

Hospital Comments, 4Q2004

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General Comments on 4th Quarter 2004 Data

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

- . Data are administrative data, collected for billing purposes, not clinical data.
- . Data are submitted in a standard government format, either the UB-92 or the 837 format, used for submitting billing data to payers. State specifications require the submission of additional data elements. These data elements include race and ethnicity. Because these data elements are not sent to payers and may not be part of the hospital's standard data collection process, there may be an increase in the error rate for these elements. Data users should not conclude that billing data sent to payers is inaccurate.
- . Data for 2004 discharges were collected in either the UB-92 or the 837 format. The 837 format allows for the collection of additional diagnosis, procedure and external cause of injury codes. Hospital data collection systems made a transition from submitting data in the UB-92 format to the 837 format during the year. Because of the unevenness of the transition by hospitals, codes beyond those collected in the earlier UB-92 format are suppressed for 2004.
- . Hospitals are required to submit the patient's race and ethnicity following categories used by the U. S. Bureau of the Census. This information may be collected subjectively and may not be accurate.
- . Hospitals are required to submit data within 90 days after the close of a calendar quarter (hospital data submission vendor deadlines may be sooner). Depending on hospitals' collection and billing cycles, not all discharges may have been billed or reported. Therefore, data for each quarter may not be complete. This can also affect the accuracy of source of payment data, particularly self-pay and charity categories, where patients may later qualify for Medicaid or other payment sources.
- . The Source of Admission data element is suppressed if the Type of Admission field indicates the patient is newborn. The condition of the newborn can be determined from the diagnosis codes. Source of admission for newborns is suppressed indefinitely.
- . Conclusions drawn from the data are subject to errors caused by the inability of the hospital to communicate complete data due to reporting form constraints, subjectivity in the assignment of codes, system mapping, and normal clerical error. The data are submitted by hospitals as their best effort to meet statutory requirements.

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PROVIDER: Austin State Hospital
THCI ID: 000100
QUARTER: 4
YEAR: 2004

Certified with comments

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

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

Admission Source = Because of system constraints, all admissions sources on the

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encounter records, are reported as court/law enforcement. The data reported also includes voluntary admissions. The Local Mental Health Authority refers the majority of admissions.

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

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

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

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

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

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

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PROVIDER: Big Spring State Hospital
 THCIC ID: 000101
 QUARTER: 4
 YEAR: 2004

Certified with comments

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

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

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

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

Due to system entry there is a slight variance between actual demographic data and what is reported.

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

Standard Source of Payment	Total Percentage (%)
Self-Pay	2. %
Worker's Comp	n/a
Medicare	4. 91%
Other Federal Programs	n/a
Commercial	1. 49%
Blue Cross	n/a
Champus	1. 06%
Other	n/a
Missing/Invalid	n/a

Non Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0. 00%
Commercial HMO	n/a
Charity	81%
Missing/Invalid	n/a

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

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PROVIDER: Rio Grande State Center
 THCIC ID: 000104
 QUARTER: 4
 YEAR: 2004

Certified with comments

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

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

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

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

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

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Standard Source of Payment	Total Percentage (%)
Self-Pay	0.55%
Worker's Comp	n/a
Medicare	5.92%
Medicaid	7.32%
Other Federal Programs	n/a
Commercial	.87%
Blue Cross	n/a
Champus	0.32%
Other	n/a
Missing/Invalid	n/a

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

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

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THCIC ID: 000105
 QUARTER: 4
 YEAR: 2004

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 was also named the best cancer center in the United States by the U.S. News & World Report's "America's Best Hospitals" survey for four out of the past five years. 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 is 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.

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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 freestanding 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 has received some form of cancer treatment before coming to the institution for subsequent advice and treatment. This proportion is far higher than in general hospitals, making it difficult to compare M.D. Anderson to community facilities.

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

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PROVIDER: Kerrville State Hospital
THCIC ID: 000106
QUARTER: 4
YEAR: 2004

Certified with comments

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

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

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

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

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

Standard Source of Payment	Total Percentage (%)
Self-Pay	4.90%
Worker's Comp	n/a
Medicare	2.92%
Medicaid	12.21%
Other Federal Programs	n/a

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Commercial Blue Cross	2.95%
Champus	n/a
Other	0.00%
Missing/Invalid	n/a

Non Standard Source of Payment Total Percentage (%)

State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	0.00%
Medicaid Managed Care	n/a
Commercial HMO	n/a
Charity	77%
Missing/Invalid	n/a

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

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PROVIDER: Rusk State Hospital
 THCIC ID: 000107
 QUARTER: 4
 YEAR: 2004

Certified with comments

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

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

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

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

Standard Source of Payment Total Percentage (%)

Self-Pay	1.65%
Worker's Comp	n/a
Medicare	9.15%
Medicaid	5.18%
Other Federal Programs	n/a
Commercial	1.99%
Blue Cross	0.00%
Other	n/a
Missing/Invalid	n/a

Non Standard Source of Payment Total Percentage (%)

State/Local Government	n/a
Commercial	n/a

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Medicare Managed Care	n/a
Medicaid Managed Care	0.12%
Commercial HMO	n/a
Charity	82%
Missing/Invalid	n/a

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

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PROVIDER: San Antonio State Hospital
 THCIC ID: 000110
 QUARTER: 4
 YEAR: 2004

Certified with comments

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

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

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

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

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

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

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

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

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PROVIDER: Terrell State Hospital
 THCIC ID: 000111
 QUARTER: 4
 YEAR: 2004

Certified with comments

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

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

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

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

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

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

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

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

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PROVIDER: North Texas State Hospital
 THCIC ID: 000114
 QUARTER: 4
 YEAR: 2004

Certified with comments

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

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

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

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

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

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

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

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PROVIDER: Waco Center for Youth
 THCIC ID: 000117
 QUARTER: 4
 YEAR: 2004

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Certified with comments

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

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

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

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

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

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

Non Standard Source of Payment	Total Percentage (%)
State/Local Government	n/a
Commercial	n/a
Medicare Managed Care	n/a
Medicaid Managed Care	0.00%
Commercial HMO	n/a
Charity	95%
Misconduct/Invalid	n/a

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

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PROVIDER: El Paso Psychiatric Center
 THCIC ID: 000118
 QUARTER: 4
 YEAR: 2004

Certified with comments

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

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

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

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

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

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

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

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

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PROVIDER: St Joseph Regional Health Center
 THCIC ID: 002001
 QUARTER: 4
 YEAR: 2004

Certified with comments

St. Joseph Regional Health Center

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

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential

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payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for St. Joseph Regional Health Center charity care, based on established rates for 2004 was \$17,473,721.

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

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

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

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

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

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PROVIDER: Matagorda General Hospital
THCIC ID: 006000
QUARTER: 4
YEAR: 2004

Certified with comments

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

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PROVIDER: Matagorda General Hospital
THCIC ID: 006001
QUARTER: 4
YEAR: 2004

Hospital Comments, 4Q2004

Certified with comments

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

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PROVIDER: Mary Shiel's Hospital
THCIC ID: 008001
QUARTER: 4
YEAR: 2004

Certified with comments

Comments:

PatCtrl# 206407 Pat resides in a foreign county. System will not accept foreign country code in ZIP field.

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PROVIDER: CHRISTUS St Joseph Hospital
THCIC ID: 015001
QUARTER: 4
YEAR: 2004

Certified with comments

Christus St. Joseph Hospital certified the data but could not account for 25 patients due to processing the patients after the data was submitted.

During this time period Christus St. Joseph Hospital provided charity care for 253 patients with total charges (-\$2,685,491.68) dollars. The system didn't identify these patients.

Christus St. Joseph data didn't correspond to the newborn admission, according to our data there were 70 premature infants, 205 sick infants and 880 normal newborns.

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PROVIDER: Baylor Medical Center-Garland
THCIC ID: 027000
QUARTER: 4
YEAR: 2004

Certified with comments

Submission Timing

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

Physician Identification

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

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The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the attending physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THCIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient. Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Diagnosis and Procedures

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

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

Race/Ethnicity

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

Standard/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 9% of the primary payers originally categorized as "Blue Cross" were recategorized as "Commercial" and 4% categorized as "Medicaid" were recategorized as "Medicare." Also 6% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self Pay" and 6% categorized as "Blue Cross" were recategorized as "Self-Pay".

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

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Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

Cost/ Revenue Codes

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

Certification Process

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

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PROVIDER: Kindred Hospital -Dallas
THCIC ID: 028000
QUARTER: 4
YEAR: 2004

Certified with comments, corrections requested

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

=====

PROVIDER: Good Shepherd Medical Center
THCIC ID: 029000
QUARTER: 4
YEAR: 2004

Certified with comments

GSMC is certify 4 quarter 2004 data with 4518 claims for a total of \$102,878,409. The file submission was 4550 claims for a total of \$103,618,999.

