TEXAS
Health and Human Services

Texas Department of State Health Services

Outpatient Web Claim Entry

(Formerly WebClaim)

Revised October 2025

Document #: 25-15006

Background Information

- Chapter 108 of the Texas Health and Safety Code established and authorizesTHCIC to collect and report on Inpatient/inpatient discharge data.

- https://statutes.capitol.texas.gov/Docs/HS/htm/HS.108.htm

THCIC Rules

- **Title 25. Health Services**

- **SubchapterA** – Collection and Release of Hospital Discharge Data

- **Subchapter D** – Collection and Release of Inpatient Surgical and Radiological Procedures at Hospitals and Ambulatory Surgical Centers

- https://texas-sos.appianportalsgov.com/rules-and-meetings?chapter=421&interface=VIEW_TAC&part=1&title=25

Texas Secretary of State

TEXAS Health and Human Services | Texas Department of State Health Services

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

E-mail: THCIChelp@dshs.texas.gov

Web site: https://www.dshs.texas.gov/texas-health-care-information-collection

THCIC Contact

- Contact Adrianna Jackson at email Adrianna.Jackson@dshs.texas.gov if submitter test/production files reject due to a submission address or EIN/NPI number.

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

- For general questions or to request information about THCIC please e-mail to thcichelp@dshs.texas.gov.

SYSTEM13 Contact


Address:
System13
1648 State Farm Blvd.
Charlottesville, VA 22911


Phone: 1-888-308-4953


Fax: 434-979-1047


E-mail: THCIChelp@system13.com


Web site: https://thcic.system13.com

Certification Due Dates

TEXAS Health and Human Services | Texas Department of State Health Services

The THCIC reporting schedule is available online at https://www.dshs.texas.gov/texas-health-care-information-collection/facility-reporting-requirements/data-reporting-schedule

Data Reporting Schedule

Texas Health Care Information Collection Center for Health Statistics

Activity	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Q1 2026	Q2 2026	Q3 2026	Q4 2026
Cutoff for initial submission	6-2-25	9-2-25	12-1-25	3-2-26	6-1-26	9-1-26	12-1-26	3-1-27
Cutoff for corrections	8-1-25	11-3-25	2-2-26	5-1-26	8-3-26	11-2-26	2-1-27	5-3-27
Facilities retrieve certification files	9-2-25	12-1-25	3-2-26	6-1-26	9-1-26	12-1-26	3-1-27	6-1-27
Certification/ comments due	10-15-25	1-15-26	4-15-26	7-15-26	10-15-26	1-15-27	4-15-27	7-15-27

The reporting schedule is a rule driven schedule, under Chapter 421, Title 25, Part 1 of the Texas Administrative Code, Subchapter D, RULE §421.66. The due dates are either the 1st or the 15th of the month, if these dates are on a weekend or state observed holiday, the data is due the next business day.

Data Due Dates

Data Reporting Schedule

Texas Health Care Information Collection
Center for Health Statistics

Activity	Q1 2025	Q2 2025	Q3 2025
Cutoff for initial submission	6-2-25	9-2-25	12-1-25
Cutoff for corrections	8-1-25	11-3-25	2-2-26
Facilities retrieve certification files	9-2-25	12-1-25	3-2-26
Certification/ comments due	10-15-25	1-15-26	4-15-26

Cutoff for initial submission, date when the data is due in the system

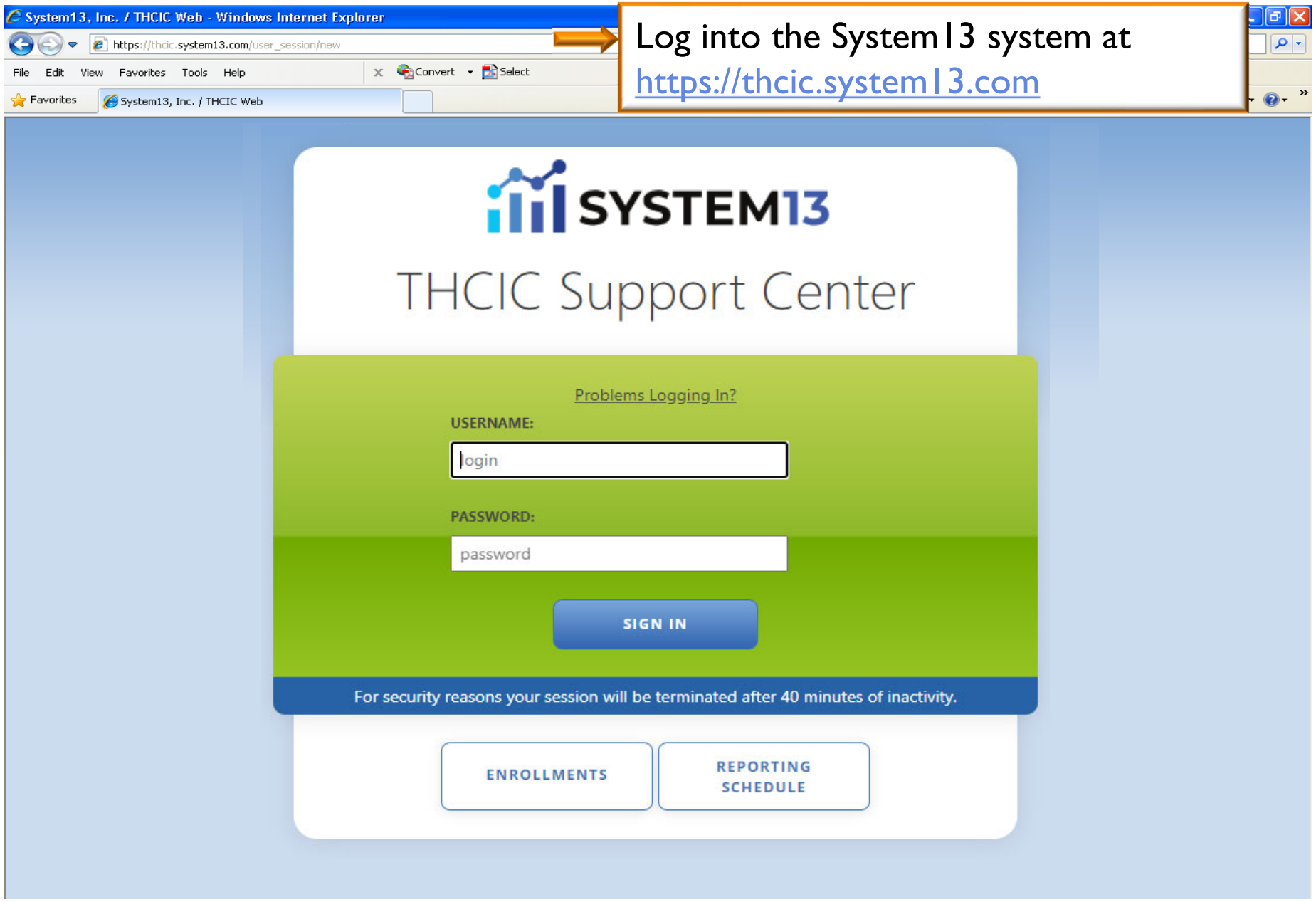
Cutoff for corrections, is when the corrections are due by for that quarter

Facilities receive certification files, by this date System13 sends the certification files

Certification/comments due, when the data must be certified and comments (if any) needed to be inputted into the system. If data is less than 100% accurate, comments must be submitted at certification.

The reporting schedule is a rule driven schedule, under Chapter 421, Title 25, Part 1 of the Texas Administrative Code, subchapter D, RULE §421.66. The due dates are either the 1st or the 15th of the month, if these dates are on a weekend or state observed holiday, the data is due the next business day.

