General Comments on 2nd Quarter 2011 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: Austin State Hospital
THCIC ID: 000100
QUARTER: 2
YEAR: 2011

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 Compn	n/a
Medicare	10.48%
Other Federal Programs	8.06%
Commercial	3.71%
Blue Cross	n/a
Champus	0.18%
Other	n/a
Missing/Invalid	n/a

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

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

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PROVIDER: Big Spring State Hospital
THCIC ID: 000101
QUARTER: 2
YEAR: 2011

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 PaymentTotal Percentage (%)

Self-Pay2.%
Worker's Compn/a
Medicare4.91%
Other Federal Programsn/a
Commercial1.49%
Blue Crossn/a
Champus1.06%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a
Medicaid Managed Care0.00%
Commercial HMOn/a
Charity81%
Missing/Invalidn/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: 2
YEAR: 2011

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%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Care0.00%
Commercial HMOn/a
Charity85%
Missing/Invalidn/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: 2
YEAR: 2011

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-Pay4.90%
Worker's Compn/a
Medicare2.92%

Medicaid12.21%
Other Federal Programsn/a
Commercial2.95%
Blue Crossn/a
Champus0.00%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Care0.00%
Medicaid Managed Caren/a
Commercial HMOn/a
Charity77%
Missing/Invalidn/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: 2
YEAR: 2011

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 PaymentTotal Percentage (%)

Self-Pay1.65%
Worker's Compn/a
Medicare9.15%
Medicaid5.18%
Other Federal Programsn/a
Commercial1.99%
Blue Cross0.00%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a
Medicaid Managed Care0.12%
Commercial HMOn/a
Charity82%
Missing/Invalidn/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: 2
YEAR: 2011

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-Pay0.87%
Worker's Compn/a
Medicare8.65%
Medicaid15.43%
Other Federal Programsn/a
Commercial1.46%
Blue Crossn/a
Champus0.44%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a
Medicaid Managed Care0.12%
Commercial HMOn/a
Charity73%
Missing/Invalidn/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: 2
YEAR: 2011

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
Medicare11.18%
Medicaid3.10%
Other Federal Programsn/a
Commercial0.36%
Blue Crossn/a
Champus0.00%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a

Medicaid Managed Care0.00%
Commercial HMOn/a
Charity84%
Missing/Invalidn/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: 2
YEAR: 2011

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-Pay1.11%
Worker's Compn/a
Medicare0.30%
Medicaid15.23%
Other Federal Programsn/a
Commercial2.16%
Blue Crossn/a
Champus0.13%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a
Medicaid Managed Care0.05%
Commercial HMOn/a
Charity81%

Missing/Invalidn/a

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

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PROVIDER: Waco Center for Youth
THCIC ID: 000117
QUARTER: 2
YEAR: 2011

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-Pay2.01%
Worker's Compn/a
Medicaren/a
Medicaid1.06%
Other Federal Programsn/a
Commercial1.19%
Blue Crossn/a
Champus0.47%
Othern/a
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Governmentn/a
Commercialn/a
Medicare Managed Caren/a
Medicaid Managed Care0.00%
Commercial HMOn/a
Charity95%
Missing/Invalidn/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: 2
YEAR: 2011

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%
Worker's Comp0%
Medicare22%
Other Federal Programs6%
Commercialembedded in Commercial%
Blue Crossembedded in Commercial%
Champus60%
Other0%
Missing/Invalidn/a

Non Standard Source of PaymentTotal Percentage (%)

State/Local Government60%
Commercial PPO0%
Medicare Managed Care0%
Medicaid Managed Care0%
Commercial HMO0%
Charity0%
Missing/Invalid40%

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: 2
YEAR: 2011

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 two quarters of 2011 was $32,223,399.
Occurrence Date The occurrence date on last menstrual period is generally not a populated field within the hospitals 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 procedures codes allowed. The data is limited to nine diagnoses codes and six procedure codes per patient visit.

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

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the 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: 2
YEAR: 2011

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: 2
YEAR: 2011

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: Good Shepherd Medical Center-Marshall
THCIC ID: 020000
QUARTER: 2
YEAR: 2011

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: 2
YEAR: 2011

Certified With Comments

Patient Ethnicity does not accurately reflect current patients. Computer system limits our choices upon registration of patients.