=====

PROVIDER: Madison St Joseph Health Center
THCIC ID: 041000
QUARTER: 4
YEAR: 2004

Certified with comments

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

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential

Hospital Comments, 4Q2004

payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Madison St. Joseph Health Center charity care, based on established rates for 2004 was \$253,979.

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

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

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

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

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

Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.

=====
PROVIDER: Trinity Medical Center
THCIC ID: 042000
QUARTER: 4
YEAR: 2004

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

Hospital Comments, 4Q2004

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.

Hospital Comments, 4Q2004

Normal Newborns

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

Race/Ethnicity

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

Cost/Revenue

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

Certification Process

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

=====

PROVIDER: Huguley Memorial Medical Center
THCIC ID: 047000
QUARTER: 4
YEAR: 2004

Certified with comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of September 1, 2005.

Under the requirements we are unable to alter our comments after September 1, 2005. If any errors are discovered in our data after this point we will be unable to communicate these due to THCIC. This data is administrative data, which hospitals collect for billing purposes, and not clinical data, from which you can make judgments about patient care.

Submission Timing

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

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state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed, which can alter the true picture of a patient's hospitalization, sometimes significantly.

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

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

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 diagnosis 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.

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.

Data Integrity

In an effort to continuously improve patient safety, communications, and information - sharing Huguley implemented a computer conversion to an electronic medical record system in January 2004. This conversion impacts the financial billing system which is used to report THIC data. Various mapping issues have been corrected since the implementation.

One encounter with Diagnosis 261 Breast Nonmalignant + Local exc mis mapped to an incorrect physician. One encounter with Diagnosis 143 Chest Pain was mapped to an incorrect physician. One encounter with Diagnosis 316 Renal Failure was incorrectly mapped to the wrong physician. One encounter with Diagnosis 385 Neonates, Died or Transferred was mapped to an incorrect physician. One encounter with Diagnosis 239 Path Frac was mapped to an incorrect physician. Two Encounters with Diagnosis 391 Normal Newborn were mapped to an incorrect physician. One encounter with Diagnosis 143 Chest Pain was mapped to an incorrect physician. One encounter with Diagnosis 167 Append W/O Comp PR Diag W/O CC was mapped to an incorrect physician. One encounter with Diagnosis 139 Card Arr & Conduct Dis W/O CC was mapped to an incorrect physician.

=====
PROVIDER: Tomball Regional Hospital
THIC ID: 076000
QUARTER: 4
YEAR: 2004

Elect not to certify

The information reported in the report is misleading to the general public. The attending physician is charged with the procedures requested or performed

Hospital Comments, 4Q2004

by the consulting or specialist physicians due to the acuity and needs of the patient.

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

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

=====

PROVIDER: Paris Regional Medical Center South Campus
THCIC ID: 095002
QUARTER: 4
YEAR: 2004

Certified with comments

Two encounters were taken by THCIC's version of the grouper, and placed in MDC 14, and reported on the certification summary report as Newborn and OB. These encounters were not births, but were adult patients with obstetrically-related cases. We felt this comment was necessary, as this facility does not have an OB department on this campus.

This is the fourth full quarter of operations under the facilities' new name: Paris Regional Medical Center - South Campus. Ownership is with Essent Healthcare.

=====

PROVIDER: Paris Regional Medical Center North Campus
THCIC ID: 095003
QUARTER: 4
YEAR: 2004

Certified with comments

This quarter represents the end of the first full year of operations at Paris Regional Medical Center - North Campus.

=====

PROVIDER: Northeast Medical Center
THCIC ID: 106000
QUARTER: 4
YEAR: 2004

Certified with comments

Patient race encounters are as follow:

American Indian/Eskimo/Alut: 0
Asian or Pacific Islander: 0
Black: 17
White: 289
Other: 3
Missing/Invalid: 0

Patient ethnicity encounters are as follow:

Hispanic origin: 3
Not of Hispanic origin: 306
Missing/Invalid: 0

=====

PROVIDER: Covenant Medical Center-Lakeside
THCIC ID: 109000
QUARTER: 4
YEAR: 2004

Certified with comments

January 2001 was the last month we had a birthing center at Covenant

Medical Center Lakeside.

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

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

4% of total discharges were charity for 4th Quarter 2004.

=====
PROVIDER: St Lukes Episcopal Hospital
THCIC ID: 118000
QUARTER: 4
YEAR: 2004

Certified with comments

The data reports for Quarter 4, 2004 do not accurately reflect patient volume or severity.

Patient Volume

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

Severity

· Descriptors for newborn admissions are based on national billing data elements (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, such as the heart's ejection fraction, can be captured and reflected in the various billing data elements including the ICD-9-CM diagnosis coding system.

As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

Claim Filing Indicator

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

=====
PROVIDER: The Methodist Hospital
THCIC ID: 124000
QUARTER: 4
YEAR: 2004

Certified with comments

The Methodist Hospital data for Q4 2004 has been certified. 122 accounts are missing due to late billing, accounts billed prior to data submission, missing charges, invalid physicians and combined accounts. Physician data is correct in this data set.

=====
PROVIDER: Navarro Regional Hospital
THCIC ID: 141000
QUARTER: 4
YEAR: 2004

Certified with comments

Navarro Regional Hospital is an acute general medical-surgical hospital with the additional services of a Skilled Nursing Facility and an Acute Rehabilitation Unit. The data in the public release file may or may not adequately allow separation of patients in the acute hospital from those in the other two units. Admixture of all three units can lead to increases for acute hospitals alone. It is notable that for the 4th quarter, 2004, in at least 11 of the 28 deaths, the patients or family members had requested that full efforts to maintain life not be pursued (Advanced Directive, Living Will or Do Not resuscitate orders).

PROVIDER: Methodist Charlton Medical Center
THCIC ID: 142000
QUARTER: 4
YEAR: 2004

Certified with comments

DATA CONTENT

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

PHYSICIAN REVIEW OF THE DATA

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

SUBMISSION TIMING

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

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

OMISSION OF OBSERVATION PATIENTS

Hospital Comments, 4Q2004

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

DIAGNOSIS AND PROCEDURES

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

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

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

NORMAL NEWBORNS

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

RACE AND ETHNICITY CODES

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

STANDARD/NON-STANDARD SOURCE OF PAYMENT

The standard and non-standard source of payment codes are an example of data required by the State that is not contained within the standard UB92 billing record. In order to meet this requirement each payer's identification must be categorized into the appropriate standard and non-standard source of payment value. It is important to note that sometimes, many months after billing and THIC 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 Group could render percentage calculations statistically non-significant if the number of cases is too small.

SEVERITY ADJUSTMENT SCORES

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

PHYSICIAN UPIN NUMBER ERRORS

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

=====

PROVIDER: University Medical Center
THIC ID: 145000
QUARTER: 4
YEAR: 2004

Certified with comments

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

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PROVIDER: Covenant Hospital -Plainview
THCIC ID: 146000
QUARTER: 4
YEAR: 2004

Certified with comments

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

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

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

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

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PROVIDER: The Institute for Rehab & Research
THCIC ID: 164000
QUARTER: 4
YEAR: 2004

Certified with comments

TIRR (The Institute for Rehabilitation and Research) was founded in 1959 in Houston's Texas Medical Center by William A. Spencer, M.D. 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 rehabilitation. 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's inpatient programs are outcome-oriented with standardized functional scales by which to measure a patient's progress. Some of these programs include:

Spinal Cord Injury. TIRR is one of only 16 hospitals in the country that has Model System designation by NIDRR for its Spinal Cord Injury Program. The hospital is recognized nationally for exemplary patient care, education and research, and especially for management of wounds and ventilator-dependent patients.

Hospital Comments, 4Q2004

Brain Injury and Stroke. The Brain Injury and Stroke Program provides a continuum of interdisciplinary management of the physical, communicative, cognitive, and behavioral problems faced by people with brain injuries.

Such injuries may be the result of trauma, stroke, anoxia, tumor, infection, or metabolic disorders.

Specialty Rehabilitation. This program serves patients with neurological and neuromuscular disorders and multiple trauma, including multiple sclerosis, Parkinson's disease, post-polio, etc.

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.

Pediatric and Adolescent Rehabilitation. TIRR treats children and adolescents with brain or spinal cord injuries, as well other types of disabling disorders and injuries.

PROVIDER: Harris Methodist HEB
THCIC ID: 182000
QUARTER: 4
YEAR: 2004

Certified with comments

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is 'over and above' the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures

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

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

The codes also do not distinguish between conditions present at the time

Hospital Comments, 4Q2004

of the patient's admission to the hospital and those occurring during hospitalization. For example, if a code indicating an infection is made, it is not always possible to determine if the patient had an infection prior to admission, or developed an infection during their hospitalization.

