Department of State Health Services
Center for Health Statistics
Texas Health Care Information Collection

Outpatient WebCorrect

Revised October 2018
The complete data reporting schedule is available at 
http://www.dhs.texas.gov/THCIC/datareportingschedule.shtm
THCIC System

Log into the System13 system at https://thcic.system13.com
Log In the System as a Submitter

Put in THCIC Submitter username and password. Click ‘sign in’.
A facility must accept the security notice and access to the database will be provided. If a facility declines this notice, access will not be granted to the database.
This is the provider home page the data administrator/primary contact will see when they log in the system. The following pages is what the other data users/data certifier will see.
Data Management/Primary Contact
Provider Home Page

THCIC Support Center
Login successful!

Provider Tabs
Other Features

Provider Dashboard

Reports
WebCorrect
WebCert
WebClaim
New Claims in Progress
Batches

Report Claim Correction
Certification
New Claim
Certifier Provider Home Page

Data certifier do not have access to the data management tab.
Data users do not have access to the data management tab, certification tab and/or WebCert desktop icon.
## Provider Tabs

<table>
<thead>
<tr>
<th>Home</th>
<th>Claims</th>
<th>Claim Correction</th>
<th>Reports</th>
<th>Data Mgmt</th>
<th>Certification</th>
<th>Batches</th>
<th>Help</th>
</tr>
</thead>
</table>

### Home
- Navigate to the ‘main’ page of the provider home page.

### Claims
- View all the claims submitted by their facility. This claim listing includes claims that need correction.

### Claim Correction
- **Provides a listing of all claims that need correction.**

### Reports
- **Various reports available for facility to view and documentation.**

### Data Mgmt
- This tab is only available to the data administrator/primary contact of the facility. It allows the provider to remove duplicate claims or replace certain bill types.

### Certification
- **Facilities can view current and historical certification data.**

### Batches
- **Allows to locate the batch numbers of batches sent in for processing.**

### Help
- View various help topics to facilitate better access to the system.

**Indicates these tabs also have desktop icons.**
The user is able to view all claims submitted for their facility, even if they need data correction or have been accepted as is. The user will only be able to see claims that are currently in the system, which includes data that has been submitted and not removed due to the cutoff for corrections.

Help gives the user various help topics. The user will be able to get training materials, search and lookups, supporting documents and frequency asked questions.

This tab is only available to the data administrator/primary contact of the facility. It allows the provider to remove duplicate claims or replace certain bill types. Removal and replace functions are part of the normal encounter and event building processes that create the certification data.
The **Claims** tab allows a facility to view a listing of all claims submitted, that are currently in the system. Under the **Errors** heading (−) are claims that are submitted and need no correction. If a claim has a number and a **GREEN A** these claims have been accepted as is. The claims with a **RED number**, indicates a claim with the errors, the number is how many errors are on this claim.
Provider Tab Help

THCIC Support Center

Training Materials
- WebClaim Help
- WebCorrect Help
- WebCert Help

Video Tutorials
- WebClaim: adding a new claim
- WebCorrect: navigating through the errors

Search and Lookup
- NPI Registry lookup
- Board of Medical Examiners: (Search for State License #)
- Pediatric Medical Examiners
- Dental Examiners
- Roster of documented midwives in Texas

Supporting Documents
- Facility Reporting Schedule
- Regularly updated pages maintained by THCIC containing detailed technical information about 837 data and field formatting:
  - Inpatient THCIC 837 Technical Specification
  - Outpatient THCIC 837 Technical Specification
- Hospital Reporting Requirements and Numbered Letters: A regularly updated page maintained by THCIC to keep hospitals informed of the hospital discharge data collection process and requirements.
- THCIC Hospital information Request change
- Submitter Test Files

Frequently Asked Questions
- I forgot my password. How can I recover it?
  - If you know your THCIC User Id, visit the password recovery page.
  - If you don’t know your THCIC User Id, send an email to thcichelp@system13.com, requesting an account reset.
- I forgot my username. How can I recover it?
  - Send email to thcichelp@system13.com, requesting your username.
- How do I update the Certifier Name?
  - You will need to fill out a form.

Need more help? Contact Help Desk
Data Management

Data Management Actions on Quarterly Data

Modify/Replace/Remove Process (MRR)

The MRR function will:
- Match claims with the same key values:
  Patient Control Number
  Medical Record Number
  Admission Start of Care
  Admission Hour
- Eliminate duplicate claims in the correct order of processing
- Apply late charges (xx5 bill types)
- Apply corrections to claims (xx6 bill types - outpatient professional only)
- Apply the replacement information (xx7 bill types)
- Remove claims that match a Void/Cancel of a prior claim (xx8 bill types)

Duplicate Remove Process (DR)

The DR function will:
- Match claims with the same key values:
  Patient Control Number
  Medical Record Number
  Admission Start of Care
  Admission Hour
  Bill Type
- Retain the most recently submitted claim

This tab is only available to the data administrator/primary contact of the facility. Before the modify/replace/remove and duplicate removal is ran, it is recommended that the data analysis report is ran through the reports tab.
Data Analysis Report through the Reports Tab

Data Analysis Report, makes suggestions concerning the MRR and DR functions. It is also recommended that when choosing to run the MRR and DR processes, other facility users should not be in the system to avoid undesired results if records are locked by users and those same records need to be removed by the MRR or DR process.
Data Analysis Report through the Reports Tab

### Quarter Analysis

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<th>Total</th>
<th>xx0</th>
<th>xx1</th>
<th>xx2</th>
<th>xx3</th>
<th>xx4</th>
<th>xx5</th>
<th>xx6</th>
<th>xx7</th>
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### Quarter Comparison

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<th>Total</th>
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<td>3q12</td>
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<tr>
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### Messages

* ONE OR MORE OF YOUR MONTHS IS MISSING DATA

* Some claims still have errors. Please use Claim Correction to correct these claims. You may also review these errors with the Frequency of Errors Report and the Hardcopy Report, both of which are available on the Reports Tab.

