

General Comments on 1st Quarter 2012 Data

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

- . Data are administrative data, collected for billing purposes, not clinical data.
- . Data are submitted in a standard government format, the 837 format used for submitting billing data to payers. State specifications require the submission of additional data elements. These data elements include race and ethnicity. Because these data elements are not sent to payers and may not be part of the hospital's standard data collection process, there may be an increase in the error rate for these elements. Data users should not conclude that billing data sent to payers is inaccurate.
- . Hospitals are required to submit the patient's race and ethnicity following categories used by the U. S. Bureau of the Census. This information may be collected subjectively and may not be accurate.
- . Hospitals are required to submit data within 60 days after the close of a calendar quarter (hospital data submission vendor deadlines may be sooner). Depending on hospitals' collection and billing cycles, not all discharges may have been billed or reported. Therefore, data for each quarter may not be complete. This can affect the accuracy of source of payment data, particularly self-pay and charity categories, where patients may later qualify for Medicaid or other payment sources.
- . The Source of Admission data element is suppressed if the Type of Admission field indicates the patient is newborn. The condition of the newborn can be determined from the diagnosis codes. Source of admission for newborns is suppressed indefinitely.
- . Conclusions drawn from the data are subject to errors caused by the inability of the hospital to communicate complete data due to reporting form constraints, subjectivity in the assignment of codes, system mapping, and normal clerical error. The data are submitted by hospitals as their best effort to meet statutory requirements.

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PROVIDER: Parkland Memorial Hospital
THCIC ID: 474000
QUARTER: 1
YEAR: 2012

Certified With Comments

Parkland Health & Hospital System comprises a network of neighborhood-based health centers and Parkland Memorial Hospital, which was established in 1894. The Parkland System is a \$995 million enterprise that is licensed for 968 beds and employs approximately 8,804 staff. 11,952 adult patients received inpatient care this quarter. The hospital delivered over 11,900 newborns during the 12 month period ending March 2012.

Specific Data Concerns

As in other large academic medical centers, teams of physicians rotating at intervals care for patients. The THCIC dataset allows only one primary physician to be assigned to the patient for the entire inpatient stay. In our institution, this represents the physician caring for the patient at the time of discharge. Many patients, particularly long-term care patients are actually

managed by as many as three to four different teams and attending physicians. For this reason, the practice of attributing patient outcomes to the report card of a single physician may result in misleading information.

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PROVIDER: Austin State Hospital
THCIC ID: 000100
QUARTER: 1
YEAR: 2012

Certified With Comments

PROVIDER: Austin State Hospital
THCIC ID: 000100
QUARTER: 1
YEAR: 2012

Certified with comments

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

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

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

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

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

Standard Source of Payment Total Percentage (%)

Self-Pay 2.52%
Worker's Comp n/a
Medicare 10.48%
Other Federal Programs 8.06%
Commercial 3.71%
Blue Cross n/a
Champus 0.18%
Other n/a
Mising/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%
Mising/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: 1
YEAR: 2012

Certified With Comments

PROVIDER: Big Spring State Hospital
THCIC ID: 000101
QUARTER: 1
YEAR: 2012

Certified with comments

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

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

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

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

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

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

Standard Source of Payment Total Percentage (%)

- Self-Pay 2.0%
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/a
Medicaid Managed Care0.00%
Commercial HMO/a
Charity81%
Missing/Invalid/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: 1
YEAR: 2012

Certified With Comments

PROVIDER: Rio Grande State Center
THCIC ID: 000104
QUARTER: 1
YEAR: 2012

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 PaymentTotal Percentage (%)

Self-Pay0.55%
Worker's Compn/a
Medicare5.92%
Medicaid7.32%
Other Federal Programsn/a
Commercial.87%
Blue Crossn/a
Champus0.32%
Other/a
Missing/Invalid/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commerci al n/a
Medi care Managed Care0.00%
Commerci al HMO n/a
Chari ty85%
Mi ssi ng/I nval i dn/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: Kerrville State Hospital
THCIC ID: 000106
QUARTER: 1
YEAR: 2012

Certi fi ed Wi th Comments

PROVIDER: Kerrville State Hospital
THCIC ID: 000106
QUARTER: 1
YEAR: 2012

Certi fi ed wi th 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.

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

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

Pati ent Di scharge 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 PaymentTotal Percentage (%)

Sel f-Pay4.90%
Worker' s Compn/a
Medi care2.92%
Medi cai d12.21%
Other Federal Programsn/a
Commerci al 2.95%
Bl ue Crossn/a
Champus0.00%
Othern/a

Mis si ng/I nval i dn/a

Non Standard Source of Payment Total Percentage (%)

State/Local Government n/a
Commerci al n/a
Medi care Managed Care 0.00%
Medi cai d Managed Care n/a
Commerci al HMO n/a
Chari ty 77%
Mi ssi ng/I nval i dn/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: 1
YEAR: 2012

Certi fied Wi th Comments

PROVIDER: Rusk State Hospital
THCIC ID: 000107
QUARTER: 1
YEAR: 2012

Certi fied wi th 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.