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does not meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Hospital Comments, 4Q2004

of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (Seimens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Texoma Medical Center
THCIC ID: 191000
QUARTER: 4
YEAR: 2004

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 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 2 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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

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

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

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

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

Hospital Comments, 4Q2004

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

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

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PROVIDER: Reba McEntire Center for Rehab
THCIC ID: 191001
QUARTER: 4
YEAR: 2004

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 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 2 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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PROVIDER: Texoma Medical Center Behavioral Health Center
THCIC ID: 191002
QUARTER: 4
YEAR: 2004

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 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 2 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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PROVIDER: Texoma Restorative Care SNU
THCIC ID: 191004
QUARTER: 4
YEAR: 2004

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 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 2 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

=====

PROVIDER: The Medical Center of Mesquite
THCIC ID: 198000

QUARTER: 4
YEAR: 2004

Elect not to certify

=====
PROVIDER: Laredo Medical Center
THCIC ID: 207001
QUARTER: 4
YEAR: 2004

Certified with comments

ETHNIC GROUP SUMMARY

Due to new application setup, 100% of patients are inaccurately classified as Non-Hispanic. This issue has been corrected. New data submissions, starting Q1 2005, will reflect accurate patient ethnic classification.

PATIENT LOCATON SUMMARY

Due to new application setup, some Out-of-Country patients were inaccurately classified as Out-of-State. The issue has been resolved. New data submissions, starting Q2 2005, will reflect accurate patient location classification.

NEWBORN ADMISSIONS SUMMARY

Most premature and sick-baby newborns were inaccurately classified as Normal Deliveries. The issue has been resolved. New data submissions, starting Q2 2005, will reflect accurate Newborn Admissions classification.

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PROVIDER: Medical Center-Plano
THCIC ID: 214000
QUARTER: 4
YEAR: 2004

Certified with comments

THCIC DATA RELEASE COMMENTS FOR 2004

Since 1975 Medical Center of Plano has maintained a reputation for superior health care as the largest and most sophisticated medical facility in Collin County. The Medical Center is a 423 bed, JCAHO Accredited Hospital which offers a broad base of quality patient services.

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

General Comments:

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

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

"The public data file does not contain all the diagnosis and procedure codes. It contains only 9 diagnosis codes and 6 procedure codes. This may affect the volume of procedures, the severity adjustment and the mortality rate.

Data Comments:

"Inpatient discharge data has been collected from information that is used for billing purposes and, is not clinical data. Due to the differences

Hospital Comments, 4Q2004

in health care organizations and data collecting practices throughout Texas, there can be limitations with comparing outcomes.

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

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

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

=====
PROVIDER: Polly Ryon Hospital Authority
THCIC ID: 230000
QUARTER: 4
YEAR: 2004

Certified with comments

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

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

Also not reflected accurately is the number of patients cared for by consulting physicians. Many consultants seldom admit patients to the inpatient setting, but consult on hundreds. This causes inaccurate mortality rates.

Since this data is taken from administrative data, it cannot accurately represent the patient's clinical picture. OakBend Medical Center urges caution in using this information to evaluate quality of care. We encourage patients to talk with the primary care physician or the hospital about this data. Our commitment to quality is strong and continuous.

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PROVIDER: Harris Methodist-Fort Worth
THCIC ID: 235000
QUARTER: 4
YEAR: 2004

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 has limited value in the evaluation of 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.

Hospital Comments, 4Q2004

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

Since there is this limited number of diagnosis and procedure codes used, there are obvious inherent problems with this data. Using this type of data to evaluate quality and outcomes cannot portray an accurate picture of quality measurements or outcomes.

Additionally, there is no standardization on how hospitals are assigning these codes. Therefore, risk adjustment based on these codes is inherently flawed.

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

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

ADMIT TYPE AND SOURCE:

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

PAYOR CODE/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 the categorization of payors.

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. The actual amount of charity care provided by the hospital will not be reflected in the data.

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

SPECIALTY SERVICE:

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

attempt to distinguish specialty services.

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

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 data is collected and the timing of the billing cycle all hospital discharges may not be captured.

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

PHYSICIAN DATA:

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

CERTIFICATION PROCESS:

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

=====
PROVIDER: Methodist Medical Center
THCIC ID: 255000
QUARTER: 4
YEAR: 2004

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

Hospital Comments, 4Q2004

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.

Hospital Comments, 4Q2004

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

NORMAL NEWBORNS

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

RACE AND ETHNICITY CODES

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

STANDARD/NON-STANDARD SOURCE OF PAYMENT

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

REVENUE CODE AND CHARGE DATA

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

Hospital Comments, 4Q2004

CAUTION ON THE USE OF DATA WITH SMALL NUMBERS OF CASES IN PERCENTAGE COMPARISONS
Besides the data limitations mentioned above, the number of cases that aggregate into a particular diagnosis, procedure or Diagnosis Related Grouping could render percentage calculations statistically non-significant if the number of cases is too small.

SEVERITY ADJUSTMENT SCORES

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

PHYSICIAN UPIN NUMBER ERRORS

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

=====

PROVIDER: Harris Methodist-Erath County
THCIC ID: 256000
QUARTER: 4
YEAR: 2004

Certified with comments

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is 'over and above' the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures

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

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

Hospital Comments, 4Q2004

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

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

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do

Hospital Comments, 4Q2004

not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (Seimens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

=====
PROVIDER: R E Thomason General Hospital
THCIC ID: 263000
QUARTER: 4
YEAR: 2004

Certified with comments

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

Mapping differences were identified in normal newborn area. This mapping difference has decreased. DRG 390 is appearing under normal newborn in THCIC mapping rather than under sick baby.

Mapping for the payor source also indicates differences. In the THCIC information, Charity and self pay appear to be included in the commercial line and the commercial insurances are itemized separately. On the THCIC report the payor source fields have increased to include CHIP, other not federal programs and HMOs.

Thru our Performance Improvement process, we review the data and strive to make changes to result in improvement. Overall, the data mapping and comparison of like data has shown steady improvement from previous quarters.

Hospital Comments, 4Q2004

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PROVIDER: Sierra Medical Center
THCIC ID: 266000
QUARTER: 4
YEAR: 2004

Certified with comments

Admission Type: Unknown
PBAR facilities capture data for admission type Other/OB, which does not map to admission types available through THCIC reporting. Admission type Unknown reflects admissions 586 under category of Other/OB and then the one encounter under missing/invalid should be reflected under elective, total (427).

Newborn Admissions: Information Not Available:
Reflects 4 encounters, which should be reflected under "Normal Delivery", total should reflect (547).

Patient Location: Missing/Invalid:
Reflects 12 encounters, which should be reflected under "Out of Country", total should reflect (49).

Patient Race: Missing/Invalid:
Reflects one encounter, which should be reflected under "White", total should reflect (3232).

Claim Filing Indicator Codes: Missing/Invalid:
Reflects 1 encounter which should be reflected under Medicare Part A - MA, total should reflect (1678).

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PROVIDER: Baylor Medical Center-Waxahachie
THCIC ID: 285000
QUARTER: 4
YEAR: 2004

Certified with comments

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

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

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the attending

Hospital Comments, 4Q2004

physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THCIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient. Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Diagnosis and Procedures

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 5% of the primary payers originally categorized as "Medicaid" and 12% categorized as "Blue Cross" were recategorized as "Commercial", while 4% categorized as "Medicaid" were recategorized as "Medicare." Also, 4% of the secondary payers originally as "Missing/Invalid" were recategorized as "Self-Pay."

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

Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

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

Hospital Comments, 4Q2004

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

Certification Process

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

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PROVIDER: Baylor Medical Center-Irving
THCIC ID: 300000
QUARTER: 4
YEAR: 2004

Certified with comments

Submission Timing

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

Physician Identification

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

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the attending physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THCIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient. Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Diagnosis and Procedures

Hospital Comments, 4Q2004

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

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

Race/Ethnicity

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

Standard/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 6% of the primary payers originally categorized as "Blue Cross" were recategorized as "Commercial". Also, approximately 8% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self Pay".

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

Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

Condition Codes

It should be noted that Condition Code 99 is being used when a patient is discharged to Home Health and neither Discharge Disposition 42 (not related to condition for which the patient was hospitalized) nor 43 (related to condition for which the patient was hospitalized) are fully appropriate.