* You should use the Summary Report on the Reports tab to obtain a snapshot of your data. This report shows data distribution by month, charges, admission type, newborns, discharge status, payer (claim filing indicator), patient geographic origin, gender, age, race, ethnicity, length of stay and diagnosis and procedure counts per claim.
Provider Tab Data Management

Modify/Replace/Remove Report

- Remove duplicate claims
- Replace certain bill types

Removal and replace functions are part of the normal encounter and event building processes that create the certification data. Providers may now run these processes ahead of time to have a better view of their actual data.

The Modify/Replace/Remove process (MRR) will match claims with the same key values except bill type (Patient Control Number, Medical Record Number, Admission Start of Care, and Admission Hour). It will then compare the bill types to see if any claims may be removed. The MRR process will:

- Eliminate duplicate claims in the correct order of processing
- Apply late charges (xx5 bill types)
- Apply corrections to claims (xx6 bill types – outpatient professional only)
- Apply the replacement information (xx7 bill types)
- Remove claims that match a Void/Cancel of a prior claim (xx8 bill types).

When a provider chooses one of these two functions, they are advised that they may wish to run the Data Analysis Report ahead of time, which makes suggestions concerning the MRR and DR functions. It is also recommended that when choosing to run the MRR and DR processes, other facility users should not be in the system to avoid undesired results if records are locked by users and those same records need to be removed by the MRR or DR process.

After the provider completes all of the prompts, the MRR or DR process is submitted to run in the background. When the process is completed, the data administrator is sent an email describing the number of records that were analyzed and any that fit each category of removal.
Data Management Actions on Quarterly Data

Modify/Replace/Remove Process (MRR)

The MRR function will:
- Match claims with the same key values:
  - Patient Control Number
  - Medical Record Number
  - Admission Start of Care
  - Admission Hour
- Eliminate duplicate claims in the correction
- Apply late charges (xx6 bill types)
- Apply corrections to claims (xx6 bill types)
- Apply the replacement information (x6 bill type)
- Remove claims that match a Void/Cain

Duplicate Remove Process (DR)

The DR function will:
- Match claims with the same key values:
  - Patient Control Number
  - Medical Record Number
  - Admission Start of Care
  - Admission Hour
  - Claim Type
- Remove in the most recently submitted claim

**MRR DR Information**

You may wish to run the Pre-Certification Data Analysis Report prior to having this process applied to your data.

This report will display the bill type of the claims in your active claim data and make suggestions concerning the DR and MRR functions.

Please see above boxes for a full description of both the DR and MRR processes.

Do you wish to continue?

- Yes
- No
Provider Tab Data Management

Data Management Actions on Quarterly Data

Modify/Replace/Remove Process (MRR)

The MRR function will:
- Match claims with the same key values:
  - Patient Control Number
  - Medical Record Number
  - Admission Start of Care
  - Admission Hour
- Eliminate duplicate claims in the correct sequence
- Apply late charges (xx5 bill types)
- Apply corrections to claims (xx6 bill types)
- Apply the replacement information (xx7 bill types)
- Remove claims that match a Void/Cancelled Code

Duplicate Remove Process (DR)

The DR function will:
- Match claims with the same key values:
  - Patient Control Number
  - Medical Record Number
  - Admission Start of Care
  - Admission Hour
- Remove claims that match a Void/Cancelled Code

You may wish to run the Pre-Certification Data Analysis Report prior to having this process applied to your data.

This report will display the bill type of the claims in your active claim data and make suggestions concerning the DR and MRR functions.

Please see above boxes for a full description of both the DR and MRR processes.

Do you wish to continue?

Yes  No
Provider Tab Data Management

Data Management Actions on Quarterly Data

Modify/Replace/Remove Process (MRR)

The MRR function will:
- Match claims with the same key values:
  - Patient Control Number
  - Medical Record Number
  - Admission Start of Care
  - Admission Hour
- Eliminate duplicate claims in the correct order
- Apply late charges (xx5 bill type)
- Apply corrections to claims (xx6 bill type)
- Apply the replacement information (xx7 bill type)
- Remove claims that match a Void/Cancel

Duplicate Remove Process (DR)

The DR function will:
- Match claims with the same key values:
  - Patient Control Number
  - Medical Record Number
  - Admission Start of Care
  - Admission Hour
- Eliminate other claims not in the most recently submitted claim

Process Submitted

Your request has been submitted. An email will be sent to the Provider Primary Contact (Data Administrator) upon completion.
This tab is only available to the data administrator/primary contact of the facility. Before the modify/replace/remove and duplicate removal is ran, it is recommended that the data analysis report is ran through the reports tab.
Provider Tab Data Management

Duplicate Removal

- Remove duplicate claims
- Replace certain bill types

Removal and replace functions are part of the normal encounter and event building processes that create the certification data. Providers may now run these processes ahead of time to have a better view of their actual data.