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PROVIDER: Baylor Medical Center-Garland
THCIC ID: 027000
QUARTER: 2
YEAR: 2011

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 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: 2
YEAR: 2011

Certified With Comments

We are a Long Term Care Hospital so we have a much greater average length of stay. In addition, our hospital averages a higher CMI (acuity index) which does result in a higher mortality rate than short term acute care hospitals. Data may hold reoccurring error for Provider name/NPI number mismatch. This data was validated against NPI Registry prior to certification. Two records containing an invalid admit source will be corrected and resubmitted.

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PROVIDER: Madison St Joseph Health Center

THCIC ID: 041000
QUARTER: 2
YEAR: 2011

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 two quarters of 2011 was $401,567.

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

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

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

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

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the 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: 2
YEAR: 2011

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: 2
YEAR: 2011

Certified With Comments

The following comments reflect concerns, errors, or limitations of discharge data for THCIC mandatory reporting requirements as of March 1, 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 no 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.

One account with DRG 794 was mapped incorrectly and should reflect DRG 765 instead. The corrections have been made to our internal system but unable to be corrected in the permanent THCIC file.
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: 2
YEAR: 2011

Certified With Comments

The data reports for Quarter 2, 2011 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: 2
YEAR: 2011

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: 2
YEAR: 2011

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.

4
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: Laredo Medical Center
THCIC ID: 207001
QUARTER: 2
YEAR: 2011

Certified With Comments

Certify with claims submitted "As Is" due to unable to correct properly.

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PROVIDER: Medical Center-Plano
THCIC ID: 214000
QUARTER: 2
YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

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PROVIDER: Texas Health Harris Methodist Hospital-Fort Worth
THCIC ID: 235000
QUARTER: 2
YEAR: 2011

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.
01/02/12
4
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: Texas Health Harris Methodist Hospital-Stephenville
THCIC ID: 256000
QUARTER: 2
YEAR: 2011

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.
01/02/12
4
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.
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: University Medical Center of El Paso
THCIC ID: 263000
QUARTER: 2
YEAR: 2011

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.

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: 2
YEAR: 2011

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: 2
YEAR: 2011

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 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: Texas Health Presbyterian Hospital-Kaufman
THCIC ID: 303000
QUARTER: 2
YEAR: 2011

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.

01/02/12

4

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: Texas Health Harris Methodist Hospital Cleburne
THCIC ID: 323000
QUARTER: 2
YEAR: 2011

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.
01/02/12
4
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: 2
    YEAR: 2011

Certified With Comments

PROVIDER: Baylor University Medical Center
THCIC ID: 331000
QUARTER: 2
YEAR: 2011

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 8% of the primary payers originally categorized as Medicaid were recategorized as Managed Care. Approximately 12% of the secondary payers originally categorized as "Missing/Invalid" were recategorized as 3% to Managed care and 9% 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 THCIC process, the data is certified to the best of our knowledge as accurate and complete given the above comments.

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PROVIDER: Cook Childrens Medical Center
THCIC ID: 332000
QUARTER: 2
YEAR: 2011

Certified With Comments

Cook Children's Medical Center has submitted and certified 2nd QUARTER 2011 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 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 2nd QUARTER OF 2011.

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: 2
YEAR: 2011

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: 2
    YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

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PROVIDER: Medical City Dallas Hospital
THCIC ID: 340000
 QUARTER: 2
    YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

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PROVIDER: Baylor All Saints Medical Center-Fort Worth
THCIC ID: 363000
 QUARTER: 2
    YEAR: 2011

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 M was dropped leaving the remaining number as the Medical Record number. This change in format will need to be considered when calculating any readmission rates or the rates will be erroneously lower.
Race/Ethnicity
There are no national standards regarding patient race categorization so hospitals may not have the same designations from which patients can choose. The state has recently attempted to standardize a valid set of race codes for this project but these are not universally used by all hospitals. Each hospital must independently map their specific codes to the state's race code categories. This mapping may not be consistent across hospitals. Thus epidemiology analysis of these two data fields does not accurately describe the true population served by the hospital.

Standard 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 27% of the primary payers originally categorized as Medicaid were recategorized as Managed Care. Approximately 11% of the secondary payers originally categorized as "Missing/Invalid" were recategorized. Approximately 5% of the secondary payers were recategorized as Commercial and 6% of the secondary payers 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-Southwest Fort Worth
THCIC ID: 363001
QUARTER: 2
YEAR: 2011

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 6% of the secondary payers originally categorized as " Missing/Invalid were recategorized as Self-Pay also approximately 6% of the secondary payers originally categorized as "Missing/Invalid 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.