Cost/ Revenue Codes

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

Certification Process

Due to the infancy of the state reporting process and the state's computer system development, the certification process is not as complete and thorough at this time, as all parties would like to see in the future. Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is

Hospital Comments, 4Q2004

not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Presbyterian Hospital -Kaufman
THCIC ID: 303000
QUARTER: 4
YEAR: 2004

Certified with comments

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is 'over and above' the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures

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

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

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

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

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

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

Hospital Comments, 4Q2004

to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

Hospital Comments, 4Q2004

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

Discharge Disposition

THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Mesquite Community Hospital
THCIC ID: 315002
QUARTER: 4
YEAR: 2004

Elect not to certify

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PROVIDER: Walls Regional Hospital
THCIC ID: 323000
QUARTER: 4
YEAR: 2004

Certified with comments

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is 'over and above' the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures

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

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

Hospital Comments, 4Q2004

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide better clarity for the accurate collection of this data. Hospitals do not routinely collect race and ethnicity as part of the admission process, that this has been added to meet the THCIC requirement. Our admissions staff indicates that many patients are very sensitive about providing

Hospital Comments, 4Q2004

race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population for a facility.

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (Seimens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Baylor University Medical Center
THCIC ID: 331000
QUARTER: 4
YEAR: 2004

Certified with comments

Submission Timing

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

Physician Identification

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

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the attending

Hospital Comments, 4Q2004

physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THCIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient. Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Diagnosis and Procedures

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

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

Normal Newborns

The best way to focus on severity of illness regarding an infant would be to check the infant's diagnosis at discharge, not the admitting source code. The actual experience of a newborn is captured elsewhere in the file, namely, in the ICD-9-CM diagnosis. Admission source does not give an accurate picture.

Mortalities

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

Race/Ethnicity

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

"Asian or Pacific Islander" encounters are not broken out separately but are included in the "Other" race category.

Standard/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 9% of the primary payers originally categorized as "Blue Cross" were recategorized as "Medicare" and 28% "Self Pay" were recategorized

Hospital Comments, 4Q2004

as "Commercial". Also, 6% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Commercial" and 2% categorized as "Blue Cross" were recategorized as "Medicare".

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

Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

Cost/ Revenue Codes

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

Certification Process

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

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PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
QUARTER: 4
YEAR: 2004

Certified with comments

Cook Children's Medical Center has submitted and certified fourth quarter 2004 discharge encounters to the Texas Health Care Information Council with the following possible data concerns based on the required submission method.

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

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

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

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PROVIDER: Brackenridge Hospital
THCIC ID: 335000
QUARTER: 4
YEAR: 2004

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 appropriate compared to other trauma centers.

The required transition to the 837 reporting format has resulted in a redistribution of our patient payor mix, although we continue to serve the same patient population. For this reason, charity patients do not appear in the claims files and other payor categories appear higher or lower than our history reports.

All physician license numbers and names have been validated with the physician and the Texas State Board of Medical Examiner web-site as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements.

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PROVIDER: Childrens Hospital of Austin
THCIC ID: 335001
QUARTER: 4
YEAR: 2004

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.

The required transition to the 837 reporting format has resulted in a redistribution of our patient payor mix, although we continue to serve the same patient population. For this reason, charity patients do not appear in the claims files and other payor categories appear higher or lower than our history reports.

All physician license numbers and names have been validated with the physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements.

Hospital Comments, 4Q2004

PROVIDER: West Houston Medical Center
THCIC ID: 337001
QUARTER: 4
YEAR: 2004

Certified with comments

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

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PROVIDER: Christus Santa Rosa Hospital
THCIC ID: 339000
QUARTER: 4
YEAR: 2004

Certified with comments

*Comments not received by THCIC

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PROVIDER: Christus Santa Rosa Medical Center
THCIC ID: 339001
QUARTER: 4
YEAR: 2004

Certified with comments

*Comments not received by THCIC

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PROVIDER: Vista Hospital -Dallas
THCIC ID: 359002
QUARTER: 4
YEAR: 2004

Certified with comments

There were 62 encounters in this certification file that do not have the principle procedure codes attached. Surgical procedures were performed, but these codes were inadvertently miskeyed during the keyclaim process. al p/pr

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PROVIDER: Baylor All Saints Medical Center-Fort Worth
THCIC ID: 363000
QUARTER: 4
YEAR: 2004

Certified with comments

Submission Timing

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

Physician Identification

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

by the Texas Board of Medical Examiners. Those physicians not yet assigned a state license number at the time of data submission are given temporary numbers by the hospital for state reporting purposes. Due to the "lag"

Hospital Comments, 4Q2004

time between when the physician is licensed and when THCIC receives the information, some physicians may remain unidentified in the THCIC Practitioner Reference Files.

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the attending physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THCIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient. Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Diagnosis and Procedures

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

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

Medical Record Number

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

Race/Ethnicity

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

Standard/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,

Hospital Comments, 4Q2004

approximately 8% of the primary payers originally categorized as "Blue Cross" were recategorized as "Medicare". Also, approximately 3% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self Pay" and 3% 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.

Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

Cost/ Revenue Codes

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

Certification Process

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

PROVIDER: Baylor All Saints Medical Center-Cityview
THCIC ID: 363001
QUARTER: 4
YEAR: 2004

Certified with comments

Submission Timing

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

Physician Identification

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

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe

Hospital Comments, 4Q2004

and treat patients on behalf of the physician listed as the attending physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient. Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Diagnosis and Procedures

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

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

Medical Record Number

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. Upon review approximately 8% of the primary payers originally categorized as "Blue Cross" were recategorized as "Commercial", and 4% categorized as "Blue Cross" were recategorized as "Medicare.". Also, approximately 3% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self Pay" and 2% 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.

Hospital Comments, 4Q2004

Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

Cost/ Revenue Codes

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

Certification Process

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

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PROVIDER: Medical Center-Lewisville
THIC ID: 394000
QUARTER: 4
YEAR: 2004

Certified with comments

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

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

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

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

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

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

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PROVIDER: John Peter Smith Hospital
THIC ID: 409000
QUARTER: 4
YEAR: 2004

Certified with comments

*Comment not received by THIC

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PROVIDER: Arlington Memorial Hospital
THIC ID: 422000

QUARTER: 4
YEAR: 2004

Certified with comments

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

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

Diagnosis and Procedures

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

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

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

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

Race/Ethnicity

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

Any assumptions based on race or ethnicity will be inaccurate.

Standard/Non-Standard Source of Payment

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

Hospital Comments, 4Q2004

Revenue

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

Charity Care

THCIC assumes charity patients are identified in advance and reports charges in a charity financial class as the amount of charity care provided in a given period. In actuality, charity patients are usually not identified until after care has been provided and in the hospital's computer system charity care is recorded as an adjustment to the patient account, not in a separate financial class. Therefore, the THCIC database shows no charity care provided by the hospital for the quarter when in fact the hospital provided \$4,878,706 in charity care during this time period.

Certification Process

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

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PROVIDER: El Campo Memorial Hospital
THCIC ID: 426000
QUARTER: 4
YEAR: 2004

Certified with comments

For the fourth quarter of 2004 El Campo Memorial Hospital submitted 245 claims. Error rate on these claims were less than 1% therefore we are certifying our fourth quarter 2004 with these comments.

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PROVIDER: Christus Spohn Hospital -Beville
THCIC ID: 429001
QUARTER: 4
YEAR: 2004

Certified with comments

*Comments not received by THCIC

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PROVIDER: Presbyterian Hospital -Dallas
THCIC ID: 431000
QUARTER: 4
YEAR: 2004

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

Hospital Comments, 4Q2004

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

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

Diagnosis and Procedures

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

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

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

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnosis codes and the first 25 procedure codes. As a result, the data sent by us does not meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Hospital Comments, 4Q2004

the certification database. It is rare that patients stay longer than 999 days, therefore, it is not anticipated that this limitation will affect this data.

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (Seimens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Brazosport Memorial Hospital
THCIC ID: 436000
QUARTER: 4
YEAR: 2004

Hospital Comments, 4Q2004

Certified with comments

Notes/Comments

1. Brazosport Memorial Hospital's length of stay statistics include its physical rehabilitation and skilled nursing units, which appropriately have longer lengths of stay.
2. Some average charges maybe skewed by one or two very high charge patients and the inclusion of physical rehabilitation and skilled nursing patients.
3. Number of expired patients may be somewhat increased over expected due to inclusion of skilled nursing unit statistics.