The Duplicate Removal process (DR) will match claims with the same key values (Patient Control Number, Medical Record Number, Admission Start of Care, Admission Hour, and Bill Type). It will retain the most recently submitted claim.

When a provider chooses one of these two functions, they are advised that they may wish to run the Data Analysis Report ahead of time, which makes suggestions concerning the MRR and DR functions. It is also recommended that when choosing to run the MRR and DR processes, other facility users should not be in the system to avoid undesired results if records are locked by users and those same records need to be removed by the MRR or DR process.

After the provider completes all of the prompts, the MRR or DR process is submitted to run in the background. When the process is completed, the data administrator is sent an email describing the number of records that were analyzed and any that fit each category of removal.

If you have multiple bill types other than xx1 or xx0, you should use the MRR function. For example if you have other types such as xx8s, then removing duplicate xx1s and later applying the xx8s during encounter processing will possibly leave no claims. If you have only xx1s or xx0s and need to remove duplicate xx1s and xx0s, then the DR function should be the choice. The Data Analysis Report can help you decide.

Running the MRR or DR function is not a requirement and is only a recommendation. If a provider chooses not to run the MRR or DR function prior to the scheduled “Cutoff for corrections at time of certification”, System13 will run these functions as part of the normal encounter and event building process that create the certification data.

This report will open as a PDF as shown below.
Data Management Actions on Quarterly Data

Modify/Replace/Remove Process (MRR)

The MRR function will:
- Match claims with the same key values: Patient Control Number, Medical Record Number, Admission Start of Care, Admission Hour
- Eliminate duplicate claims in the correct provider group
- Apply late charges (xx5 bill type)
- Apply corrections to claims (xx6 bill type)
- Apply the replacement information (xx8 bill type)
- Remove claims that match a Void/Care

Duplicate Remove Process (DR)

The DR function will:
- Match claims with the same key values: Patient Control Number, Medical Record Number, Admission Start of Care, Admission Hour
- Remove claims of the most recently submitted claim type

MRR DR Information

You may wish to run the Pre-Certification Data Analysis Report prior to having this process applied to your data.

This report will display the bill type of the claims in your active claim data and make suggestions concerning the DR and MRR functions.

Please see above boxes for a full description of both the DR and MRR processes.

Do you wish to continue?
- Yes
- No
Data Management Actions on Quarterly Data

Modify/Replace/Remove Process (MRR)
The MRR function will:
- Match claims with the same key values:
  - Patient Control Number
  - Medical Record Number
  - Admission Start of Care
  - Admission Hour
- Eliminate duplicate claims in the order from newest to oldest
- Apply late charges (xx5 bill types)
- Apply corrections to claims (xx6 bill types)
- Apply the replacement information (xx7 bill types)
- Remove claims that match a Voided claim (xx8 bill types)

Duplicate Remove Process (DR)
The DR function will:
- Match claims with the same key values:
  - Patient Control Number
  - Medical Record Number
  - Admission Start of Care
  - Admission Hour
- The most recently submitted claim

Duplicate Removal Alert
Be forewarned: The DR function should not be selected unless the only bill type in the currently active claims is (xx1).

To view your bill types go to the Reports Tab and run the Pre-certification Data Analysis Report.

If you have bill types other than final bill type (xx1), you should choose the MRR Function. The MRR function removes duplicates as well as modifies claims with other bill types in the proper order.

Do you wish to continue?

[Yes] [No]
Provider Tab Data Management

Data Management Actions on Quarterly Data

Modify/Replace/Remove Process (MRR)
- Match claims with the same key values:
  - Patient Control Number
  - Medical Record Number
  - Admission Start of Care
  - Admission Hour
- Eliminate duplicate claims in the correct order
- Apply late charges (xx5 bill types)
- Apply corrections to claims (xx8 bill types)
- Apply the replacement information (xx9 bill types)
- Remove claims that match a Void/Cancel

Duplicate Remove Process (DR)
- Match claims with the same key values:
  - Patient Control Number
  - Medical Record Number
  - Admission Start of Care
  - Admission Hour
  - Bill Type
- Eliminate duplicate claims in the correct order
- Your request has been submitted. An email will be sent to the Provider Primary Contact (Data Administrator) upon completion.