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

Admi ssi on Source = Because of system constraints, all admissions sources on the encounter records, are reported as court/law enforcement. The data reported also includes voluntary admi ssi ons. The Local Mental Health Authority refers the maj ori ty of admi ssi ons.

Pati ent Di schar ge Status = All patients, when discharged are referred to the Local Mental Health Authority.

Standard Source of Payment Total Percentage (%)

Sel f-Pay 1.65%
Worker' s Compn/a
Medi care 9.15%
Medi cai d 5.18%
Other Federal Programs n/a
Commerci al 1.99%
Bl ue Cross 0.00%
Other n/a
Mi ssi ng/I nval i dn/a

Non Standard Source of Payment Total Percentage (%)

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

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

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PROVIDER: San Antonio State Hospital
THCIC ID: 000110
QUARTER: 1
YEAR: 2012

Certified With Comments

PROVIDER: San Antonio State Hospital
THCIC ID: 000110
QUARTER: 1
YEAR: 2012

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 Crossn/a
Champus0.44%
Othern/a
Mising/Invali dn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commerci al n/a
Medicare Managed Caren/a
Medicaid Managed Care0.12%
Commerci al HMOn/a
Charity73%
Mising/Invali dn/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: Terrell State Hospital
THCIC ID: 000111
QUARTER: 1
YEAR: 2012

Certified With Comments

PROVIDER: Terrell State Hospital
THCIC ID: 000111
QUARTER: 1
YEAR: 2012

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 PaymentTotal Percentage (%)

Self-Pay1.29%
Worker's Compn/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
Mising/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%
Mising/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: 1
YEAR: 2012

Certified With Comments

PROVIDER: North Texas State Hospital - Vernon
THCIC ID: 000114
QUARTER: 1
YEAR: 2012

Certified with comments

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

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

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

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

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

Standard Source of Payment Total Percentage (%)

Self-Pay 1.11%
Worker's Comp n/a
Medicare 0.30%
Medicaid 15.23%
Other Federal Programs n/a
Commercial 2.16%
Blue Cross n/a
Champus 0.13%
Other n/a
Mising/Invalid n/a

Non Standard Source of Payment Total Percentage (%)

State/Local Government n/a
Commercial n/a
Medicare Managed Care n/a
Medicaid Managed Care 0.05%
Commercial HMO n/a
Charity 81%
Mising/Invalid n/a

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

PROVIDER: Waco Center for Youth
THCIC ID: 000117
QUARTER: 1
YEAR: 2012

Certified With Comments

PROVIDER: Waco Center for Youth
THCIC ID: 000117
QUARTER: 1
YEAR: 2012

Certified with comments

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

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

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

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

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

Standard Source of Payment Total Percentage (%)

Self-Pay 2.01%
Worker's Comp n/a
Medicare n/a
Medicaid 1.06%
Other Federal Programs n/a
Commercial 1.19%
Blue Cross n/a
Champus 0.47%
Other n/a
Mising/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%
Mising/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: 1
YEAR: 2012

Certified With Comments

PROVIDER: El Paso Psychiatric Center
THCIC ID: 000118
QUARTER: 1
YEAR: 2012

Certified with comments

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

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

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

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

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

Standard Source of Payment Total Percentage (%)

Self-Pay 0%
Worker's Comp 0%
Medicare 22%
Other Federal Programs 6%
Commercial embedded in Commercial %
Blue Cross embedded in Commercial %
Champus 60%
Other 0%
Mising/Invalid/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%
Mising/Invalid/d 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: 1
YEAR: 2012

Certified With Comments

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

Charity Care This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for St. Joseph Regional Health Center charity care, based on established rates for the first quarter of 2012 was \$20,350,023.

Occurrence Date The occurrence date on last menstrual period is generally not a populated field within the hospital's abstracting system. Accordingly this date for some patients has been estimated in this date set.

Patient Mix - All statistics for St. Joseph Regional Health Center include patients from our Rehabilitation, and Acute Care populations. Our 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 patients 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 patients 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 Regional Medical Center
THCIC ID: 006000
QUARTER: 1
YEAR: 2012

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 Regional Medical Center
THCIC ID: 006001
QUARTER: 1
YEAR: 2012

Certified With Comments

Hospital Comments, 102012.txt

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: Good Shepherd Medical Center-Marshall
THCIC ID: 020000
QUARTER: 1
YEAR: 2012

Certified With Comments

This data is submitted in an effort to meet statutory requirements. Conclusions drawn could be erroneous due to communication difficulties in reporting complete data caused by reporting constraints, subjectivity in assignment of codes, various system mapping and normal clerical error. Data submission deadlines prevent inclusion of all applicable cases therefore this represents administrative claims data at the time of preset deadlines. Diagnostic and procedural data may be incomplete due to data field limitations. Data should be cautiously used to evaluate health care quality and compare outcomes.