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PROVIDER: Presbyterian Hospital -Winnboro
THCIC ID: 446000
QUARTER: 4
YEAR: 2004

Certified with comments

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is 'over and above' the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures

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

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

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

Hospital Comments, 4Q2004

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Hospital Comments, 4Q2004

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (Seimens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

PROVIDER: St Paul University Hospital
THCIC ID: 448000
QUARTER: 4
YEAR: 2004

Certified with comments

Physician Identification

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions, many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the Attending Physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The payer codes utilized in the THCIC database were defined by the state and are not using standard payer information from the claim. The mapping process of specific payers to the THCIC payer codes was not standardized by THCIC; therefore, each hospital may map differently which can create variances in coding. These values might not accurately reflect the hospital payer information because those payers identified contractually as both

Hospital Comments, 4Q2004

"HMO and "PPO" are categorized as "Commercial HMO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis. The majority of charity care cases are not identified until after discharge when other potential payment sources have been processed.

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

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

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PROVIDER: DeTar Hospital -Navarro
THCIC ID: 453000
QUARTER: 4
YEAR: 2004

Certified with comments

The DeTar Healthcare System includes two hospital campuses: the newly renovated DeTar Hospital Navarro at Navarro and Rio Grande and DeTar Hospital North also named Women and Children's Center which opened 12/17/03 located at 101 Medical Drive, both in Victoria, Texas. In addition to services provided by full service acute care hospitals, the system also includes: a Skilled Nursing Unit, Level 3 Trauma Designation Emergency Room at DeTar Hospital Navarro and Emergency Department at DeTar Hospital North, fast track clinic at DeTar Hospital Navarro, Rural Health Clinic in a surrounding community, DeTar Health & Wellness Center, DeTar Medworks Occupational Medicine Center, DeTar Outpatient Rehabilitation Center, DeTar Inpatient Rehabilitation Center, DeTar SeniorCare Center, Active Advantage, DeTar's Sleep Disorders Center, Community Mother & Child Health Clinic, Day Surgery Centers at both DeTar Hospital Navarro and DeTar Hospital North, and a free Physician Referral Service by dialing (361) 788-6113. To find out more, check out DeTar's website at www.detar.com

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PROVIDER: Covenant Medical Center
THCIC ID: 465000
QUARTER: 4
YEAR: 2004

Certified with comments

Data does not accurately reflect the hospital's newborn population.
Total Births = 706
Live = 578
Premature = 128

Data does not accurately reflect the number of charity cases for the time period. This is due to internal processing for determination of the source of payment. 4% of total discharges were charity for 4th Quarter 2004.

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PROVIDER: Harris Methodist-Northwest

THCIC ID: 469000
QUARTER: 4
YEAR: 2004

Certified with comments

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is 'over and above' the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures

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

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

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual

Hospital Comments, 4Q2004

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Hospital Comments, 4Q2004

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

Discharge Disposition

THR has identified a problem with a vendor (Seimens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Parkland Memorial Hospital
THCIC ID: 474000
QUARTER: 4
YEAR: 2004

Certified with comments

Parkland Health & Hospital System comprises a network of neighborhood-based health centers and Parkland Memorial Hospital, which was established in 1894 to care for the city's poor. Today, the hospital is often ranked among the 25 best hospitals in the United States - public or private. Due to Parkland's affiliation with the University of Texas Southwestern Medical Center, the finest in medical care is now available to all Dallas County residents.

The Parkland System is a \$820 million enterprise that is licensed for 990 beds and employs approximately 7,752 staff. Its 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 US - 15,990 babies during the 12 month period ending December 2003. 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, its transplant success among African-Americans is the nation's best.

Parkland's network of neighborhood-based health centers is 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; there are now 9 neighborhood health 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.

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.

Specific Concerns

There is a concern at Parkland, as with other reporting hospitals, that no ethnicity category for Hispanics exists. 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 reporting data set needs to provide a category for this ethnicity to accurately reflect the hospital's demographics.

Another concern is the convention by which patients are assigned to primary physicians. In this database only one primary physician is allowed and

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in our institution this represents the physician at the time of discharge. In the reality of an academic medical center such as Parkland, teams of physicians rotating at varying intervals care for patients. Therefore, many patients, particularly long-term patients such as those in the neonatal nursery, are actually managed by as many as three to four different teams. Thus, the practice of attributing patient outcomes to the report card of a single physician results in misleading information.

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PROVIDER: Nacogdoches Memorial Hospital
THCIC ID: 478000
QUARTER: 4
YEAR: 2004

Certified with comments

*Comments not received by THCIC

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PROVIDER: Knapp Medical Center
THCIC ID: 480000
QUARTER: 4
YEAR: 2004

Certified with comments

KNAPP MEDICAL CENTER THCIC DISCLAIMER STATEMENT AND COMMENTS FOR FOURTH QUARTER 2004

DISCLAIMER STATEMENT

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

CHARITY COMMENT

Knapp Medical Center has a long tradition of providing charity care for the population it serves. Prior to designation as charity, program qualification attempts are exhausted. This results in designation of charity being made after the patient is discharged, sometimes many months. Patient specific charity amounts are not available, therefore, at the time of submission of data to THCIC. Due to the impracticality at this time of identifying specific patients designated as charity and submitting corrections, the aggregate amount of charity provided during the FOURTH Quarter 2004 was \$2,703,797.64 for 104 patients.

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PROVIDER: Seton Medical Center
THCIC ID: 497000
QUARTER: 4
YEAR: 2004

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

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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.

The required transition to the 837 reporting format has resulted in a redistribution of our patient payor mix, although we continue to serve the same patient population. For this reason, charity patients do not appear in the claims files and other payor categories appear higher or lower than our history reports.

All physician license numbers and names have been validated with the Physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements.

PROVIDER: Baylor Medical Center-Grapevine
THCIC ID: 513000
QUARTER: 4
YEAR: 2004

Certified with comments

Submission Timing

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

Physician Identification

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

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the attending physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THCIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient. Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded

from the patient cases.

Diagnosis and Procedures

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

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

Race/Ethnicity

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

Standard/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 13% of the primary payors originally categorized as "Blue Cross" were recategorized as "Commercial" and 2% categorized as "Blue Cross" were recategorized as "Medicare." Also approximately 2% of the secondary payors originally categorized as "Missing/Invalid" and 3% "Blue Cross" were recategorized as "Self-Pay", and 4% categorized as "Missing/Invalid" were recategorized as "Commercial".

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

Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

Cost/Revenue Codes

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

Certification Process

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

Hospital Comments, 4Q2004

best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Richardson Regional Medical Center
THCIC ID: 549000
QUARTER: 4
YEAR: 2004

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, the data from the UB92 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, or all procedures performed, by the hospital. Therefore total volumes and severity of illness indicators represented by the state required UB92 data file, may not be accurate, making percentage calculations inaccurate.

Race/Ethnicity

Although race/ethnicity is an admission field, the hospital does sometimes encounter difficulties in obtaining race/ethnicity information. These difficulties are due to a variety of reasons, including information not supplied by the patient. Thus analysis of these two data fields may not accurately describe the true population served by the hospital. The hospital does not discriminate based on race, color, ethnicity, gender or national origin.

Cost/ Revenue Codes

The state data files will include charge information. It is important to understand that charges do not equal payments received by the hospital. Payments due to managed care-negotiated discounts and denial of payment by insurance companies, will always be much less than charges. Also, charges 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. For this reason, steps are taken to ensure that the information sent to the state mirrors what is contained within the hospital's source system. On rare occasions, 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.

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PROVIDER: Baylor Specialty Hospital
THCIC ID: 586000
QUARTER: 4
YEAR: 2004

Certified with comments

Submission Timing

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

Physician Identification

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

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the attending physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THCIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient. Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Diagnosis and Procedures

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

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

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

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

Length of Stay

Medical recovery at BSH can be a long, arduous process depending on the

Hospital Comments, 4Q2004

severity of illness or injury. Due to the unique nature of medically complex patients, length of stay data cannot accurately be compared with data from hospitals that primarily treat an acute or emergent episode of illness or injury.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

The standard and non-standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. Upon review approximately 8% of the primary payers originally categorized as "Blue Cross" were recategorized as "Commercial". Also, 3% of the secondary payers originally categorized as "Blue Cross" were recategorized as "Commercial", and 3% originally categorized as "Blue Cross" were recategorized as "Medicare".

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

Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

Cost/ Revenue Codes

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

Certification Process

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

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PROVIDER: Baylor Specialty Hospital
THCIC ID: 586001
QUARTER: 4
YEAR: 2004

Certified with comments

Submission Timing

Baylor Specialty Hospital -Garland (BSH) estimates that our data volumes

Hospital Comments, 4Q2004

for the calendar year time period submitted may include 93% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in.

Physician Identification

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

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the attending physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THCIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient. Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Diagnosis and Procedures

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

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

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

Patient diagnoses and procedures for a particular hospital stay at BSH are assigned ICD-9-CM codes according to standard coding practices. Because

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of our unique patient population, however, comparisons against all other hospitals in the database would not be accurate. It is unclear whether coding practice across all long term acute care hospitals is consistent, so caution should be used when making comparisons and/or drawing conclusions from the data.