Select Claim Type
- Inpatient
- Outpatient

Select Action
- Modify/Replace/Remove (MRR)
- Remove Duplicates (DR)
Data Management Actions on Quarterly Data

**Modify/Replace/Remove Process (MRR)**
- The MRR function will:
  - Match claims with the same key values:
    - Patient Control Number
    - Medical Record Number
    - Admission Start of Care
    - Admission Hour
  - Eliminate duplicate claims in the correct order of processing
  - Apply late charges (xx5 bill types)
  - Apply corrections to claims (xx6 bill types - outpatient professional only)
  - Apply the replacement information (xx7 bill types)
  - Remove claims that match a Void/Cancel of a prior claim (xx8 bill type)

**Duplicate Remove Process (DR)**
- The DR function will:
  - Match claims with the same key values:
    - Patient Control Number
    - Medical Record Number
    - Admission Start of Care
    - Admission Hour
    - Bill Type
  - Retain the most recently submitted claim

---

**The Duplicate Claim Removal (DR) process has completed for provider 000006 Outpatient Data [G2]**

\[\] Do Not Reply <noreply@system13.com>

- **Sent:** Wed 3/11/2013 1:51 PM
- **To:** Overton, Tiffany (SOMR)| Overton, Tiffany (SSHR)

The Duplicate Claim Removal (DR) process has completed for provider 000006 Outpatient data. The DR reviewed 6 active claims, eliminated 0 duplicate claims, leaving 6 active claims.

Sincerely,

System13, Inc. Customer Support

Please do not reply directly to this email. System13, Inc. will not receive any reply message. For questions or comments, email thcichelp@system13.com
The ‘User Management’ option will only be visible to provider primary contact/data administrator for the facility. Otherwise other user will only have the ‘My Account’ and ‘Logout’ features pictured below.
User Management

User management is a new feature will allow providers/facilities to have multiple login user IDs for access to the System, if it is desired.

The assigned Provider Primary Contact/Data Administrator will be authorized to access the “User Management” option, which is on the System dashboard screen. Only the person listed as the Provider Primary Contact/ Data Administrator will be able to access the User Management screen, which allows them to add or delete user(s) from the system. Each facility can allow for the addition of up to six (6) individual users for the facility. The individual users are assigned specific accesses to the System by the Provider Primary Contact/Data Administrator under the User Management link. There will be two types of user “roles”: Data User and Data Certifier.

A complete overview of this process is available in the Volume 15 Number 3 numbered letter available at http://www.dshs.state.tx.us/thcic/hospitals/numberedletters/2012/Vol15No3.pdf
User Management – To Add User

To add a user, click ‘create new user.’

The screen below will open...

To add a user, you must fill out the information accordingly and choose the type of user ID and/or email scheme for this user. The data administrator is the only one who can add a user to the system.
From the role descriptions listed above, add the user as to how the user will have access to the system. An e-mail will be sent the user that indicates they have been added to the system and will also give them their userID and a link to change their password to access the system.
User Management – User Roles / Email Schemes

User Management - User Roles

- **Data User**
  - Authorized to add new claims (WebClaim)
  - Authorized to correct claims (WebCorrect)
  - Authorized to delete claims
  - Authorized to view batch submissions
  - Authorized to perform advance searches
  - Authorized to generate a Pre-Certification Data Report

- **Data Certifier**
  - Authorized to perform all functions as a Data User
  - Authorized to generate Certification Data (Encounter on Demand (EOD))
  - Authorized to download Certification File
  - Authorized to download Certification Reports
  - Authorized to Certify quarterly data (WebCert)
  - Authorized to request free regeneration (rejen) of Certification data

User Management - Email Schemes

- **Data User** (Scheme Name 'Data User')
  - FER (Frequency of Errors Report)
  - Count of Excluded/Rejected Claims

- **Data Certifier** (Scheme Name 'Data Certifier')
  - All Notifications received by the Data User
  - Certification Download File Availability
  - Certified
  - Rejected - Elected Not to Certify
  - EOD (Encounter on Demand) Generated

- **Data Administrator** (Scheme Name 'Data Administrator')
  - All Notifications received by the Data Certifier and Data User
  - MRR (Merge, Remove, Replace)
  - DR (Duplicate Removal)

Choose what type of access the user will have in the system and also which emails they will receive, an option of no emails is available also.
User Management – Adding a User

Choose what type of UserID to be assigned and/or the e-mail scheme to assign to the user.
# User Management – Adding a User

## THCIC Support Center

### User Management

<table>
<thead>
<tr>
<th>Locked</th>
<th>Name</th>
<th>Phone</th>
<th>Email</th>
<th>UserID</th>
<th>Data Certifier</th>
<th>Data User</th>
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<tbody>
<tr>
<td></td>
<td>DOE, JACK</td>
<td>(123) 456-7890</td>
<td><a href="mailto:jdoe@yourfacility.com">jdoe@yourfacility.com</a></td>
<td>th000002n</td>
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<td>th0000020</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

2 users
User Management – Lock Features

The administrator can clear intrusion or account lock(s). A user will get locked out of the system if they have more than three (3) failed login attempts. The administrator can clear the ‘intrusion lock’ by unchecking the box above. The administrator can put an ‘account lock’ on a user’s account to prevent a user’s account from being used. (i.e. employee was on an extended leave.)
Other Features My Account

NEW FEATURE - When a user’s account has been disabled due to three failed login attempts, the user currently receives the message “Consecutive failed login limit exceeded, account has been disabled”. The System has been modified to display a new message, “Contact the help desk or <data administrator’s actual name>”, if the user is not the provider’s Data Administrator.

The user will put in the current password, then a new password and confirm the new password. The password perimeters are listed above when changing your password. Click Update to change the password. Log back into the system with the new password.