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PROVIDER: Yoakum Community Hospital
THCIC ID: 023000
QUARTER: 1
YEAR: 2012

Certified With Comments

Patient Ethnicity is not correct. The numbers are actually opposite. We have majority hispanic. This was a HMS computer system issue that is now corrected. This data does not reflect the corrections.

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PROVIDER: Baylor Medical Center-Garland
THCIC ID: 027000
QUARTER: 1
YEAR: 2012

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 THIC 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, 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.

Race/Ethnicity

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

Standard Source of Payment

The standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 10% of the primary payers originally categorized as Medicaid were recategorized as Managed Care, 3.31% originally categorized as Other were recategorized as Medicare, and 2% originally categorized as Self-Pay were recategorized as Medicare. And 35% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Medicare", 34% originally categorized as Missing/Invalid were recategorized as Managed Care, and 10% originally categorized as Commercial were recategorized as Self-Pay.

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

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

Cost/ Revenue Codes

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

Certification Process

Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Kindred Hospital -Dallas
THCIC ID: 028000
QUARTER: 1
YEAR: 2012

Certified With Comments

Certified by Robert Gladney.

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PROVIDER: Good Shepherd Medical Center
THCIC ID: 029000
QUARTER: 1
YEAR: 2012

Certified With Comments

This data is submitted in an effort to meet statutory requirements. Conclusions drawn could be erroneous due to communication difficulties in reporting complete data caused by reporting constraints, subjectivity in assignment of codes, various system mapping and normal clerical error. Data submission deadlines prevent inclusion of all applicable cases therefore this represents administrative claims data at the time of preset deadlines. Diagnostic and procedural data may be incomplete due to data field limitations. Data should be cautiously used to evaluate health care quality and compare outcomes.

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PROVIDER: Madison St Joseph Health Center
THCIC ID: 041000
QUARTER: 1
YEAR: 2012

Certified With Comments

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

Charity Care This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in

the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Madison St. Joseph Health Center charity care, based on established rates for the first quarter of 2012 was \$110,213.

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 diagnosis 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 patients 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 patients 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: Baylor Medical Center at Carrollton
THCIC ID: 042000
QUARTER: 1
YEAR: 2012

Certified With Comments

PROVIDER: Baylor Medical Center Carrollton
THCIC ID: 042000
QUARTER: 1
YEAR: 2012

Certified with comments

Submission Timing

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

Physician Identification

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

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

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

Diagnosis and Procedures

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

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

Normal Newborns

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

Mortalities

Due to insurance payer requirements, organ donor patients are readmitted and expired in the system to address the issues of separate payers. This

results in double counting some "expired" cases which will increase the mortality figure reported and not accurately reflect the actual number of mortalities.

Race/Ethnicity

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

Standard Source of Payment

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

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

Cost/ Revenue Codes

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

Certification Process

Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Huguley Memorial Medical Center
THCIC ID: 047000
QUARTER: 1
YEAR: 2012

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of December 3, 2012. 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 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 ICD-9-CM. This is mandated by the federal government and all hospitals must comply.

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

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

Physician

While the hospital documents many treating physicians for each case, the THCIC minimum data set has only (2) physician fields, Attending and Operating Physicians. Many physicians provide care to patients throughout a hospital stay. Consulting physicians may prescribe and treat patients on behalf of the physician listed as the Attending. "Other" physician case volumes, mortality, case costs and LOS, will frequently be inaccurate because of this limitation. Analysis of "Other physician" information should, therefore, take into consideration that a significant portion of treating physicians are excluded from the patient cases.

Three accounts with DRG's 202, 897, and 419 were mapped to incorrect physicians but unable to be corrected in the permanent THCIC file. One account with DRG 999 should have been mapped to APR-DRG 589.

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. To meet the state's mandates to submit hospital Outpatient visits with specific procedures, Huguley underwent a major program conversion to the HCFA 837 EDI electronic claim format. All known errors have been corrected to the best of our knowledge. 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: St Lukes Episcopal Hospital
THCIC ID: 118000
QUARTER: 1
YEAR: 2012

Certified With Comments

The data reports for Quarter 1, 2012 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 that have been billed prior to the reporting deadline. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

Not all clinically significant conditions, such as the hearts 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.

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PROVIDER: University Medical Center
THCIC ID: 145000
QUARTER: 1
YEAR: 2012

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: Texas Health Harris Methodist HEB
THCIC ID: 182000
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Content

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

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

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

Diagnosis and Procedures

Patient diagnoses and procedures for a particular hospital stay are coded by the hospital using a universal standard called the International Classification of Disease, or ICD 9 CM. This is mandated by the federal government. The hospital complies with the guidelines for assigning these diagnosis codes, however, this is often driven by physician's subjective criteria for defining a diagnosis. For example, while one physician may diagnose a patient with anemia when the patient's blood hemoglobin level falls below 9.5, another physician may not

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

Race/Ethnicity

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

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (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: Medical Center-Piano
THCIC ID: 214000
QUARTER: 1
YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

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PROVIDER: Texas Health Harris Methodist Hospital -Fort Worth
THCIC ID: 235000
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

The length of stay data element contained in the states 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. Texas Health Fort Worth recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (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: Wise Regional Health System
THCIC ID: 254000
QUARTER: 1
YEAR: 2012

Certified With Comments

Reported Data is a snapshot of information available at time of certification.
Dawn Byrd

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PROVIDER: Wise Regional Health System
THCIC ID: 254001
QUARTER: 1
YEAR: 2012

Certified With Comments

Certifying data as accurate at time of certification since this is a snapshot of
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the data and data may be subject to change. Thank you.