Length of Stay

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

Race/Ethnicity

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

"Asian or Pacific Islander" encounters are not broken out separately but are included in the "Other" race category.

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 3% of the primary payers originally categorized as "Blue Cross" were recategorized as "Medicare", and 2% originally categorized as "Blue Cross" recategorized as "Worker's Comp.". Also, 15% of the secondary payers originally categorized as "Blue Cross" were recategorized as "Commercial", and 2% originally categorized as "Missing/Invalid" recategorized as "Self Pay."

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

Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

Cost/Revenue Codes

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

Certification Process

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

Hospital Comments, 4Q2004

best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Baylor Specialty Hospital -Irving
THCIC ID: 586002
QUARTER: 4
YEAR: 2004

Certified with comments

Submission Timing

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

Physician Identification

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

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the attending physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THCIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient. Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Diagnosis and Procedures

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

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

all hospitals must comply.

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

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

Length of Stay

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

Race/Ethnicity

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

Standard/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 4.5% of the primary payers originally categorized as "Blue Cross" were recategorized as "Medicaid" and 9.5% categorized as "Commercial" were recategorized as "Medicare". Also, approximately 6% of the secondary payers originally categorized as "Blue Cross" were recategorized as "Commercial", and 3.5% originally categorized as "Blue Cross" were recategorized as "Medicare."

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

Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

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

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

Certification Process

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

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PROVIDER: CHRISTUS St John Hospital
THCIC ID: 600001
QUARTER: 4
YEAR: 2004

Certified with comments

Christus St. John Hospital certified the data but could not account for 1 patient due to processing the patients after the data was submitted.

During this time period Christus St. John Hospital provided charity care for 114 patients with total charges (-\$910,457.07) dollars. The system did't identify these patients.

Christus St. John data didn't correspond to the newborn admission, according to our data there were 6 premature infants, 19 sick infants and 109 normal newborns.

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PROVIDER: South Austin Hospital
THCIC ID: 602000
QUARTER: 4
YEAR: 2004

Certified with comments

*Comments not received by THCIC

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PROVIDER: Round Rock Medical Center
THCIC ID: 608000
QUARTER: 4
YEAR: 2004

Certified with comments

*Comments not received by THCIC

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PROVIDER: Harris Methodist-Southwest
THCIC ID: 627000
QUARTER: 4
YEAR: 2004

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 judgments about patient care.

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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 837 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:

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.

Diagnosis and Procedures

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

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

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

The State is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses and the first 25 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 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

Hospital Comments, 4Q2004

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

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. Harris Methodist Southwest'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.

Race/Ethnicity

Our Admissions staff indicates that many patients are very sensitive about providing race and ethnicity information. Therefore, depending on the circumstances of the patient's admission, race and ethnicity data may be subjectively collected. Therefore, the race and ethnicity data may not provide an accurate representation of the patient population at HMSW. This issue has both federal and state law implications, as well as ethical and clinical ramifications. Additionally, the THCIC in a Board meeting on December 7, 2001 indicated that the THCIC would be creating guidelines for use by hospitals to assist with more accurate collection of this information. However, these guidelines have not been forthcoming.

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 comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis. Once again, due to continued "mapping" problems, HMSW appears to have no Charity patients which is incorrect.

Cost/ Revenue Codes

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

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PROVIDER: Living Hope New Boston Medical Center
THCIC ID: 632001
QUARTER: 4
YEAR: 2004

Elect not to certify

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PROVIDER: Christus Santa Rosa Childrens Hospital

THCIC ID: 634000
QUARTER: 4
YEAR: 2004

Certified with comments

*Comments not received by THCIC

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PROVIDER: North Dallas Rehab Hospital
THCIC ID: 635000
QUARTER: 4
YEAR: 2004

Certified with comments

*Comments not received by THCIC

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PROVIDER: Baylor Institute for Rehab@Gaston Episcopal Hosp
THCIC ID: 642000
QUARTER: 4
YEAR: 2004

Certified with comments

Submission Timing

Baylor Institute for Rehabilitation (BIR) estimates that our data volumes for the calendar year time period submitted may include 96% to 100% of all cases for that time period. The state requires us to submit a snapshot of billed claims, extracted from our database approximately 20 days following the close of the calendar year quarter. Any discharged patient encounters not billed by this cut-off date will not be included in the quarterly submission file sent in. BIR has a 10-day billing cycle; therefore we will have a higher percentage of incomplete encounters than hospitals with a 30-day billing cycle.

Physician Identification

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

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the attending physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THCIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient.

Hospital Comments, 4Q2004

Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Race/Ethnicity

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

Standard/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 14% of the primary payers originally categorized as "Blue Cross" were recategorized as "Commercial." Also, approximately 6% of the secondary payers originally categorized as "Blue Cross" were recategorized as "Commercial" and 3% that were categorized as "Blue Cross" were recategorized as "Medicare".

Additionally, those payers identified contractually as both "HMO and PPO" are categorized as "Commercial PPO". Thus any true managed care

comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

Cost/Revenue Codes

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

Certification Process

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

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PROVIDER: Harris Continued Care Hospital
THCIC ID: 652000
QUARTER: 4
YEAR: 2004

Certified with comments

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is 'over and above' the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures

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

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

Hospital Comments, 4Q2004

apples' comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would be creating guidelines for use by hospitals. These guidelines will provide

Hospital Comments, 4Q2004

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Zale Lipshy University Hospital
THCIC ID: 653000
QUARTER: 4
YEAR: 2004

Certified with comments

Physician Identification

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions, many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the Attending Physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

Race/Ethnicity

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

Hospital Comments, 4Q2004

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

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

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

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PROVIDER: Presbyterian Hospital - Plano
THCIC ID: 664000
QUARTER: 4
YEAR: 2004

Certified with comments

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is 'over and above' the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures

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

Hospital Comments, 4Q2004

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

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Hospital Comments, 4Q2004

to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Kingwood Medical Center
THCIC ID: 675000
QUARTER: 4
YEAR: 2004

Certified with comments

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

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PROVIDER: Burlison St Joseph Health Center-Caldwell
THCIC ID: 679000
QUARTER: 4
YEAR: 2004

Certified with comments

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

Hospital Comments, 4Q2004

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Burleson St. Joseph Health Center charity care, based on established rates for 2004 was \$279,443.

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

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

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

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

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

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PROVIDER: HEALTHSOUTH Rehab Hospital -Texarkana
THCIC ID: 684000
QUARTER: 4
YEAR: 2004

Certified with comments

*Comments not received by THCIC

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PROVIDER: Covenant Childrens Hospital
THCIC ID: 686000
QUARTER: 4
YEAR: 2004

Hospital Comments, 4Q2004

Certified with comments

Data does not accurately reflect the number of charity cases for the time period. This is due to internal processing for determination of the source of payment.
4% of total discharges were charity for 4th Quarter 2004.

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PROVIDER: Kindred Hospital -Tarrant County Arlington Campus
THCIC ID: 690000
QUARTER: 4
YEAR: 2004

Certified with comments

ID 690000 KINDRED HOSPITAL TARRANT COUNTY FT. WORTH ARLINGTON CAMPUS

MORTALITY RATES IN LTAC FACILITY IN COMPARISON TO STAC HOSPITALS ARE NOT MEANINGFUL. KINDRED HOSPITAL ARLINGTON IS AN LTAC FACILITY . ID 690000

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PROVIDER: HEALTHSOUTH Rehab Hospital -Tyler
THCIC ID: 692000
QUARTER: 4
YEAR: 2004

Elect not to certify

Fourth quarter data is not certified due to irreparable damage to the database file. Data is incomplete.

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PROVIDER: Vista Medical Center Hospital
THCIC ID: 694100
QUARTER: 4
YEAR: 2004

Certified with comments

The certification summary indicates Patient Race information as follows:

American Indian/Esquimo/Alut 82
White 0

This should read: American Indian/Esquimo/Alut 0
White 82.

One DRG 176 should be an admit source of 7.
One DRG 188 should be an admit source of 7.

The procedure code 81.62 appears 22 times throughout the "Patients for Attending Practitioner" report with a narrative of "Replace Femoral Head NEC". The narrative should read "Fusion or refusion of 2-3 Vertebrae".

The procedure code 81.63 appears 2 times throughout the "Patients for Attending Practitioner" report with a narrative of "Replace Acetab-Methacryl". The narrative should read "Fusion or refusion of 4-8 Vertebrae".