Passwords must:
- expire and be changed every 60 days
- be at least 8 characters long
- contain at least 1 alpha, 1 numeric, and 1 special character
- contain uppercase and lowercase letters
- begin and end with a letter

Passwords must not:
- be reused for 1 year
- contain username
- contain letter or number sequences greater than 2
- repeat characters more than twice in a row

Password Notes:
1. Within this application, the following is defined as the set of Special Characters: !@#$%^&* _-`
2. Here are some examples of a letter or number sequence greater than 2: "abc", "123", "4567", "qdhik"
3. Here are some examples of a letter, number, or sequence that is repeated more than twice: "aad" (2-letter repetition), "111" (2-number repetition), "abcabc" (letter sequence repetition), "123123" (number sequence repetition)
Other Features Logout

THCIC Support Center

- Reports
- WebClaim
- New Claims in Progress
- WebCert
- Batches

Message from webpage: Are you sure you want to logout?

Options: OK, Cancel
Inactivity

If you have been idle in the system for 40 minutes, you will be logged out of the system and will have to log back in to have access. If you were in WebCorrect or WebClaim and have not saved before you went idle in the system, you will lose these changes.
The user can go to Reports by the provider tab or by the provider dashboard icon.
The only data a facility can run reports on is data that is currently in the system, this excludes certification data. Data for previous quarters will remain in the system until the last day for cutoff for corrections. Other options will become available once the type of report is selected.
Type of Reports

Frequency of Errors - Allows the user to verify the number of claims System13 received and verify that the dates are the same as the user submitted for the quarter. Frequency of Error Report provides the user information on the number of claims processed, number of claims in error, number of fields in error, error summary and accuracy rate.

Hardcopy Report - shows every error and warning on each claim.

Summary Report - use this report to validate if the data for the period is correct, such as record counts, min/max/average charges, admission type and source, payer type, patient age, gender, race, and ethnicity.

Data Analysis Report - shows counts per month, types of bills, and other data items, and makes suggestions for continuing, such as removing duplicates, correcting invalid data, etc.

Claim Count for First Physician - Use this to determine if the physicians (attending, operating, other) who utilize your facility are represented correctly. This report will give a claim count by physician name, sorted by name. It will also include the physician ID, but will not include patient information.

Claim Count for Second Physician - Use this to determine if the second physicians (attending, operating, other) who utilize your facility are represented correctly. This report will give a claim count by second physician name, sorted by name. It will also include the physician ID, but will not include patient information.

Error Type List - use this to determine if you have made all possible corrections to your data, if needed.
WebCorrect/ Claim Correction

When there are errors in the system for the facility. The number of errors will be shown underneath WebCorrect as pictured above.

The user can go to data corrections by provider tab the tab or the dashboard icon.
Before the system opens up to the WebCorrect listing, it will load tables. Loading tables allows the system to provide drop down menus that are available to look up data in certain data fields. This process can take up to a few minutes to load, but once loaded the user will get this WebCorrect listing that list all the claims in the system with errors.
The user can go to Certification by the provider tab Certification or by the provider dashboard icon.
WebCert/Certification

WebCert (certification) is the data certification process. It will allow facilities to view their previously submitted data and certify that the data was accurately submitted. If the user has inpatient and outpatient claims, their WebCert page will show both inpatient and outpatient data. If the facility only submits outpatient data, it will only show outpatient data, as indicated here.
The user can go to WebClaim by the provider dashboard icon.

WebClaim is a desktop icon that allows the user to manually enter claims into the system one by one.
Before the system opens up to the WebClaim, which allows facilities to manually enter claims, it will load tables. Loading tables allows the system to provide drop down menus that are available to look up data in certain data fields. This process can take up to a few minutes to load, but once loaded the user will have to choose the type of claim to enter as pictured above.
New Claims in Progress

The user can go to New Claims in progress by the provider dashboard icon.

New Claims in Progress allows the user to complete claims saved via WebClaim.
New Claims in Progress

Before the system opens up to the New Claims in Progress from the home page, it will load tables. Loading tables allows the system to provide drop down menus that are available to look up data in certain data fields. This process can take up to a few minutes to load. Once loaded the user will get this New Claims in Progress listing that lists WebClaim submissions that have been saved, but not submitted.
The user can go to Batches by the provider tab or the dashboard icon.
Batches is a list of files sent in by 5010 upload. This listing is only for batches currently in the system. *Only the system administrator can delete batches.*
The user can go to data corrections by provider tab the tab
or the dashboard icon.
WebCorrect

- Data Correction Schedule
- New System Feature
- Navigating In WebCorrect
- Making corrections to your data by using WebCorrect
- Data Correction – Methods

- Hospitals will use one of the following methods for correcting files or claims:
  - Hospital submits a corrected replacement claim (XX7) file or void/cancel (XX8) claim file and a corrected original bill type claim file to System 13 through the hospital’s own information system (But an original XX1 must be originally submitted.)
  - Vendor’s Correction Mechanism
# WebCorrect Due Dates