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PROVIDER: Texas Health Harris Methodist Hospital -Stephenville
THCIC ID: 256000
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

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

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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: University Medical Center of El Paso
THCIC ID: 263000
QUARTER: 1
YEAR: 2012

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 University Medical Center of El Paso, patients are cared for by teams of physicians who 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.

The newborn data is being reported as Born in Hospital and Born outside Hospital which includes our well, premature and sick babies.

Through our Performance Improvement process, we review the data and strive to make changes to result in improvement.

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PROVIDER: Baylor Medical Center-Waxahachie
THCIC ID: 285000
QUARTER: 1
YEAR: 2012

Certified With Comments

Submission Timing

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

Physician Identification

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

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

but also reflect the varied use of consultants.

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

Diagnosis and Procedures

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

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

Race/Ethnicity

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

Standard Source of Payment

The standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 14% of the primary payers originally categorized as Medicaid were recategorized as Managed Care. And approximately 7% 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.

Cost/ Revenue Codes

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

Certification Process

Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the

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

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PROVIDER: Baylor Medical Center-Irving
THCIC ID: 300000
QUARTER: 1
YEAR: 2012

Certified With Comments

Submission Timing

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

Physician Identification

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

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

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

Diagnosis and Procedures

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

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

Race/Ethnicity

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

Standard Source of Payment

The standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard and non-standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 17% of the primary payers originally categorized as Medicaid were recategorized as Managed Care. And approximately 9% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as "Self Pay".

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

Cost/ Revenue Codes

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

Certification Process

Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current 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: Texas Health Presbyterian Hospital -Kaufman
THIC ID: 303000
QUARTER: 1
YEAR: 2012

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 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 states 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. Texas Health Kaufman recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (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: Covenant Hospital -Level I and
THCIC ID: 307000
QUARTER: 1
YEAR: 2012

Certified With Comments

Revenue code 0320 claims are missing for this quarter.

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PROVIDER: Texas Health Harris Methodist Hospital Cleburne
THCIC ID: 323000
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

The length of stay data element contained in the states 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. Texas Health Cleburne 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 (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: Baylor University Medical Center
THCIC ID: 331000
QUARTER: 1
YEAR: 2012

PROVIDER: Baylor University Medical Center
THCIC ID: 331000
QUARTER: 1
YEAR: 2012

Certified with comments

Submission Timing

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

Physician Identification

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

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

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

Diagnosis and Procedures

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

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

Normal Newborns

The best way to focus on severity of illness regarding an infant would

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

Mortalities

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

Race/Ethnicity

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

Standard Source of Payment

The standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. Upon review, approximately 9% of the primary payers originally categorized as Medicaid were recategorized as Managed Care. Approximately 8% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as 3% to Managed care and 5% to "Self-Pay".

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

Cost/ Revenue Codes

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

Certification Process

Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current 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: Cook Childrens Medical Center
THIC ID: 332000
QUARTER: 1
YEAR: 2012

Certified With Comments

Hospital Comments, 102012.txt

Cook Children's Medical Center has submitted and certified 1st QUARTER 2012 inpatient, outpatient surgery and outpatient radiology encounters to the Texas Health Care Information Council with the following possible data concerns based on the required submission method.

Since our data was submitted to the State we have uncovered medical coding errors regarding the following patient conditions in 2005 and 2010 discharges:

Post-operative infections
Accidental puncture and lacerations
Post-operative wound dehiscence
Post-operative hemorrhage and hematoma

Comparative complication reports reflecting the above conditions could misstate the true conditions at Cook Children's Medical Center for the 1st QUARTER OF 2012.

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: University Medical Center-Brackenridge
THCIC ID: 335000
QUARTER: 1
YEAR: 2012

Certified With Comments

As the public teaching hospital in Austin and Travis County, University Medical Center Brackenridge (UMCB) 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.

UMCB has a perinatal program that serves a population that includes mothers with late or no prenatal care. It 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 cost of care, length of stay and mortality rates.

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

other trauma centers.

All physician license numbers and names have been validated with the Physician and the 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: Denton Regional Medical Center
THCIC ID: 336001
QUARTER: 1
YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

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PROVIDER: Medical City Dallas Hospital
THCIC ID: 340000
QUARTER: 1
YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

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PROVIDER: Baylor Medical Center-Southwest Fort Worth
THCIC ID: 363001
QUARTER: 1
YEAR: 2012

Certified With Comments

PROVIDER: Baylor Medical Center Southwest Fort Worth
THCIC ID: 363001
QUARTER: 1
YEAR: 2012

Certified with comments

Submission Timing

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

Physician Identification

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

Reference Files.