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PROVIDER: Medical Center-Lewisville
THCIC ID: 394000
QUARTER: 2
YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

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PROVIDER: John Peter Smith Hospital
THCIC ID: 409000
QUARTER: 2
YEAR: 2011

Certified With Comments

JPS Health Network
Comments on THCIC Data Submission
For
2nd Quarter 2011

Introduction

John Peter Smith Hospital (JPSH) is operated by the JPS Health Network under the auspices of the Tarrant County Hospital District. The JPS Health Network is accredited by the Joint Commission. 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: 2
YEAR: 2011

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.
01/02/12
4
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
THCIC Executive Director.

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PROVIDER: Texas Health Presbyterian Hospital Dallas
THCIC ID: 431000
QUARTER: 2
YEAR: 2011

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.
01/02/12
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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 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: 2
YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

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PROVIDER: Midland Memorial Hospital
THCIC ID: 452000
QUARTER: 2
YEAR: 2011

Certified With Comments

Claim corrections for this quarter were not able to be completed.

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PROVIDER: DeTar Hospital-Navarro
THCIC ID: 453000
QUARTER: 2
YEAR: 2011

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; 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.

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PROVIDER: Texas Health Harris Methodist Hospital Azle
THCIC ID: 469000
QUARTER: 2
YEAR: 2011

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
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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

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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
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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
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therefore make percentage calculations inaccurate (i.e. mortality percentages for any given diagnosis or
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sicker patients (more diagnoses and procedures) are less accurately reflected by the 837 format. It then
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Length of Stay
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any patients discharged with a length of stay greater than 999 days will not be accurately stored within the
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this limitation will affect this data.
01/02/12
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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
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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: Parkland Memorial Hospital
THCIC ID: 474000
QUARTER: 2
YEAR: 2011

Certified With Comments

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 8,065 staff. 11,055 adult patients

received inpatient care this quarter. The hospital delivered over 12,500 newborns during the 12 month period ending June 2011.

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: Plaza Medical Center-Fort Worth
THCIC ID: 477000
QUARTER: 2
YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

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PROVIDER: Knapp Medical Center
THCIC ID: 480000
QUARTER: 2
YEAR: 2011

Certified With Comments

2011 Q2 Inpatient

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PROVIDER: Seton Medical Center
THCIC ID: 497000
QUARTER: 2
YEAR: 2011

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: 2
YEAR: 2011

Certified With Comments

To the best of my knowledge data is valid and accurate.

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PROVIDER: Fort Duncan Regional Medical Center
THCIC ID: 547001
QUARTER: 2
YEAR: 2011

Certified With Comments

no comments.

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PROVIDER: Methodist Richardson Medical Center
THCIC ID: 549000
QUARTER: 2
YEAR: 2011

Certified With Comments

Certified by Ken Hutchenrider

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PROVIDER: Seton Highland Lakes Hospital
THCIC ID: 559000
QUARTER: 2
YEAR: 2011

Certified With Comments

Seton Highland Lakes is a member of the SETON Healthcare Network. The facility is located off Highway 281 South in rural Burnet, Texas.

The SETON Healthcare Network, a not-for-profit organization, is the leading provider of healthcare services in Central Texas. As the regions largest community service organization, SETON contributed more than $103 million to care for the poor and community benefit last year.

Our mission inspires us to care for and improve the health of those we serve with a special concern for the sick and the poor. We are called to be a sign of God's unconditional love for all and believe that all persons by their creation are endowed with dignity. SETON continues the Catholic tradition of service established by our founders: Vincent de Paul, Louise de Marillac and Elizabeth Ann Seton.

SETONs services include:
Acute adult hospital care, including critical care, surgery, obstetric and diagnostic services
Childrens hospital care, including emergency services, critical care, neonatal intensive care unit, surgery, diagnostic services and specialty outpatient programs
Emergency medical care and Central Texas Austins only Level II Trauma Center

Participation in emergency medical care and transportation services including arrangements for air medical transfers throughout the Central Texas region
Heart and kidney transplant programs
Inpatient and outpatient behavioral health program for children, adolescents, adults and seniors who may be experiencing mental health and/or substance abuse difficulties
Outpatient diagnosis and treatment including radiology, endoscopy, rehabilitation, surgery, and laboratory
Third-party administrative services to handle insurance claims for self-insuring employers
Social service and pastoral care services to support patients and families in their management of care
Primary and specialty care medical services for the uninsured
Graduate medical education
Wellness, prevention and community health education services for the community

For more information on Seton Highland Lakes and the SETON Healthcare Network, visit www.seton.net.