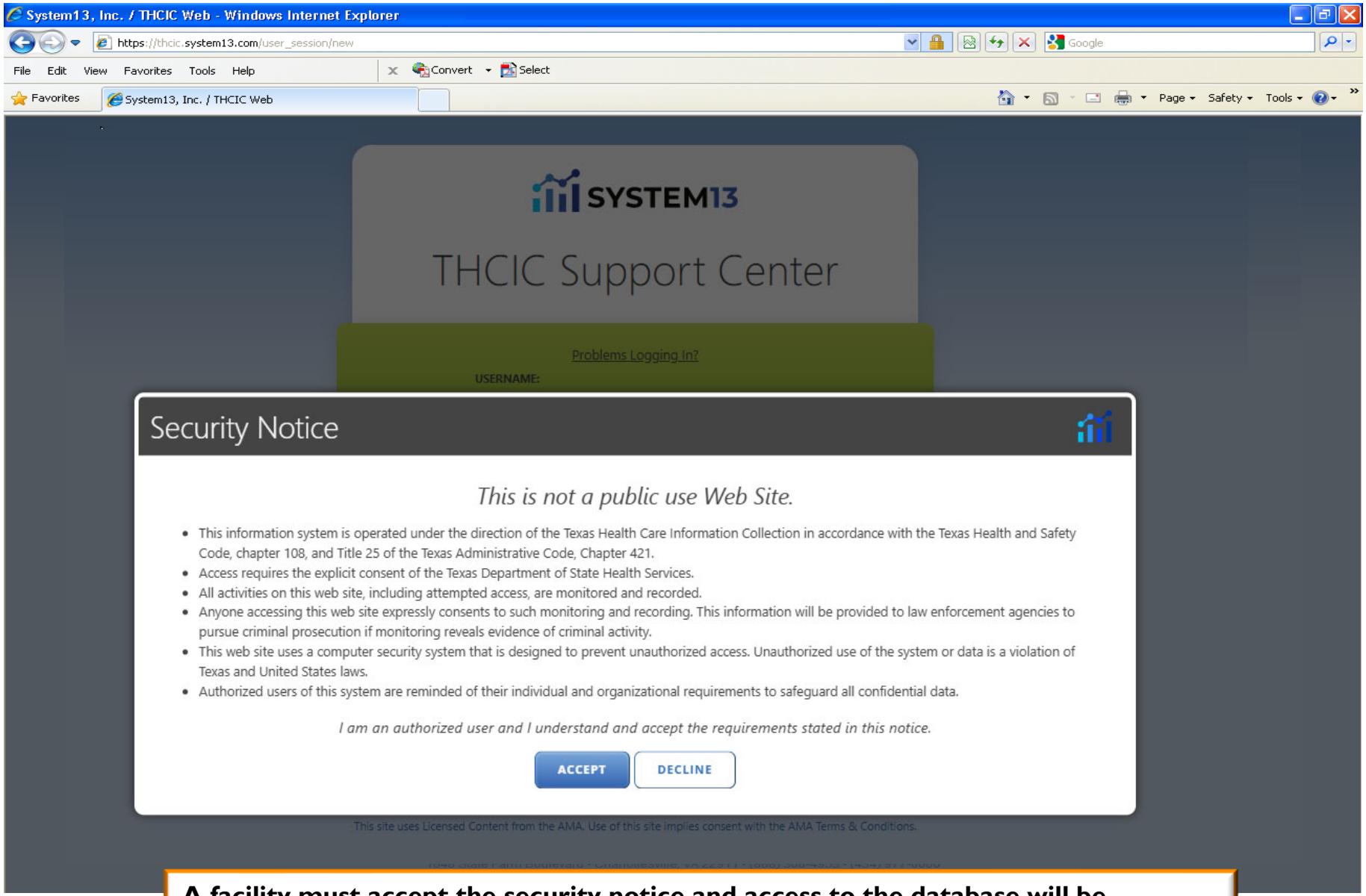
THCIC System



Log In the System as a Provider

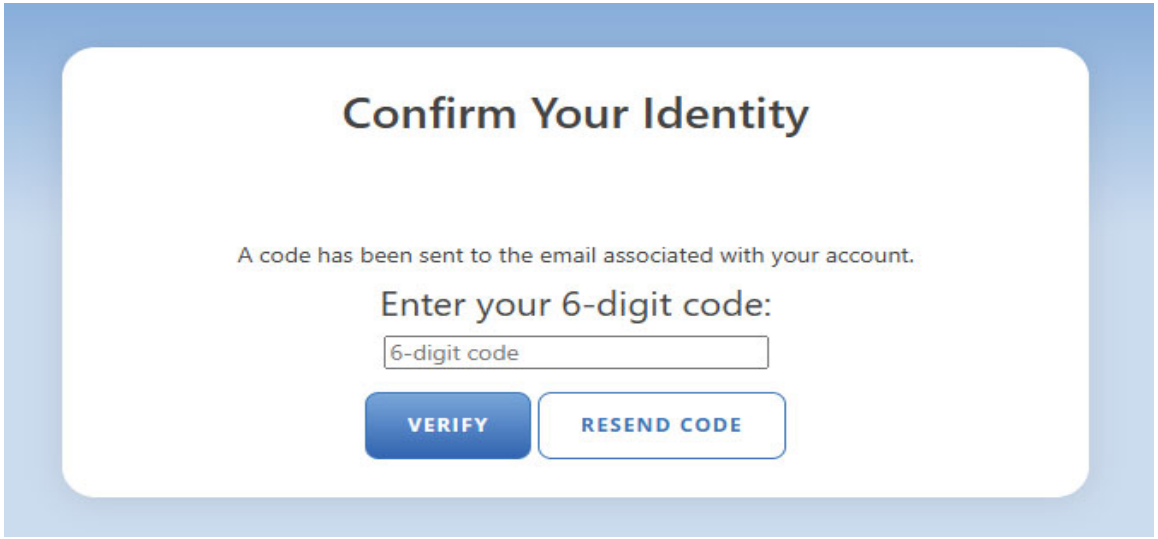
Put in THCIC ID username and password. Click 'sign in'.

Security Notice



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.

Multi-Factor Authentication (MFA)



Code received via email.

From: System13 Trainer Notifier
To: Your Email Address
Subject: THCIC HCDCS Account Sign In: Confirm Your Identity
Date: Wednesday, April 16, 2025 12:54:16 PM

WARNING: This email is from outside the HHS system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Please Confirm Your Identity

Dear THCIC Contact: (Your Name)

To complete the login process for your th******** account, enter this one-time code to confirm your identity:
504057

Please use caution and do not forward or share this information with any unknown third party. To help protect your privacy, this code will expire within 5 minutes.

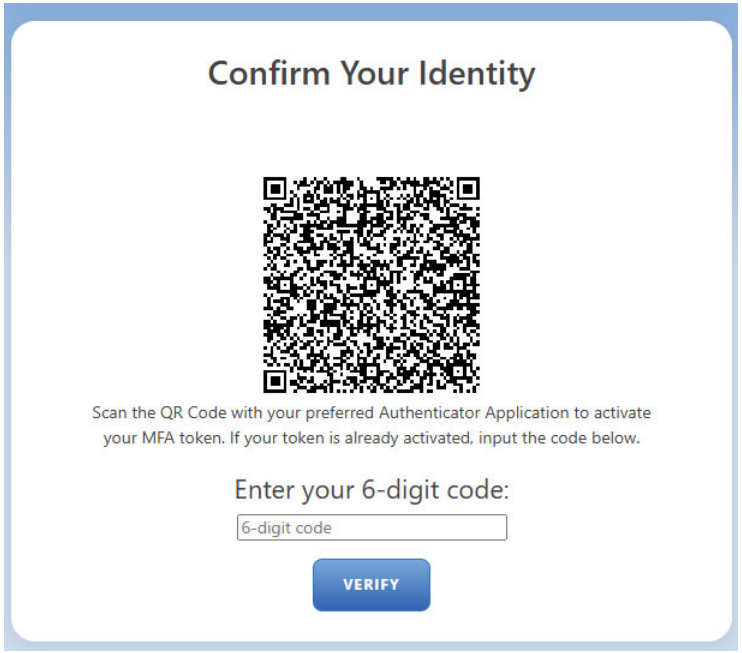
Neither THCIC nor System13 will call you and ask you for this code, nor will we ask you for a password. Please report any suspicious activity.

Thank you.
-- THCIC/System13 Support

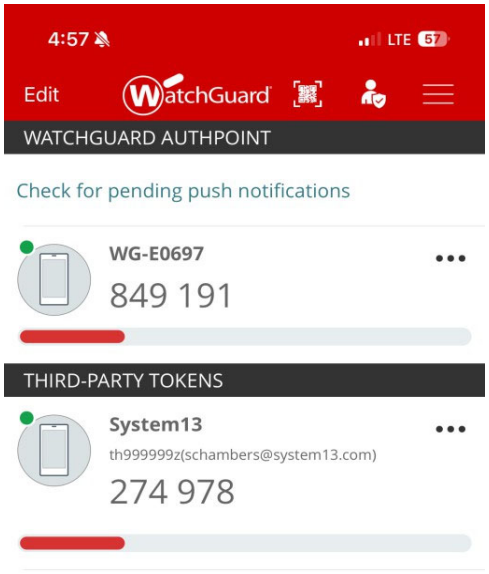
Organization Information:

- **Facility Name:** THCIC Facility
- **Facility Identifier:** *******

Multi-Factor Authentication (MFA)



Code by scanning the QR Code.



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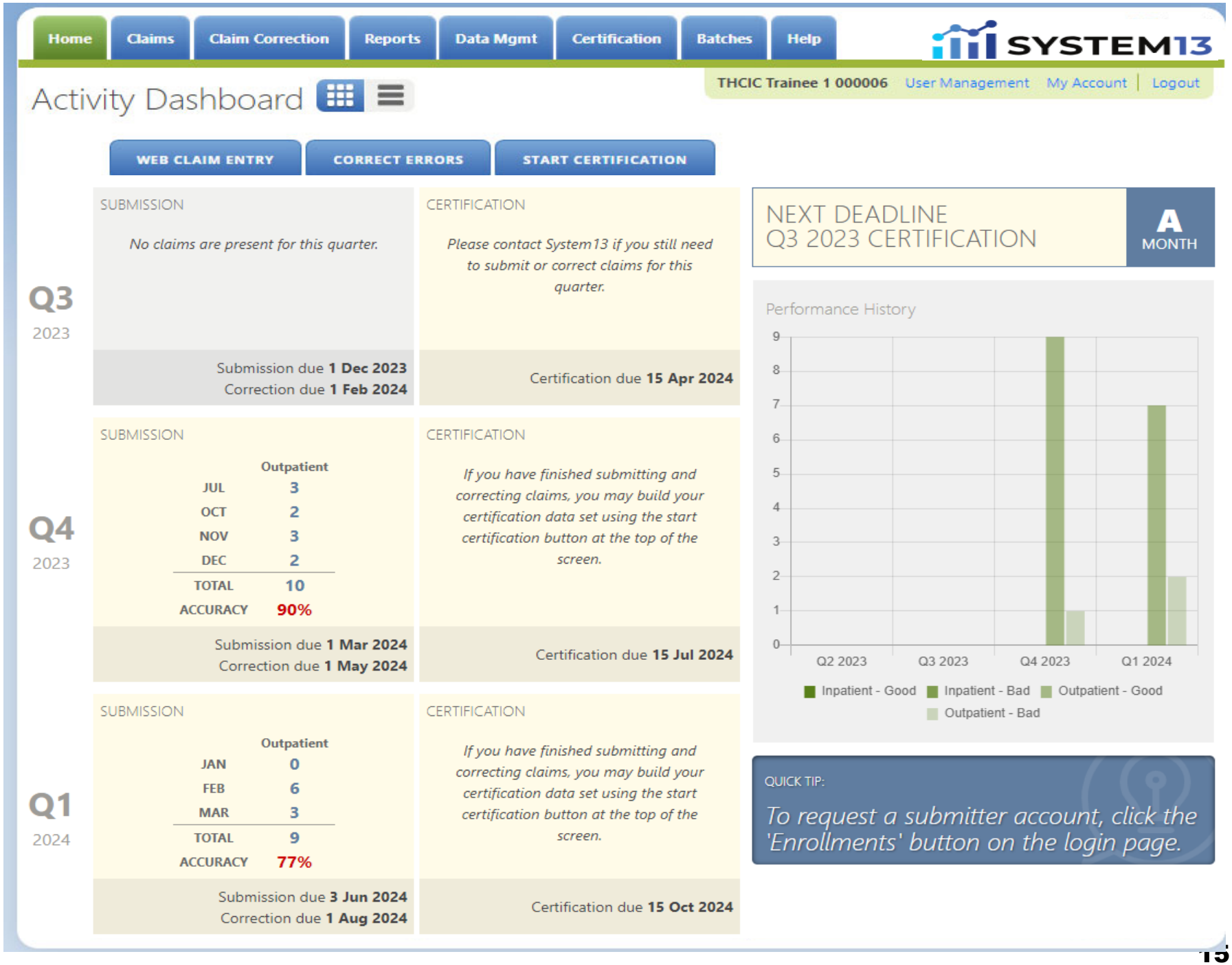
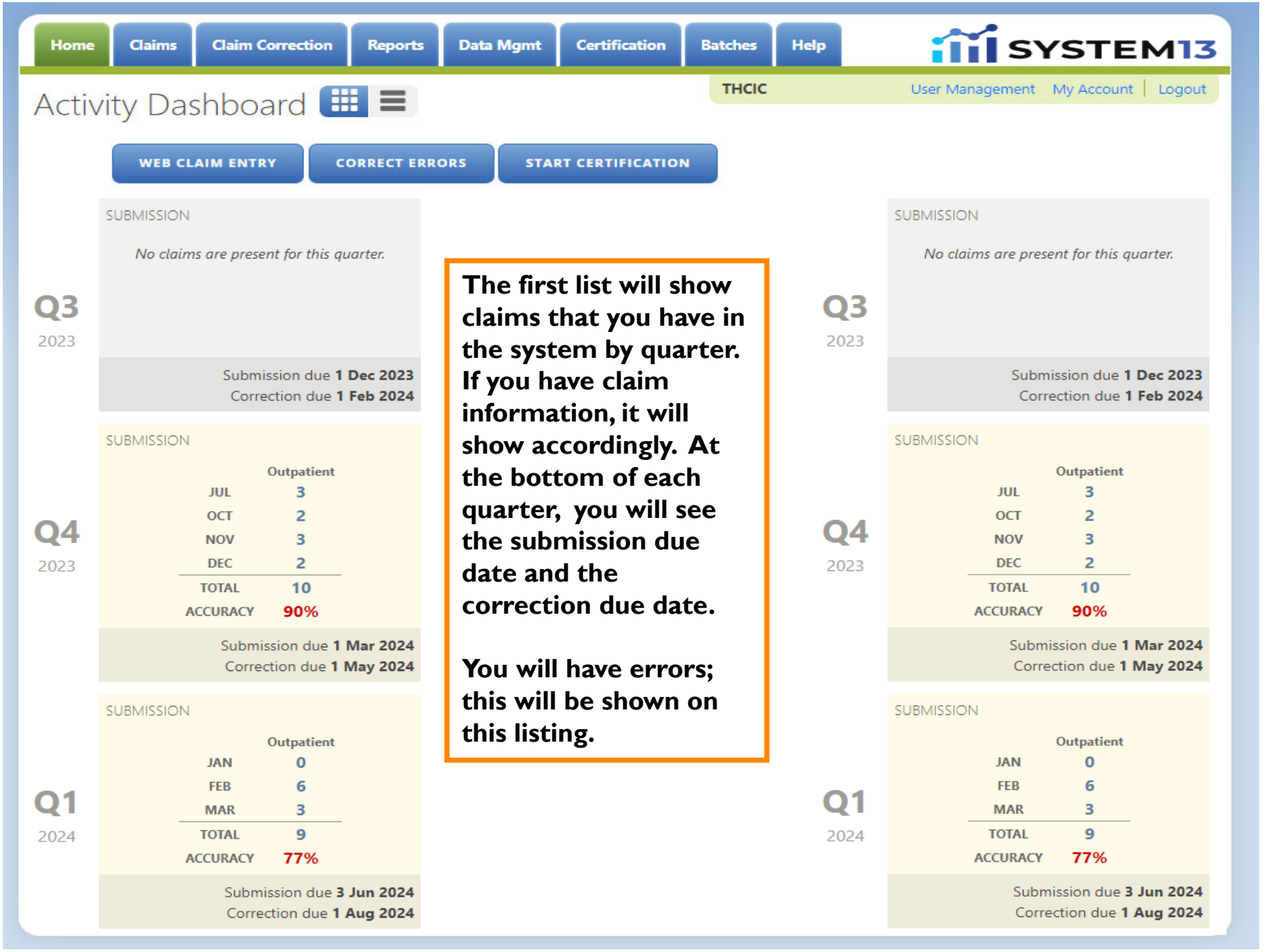
Provider Dashboard