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

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

Diagnosis and Procedures

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

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

Medical Record Number

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

Race/Ethnicity

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

Standard Source of Payment

The standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record might change over time. Approximately 4% of the secondary payers originally categorized as "

Medicaid were recategorized as Medicare also approximately 10% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as 5% as Champus and 5% as Self pay. Additionally, those payers identified contractually as both "HMO, and PPO" are categorized as "Commercial PPO". Thus any true managed care comparisons by contract type (HMO vs. PPO) may result in inaccurate analysis.

Cost/ Revenue Codes

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

Certification Process

Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Medical Center-Lewisville
THCIC ID: 394000
QUARTER: 1
YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

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PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
QUARTER: 1
YEAR: 2012

Certified With Comments

John Peter Smith Hospital (JPSH) is operated by the JPS Health Network under the auspices of the Tarrant County Hospital District. The JPS Health Network is accredited by the Joint Commission. In addition, JPSH holds Joint Commission accreditation as a hospital.

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

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

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

health centers, special outpatient programs for pregnant women and a wide range of wellness education programs.

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PROVIDER: Texas Health Arlington Memorial Hospital
THCIC ID: 422000
QUARTER: 1
YEAR: 2012

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 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 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. Texas Health Arlington Memorial Hospital recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (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 THIC Executive Director.

PROVIDER: Texas Health Presbyterian Hospital Dallas
THIC ID: 431000
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses

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

Length of Stay

The length of stay data element contained in the states 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. Texas Health 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 (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: North Hills Hospital
THCIC ID: 437000
QUARTER: 1
YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

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PROVIDER: UT Southwestern University Hospital -St Paul
THCIC ID: 448001
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Source

The data included in this file is submitted in an effort to meet statutory requirements. Data should be cautiously used to evaluate health care quality and compare outcomes.

Physicians

All physicians names and license numbers have been validated as accurate pursuant to the physicians reference file from the Texas Board of Medical Examiners. Some physician may remain unidentified in the THCIC Practitioner Reference Files as a result of the delay in state license number assignment.

Costs 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 actual cost of providing services.

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PROVIDER: DeTar Hospital -Navarro
THCIC ID: 453000
QUARTER: 1
YEAR: 2012

Certified With Comments

The DeTar Healthcare System includes two full-service acute care hospitals: DeTar Hospital Navarro located at 506 E. San Antonio Street and DeTar Hospital North located at 101 Medical Drive. Both acute care hospitals are in Victoria, Texas. DeTar Healthcare System is both Joint Commission accredited and Medicare certified. The system also includes a Skilled Nursing Unit; two Emergency Departments with Level III Trauma Designation at DeTar Hospital Navarro and Level IV Trauma Designation at DeTar Hospital North; DeTar Health Center; a comprehensive Cardiology Program including Cardiothoracic Surgery; Accredited Chest Pain Center; Inpatient and Outpatient Rehabilitation Centers; an Inpatient Geriatric Mental Health Center; the DeTar SeniorCare Center; Senior Circle; Primary Stroke Center; and a free Physician Referral Call Center. To learn more, please visit our website at www.detar.com.

PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

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

severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

The length of stay data element contained in the states 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. Texas Health Azle 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 (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: Plaza Medical Center-Fort Worth
THCIC ID: 477000
QUARTER: 1
YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

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PROVIDER: Seton Medical Center
THCIC ID: 497000
QUARTER: 1
YEAR: 2012

Certified With Comments

Seton Medical Center Austin 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. The NICU serves very seriously ill infants substantially increasing cost, lengths of stay and mortality rates. As a regional referral center and tertiary care hospital for cardiac and critical care services, Seton Medical Center Austin receives numerous transfers from hospitals not able to serve a more complex mix of patients. This increased patient complexity may lead to longer lengths of stay, higher costs and increased mortality.

All physician license numbers and names have been validated with the Physician and the 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: Medical Center-Arlington
THCIC ID: 502000
QUARTER: 1
YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

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PROVIDER: Seton Highland Lakes Hospital
THCIC ID: 559000
QUARTER: 1
YEAR: 2012

Certified With Comments

Seton Highland Lakes, a member of the Seton Family of hospitals, is a 25 bed acute care facility located between Burnet and Marble Falls on Highway 281. The hospital offers 24-hour Emergency services, plus comprehensive diagnostic and treatment services for residents in the surrounding area. Seton Highland Lakes also offers Home Health and Hospice service. For primary and preventative care, Seton Highland Lakes offers clinics in Burnet, Marble Falls, Bertram, Lampasas and a pediatric mobile clinic in the county.

This facility is designated by the Center for Medicare and Medicaid Services as a Critical Access Hospital and is fully accredited by the Joint Commission on Accreditation of Healthcare Organization under its Critical Access designation program.

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PROVIDER: Seton Edgar B Davis Hospital
THCIC ID: 597000
QUARTER: 1
YEAR: 2012

Certified With Comments

Seton Edgar B. Davis, a member of the Seton Family of Hospitals, is a general acute care; 25-bed facility committed to providing quality inpatient and outpatient services for residents of Caldwell and surrounding counties.