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PROVIDER: Seton Edgar B Davis Hospital
THCIC ID: 597000
 QUARTER: 2
    YEAR: 2011

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: 2
    YEAR: 2011

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
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state's data file may not fully represent all diagnoses treated by the hospital or all procedures performed,
which can alter the true picture of a patient's hospitalization, sometimes significantly.
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.
01/03/12
4
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
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: Texas Health Specialty Hospital-Fort Worth
THCIC ID: 652000
QUARTER: 2
YEAR: 2011

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
Texas Health Specialty Hospital does not have a newborn population.
01/02/12
4
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: Kindred Hospital-Mansfield
THCIC ID: 657000
QUARTER: 2
YEAR: 2011

Certified With Comments

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

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PROVIDER: Texas Health Presbyterian Hospital-Plano
THCIC ID: 664000
QUARTER: 2
YEAR: 2011

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.
01/02/12
4
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: 2
YEAR: 2011

Certified With Comments

Results may not be 100% accurate.

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PROVIDER: Burleson St Joseph Health Center-Caldwell
THCIC ID: 679000
QUARTER: 2
YEAR: 2011

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 two quarters of 2011 was $481,540.

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 procedures codes allowed. The data is limited to nine diagnoses codes and six procedure codes per patient visit.

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

result in unreliable results.

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the 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: Kindred Hospital-Tarrant County
THCIC ID: 690000
QUARTER: 2
YEAR: 2011

Certified With Comments

We are a Long Term Care Hospital so we have a much greater average length of stay. In addition, our hospital averages a higher CMI (acuity index) which does result in a higher mortality rate than short term acute care hospitals. Data may hold reoccurring error for Provider name/NPI number mismatch. This data was validated against NPI Registry prior to certification. Two records containing an invalid admit source will be corrected and resubmitted.

==========

PROVIDER: Corpus Christi Medical Center-Bay Area
THCIC ID: 703000
QUARTER: 2
YEAR: 2011

Certified With Comments

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

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

Consolidation efforts for all women's and OB services to be located at Corpus Christi Medical Center's Women's Center at Bay Area were completed in May 2005.

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PROVIDER: Corpus Christi Medical Center-Doctors Regional
THCIC ID: 703002
QUARTER: 2
YEAR: 2011

Certified With Comments

The summary numbers under the caption "Severity Index" are not calculated using the same system used by the Corpus Christi Medical Center, therefore,

the accuracy of these numbers cannot be verified.

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

Consolidation efforts for all women's and OB services to be located at Corpus Christi Medical Center's Women's Center at Bay Area were completed in May 2005.

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PROVIDER: Corpus Christi Medical Center-Heart Hospital
THCIC ID: 703003
QUARTER: 2
YEAR: 2011

Certified With Comments

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

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

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PROVIDER: Corpus Christi Medical Center-Northwest
THCIC ID: 704004
QUARTER: 2
YEAR: 2011

Certified With Comments

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

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

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PROVIDER: CHRISTUS Dubuis Hospital-Beaumont
THCIC ID: 708000
QUARTER: 2
YEAR: 2011

Certified With Comments

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

frequent secondary problems. Subsequently they require a longer hospital l stay than the younger population.

==========
PROVIDER: CHRISTUS Dubuis Hospital-Port Arthur
THCIC ID: 708001
 QUARTER: 2
    YEAR: 2011

Certified With Comments

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

==========
PROVIDER: Kindred Hospital-White Rock
THCIC ID: 719400
 QUARTER: 2
    YEAR: 2011

Certified With Comments

We are a Long Term Care Hospital so we have a much greater average length of stay. In addition, our hospital averages a higher CMI (acuity index) which does result in a higher mortality rate than short term acute care hospitals. Data may hold reoccurring error for Provider name/NPI number mismatch. This data was validated against NPI Registry prior to certification. Two records containing an invalid admit source will be corrected and resubmitted.

==========
PROVIDER: Texas Health Seay Behavioral Health Center
THCIC ID: 720000
 QUARTER: 2
    YEAR: 2011

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.
01/02/12
4
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.