- The user dashboard for facility users that provides insights into the claim counts broken down by quarter and month as well as providing the accuracy percentage.
- A graph of historical clam counts and a section with helpful tips.
- The dashboard also provides key deadlines broken down by quarter as well as prominently displaying the next deadline for submission, correction and certification,.
- Two views (List and Grid View).

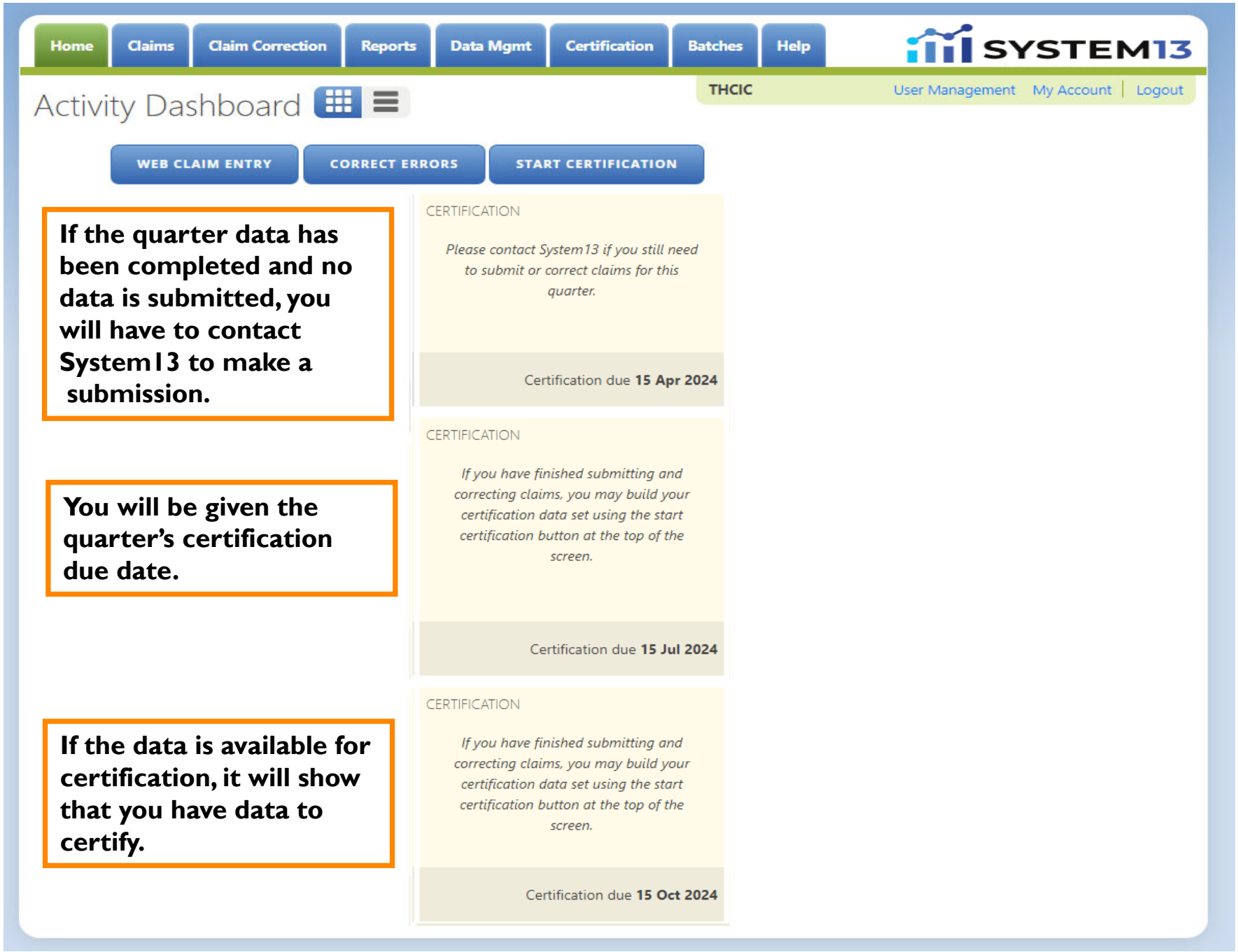
Provider Home Page – Grid View



Provider Home Page – 1st Row



Provider Home Page – 2nd Row

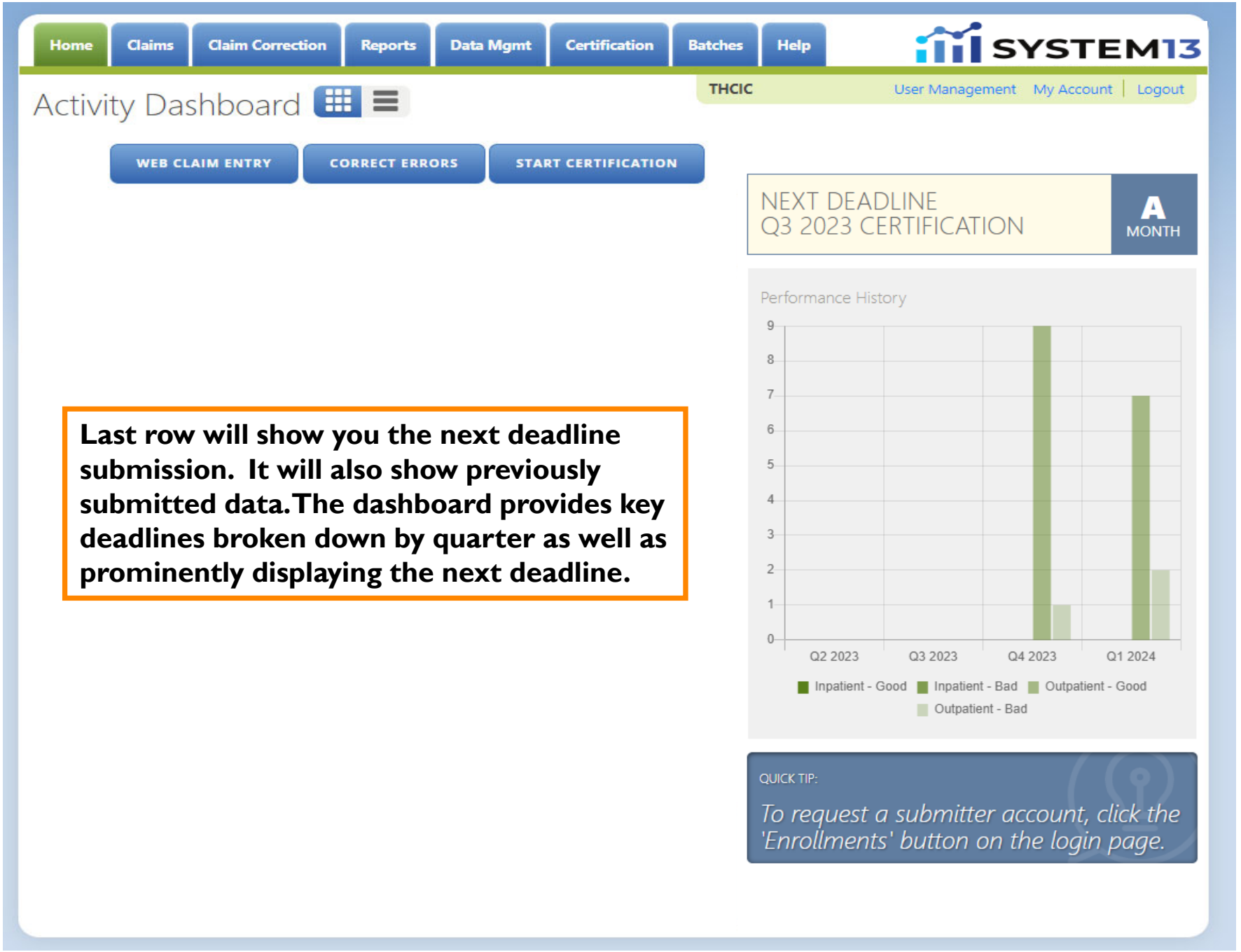


If the quarter data has been completed and no data is submitted, you will have to contact System13 to make a submission.

You will be given the quarter's certification due date.

