90 yrs. Old.
Diagnosis: decubitus ulcer
3. White female 77 yrs. Old.
Diagnosis: decubitus ulcer
4. Black female 99 yrs. Old.
Diagnosis: decubitus ulcer
5. White female 78 yrs. Old.
Diagnosis: decubitus ulcer
6. White male 85 yrs. Old.
Diagnosis: cva
7. White female 88 yrs. Old.
Diagnosis: decubitus ulcer

Total Charges: \$380,646.89

=====
THCIC ID: 806001 / Cedar Crest Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

We are aware that all of our Non-Standard Sources of Payment are listed as "Missing/Invalid". We are currently looking into this problem.

=====
THCIC ID: 807000 / Dubuis Hospital for Continuing Care - Houston
QUARTER: 3
YEAR: 1999

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. 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.

=====
THCIC ID: 810000 / Harris Continued Care Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Some "Admission Types" were listed as Urgent. All admissions are elective.

=====
THCIC ID: 814000 / Las Colinas Medical Center
QUARTER: 3
YEAR: 1999

Certified with comments

Las Colinas Medical Center Patient Race statistics should be reported as: Asian or Pacific Islander 32 NOT 135; Black 103 NOT 0; White 481; Other 263; Missing/Invalid 0; and American Indian/Eskimo/Aleut 0. THCIC statistics report one claim with DRG 470 in error.

=====
THCIC ID: 819000 / SCCI Hospital - San Angelo
QUARTER: 3
YEAR: 1999

Certified with comments

There were 12 patients whose data did not come across for certification

due to corrections not being submitted back in time. I have compiled some information on these patient's and have listed them below by age; sex; length of stay; principal diagnosis; and total charges billed.

24-year-old Male; LOS 23 days; principal diagnosis 7070; total charges billed \$18510.23

79-year-old Male; LOS 16 days; principal diagnosis 570; total charges billed \$22244.92

64-year-old Male; LOS 14 days; principal diagnosis 5070; total charges billed \$16869.94

45-year-old Male; LOS 28 days; principal diagnosis 95200; total charges billed \$54603.07

75-year-old Male; LOS 13 days; principal diagnosis 486; total charges billed \$15832.58

65-year-old Male; LOS 88 days; princicpal diagnosis 43491; total charges billed \$ 76782.11

90-year-old Male; LOS 23 days; princicpal diagnosis 5070; total charges billed \$62287.89

47-year-old Female; LOS 38 days; principal diagnosis 43411; total charges billed \$45092.58

45-year-old Male; LOS 33 days; principal diagnosis 34400; total charges billed \$47675.59

66-year-old Male; LOS 21 days; principal diagnosis 5070; total charges billed \$17515.26

83-year-old Male; LOS 8 days; principal diagnosis 4821; total charges billed \$13668.36

34-year-old Female; LOS 32 days; prncicipal diagnosis 73008; total charges billed \$53688.99

=====
THCIC ID: 821000 / LifeCare Hospital of South Texas
QUARTER: 3
YEAR: 1999

Elect not to certify

Admission source needs to be 100% transfer from another facility. Medicaid admission need to be moved to Medicare. We do not have any Medicaid patients as we do not participate in that program.

=====
THCIC ID: 822000 / The Dubuis Hospital for Continuing Care-Texarkana
QUARTER: 3
YEAR: 1999

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. 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.

=====
THCIC ID: 823000 / Methodist Health Center - Sugar Land
QUARTER: 3
YEAR: 1999

Certified with comments

Certified with three files missing.

=====
THCIC ID: 827000 / Rio Grande Rehabilitation Hospital
QUARTER: 3
YEAR: 1999

Certified with comments

Many of our physicians are concerned with errors they discovered in their mortality rates as well as diagnosis and treatment data. One of our gastroenterologists found a procedure that could only be done by a cardiologist in his data.

Our physicians are aware that their data will be suppressed but are not satisfied with that. They have many concerns because the accuracy of the data is so poor and want to know what THCIC plans to do with the suppressed data and all its errors.

=====
THCIC ID: 829000 / Heart Hospital of Austin
QUARTER: 3
YEAR: 1999

Certified with comments

HHA's 3rd quarter 1999 report summary lists two encounters for extramural birth. Both encounters are errors that were not caught in time to be correctly reported on the certification report summary.

=====
THCIC ID: 831000 / Victoria Warm Springs Rehabilitation Hospital
QUARTER: 3
YEAR: 1999

Certified without comments