==========

PROVIDER: Texas Health Presbyterian Hospital Allen
THCIC ID: 724200
QUARTER: 2
YEAR: 2011

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.
01/02/12
4
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.

==========
PROVIDER: Methodist Willowbrook Hospital
THCIC ID: 724700
QUARTER: 2
YEAR: 2011

Certified With Comments

The 2011-Q2 Data is understated by 32 records which errored out incorrectly and failed to be submitted.

==========
PROVIDER: Grimes St Joseph Health Center
THCIC ID: 728800
QUARTER: 2
YEAR: 2011

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 two quarters of 2011 was $418,999.
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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 procedures codes allowed. The data is limited to nine diagnoses codes and six procedure codes per patient visit.

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

Severity Adjustment - THCIC is using the 3M APR-DRG grouper to assign the APR-DRG (All-Patient Refined Diagnoses Related Grouping) severity and risk of mortality scores. The assignment is made by evaluation of the 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: 2
YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

==========
PROVIDER: Texas Health Springwood Hospital
THCIC ID: 778000
QUARTER: 2

YEAR: 2011

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.
01/02/12
4
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: South Texas Spine & Surgical Hospital
THCIC ID: 786800
QUARTER: 2
YEAR: 2011

Certified With Comments

Correction to the case count for 2nd quarter of 2011. Total inpatient cases should be April = 104, May = 99 and June = 77. The quarter is understated by 45 cases.
Missing cases will be submitted as "late" cases with the 3rd quarter data set.

==========
PROVIDER: Baylor Medical Center-Frisco
THCIC ID: 787400
QUARTER: 2
YEAR: 2011

Certified With Comments

Modifications to current system have allowed us to capture data more accurately. Final modifications still pending.

==========
PROVIDER: Dubuis Hospital-Paris
THCIC ID: 787500
QUARTER: 2
YEAR: 2011

Certified With Comments

Christus Dubuis Hospital is a Long Term Acute Care Hospital. This designation of Long Term Acute separates Dubuis Hospital from Short Term Acute Hospitals in many aspects. Therefore relevant comparisons should be made with only other Long Term Acute Hospitals. Only acutely ill patients requiring an average

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

==========

PROVIDER: LifeCare Hospital-Plano
THCIC ID: 789800
QUARTER: 2
YEAR: 2011

Certified With Comments

789800- IP- Q2 2011 certify with comments

Unable to duplicate all data elements to confirm.

==========

PROVIDER: Kindred Hospital Tomball
THCIC ID: 792601
QUARTER: 2
YEAR: 2011

Certified With Comments

Certified by Eric Cantrell

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PROVIDER: St Lukes The Woodlands Hospital
THCIC ID: 793100
QUARTER: 2
YEAR: 2011

Certified With Comments

The data reports for Quarter 2, 2011 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: Dubuis Hospital-Corpus Christi

THCIC ID: 797001
QUARTER: 2
YEAR: 2011

Certified With Comments

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

==========

PROVIDER: Seton Southwest Hospital
THCIC ID: 797500
QUARTER: 2
YEAR: 2011

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: 2
YEAR: 2011

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: Kindred Hospital-Tarrant County
THCIC ID: 800000
QUARTER: 2
YEAR: 2011

Certified With Comments

We are a Long Term Care Hospital so we have a much greater average length of stay. In addition, our hospital averages a higher CMI (acuity index) which does result in a higher mortality rate than short term acute care hospitals. Data may hold reoccurring error for Provider name/NPI number mismatch. This data was validated against NPI Registry prior to certification. Two records containing an

invalid admit source will be corrected and resubmitted.

==========
PROVIDER: Kindred Hospital-Fort Worth
THCIC ID: 800700
QUARTER: 2
YEAR: 2011

Certified With Comments

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

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PROVIDER: Kindred Hospital Bay Area
THCIC ID: 801000
QUARTER: 2
YEAR: 2011

Certified With Comments

Kindred Hosptial Bay Area is a Long Term Acute Care Facility.

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PROVIDER: Lubbock Heart Hospital
THCIC ID: 801500
QUARTER: 2
YEAR: 2011

Elected Not to Certify

This information is so voluminous that I cannot accurately assess the information with 100% accurancy.

==========
PROVIDER: CHRISTUS Dubuis Hospital-Houston
THCIC ID: 807000
QUARTER: 2
YEAR: 2011

Certified With Comments

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

==========
PROVIDER: Las Colinas Medical Center
THCIC ID: 814000
QUARTER: 2

YEAR: 2011

Certified With Comments

To the best of my knowledge, the data is valid and accurate.