## Inpatient and Outpatient Data Reporting Schedule

Texas Health Care Information Collection  
Center for Health Statistics

<table>
<thead>
<tr>
<th>Activity</th>
<th>Q4 2017</th>
<th>Q1 2018</th>
<th>Q2 2018</th>
<th>Q3 2018</th>
<th>Q4 2018</th>
<th>Q1 2019</th>
<th>Q2 2019</th>
<th>Q3 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cutoff for initial submission</td>
<td>3-1-18</td>
<td>6-1-18</td>
<td>9-3-18</td>
<td>12-3-18</td>
<td>3-1-19</td>
<td>6-3-19</td>
<td>9-2-19</td>
<td>12-2-19</td>
</tr>
<tr>
<td>Cutoff for corrections (Free)</td>
<td>5-1-18</td>
<td>8-1-18</td>
<td>11-1-18</td>
<td>2-1-19</td>
<td>5-1-19</td>
<td>8-1-19</td>
<td>11-1-19</td>
<td>2-3-20</td>
</tr>
<tr>
<td>Facilities retrieve certification files</td>
<td>6-1-18</td>
<td>9-3-18</td>
<td>12-3-18</td>
<td>3-1-19</td>
<td>6-3-19</td>
<td>9-2-19</td>
<td>12-2-19</td>
<td>3-2-20</td>
</tr>
<tr>
<td><strong>Cutoff for corrections at time of certification (Associated Fees)</strong></td>
<td>7-16-18</td>
<td>*10-1-18</td>
<td>*1-2-19</td>
<td>*4-1-19</td>
<td>*7-1-19</td>
<td>*10-1-19</td>
<td>*1-2-20</td>
<td>*4-1-20</td>
</tr>
</tbody>
</table>

* Indicates this is an anticipated date.

‘Cutoff for corrections’ is the date when all corrections must be submitted via WebCorrect or uploading a new file data file. If changes are to be made to the data after the cutoff for corrections, System13 will assess a fee. **Please note,** cutoff for corrections at the time of certification is for facilities that make changes to their data at the time of certification. A fee will be assessed through System13 to make these changes to data at certification.
New System Feature

After the *Cutoff for initial submission* the Data Administrator (aka Provider Primary Contact) and Certifier will now receive an email a few days after the “Cutoff for Initial Submission. This email will be sent approximately sixty days after the end of each quarter. The email will have four reports attached to it:

- **Summary Report** – use this report to validate if the data for the period is correct, such as record counts, min/max/average charges, admission type and source, payer type, patient age, gender, race, and ethnicity

- **Claim Count for First Physician Report** - Use this to determine if the physicians (attending, operating, other) who utilize your facility are represented correctly. This report will give a claim count by physician name, sorted by name. It will also include the physician ID, but will not include patient information.

- **Claim Count for Second Physician Report** - Use this to determine if the second physicians (attending, operating, other) who utilize your facility are represented correctly. This report will give a claim count by physician name, sorted by name. It will also include the physician ID, but will not include patient information.

- **Error Type List Report** - use this to determine if you have made all possible corrections to your data, if needed.

The email will suggest that if the Certifier determines that the data is complete and accurate after reviewing the reports, then they should consider choosing the Encounter or Event on Demand (EOD) option on their certification tab for that quarter. If you do not choose to start the EOD option, the certification process will start after the cutoff for corrections as it does now.

*Cutoff for initial submission is the date when the submission data is due in the system.*
Loading Lookup Tables

When the system is loading tables it's loading drop down menus that are available to look up data in certain data fields. This process can take up to a few minutes to load. ‘Loading Tables…’ will appear when opening WebClaim, Claims and New Claims in Progress from the home menu.
## WebCorrect Listing

### THCIC Support Center

<table>
<thead>
<tr>
<th>Patient Control #</th>
<th>Medical Record #</th>
<th>Claim #</th>
<th>Processed Date</th>
<th>Patient Name</th>
<th>In/Out</th>
<th>Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>8007752</td>
<td>8910595</td>
<td>2015071400900001</td>
<td>07/14/2015</td>
<td>Wehner, Marcos</td>
<td>Out-P</td>
<td>1</td>
</tr>
<tr>
<td>6510696</td>
<td>6720774</td>
<td>2015071400900001</td>
<td>07/14/2015</td>
<td>Bosco, Pinkie</td>
<td>Out-P</td>
<td>1</td>
</tr>
<tr>
<td>7080563</td>
<td>6789311</td>
<td>2015071400900001</td>
<td>07/14/2015</td>
<td>Schinner, Lisette</td>
<td>Out-P</td>
<td>1</td>
</tr>
<tr>
<td>6787104</td>
<td>6085171</td>
<td>2015071400900001</td>
<td>07/14/2015</td>
<td>Labadie, Brendan</td>
<td>Out-P</td>
<td>1</td>
</tr>
<tr>
<td>5983592</td>
<td>7873997</td>
<td>2015071400900000</td>
<td>07/14/2015</td>
<td>Spinka, Anderson</td>
<td>Out-P</td>
<td>1</td>
</tr>
<tr>
<td>8575586</td>
<td>6577730</td>
<td>2015071400900000</td>
<td>07/14/2015</td>
<td>Hilpert, Raheem</td>
<td>Out-P</td>
<td>1</td>
</tr>
<tr>
<td>6826644</td>
<td>8301142</td>
<td>2015071400900000</td>
<td>07/14/2015</td>
<td>Stoltenberg, Pablo</td>
<td>Out-P</td>
<td>1</td>
</tr>
<tr>
<td>6317009</td>
<td>6058464</td>
<td>2015071400900000</td>
<td>07/14/2015</td>
<td>White, Ike</td>
<td>Out-P</td>
<td>1</td>
</tr>
<tr>
<td>5545570</td>
<td>6568505</td>
<td>2015071400900000</td>
<td>07/14/2015</td>
<td>Breitenberg, Jaren</td>
<td>Out-P</td>
<td>1</td>
</tr>
<tr>
<td>6162032</td>
<td>7753642</td>
<td>2015071400900000</td>
<td>07/14/2015</td>
<td>Bednar, Ernestine</td>
<td>Out-P</td>
<td>1</td>
</tr>
<tr>
<td>9035587</td>
<td>6643802</td>
<td>2015071400900000</td>
<td>07/14/2015</td>
<td>Ebert, Modesta</td>
<td>Out-P</td>
<td>1</td>
</tr>
<tr>
<td>8019658</td>
<td>6843348</td>
<td>2015071400900000</td>
<td>07/14/2015</td>
<td>Schowalter, Scolty</td>
<td>Out-P</td>
<td>1</td>
</tr>
<tr>
<td>5501748</td>
<td>7641241</td>
<td>2015071400900000</td>
<td>07/14/2015</td>
<td>Aubilder, Lorrie</td>
<td>Out-P</td>
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<tr>
<td>6509607</td>
<td>80668712</td>
<td>2015071400900000</td>
<td>07/14/2015</td>
<td>Robel, Myah</td>
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<tr>
<td>6870754</td>
<td>6515348</td>
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<td>07/14/2015</td>
<td>Ziemann, Floy</td>
<td>Out-P</td>
<td>1</td>
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<tr>
<td>7995682</td>
<td>5440706</td>
<td>2015071400900000</td>
<td>07/14/2015</td>
<td>Jaskolski, Chase</td>
<td>Out-P</td>
<td>1</td>
</tr>
</tbody>
</table>