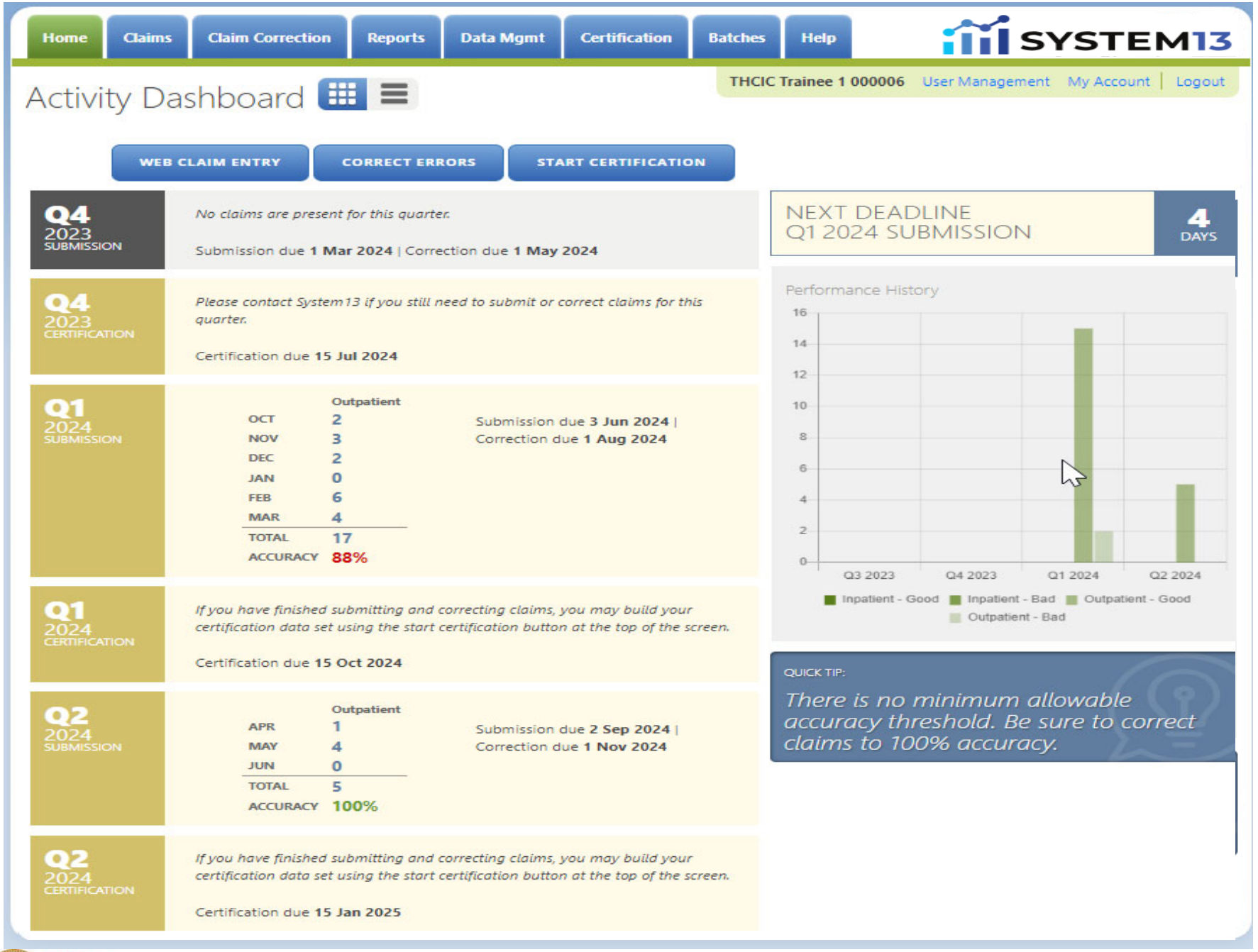
If the data is available for certification, it will show that you have data to certify.

Provider Home Page – 3rd Row

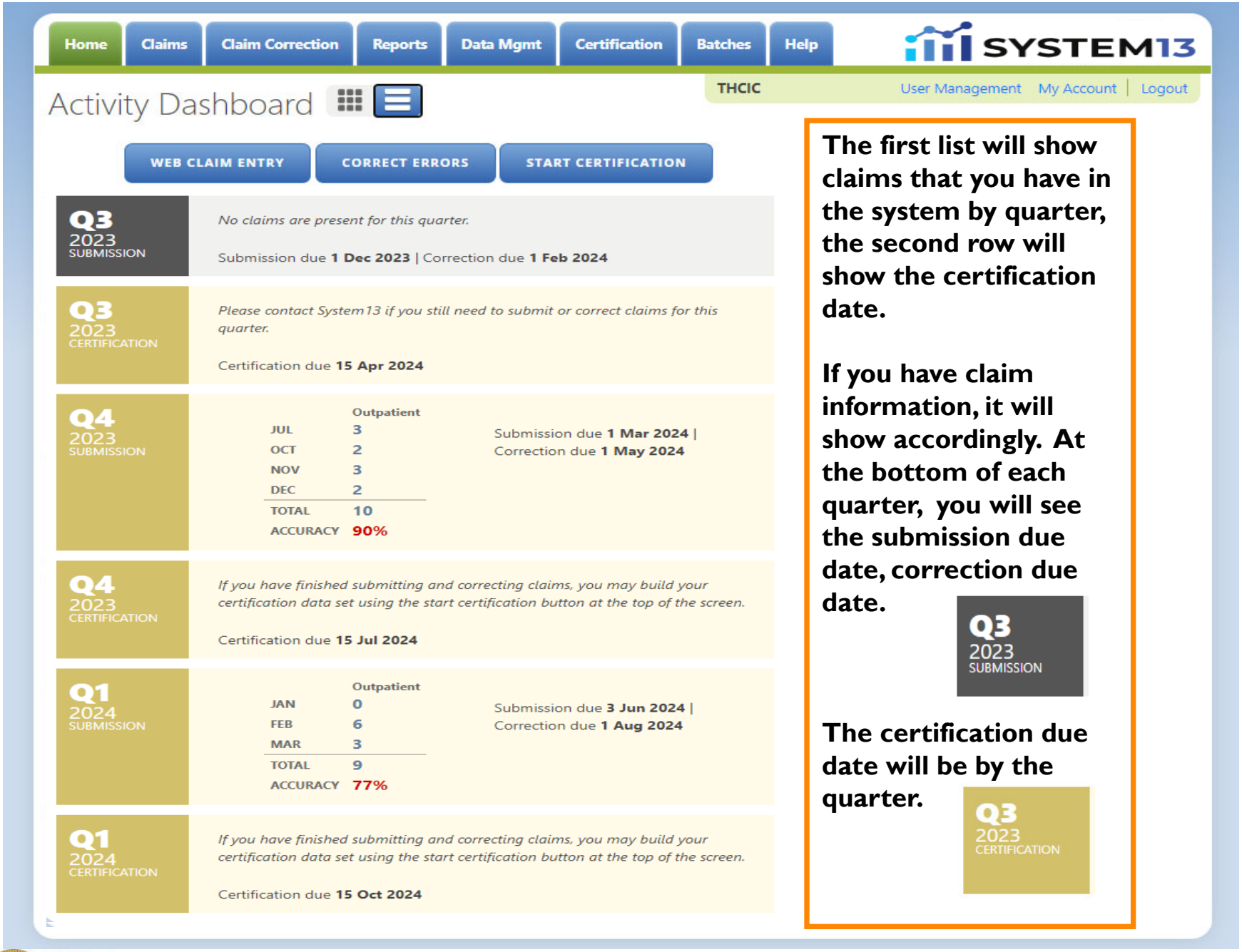


Last row will show you the next deadline submission. It will also show previously submitted data.The dashboard provides key deadlines broken down by quarter as well as prominently displaying the next deadline.

Provider Home Page – List View



Provider Home Page – 1st Row

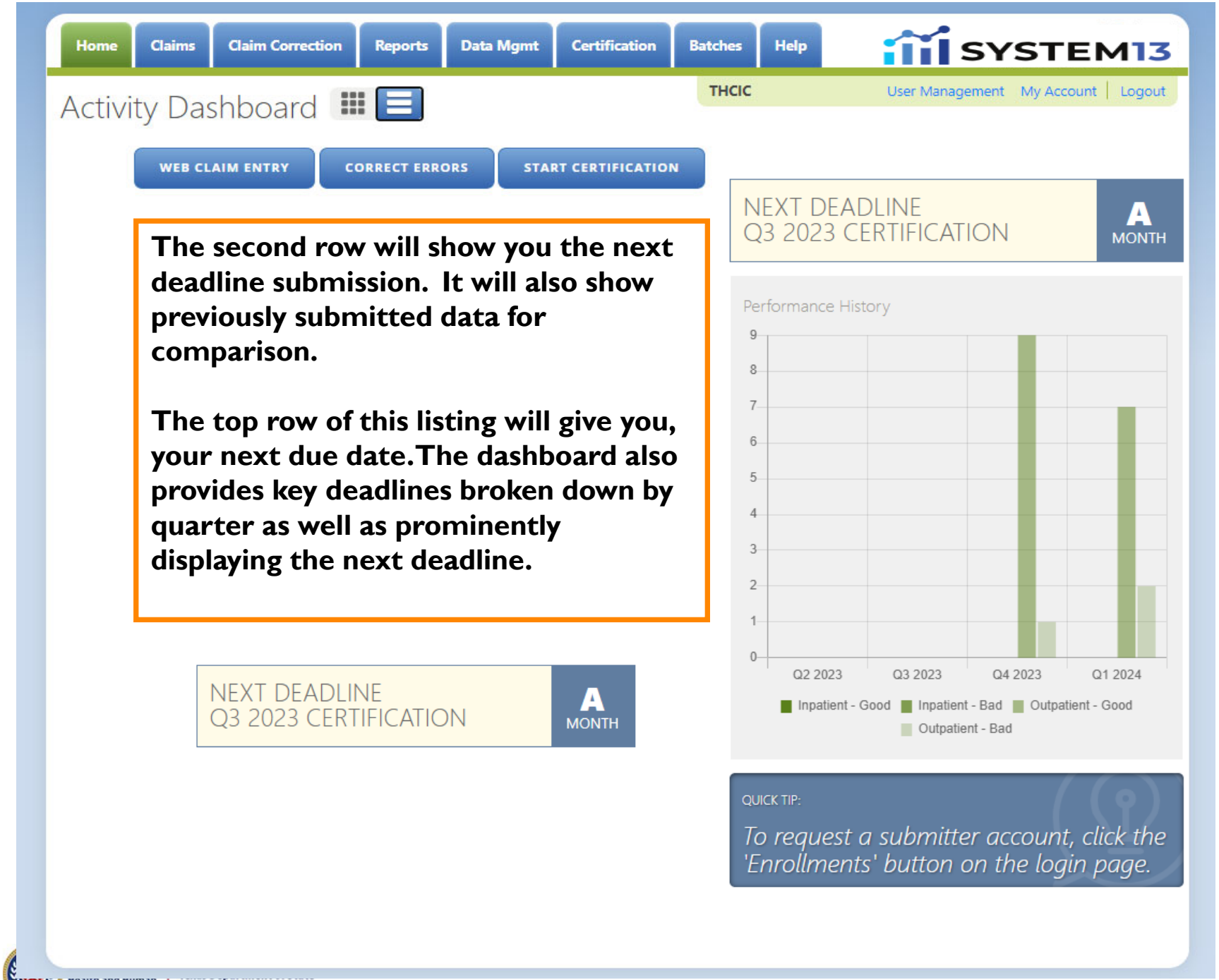


The first list will show claims that you have in the system by quarter, the second row will show the certification date.