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PROVIDER: Baylor Regional Medical Center-Plano
THCIC ID: 814001
QUARTER: 2
YEAR: 2011

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 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 Presbyterian Hospital-Denton
THCIC ID: 820800
QUARTER: 2
YEAR: 2011

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.
01/02/12
4
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.

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PROVIDER: Dubuis Hospital-Texarkana
THCIC ID: 822000
QUARTER: 2
YEAR: 2011

Certified With Comments

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

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PROVIDER: Hickory Trail Hospital
THCIC ID: 837800
QUARTER: 2
YEAR: 2011

Certified With Comments

No errors reported for this quarter.

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PROVIDER: Mesquite Specialty Hospital
THCIC ID: 840000
QUARTER: 2
YEAR: 2011

Certified With Comments

Admission status on 1 account reflects law enforcement this is incorrect, The correct admit status should be reflected as transfer from another facility.

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PROVIDER: University General Hospital
THCIC ID: 840200
QUARTER: 2
YEAR: 2011

Certified With Comments

Certified with errors.

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PROVIDER: Heart Hospital Baylor Plano
THCIC ID: 844000
QUARTER: 2
YEAR: 2011

Certified With Comments

Bryan has approved this report

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PROVIDER: Texoma Medical Center
THCIC ID: 847000
QUARTER: 2
YEAR: 2011

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 patient's outcomes and service utilization.
* The Hospital can only list 2 physicians that were involved with any one patient. Other physicians who were involved in those cases will not be identified.

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

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

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

Timing of Data Collection. Hospitals must submit data to THCIC no later than 60 days after the close of the quarter.
* Not all claims may have been billed at this time.
* Internal data may be updated later and appear different than the data on the claim. Unless the payment is impacted, the hospitals does not rebill when a data field is changed internally. This results in differences between internal systems and the snapshot of data that was taken at the end of the quarter.

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PROVIDER: Dubuis Hospital-Texarkana-Wadley
THCIC ID: 847600
QUARTER: 2
YEAR: 2011

Certified With Comments

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

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PROVIDER: Dell Childrens Medical Center
THCIC ID: 852000
QUARTER: 2
YEAR: 2011

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 and the Texas State Board of Medical Examiner website as accurate but some remain unidentified in the THCIC Practitioner Reference Files.

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

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PROVIDER: Seton Medical Center Williamson
THCIC ID: 861700
QUARTER: 2
YEAR: 2011

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.

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PROVIDER: Kate Dishman Rehab Hospital
THCIC ID: 861900
QUARTER: 2
YEAR: 2011

Certified With Comments

The patient listed as a discharge 09 was actually admitted to a short term hospital or 02.

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PROVIDER: CHRISTUS Dubuis Hospital-Bryan
THCIC ID: 864800
QUARTER: 2
YEAR: 2011

Certified With Comments

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

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PROVIDER: TrustPoint Hospital
THCIC ID: 865800
QUARTER: 2
YEAR: 2011

Elected Not to Certify

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

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PROVIDER: St Lukes Sugar Land Hospital
THCIC ID: 869700
QUARTER: 2
YEAR: 2011

Certified With Comments

The data reports for Quarter 2, 2011 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: Reliant Rehab Hospital Abilene
THCIC ID: 920000
QUARTER: 2
YEAR: 2011

Certified With Comments

Certify with no comments

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PROVIDER: Seton Medical Center Hays
THCIC ID: 921000
QUARTER: 2
YEAR: 2011

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.

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PROVIDER: St Lukes Lakeside Hospital
THCIC ID: 923000
QUARTER: 2
YEAR: 2011

Certified With Comments

The data reports for Quarter 2, 2011 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: Westbury Community Hospital
THCIC ID: 956000
QUARTER: 2
YEAR: 2011

Certified

No comment

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PROVIDER: Carrus Rehab Hospital
THCIC ID: 957000
QUARTER: 2
YEAR: 2011

Certified

we were late in certifying the quater due to staff changes.

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PROVIDER: Texas Health Heart & Vascular Hospital
THCIC ID: 730001
QUARTER: 2
YEAR: 2011

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.

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: St Lukes Hospital at the Vintage
THCIC ID: 740000
 QUARTER: 2
    YEAR: 2011

Certified With Comments

The data reports for Quarter 2, 2011 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.