Seton Edgar B. Davis offers health education and wellness programs. In addition, specialists offer a number of outpatient specialty clinics providing area residents local access to the services of medical specialists. Seton Edgar B. Davis is located at 130 Hays St. in Luling, Texas. This facility is designated by the Center for Medicare & Medicaid Services as a Critical Access Hospital and is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations under its Critical Access program.

All physician national provider identifiers 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: Texas Health Harris Methodist Hospital -Southwest Fort Worth
THCIC ID: 627000
QUARTER: 1
YEAR: 2012

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

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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 states 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. Texas Health Southwest recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

As of the December 7, 2001, the THCIC Board indicated that they would be

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

Standard/Non-Standard Source of Payment

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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: Texas Health Specialty Hospital -Fort Worth
THCIC ID: 652000
QUARTER: 1
YEAR: 2012

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.

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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

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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. Texas Health Specialty Hospital recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (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: UT Southwestern University Hospital -Zale Lipshy
THCIC ID: 653001
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Source

The data included in this file is submitted in an effort to meet statutory requirements. Data should be cautiously used to evaluate health care quality and compare outcomes.

Physicians

All physicians names and license numbers have been validated as accurate pursuant to the physicians reference file from the Texas Board of Medical Examiners. Some physician may remain unidentified in the THCIC Practitioner Reference Files as a result of the delay in state license number assignment.

Costs 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 actual cost of providing services.

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PROVIDER: Texas Health Presbyterian Hospital -Plano
THCIC ID: 664000
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

The length of stay data element contained in the states 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. Texas Health Plano recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (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: HEALTHSOUTH Plano Rehab Hospital
THCIC ID: 670000
QUARTER: 1

YEAR: 2012

Certified With Comments

Results may not be 100% accurate.

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PROVIDER: Burleson St Joseph Health Center-Caldwell
THCIC ID: 679000
QUARTER: 1
YEAR: 2012

Certified With Comments

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

Charity Care This data does not accurately reflect the number of charity cases for the time period. Charity and self-pay patients are difficult to assign in the data submitted to the state. We are not able to classify a patient account as "charity" until after discharge when other potential payment sources have been exhausted. Because of this, charity care is combined with the Self Pay category. The amount of charges forgone for Burleson St. Joseph Health Center charity care, based on established rates for the first quarter of 2012 was \$368,228.

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 patients 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 patients diagnosis codes were available the APR-DRG assignment may possibly differ from

Hospital Comments, 102012.txt

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: Red River Hospital
THCIC ID: 709001
QUARTER: 1
YEAR: 2012

Certified With Comments

1st Qt. Certify 10.12.12

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PROVIDER: Big Bend Regional Medical Center
THCIC ID: 711900
QUARTER: 1
YEAR: 2012

Certified With Comments

Reported high as a result of running 2 quarters for this quarter.

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PROVIDER: CHRISTUS St Michael Rehab Hospital
THCIC ID: 713001
QUARTER: 1
YEAR: 2012

Certified With Comments

To the best of my knowledge.

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PROVIDER: CHRISTUS St Catherine Hospital
THCIC ID: 715901
QUARTER: 1
YEAR: 2012

Certified With Comments

Still having issues with incorrect physician NPI number. Number is correct as but is still saying that its an error.

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PROVIDER: Kindred Hospital -White Rock
THCIC ID: 719400
QUARTER: 1
YEAR: 2012

Certified With Comments

Certified by Justin Smith

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PROVIDER: Texas Health Seay Behavioral Health Center
THCIC ID: 720000
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

The codes are assigned based on documentation in the patient's chart and are used by hospitals for billing purposes. The hospital can code up to 99 diagnoses and 99 procedures for each patient record. The state is requiring us to submit ICD-9-CM data on each patient but has limited the number of diagnoses and procedures to the first 25 diagnoses codes and the first 25 procedure codes. As a result, the data sent by us does meet state requirements but cannot reflect all the codes an individual patient's record may have been assigned. This means also that true total volumes may not be represented by the state's data file, which therefore make percentage calculations inaccurate (i.e. mortality

percentages for any given diagnosis or procedure, percentage of patients in each severity of illness category). It would be obvious; therefore, those sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then stands to reason that hospitals, which treat sicker patients, are likewise less accurately reflected.

Length of Stay

The length of stay data element contained in the states 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. Texas Health Seay Behavioral Center recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (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: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
QUARTER: 1
YEAR: 2012

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 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 states 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. Texas Health Allen recommends use of ICD9 coding data to identify neonates. This methodology will ensure correct identification of the clinical status of the newborn admission.

Race/Ethnicity

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

Standard/Non-Standard Source of Payment

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

Cost/ Revenue Codes

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

Discharge Disposition

THR has identified a problem with a vendor (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: Methodist Willowbrook Hospital
THCIC ID: 724700
QUARTER: 1
YEAR: 2012

Certified With Comments

59 records errored out incorrectly and failed to be submitted.