120 claims
Sorting WebCorrect Listing

The user can sort the WebCorrect listing by clicking on the title listings patient control #, medical record #, claim #, processed date, patient name, in/out and errors. Click the title tab to sort the tabs by. The list will sort by this tab. The arrow direction will indicate will determine the direction of the listing.
Search for Claims

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The user can search claims by:
- Control #
- Medical record #
- Patient or Claim #

Pressing ‘clear’ will take user back to WebCorrect listing.
Advanced Search for Claims

- **Advanced Search** – The user can search by the search criteria below

- Type in search request or choose search criteria.
- Click search to sort listing by search criteria requested.
- Click ✗ to return to the unfiltered list of claims.
Advanced Search for Claims

Choose Search criteria.

The claim can be modified by error code for claims with this error code. The claim can also have the error code excluded.

Click Search. A listing with the modified search criteria will display. If no information matching the search criteria then a blank listing will be displayed. Click to close this modified list, the listing can also be reset to exclude search criteria. To reset, click reset and click search again.
Accept As Is

When the user has a claim ‘checked’ ✓ the user can ‘Accept As Is’ and this claim will be taken from the correction listing. Accept as is will not verify how many claim are checked. Please take a note of the number of claims on listing before and after, ‘Accept As It.’
Delete Claims

When the user has a claim(s) checked, 'Delete' will be an option. Delete will completely delete the claim(s) from the system. The count of claim(s) will be verified.
Start Corrections

When using start corrections the correction process will go through each claim as they are listed on the WebCorrect listing.

Start Corrections will move sequentially through all claims in the current claims correction list and open the edit screen focused on the first error in the claim. By using Start Corrections followed by SUBMIT and Next Claim all errors can be accessed in order.

The start correction will go through each claim as they are listed on the WebCorrect listing.
To start corrections with WebCorrect, click
Errors in a Claim

The errors in a claim will be identified by a pink tint.

When changes are made to a claim’s field the changes will be indicated by a green tint.

On the tab that identifies the different tab of the claim, the number encircled in red will indicate how many errors are on the claim, as shown below.

Each claim gives an error count as to how many errors are on the claim at the lower left corner.

By clicking the , this allows the user to open that part of the claim to make corrections.

As a user modifies the data, the error count goes down.
Date Fields

✔️ If a date field is highlighted the user must press delete to remove the current contents before modifying the date.

✔️ If the user types in a date field the data will overstrike the current contents of the field (preferred method to modify dates.)
Save, Save Next Error & Submit

- Moving through tabs without explicitly saving will not preserve modifications while the user remains within the currently loaded claim. The user should save and/or submit before moving to next claim.

- Clicking **Save** will save modified data. The user will be able to submit claim or just click another tab to modify it.

- Clicking **Save, Next Error** will save modification and take the user to the next error in the claim, if the claim has more than one error. After the user has gone through all errors or saves will become an option.

- Always submit a claim before moving to the next claim so the error count and error status of the claim will be updated. If the claim is saved and not submitted the error status will not be accurate and the claim will stay on the WebCorrect listing. The claim may still have other errors also. Saving does not mean that the claim is now correct, the user has to submit for the claim to be checked for errors.

**Save** saves the modification to the claim that were made.

**Save, Next Error** will save modifications and take user to next error.

**Submit Claim** submits the claim to be checked for other errors.
Submit Claim

**Review Errors button:**

Claim has been successfully submitted, but still contains errors.