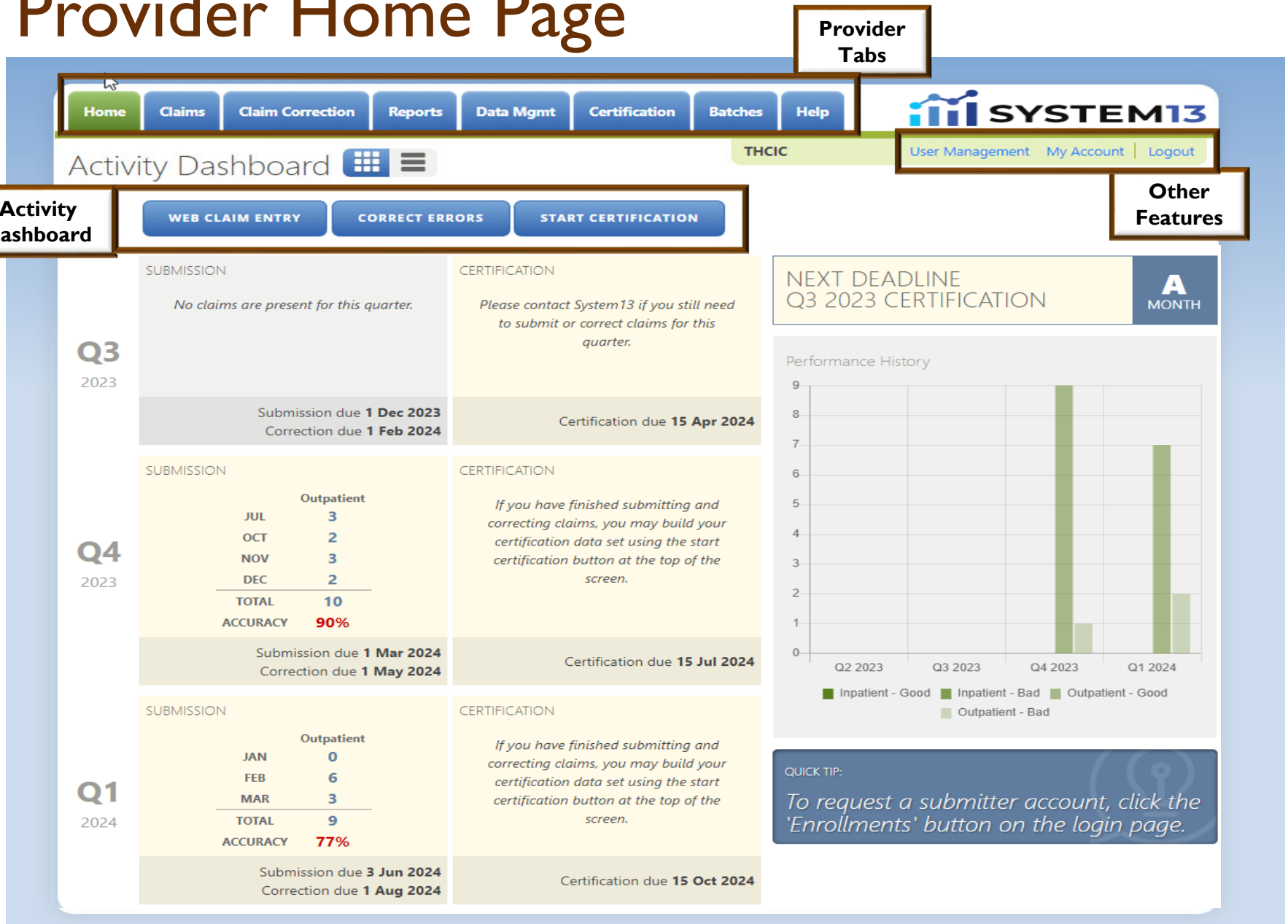
If you have claim information, it will show accordingly. At the bottom of each quarter, you will see the submission due date, correction due date.

The certification due date will be by the quarter.

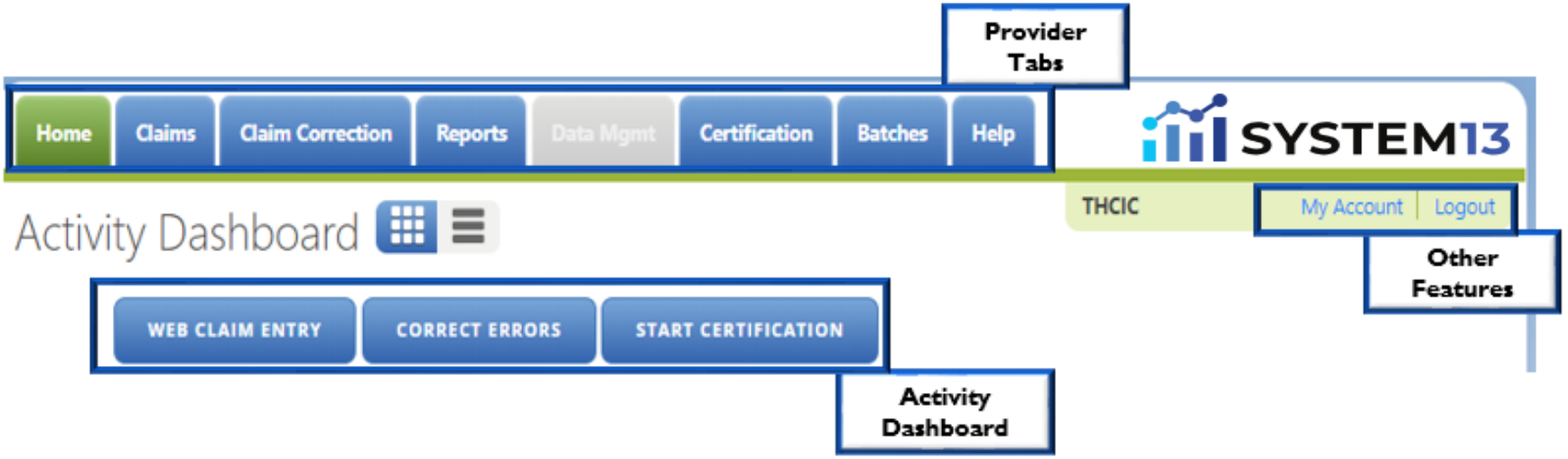
Provider Home Page – 2nd Row



Data Management/Primary Contact Provider Home Page



Data Certifier / Data Manager Provider Home Page



Only the primary contact have access to the data management.

Data Managers do not have access to the data management tab and certification tab and WebCert desktop icon.

Provider Tabs

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.

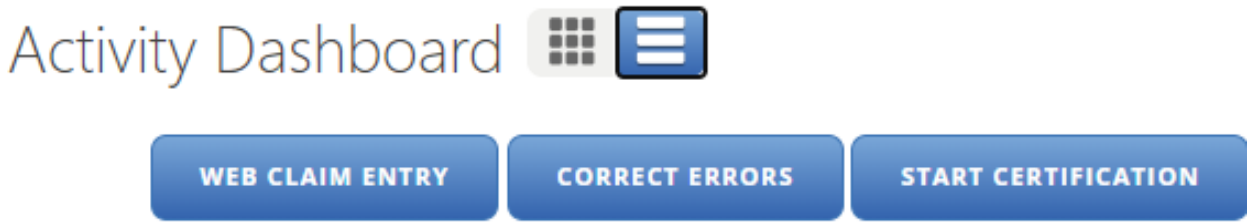
Reports — Various reports available for facility to view and documentation.

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.



Activity Dashboard

Web Claim Entry – Allows facilities to manually enter claims in the system.

Correct Errors is the same as the tab WebCorrect – Allows facilities to correct claim data that is in error.

Start Certification is the same feature as the tab WebCertification – Allows facilities to certify their data.

Web Claim Entry

WEB CLAIM ENTRY

ADD NEW CLAIM

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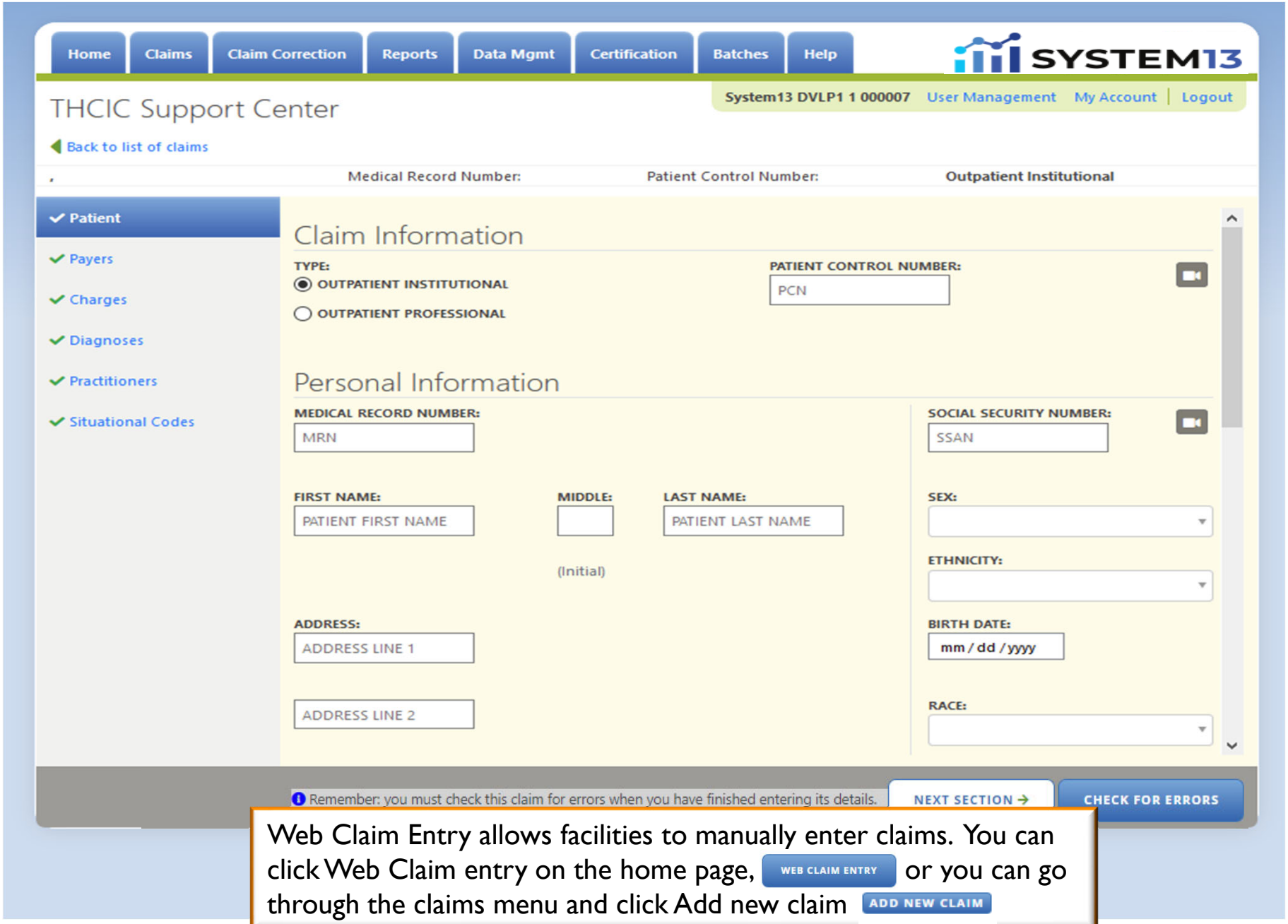
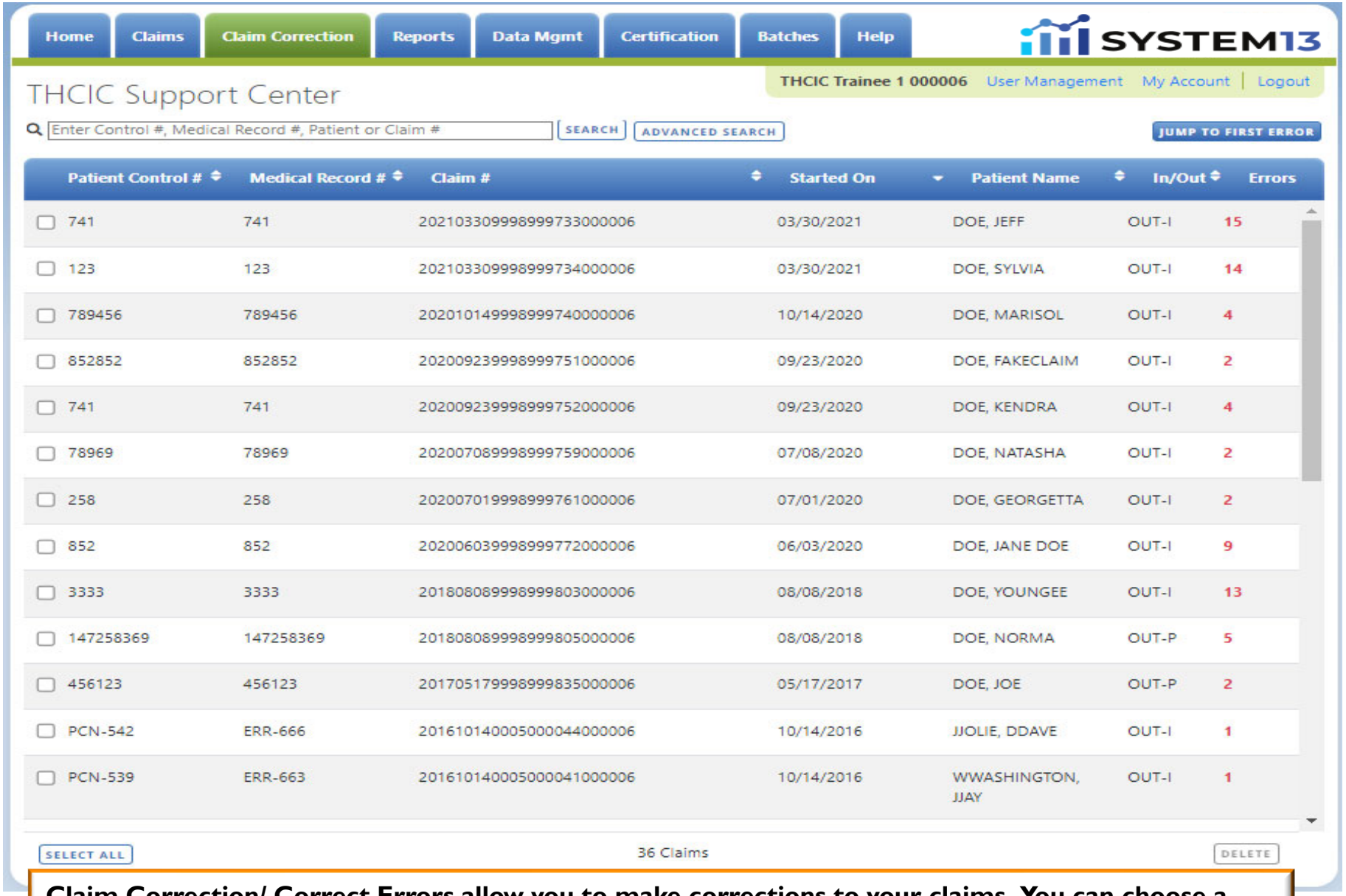