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PROVIDER: Grimes St Joseph Health Center
THCIC ID: 728800
QUARTER: 1
YEAR: 2012

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 the first quarter of 2012 was \$217,537.

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

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

Diagnosis and Procedures - Data submitted to the state may be incomplete for some patients due to the limitation on the number of diagnosis and 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 patients 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 patients 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: Green Oaks Hospital
THCIC ID: 766000
QUARTER: 1
YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate..

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PROVIDER: Texas Health Springwood Hospital
THCIC ID: 778000
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Content

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

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

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

Diagnosis and Procedures

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

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health 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 (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: CHRISTUS St Michael Health System
THCIC ID: 788001
QUARTER: 1
YEAR: 2012

Certified With Comments

To the best of my knowledge.

=====

PROVIDER: LifeCare Hospital -Piano
THCIC ID: 789800
QUARTER: 1
YEAR: 2012

Certified With Comments

Inpatient THCIC Certification Reports for 01 Qtr 2012- certify with comment
Unable to replicate all data elements

=====

PROVIDER: St Lukes The Woodlands Hospital
THCIC ID: 793100
QUARTER: 1
YEAR: 2012

Certified With Comments

The data reports for Quarter 1, 2012 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 that have been billed prior to the reporting deadline.

If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

Not all clinically significant conditions, such as the hearts 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.

=====

PROVIDER: Seton Southwest Hospital
THCIC ID: 797500
QUARTER: 1
YEAR: 2012

Certified With Comments

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: Seton Northwest Hospital
THCIC ID: 797600
QUARTER: 1
YEAR: 2012

Certified With Comments

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: Lubbock Heart Hospital
THCIC ID: 801500
QUARTER: 1
YEAR: 2012

Elected Not to Certify

This information is so voluminous that I cannot accurately assess the information for 100% accuracy.

=====

PROVIDER: Kindred Hospital Victoria
THCIC ID: 812000
QUARTER: 1
YEAR: 2012

Certified With Comments

One patient has an incorrect operating physician listed.

=====

PROVIDER: Texas Health Harris Methodist Hospital Southlake
THCIC ID: 812800
QUARTER: 1
YEAR: 2012

Certified With Comments

Files could be missing claims and/or contain duplicates

=====

PROVIDER: Texas Institute for Surgery-Texas Health Presbyterian-Dallas
THCIC ID: 813100
QUARTER: 1
YEAR: 2012

Certified With Comments

Files could be missing claims and/or contain duplicates

=====

PROVIDER: Las Colinas Medical Center
THCIC ID: 814000
QUARTER: 1
YEAR: 2012

Certified With Comments

To the best of my knowledge, all data and information are accurate.

=====

PROVIDER: Baylor Regional Medical Center-Plano
THCIC ID: 814001
QUARTER: 1
YEAR: 2012

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.

Hospital Comments, 102012.txt

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

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

Diagnosis and Procedures

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

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

Race/Ethnicity

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

Standard Source of Payment

The standard source of payment codes are an example of data required by the state that is not contained within the standard UB92 billing record. In order to meet this requirement each payer identification must be categorized into the appropriate standard source of payment value. It should also be noted that the primary payer associated to the patient's encounter record may change over time. With this in mind, approximately 7% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as Self-Pay, 9% originally categorized as Other were recategorized as Managed Care, and 3% originally categorized as Indemnity were recategorized as Champus.

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

Cost/ Revenue Codes

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

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

Certification Process

Given the current certification software, there is not an efficient mechanism to edit and correct the data. In addition, due to hospital volumes, it is not feasible to perform encounter level audits and edits. Within the constraints of the current THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

=====

PROVIDER: Texas Health Center-Diagnostics & Surgery Plano
THCIC ID: 815300
QUARTER: 1
YEAR: 2012

Certified With Comments

Files could be missing claims and/or contain duplicates

=====

PROVIDER: Texas Health Presbyterian Hospital -Denton
THCIC ID: 820800
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Content

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

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

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

Diagnosis and Procedures

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

an accurate comparison of hospital or physician performance.

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

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

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

Length of Stay

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

Admit Source data for Normal Newborn

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

If admission source is used to examine length of stay or mortality for normal neonates using the admit source to identify the cases, the data will reflect premature and sick babies mixed in with the normal newborn data. Texas Health Denton 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 (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: Good Shepherd Medical Center-Linden
THCIC ID: 822100
QUARTER: 1
YEAR: 2012

Certified With Comments

This data is submitted in an effort to meet statutory requirements. Conclusions drawn could be erroneous due to communication difficulties in reporting complete data caused by reporting constraints, subjectivity in assignment of codes, various system mapping and normal clerical error. Data submission deadlines prevent inclusion of all applicable cases therefore this represents administrative claims data at the time of preset deadlines. Diagnostic and procedural data may be incomplete due to data field limitations. Data should be cautiously used to evaluate health care quality and compare outcomes.