[Review Errors]  [Next Claim]

- 602 - Invalid Patient State
- 627 - Missing Patient ZIP
- 665 - Missing Patient Social Security Number
- 633 - Missing Patient Gender
- 630 - Missing Patient Birth Date

The user will get a list of all errors that are still on the claim.

Click [Review Errors] and the user will be taken back into the claims that was just submitted to review the error(s) on the claim.

Press ENTER to navigate on a tab to go through errors or click [Save, Next Error], which will save the modified data and take the user to the next error in the claim. Once all error has been reviewed or modified, [Submit Claim]

If there are no more errors the user will get the following message.

Claim has been successfully submitted.

[Next Claim]
**Next Claim**

**Next Claim button:**

- Click to move to the next claim on the WebCorrect listing.

- **NOTE:** If the user has moved through all claims on the list the Next Claim button will be disabled.

- This button will load the next claim in the current list and open the next claim’s first error.

- If the user is on a modified list, then the next claim will be the next claim on the modified listing.
Look Up Menus

The fields that have the drop down arrow ▼ have look up menus like listed below.
Errors in the Claim

The number of errors in a given tab is indicated by the number circled in red next to the tab name.

Number of errors in the claim is 14.
If the user clicks in the field that has the error an explanation of this error will be displayed.

Clicking \( \times \) will close the tab.

If the option 'ZZ – Mutually defined, or Self Pay, or Unknown, or Charity' is chosen as the payer, do not identify the payer’s name under the payer name. Payer name should also be Self Pay, as pictured below.
Click Save
Error in the Claim

Which tabs the errors are on now.

Number of errors in the claim goes down from 14 to 7.

If an error is on the patient control number, this indicates that an error on the charges tab.
Next Error in Claim

When you click save, next error the next error in the claim will open.
Charges Tab

- Monetary amounts can be entered as partial dollar amounts by entering a decimal.
- The user must select a qualifier to enable the Procedure Code List.
- The modifiers are entered in sequence with the next modifier being activated as the user navigates from left to right.
- If the Total Claim Charges are marked in error a Recalculate button will appear. Clicking will sum the charges in all the revenue line items present in the claim.
- Click on the Add Charge button that is located next to Total Claim Charges to add a new charge to the claim.
- Click on the line item on the left screen to display the detail charge record in right screen.
Next Error in Claim

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Patient

Revenue Code: Qualifier:
0490 HC

Procedure Code:
00222 - ANESTH HEAD NERVE SURGERY

Modifiers:

Procedure Date: Procedure Thru Date:
05/05/2011 05/05/2011

Rate: Qty: Unit: Charge:
S  =

Total Charges: $0.00

6 errors in this claim
Diagnosis & Procedure Tab and Situational Tab

Selection of codes in the procedure code, value code, occurrence spans and Occurrences by dates fields without an accompanying entry of the associated field on the line item **will not be saved** when the user clicks save.

Enter all data prompted for on the line before saving.

Tabbing out of the last field on the line will generate a new entry line for additional line item entry up to the maximum amount allowed for the type of data being entered.
Next Error in Claim
Make Necessary Change
Please be advised the physician error will always show on the ID number, even if the error is with the physician's ID type and/or name. Please make sure the ID type, number and name are correct.
Make Changes
Submit Claim

THCIC Support Center

Back to list of claims

JOE DOE

Medical Record Number: 7141528
Patient Control Number: 5727928
Outpatient Institutional

- Patient
- Payer
- Charges
- Diagnosis
- Practitioners
- Situational Codes

Physician 1 (Operating)

Name
PHYSICIAN 1 FAKE

ID
XX - NPI - National Provider Identifier: 1111111111

Physician 2 (Other/ED Attending)

Name
PHYSICIAN 2 FAKE

ID
XX - NPI - National Provider Identifier: 2222222222

Submitting Claim
Claim Successfully Submitted

Click ‘Back To List of Claims’ to go back to the list of corrections or click ‘Next Claim’ and the next claim on the WebCorrect listing will be displayed. The claim will open up to the first error on the next claim.
The changes will need to be made to the professional form, as they were made to the institutional form. The facility will be able to save, save next error and submit the claim.
Professional Charges Tab
Professional Charges Tab
WebCorrect

Questions/ Comments

Questions, comments or need clarification please e-mail

@ thcichelp@dshs.texas.gov

The e-mail should include the facility’s THCIC ID.
THCIC Contact

Address:
Texas Health Care Information Collection
Dept of State Health Services – Center for Health Statistics
1100 W 49th St, Ste M-660
Austin, TX 78756

Phone: 512- 776-7261
Fax: 512- 776-7740
E-mail: THCIChelp@dshs.texas.gov
Web site: http://www.dshs.texas.gov/THCIC
THCIC Contact

Contact Tiffany Overton at ☎ 512-776-2352 or Tiffany.Overton@dshs.texas.gov if a facility has questions concerning the submission, correction, or certification of data.

Contact Dee Roes at ☎ 512-776-3374 or Dee.Roes@dshs.texas.gov if submitter test/production files reject due to a submission address or EIN/NPI number.

For general questions or to request information about THCIC please e-mail to thcichelp@dshs.texas.gov.
Address:
System13, Inc
1648 State Farm Blvd.
Charlottesville, VA 22911

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Fax: 434-979-1047
E-mail: THCIChelp@system13.com
Web site: https://thcic.system13.com