Web Claim Entry allows facilities to manually enter claims. You can click Web Claim entry on the home page, WEB CLAIM ENTRY or you can go through the claims menu and click Add new claim ADD NEW CLAIM

Claim Corrections / Correct Errors

CORRECT ERRORS

Claim Correction



Claim Correction/ Correct Errors allow you to make corrections to your claims. You can choose a claim from the listing, modify your listing or click start correction: JUMP TO FIRST ERROR which opens the first claim on your listing and allows you to use NEXT CLAIM → through the navigation.

Services | Health Services

Start Certification /Certification

START CERTIFICATION

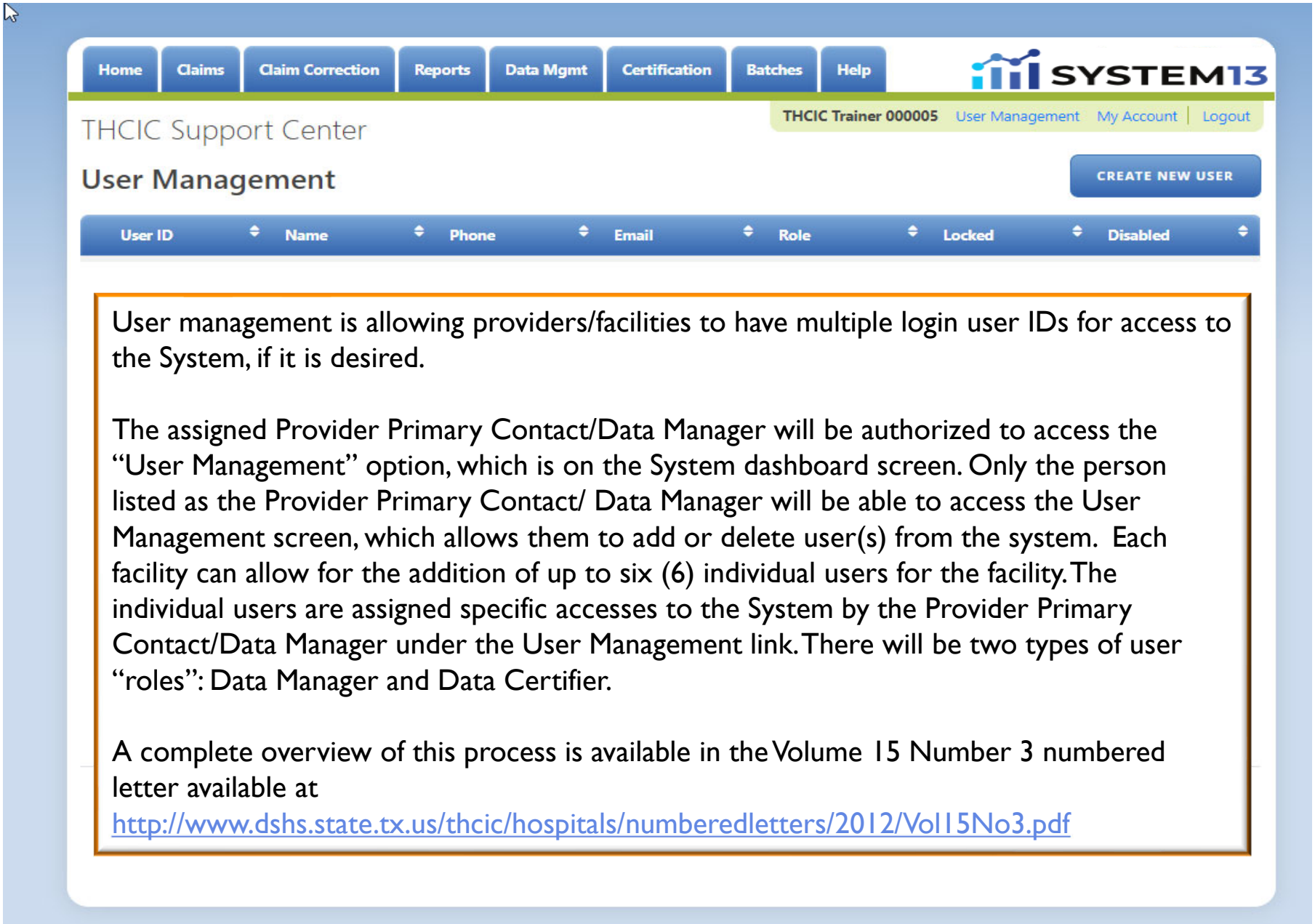
Certification

Start Certification/ 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.

Provider Other Features

The 'User Management' option will only be visible to provider primary contact/Data Managerfor the facility. Otherwise, other user will only have the 'My Account' and 'Logout' features pictured below.

User Management

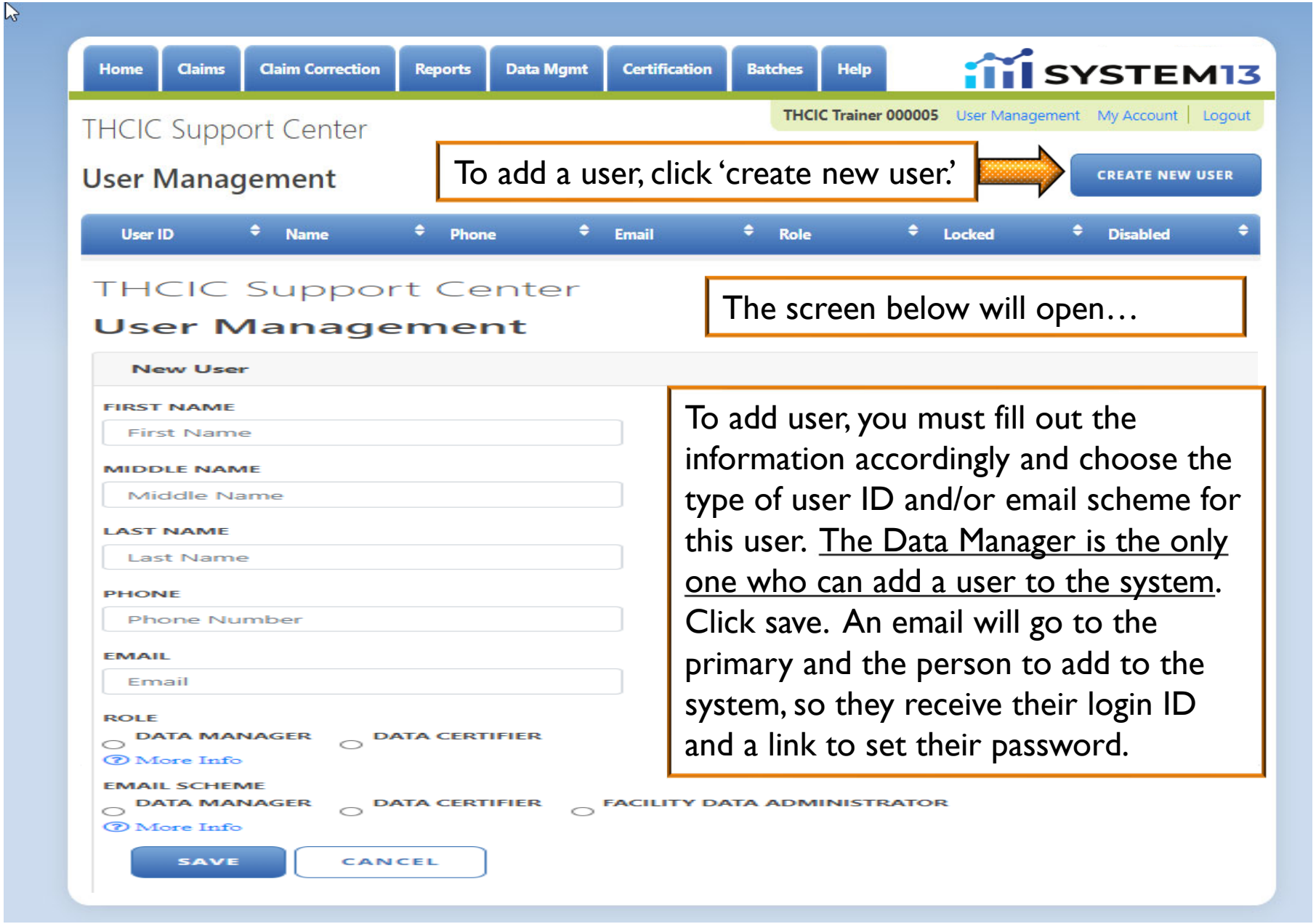


User management is allowing providers/facilities to have multiple login user IDs for access to the System, if it is desired.