=====
PROVIDER: Hickory Trail Hospital
THCIC ID: 837800
QUARTER: 1
YEAR: 2012

Certified With Comments

Certify without comments.

=====
PROVIDER: University General Hospital
THCIC ID: 840200
QUARTER: 1
YEAR: 2012

Certified With Comments

Certified

=====

PROVIDER: Texoma Medical Center
THCIC ID: 847000
QUARTER: 1
YEAR: 2012

Certified With Comments

Data Source. The source of this data, the electronic bill, 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 billing data file limits the diagnosis codes to 25 (principal plus 24 secondary diagnosis codes); the admission diagnosis and up to nine E-code fields.

*The procedure codes are limited to 25 (principal plus 24 secondary).

*The fewer the codes the less information is available to evaluate the patients 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 patients age, sex, diagnosis codes, procedure codes, and discharge status.

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 hospital does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

=====

PROVIDER: Dell Childrens Medical Center
THCIC ID: 852000
QUARTER: 1
YEAR: 2012

Certified With Comments

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

All physician license numbers and names have been validated with the Physician

Hospital Comments, 1Q2012.txt

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: Central Texas Rehab Hospital
THCIC ID: 854400
QUARTER: 1
YEAR: 2012

Certified With Comments

46 patients incorrectly in Patient of Origin - 2.

=====

PROVIDER: Texas Health Presbyterian Hospital -Rockwall
THCIC ID: 859900
QUARTER: 1
YEAR: 2012

Certified With Comments

Files could be missing claims and/or contain duplicates

=====

PROVIDER: Reliant Rehab Hospital North Texas
THCIC ID: 861300
QUARTER: 1
YEAR: 2012

Certified With Comments

certify with no comments

=====

PROVIDER: Seton Medical Center Williamson
THCIC ID: 861700
QUARTER: 1
YEAR: 2012

Certified With Comments

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: Carrus Specialty Hospital
THCIC ID: 864600
QUARTER: 1
YEAR: 2012

Certified With Comments

none

=====

PROVIDER: TrustPoint Hospital
THCIC ID: 865800
QUARTER: 1
YEAR: 2012

Elected Not to Certify

DATA HAS "FACE VALIDITY" BUT FORMAL LINE-BY-LINE HAS NOT BEEN COMPLETED.

=====

PROVIDER: Reliant Rehab Hospital Central Texas
THCIC ID: 866100
QUARTER: 1
YEAR: 2012

Certified With Comments

certify without comments

=====

PROVIDER: St Lukes Sugar Land Hospital
THCIC ID: 869700
QUARTER: 1
YEAR: 2012

Certified With Comments

The data reports for Quarter 1, 2012 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 that have been billed prior to the reporting deadline. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

Not all clinically significant conditions, such as the hearts 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.

=====

PROVIDER: Reliant Rehab Hospital North Houston
THCIC ID: 873700
QUARTER: 1
YEAR: 2012

Certified With Comments

certify with no comments

=====

PROVIDER: Reliant Rehab Hospital Abilene
THCIC ID: 920000
QUARTER: 1
YEAR: 2012

Certified With Comments

certify without comments

=====

PROVIDER: Seton Medical Center Hays
THCIC ID: 921000
QUARTER: 1
YEAR: 2012

Certified With Comments

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: St Lukes Lakeside Hospital
THCIC ID: 923000
QUARTER: 1
YEAR: 2012

Certified With Comments

The data reports for Quarter 1, 2012 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 that have been billed prior to the reporting deadline. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

Not all clinically significant conditions, such as the hearts 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.

=====

PROVIDER: Mother Frances Hospital Winstboro
THCIC ID: 446001
QUARTER: 1
YEAR: 2012

Elected Not to Certify

Charge totals are believed to be up to 30% inaccurate as compared to internal records.

=====

PROVIDER: Texas Health Presbyterian Hospital Flower Mound
THCIC ID: 943000
QUARTER: 1
YEAR: 2012

Certified With Comments

Files could be missing claims and/or contain duplicates

=====

PROVIDER: Carrus Rehab Hospital
THCIC ID: 957000
QUARTER: 1
YEAR: 2012

Certified With Comments

no comments

=====

PROVIDER: Reliant Rehab Hospital Dallas
THCIC ID: 680001
QUARTER: 1
YEAR: 2012

Certified With Comments

certify with no comments

=====

PROVIDER: Reliant Rehab Hospital Mid-Cities
THCIC ID: 700003
QUARTER: 1
YEAR: 2012

Certified With Comments

certify with no comments

=====

PROVIDER: Texas Health Heart & Vascular Hospital
THCIC ID: 730001
QUARTER: 1
YEAR: 2012

Certified With Comments

THHV - Inpatient

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 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.

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 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.

=====

PROVIDER: St Lukes Hospital at the Vintage

THCIC ID: 740000

QUARTER: 1

YEAR: 2012

Certified With Comments

The data reports for Quarter 1, 2012 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 that have been billed prior to the reporting deadline. If the encounter has not yet been billed, data will not be reflected in this quarter.

Severity

Not all clinically significant conditions, such as the hearts 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.