The procedure code 81.64 appears 1 time in the "Patients for Attending Practitioner" report with a narrative of "Replace Acetabulum NEC". The narrative should read as "Fusion or refusion of 9 or more vertebrae".

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PROVIDER: The Corpus Christi Medical Center-Bay Area
THCIC ID: 703000
QUARTER: 4
YEAR: 2004

Certified with comments

Hospital Comments, 4Q2004

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

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

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PROVIDER: The Corpus Christi Medical Center-Doctor's Regional
THCIC ID: 703002
QUARTER: 4
YEAR: 2004

Certified with comments

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

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

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PROVIDER: The Corpus Christi Medical Center-Heart Hospital
THCIC ID: 703003
QUARTER: 4
YEAR: 2004

Certified with comments

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

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

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PROVIDER: Texoma Medical Center Restorative Care Hospital
THCIC ID: 705000
QUARTER: 4
YEAR: 2004

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 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 2 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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PROVIDER: Dubuis Hospital -Beaumont
THCIC ID: 708000
QUARTER: 4
YEAR: 2004

Hospital Comments, 4Q2004

Certified with comments

Dubuiss Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuiss 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 Dubuiss Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital. In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

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PROVIDER: Dubuiss Hospital -Port Arthur
THCIC ID: 708001
QUARTER: 4
YEAR: 2004

Certified with comments

Dubuiss Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuiss 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 Dubuiss Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital. In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

=====
PROVIDER: Our Childrens House Baylor
THCIC ID: 710000
QUARTER: 4
YEAR: 2004

Certified with comments

Submission Timing

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

Physician Identification

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

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data

Hospital Comments, 4Q2004

calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the attending physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient. Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Race/Ethnicity

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

Hospital Comments, 4Q2004

across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital. "Asian or Pacific Islander" encounters are not broken out separately but are included in the "Other" race category.

Standard/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 25% of the primary payers originally categorized as "Medicaid" and 14% categorized as "Blue Cross" were recategorized as "Medicare", while 25% categorized as "Medicaid" were recategorized as "Blue Cross".

Also, 7% of secondary payors categorized as "Medicaid" were recategorized as "Medicare."

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

Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

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.

Total Charges

Due to a programming error, two (2) accounts that were reported reflect an over inflated total charge amount. The total charges for each were miscalculated due to duplicate charge billing resulting in an accumulated total of \$301,967 in overstated charges.

Certification Process

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

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PROVIDER: CHRISTUS St Catherine Health & Wellness Center
THIC ID: 715901
QUARTER: 4
YEAR: 2004

Certified with comments

During the 4th quarter 2004 CHRISTUS St. Catherine Hospital provided \$1,866,128 in charity care.

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PROVIDER: The Physicians Centre
THIC ID: 717500

Hospital Comments, 4Q2004

QUARTER: 4
YEAR: 2004

Certified with comments

Due to data entry errors, subscriber information was submitted as patient information.

The stats should look as follows:

Pt Gender	Actual	Submitted
Male:	63	66
Female:	122	119
Age brkdw:		
1-17:	2	1
18-44:	64	63
45-64:	69	70
65-74:	34	35

 PROVIDER: Seay Behavioral Health Center
 THCIC ID: 720000
 QUARTER: 4
 YEAR: 2004

Certified with comments

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is 'over and above' the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures

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

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

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

Hospital Comments, 4Q2004

prior to admission, or developed an infection during their hospitalization. This makes it difficult to obtain accurate information regarding things such as complication rates.

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnosis codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Hospital Comments, 4Q2004

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (Siemens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

PROVIDER: Presbyterian Hospital -Allen
THCIC ID: 724200
QUARTER: 4
YEAR: 2004

Certified with comments

Data Content

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

The state requires us to submit inpatient claims, by quarter year, gathered from a form called an UB92, in a standard government format called HCFA 837 EDI electronic claim format. Then the state specifications require additional data elements to be included over and above that. Adding those additional data places programming burdens on the hospital since it is 'over and above' the actual hospital billing process. Errors can occur due to this additional programming, but the public should not conclude that billing data sent to our payers is inaccurate. These errors have been corrected to the best of our knowledge.

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

Diagnosis and Procedures

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

The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not diagnose the patient with anemia until their blood hemoglobin level is below 9.0. In both situations,

Hospital Comments, 4Q2004

a diagnosis of anemia is correctly assigned, but the criteria used by the physician to determine that diagnosis was different. An 'apples to apples' comparison cannot be made, which makes it difficult to obtain an accurate comparison of hospital or physician performance.

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

Hospital Comments, 4Q2004

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (Seimens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: Methodist Willowbrook Hospital
THCIC ID: 724700
QUARTER: 4
YEAR: 2004

Certified with comments

The data for Methodist Willowbrook Hospital for the 4th Quarter, 2004 reflects the period 12/7/04 through 12/31/04 only. The hospital changed information systems on 12/7/04. The previous information system vendor was unable to make the required changes to the system to meet the updated THCIC requirements. As a result, data is unavailable for 10/1/04 through 12/6/04. THCIC is aware of the issue and Methodist Willowbrook Hospital is in compliance with data submission requirements.

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PROVIDER: Grimes St Joseph Health Center
THCIC ID: 728800
QUARTER: 4
YEAR: 2004

Certified with comments

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

health care quality and compare outcomes.

Charity Care - This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Grimes St. Joseph Health Center charity care, based on established rates for 2004 was \$353,908.

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

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

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

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

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

Additionally, the lack of education regarding how this grouper calculates the severity adjustments or how it functions can greatly impact the interpretation of the data.

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PROVIDER: Harris Methodist-Springwood
THCIC ID: 778000
QUARTER: 4
YEAR: 2004

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.

Hospital Comments, 4Q2004

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

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

Diagnosis and Procedures

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

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

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

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

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

Hospital Comments, 4Q2004

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (Seimens) extract that diverts some patient discharges to "home" as opposed to rehab. THR will communicate this issue and the plan to address this issue in writing to the THCIC Executive Director.

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PROVIDER: The Cedars Hospital
THCIC ID: 779001

QUARTER: 4
YEAR: 2004

Certified with comments

*Comments not received by THCIC

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PROVIDER: Baylor Heart & Vascular Center
THCIC ID: 784400
QUARTER: 4
YEAR: 2004

Certified with comments

Submission Timing

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

Physician Identification

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

The THCIC minimum data set houses only two (2) physician fields; Attending Physician and Operating or Other Physician (if applicable) as reflected on the UB92 billing document. Mortality rates, case costs and other data calculated for this population of physicians may be misrepresentative. Due to the complexity of most inpatient admissions many physicians provide care to patients throughout an admission. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the attending physician. Analysis of this physician information should carefully consider that significant variations in case count, case cost, and mortality may not be directly related to the care provided by the attending physician, but also reflect the varied use of consultants.

While hospitals document many treating physicians (surgeons and consultants) for each case, THCIC maintains only one (1) additional physician per case besides the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Surgeons and consulting physicians beyond one that may have been involved on a case will not be credited with providing care for that patient. Analysis of "other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Diagnosis and Procedures

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code as many as 25 diagnoses and 25 procedures for each patient record. One limitation

Hospital Comments, 4Q2004

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

Race/Ethnicity

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

Standard/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 13% of the primary payers originally categorized as "Blue Cross"

were recategorized as "Medicare" and 32% categorized as "Commercial" were "Medicare". Also approximately 8% of the secondary payers originally categorized as "Blue Cross" were recategorized as "Missing/Invalid."

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

Value Codes

It should be noted that Value code ZZ is being used to identify the DRG amount as required by United Health Care insurance plans.

Cost/ Revenue Codes

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

Certification Process

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

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PROVIDER: BSA Panhandle Surgery
THIC ID: 785001
QUARTER: 4
YEAR: 2004

Elect not to certify

=====
PROVIDER: Frisco Medical Center
THIC ID: 787400

QUARTER: 4
YEAR: 2004

Certified with comments

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

Data Content:

Due to system limitations, note, that this is just an estimate and relates to identified sources of funds, rather than actual collections from identified sources. This data is administrative data, which hospitals collect for billing and reimbursement purposes, and not clinical data in the medical records from which judgments concerning medical care can be made. The state requires us to submit inpatient claims by quarter end; our data is gathered from a form called a UB92, then manually entered in the Key Claim software. This software was created for the purpose of capturing medical data to be used by THCIC. The THCIC has contracted with Commonwealth Clinical Systems, Inc. to perform work associated with collecting, auditing, and warehousing the Texas inpatient health care claims data. The data is submitted to Commonwealth Clinical Systems in a Kermit format through a hyper-terminal link to be formatted and reviewed for errors according to THCIC justification logic. Due to system changes and software changes data was lost to errors and misinterpretation from hospital to state. There were several changes made to the Key Claim software and CertView software this year which created several delays and numerous problems for certain providers.