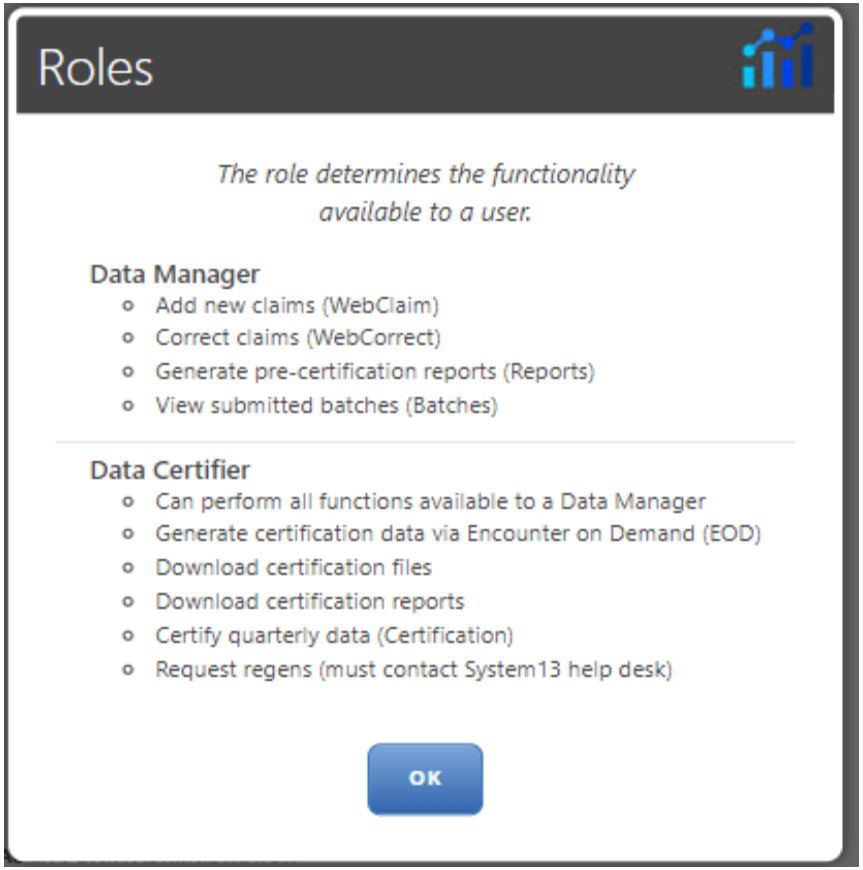
The assigned Provider Primary Contact/Data Manager will be authorized to access the "User Management" option, which is on the System dashboard screen. Only the person listed as the Provider Primary Contact/ Data Manager will be able to access the User Management screen, which allows them to add or delete 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 Manager under the User Management link. There will be two types of user "roles": Data Manager and Data Certifier.

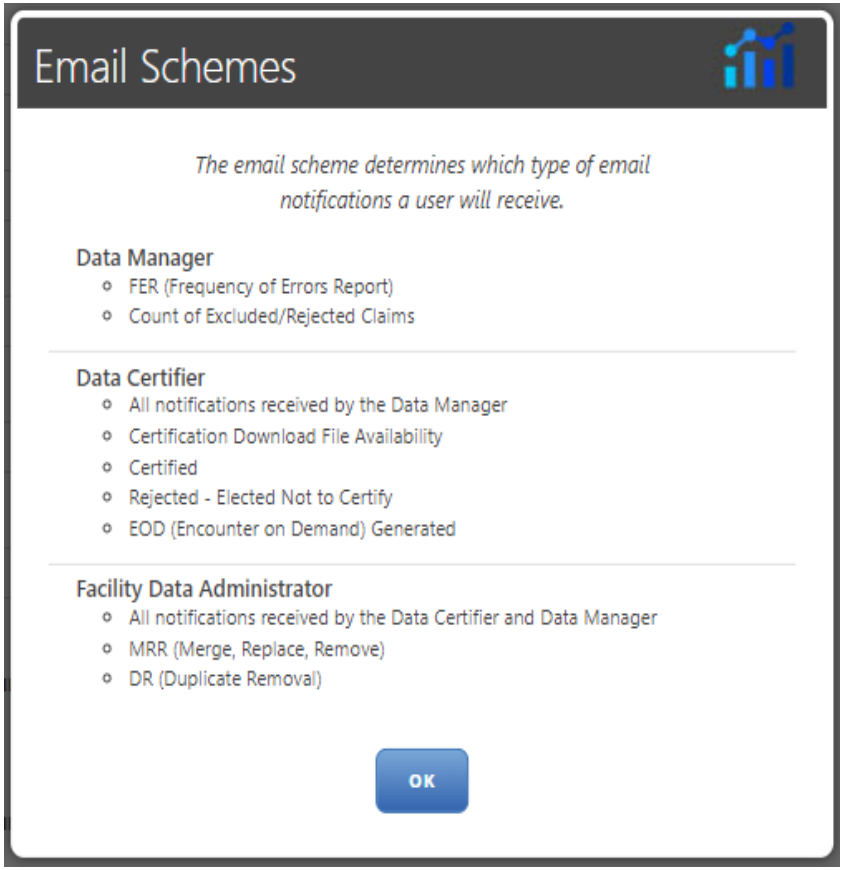
A complete overview of this process is available in the Volume 15 Number 3 numbered letter available at
http://www.dshs.state.tx.us/thcic/hospitals/numberedletters/2012/Vol15No3.pdf

User Management – To Add User



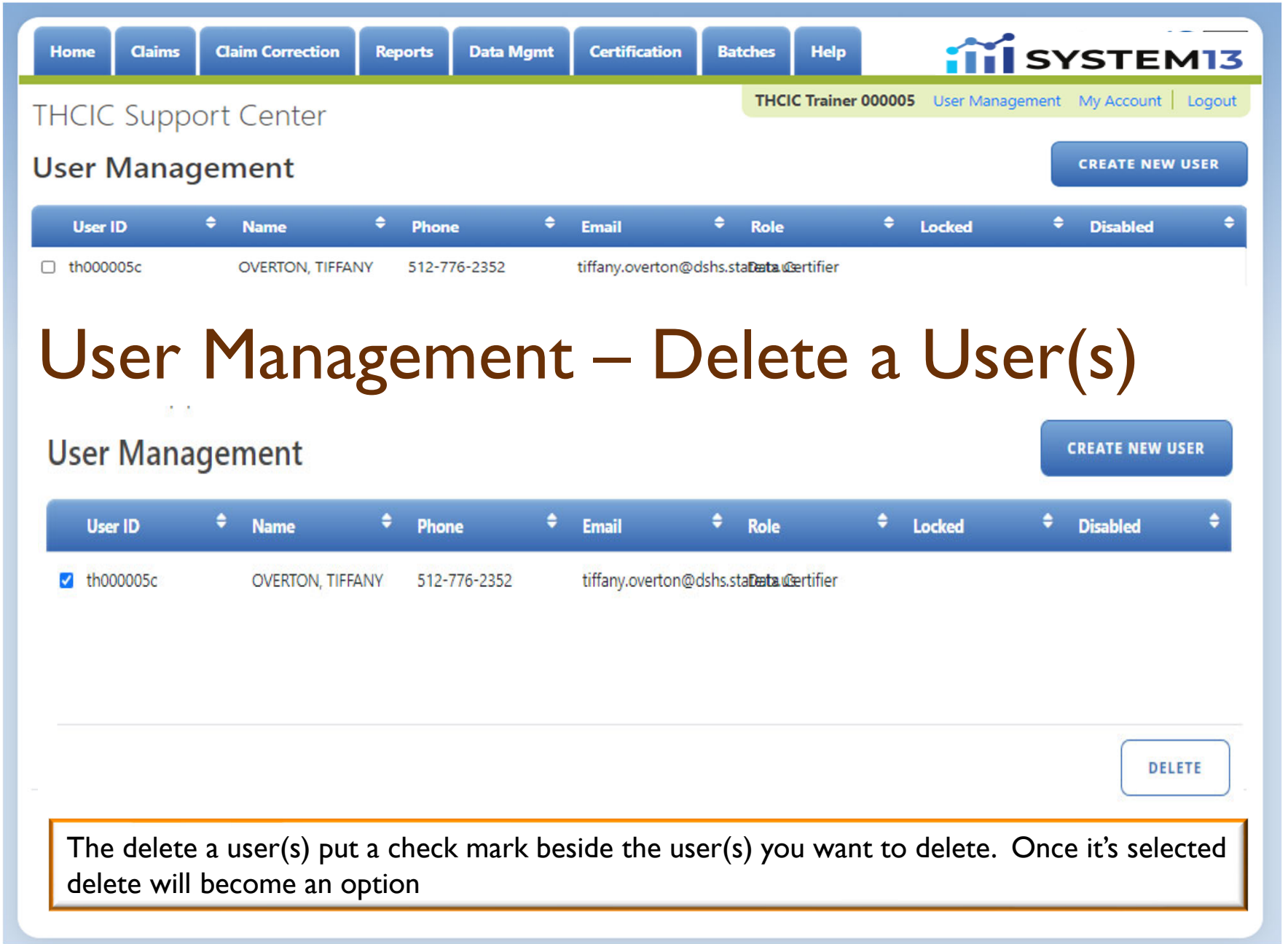
User Management – User Roles / Email Schemes





Choose what type of access the user will have in the system, and which emails they will receive.