Submission Timing:

The hospital estimates that our data volumes for the calendar year time period submitted may be less than the total % of all cases for that period.

The state requires us to submit a snapshot of billed claims, extracted from our discharge database following the close of the calendar year quarter.

Any discharged patient encounter not billed by the cut off date will not be included in the quarterly submission file. Frisco Medical Center has submitted its fourth quarter of data for the year 2004. We had approximately 225 inpatient discharges during the fourth quarter 93% were submitted. Claims were pulled from this period to be submitted to THCIC.

Cost and Charges:

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

Physicians:

All physicians on staff at Frisco Medical Center go thru the credentialing process where their license number and names are validated as accurate.

The THCIC practitioner reference files are not updated timely enough to capture all the new physicians. Because of this some of our physicians are unidentified in the data, or consulting physicians are credited with assisting in the procedure. THCIC has provided a UPIN lookup for physician identification numbers however this was unavailable during this data submission

and the software did not allow changes to the fields.

Diagnosis and Procedures:

The data submitted matches the states reporting requirements but may be incomplete due to limitations with the Key Claim software for reporting procedures and diagnosis. Several of the new procedures provided at our facility could not be reported because the software would not accept them as valid procedure or diagnosis numbers. We are still looking at other means of capturing the data for submission. The data submitted might not fully represent all diagnosis or procedures performed at our facility, which could alter the true picture of a patient's hospitalization. Frisco Medical Center utilizes the 3M Coding Software to assign a universal standard set of codes recognized by the World Health Organization called the ICD-9CM or International Classification of Disease Index. We receive quarterly updates of new codes, reference material and HCFA regulation changes. We obtain quarterly coding audits from Precyse Solutions to verify the accuracy of our coding, which always falls within the 95 to 100% accuracy rating.

Race and Ethnicity:

The hospital admission staff is responsible for capturing demographic data on all our patients during the registration process. This is a sensitive area and information is gathered from the patient's driver's license, or questionnaire. Since there is no national standard for determining race or ethnicity the data may be subjective and may not fully represent all the patients treated at our facility. We have included an ethnicity question in our registration procedure and hope to capture more accurate data.

William Keaton
CEO Frisco Medical Center

PROVIDER: Dubuis Hospital -Paris
THCIC ID: 787500
QUARTER: 4
YEAR: 2004

Certified with comments

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

PROVIDER: CHRISTUS St Michael Health System
THCIC ID: 788001
QUARTER: 4
YEAR: 2004

Certified with comments

Data Accurate to the best of knowledge.
Chris Karam
Christus St Michael
CEO

Hospital Comments, 4Q2004

PROVIDER: LifeCare Hospital -Plano
THCIC ID: 789800
QUARTER: 4
YEAR: 2004

Certified with comments

Quarter 4, 2004: Certified with comment

unable to comment on payment source and severity index as internal database can not replicate this data

variations in age and discharge status

variation in ranking of DRG, diagnoses and procedures

DRG Mortality Statistics by Practitioner: mortality rate calculation is incorrect for several physicians

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PROVIDER: Texas Orthopedic Hospital
THCIC ID: 792000
QUARTER: 4
YEAR: 2004

Elect not to certify

I, Jay Woodall, CEO, elect not to certify fourth quarter 2004 data for Texas Orthopedic Hospital due to the fact Texas Orthopedic Hospital is licensed as a 49 bed acute care hospital which operates as an ambulatory specialty orthopedic facility. Approximately 80% of all surgical procedures are performed on an outpatient basis. Because of the specialty nature and the high percentage of outpatient surgeries, Texas Orthopedic Hospital has a uniqueness that would limit the general population's ability to form an accurate opinion or decision on the quality of services provided.

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

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PROVIDER: St Lukes Community Medical Center-The Woodlands
THCIC ID: 793100
QUARTER: 4
YEAR: 2004

Certified with comments

The data reports for Quarter 4, 2004 do not accurately reflect patient volume or severity.

Patient Volume

Hospital Comments, 4Q2004

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

Severity

· Descriptors for newborn admissions are based on national billing data elements (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, such as the heart's ejection fraction, can be captured and reflected in the various billing data elements including the ICD-9-CM diagnosis coding system.

As a result, the true clinical picture of the patient population cannot be adequately demonstrated using admissions and billing data.

Claim Filing Indicator

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

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PROVIDER: HEALTHSOUTH Surgical Hospital -Austin
THCIC ID: 794000
QUARTER: 4
YEAR: 2004

Certified with comments

Two accounts were submitted with three errors (637-invalid pt ss#, 690-invalid physician, 693-invalid operating physician) that may skew our data.

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PROVIDER: North Austin Medical Center
THCIC ID: 797000
QUARTER: 4
YEAR: 2004

Certified with comments

THCIC Data Release Comments

*Inpatient discharge data have been collected from claims data. The data are used for billing purposes and are not clinical data. Due to the diversity of healthcare organizations and data collecting practices throughout Texas, there are inherent limitations on comparing outcomes.

*The public data file does not contain all the diagnosis and procedure codes. It contains only 9 diagnosis codes and 6 procedure codes per encounter. This will affect the volume of procedures, the severity adjustment and mortality rates.

*The data reflect only those patients admitted to a hospital during the year and are aggregated, not trended. Data over time is needed for a more accurate assessment of the health care facilities' performance.

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

*Race 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.

General Comments:

1. North Austin Medical Center is a member of the St. David's Healthcare Partnership and supports the effort of the THCIC to provide publicly

Hospital Comments, 4Q2004

released hospital data as an integral part of our ongoing organizational quality improvement process. We have been tracking similar data and developing improvement measures as applicable over the past three years.

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

3. Since medical mortalities are relatively infrequent events and occur at irregular intervals, the data can and do vary considerably over time.

We have noticed considerable fluctuation and variation in all of our facilities over the past three years, depending upon the time period that the data were measured.

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PROVIDER: Dubuis Hospital -Corpus Christi
THCIC ID: 797001
QUARTER: 4
YEAR: 2004

Certified with comments

Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects.

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

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PROVIDER: Seton Southwest Hospital
THCIC ID: 797500
QUARTER: 4
YEAR: 2004

Certified with comments

The required transition to the 837 reporting format has resulted in a redistribution of our patient payor mix, although we continue to serve the same patient population. For this reason, charity patients do not appear in the claims files and other payor categories appear higher or lower than our history reports.

All physician license numbers and names have been validated with the physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements.

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PROVIDER: Seton Northwest Hospital
THCIC ID: 797600
QUARTER: 4
YEAR: 2004

Certified with comments

The required transition to the 837 reporting format has resulted in a redistribution of our patient payor mix, although we continue to serve the same patient population. For this reason, charity patients do not

Hospital Comments, 4Q2004

appear in the claims files and other payor categories appear higher or lower than our history reports.

All physician license numbers and names have been validated with the physician and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

These data are submitted by the hospital as their best effort to meet statutory requirements.

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PROVIDER: Kindred Hospital -Tarrant County
THCIC ID: 800000
QUARTER: 4
YEAR: 2004

Certified with comments

The mortality rates in a Long Term Acute Care Facility are not meaningful in comparison to a Short Term Acute Care facility. Please note: ID 800000 Kindred Hospital Tarrant County Ft. Worth Southwest is a Long Term Acute Care facility.

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PROVIDER: Kindred Hospital
THCIC ID: 801000
QUARTER: 4
YEAR: 2004

Certified with comments

Kindred Hospital Bay Area is a Long Term Acute Care Facility.

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PROVIDER: Kindred Hospital -Corpus Christi
THCIC ID: 804100
QUARTER: 4
YEAR: 2004

Certified with comments

All claim filing indicator codes defaulted to Mutual Defined Unknown ZZ due to incorrect mapping of financial class.

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PROVIDER: Dubuis Hospital -Houston
THCIC ID: 807000
QUARTER: 4
YEAR: 2004

Certified with comments

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

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PROVIDER: Dubuis Hospital -Texarkana
THCIC ID: 822000
QUARTER: 4

YEAR: 2004

Certified with comments

Dubuiss Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuiss 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 Dubuiss Hospital per our designation as Long Term Acute. Therefore our length of stay is much longer than a regular Short Term Hospital. In addition, our patient mix is predominately elderly as they most often have more serious illnesses with more frequent secondary problems. Subsequently they require a longer hospital stay than the younger population.

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PROVIDER: Methodist Sugar Land Hospital
THCIC ID: 823000
QUARTER: 4
YEAR: 2004

Certified with comments

The Methodist Sugar Land Hospital data for Quarter 4 2004 has been certified. 37 accounts are missing. Physician data is correct in this data set.

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