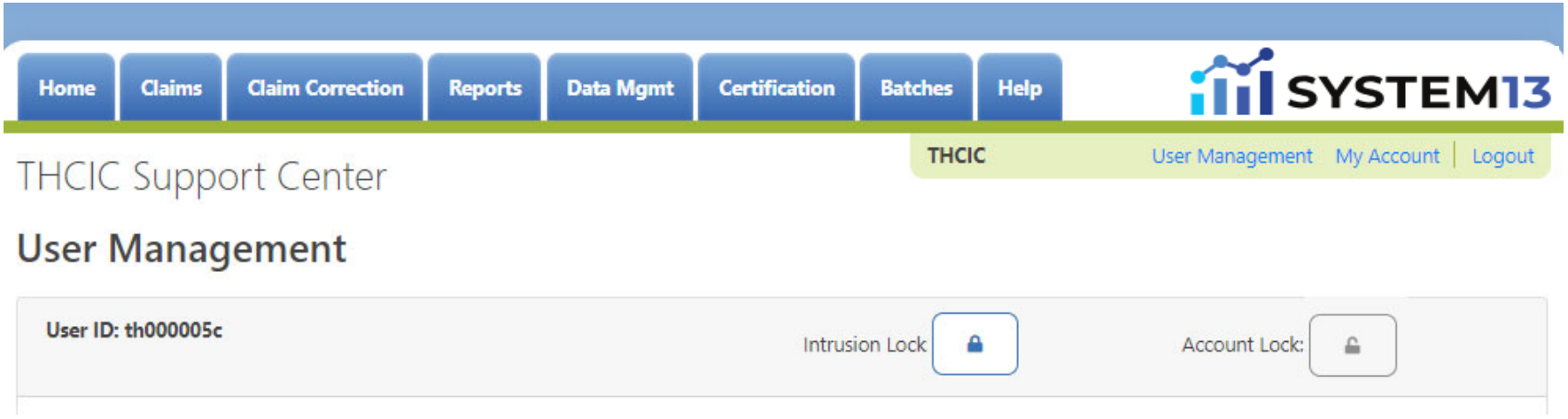
User Management – List of User(s)



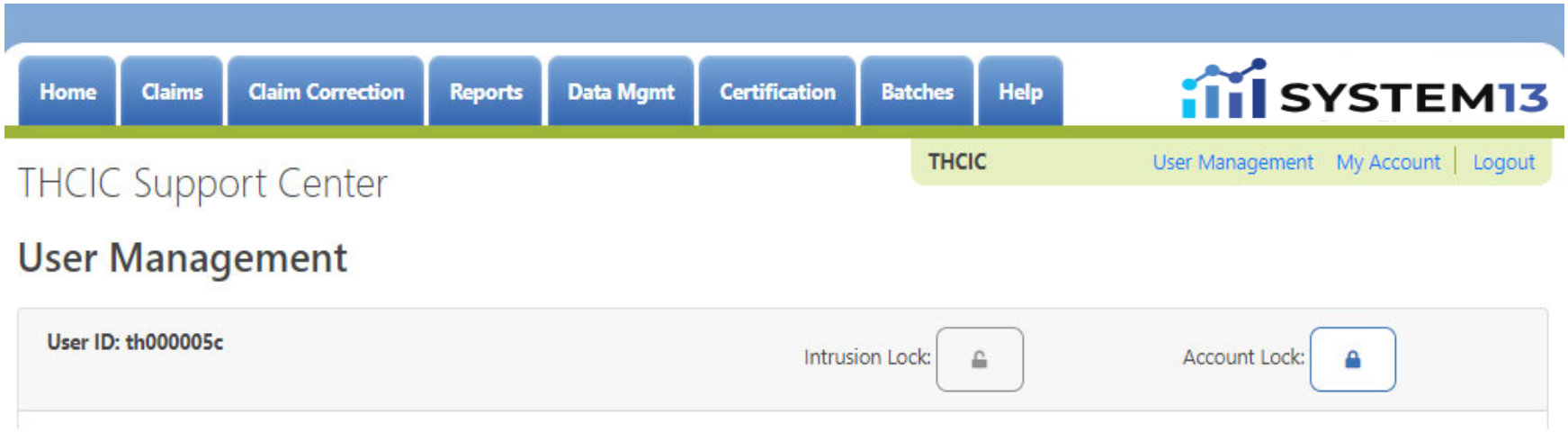
User Management – Delete a User(s)

The delete a user(s) put a check mark beside the user(s) you want to delete. Once it's selected delete will become an option

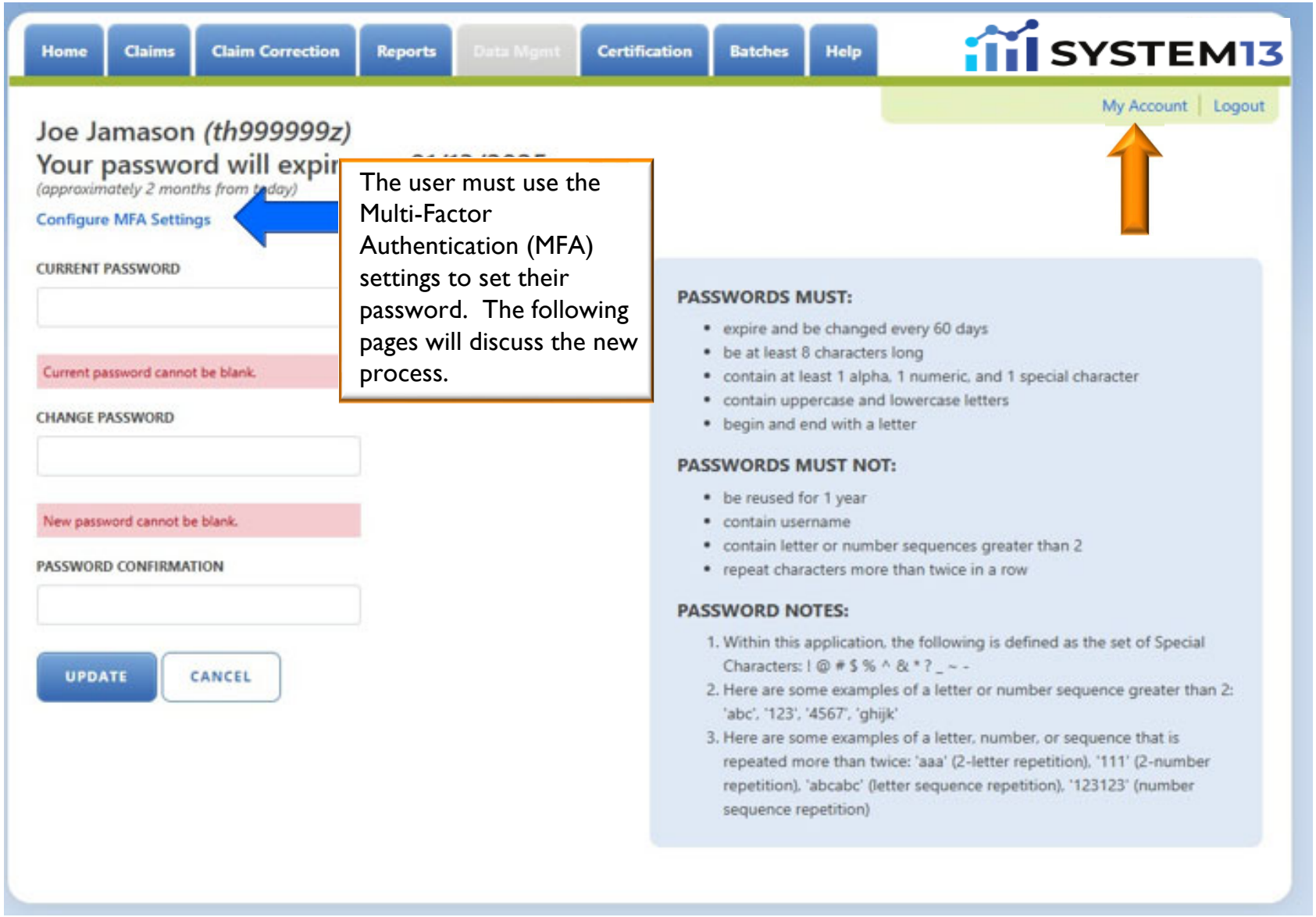
User Management – Lock Features



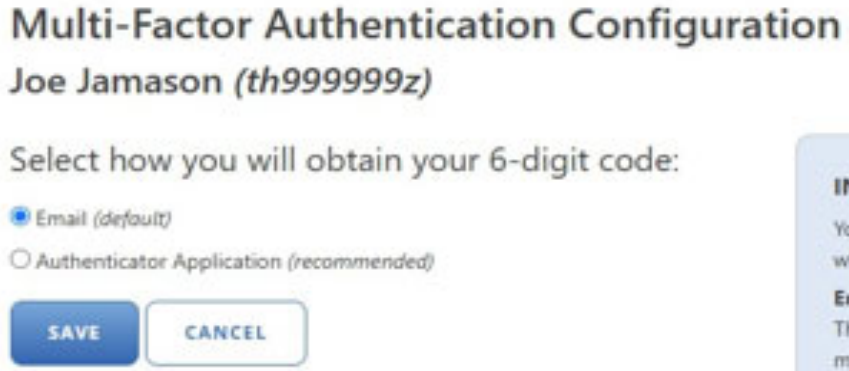
The administrator can clear intrusion or account lock(s). When the locks are on the system, they will be colored blue. A user will get locked out of the system if they have more than three (3) failed login attempts. The administrator can clear the 'intrusion lock' by unchecking the box above. The administrator 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.)

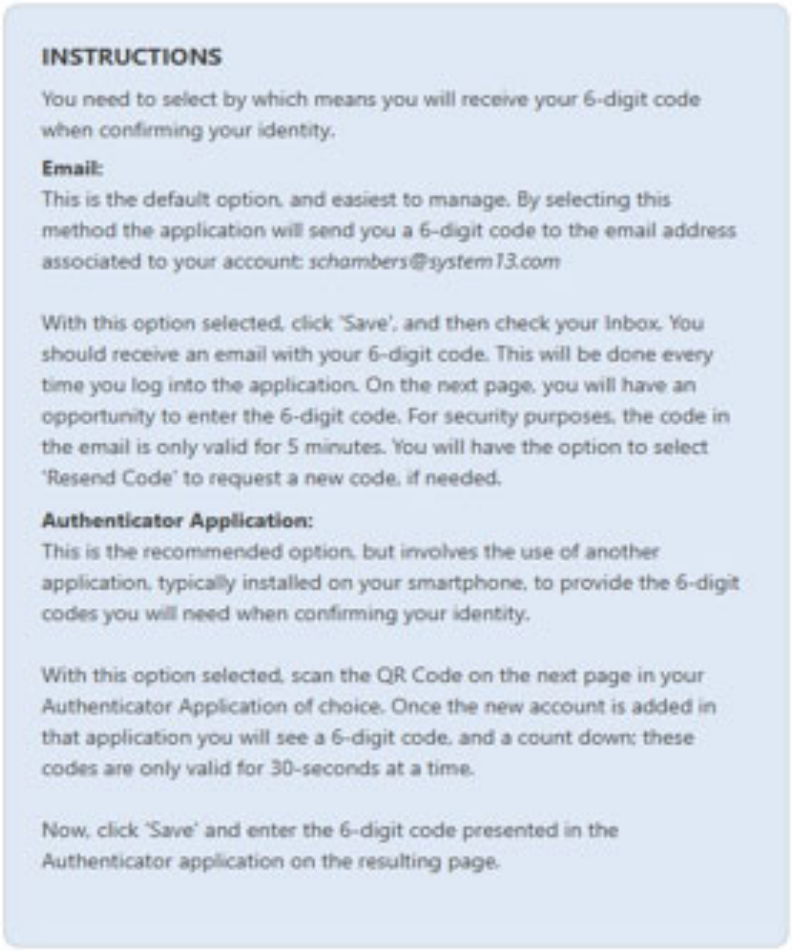


Other Features - My Account Password Update/Change



Multi-Factor Authentication (MFA) Configuration





The configuration page will be presented to all users upon the first time they login.

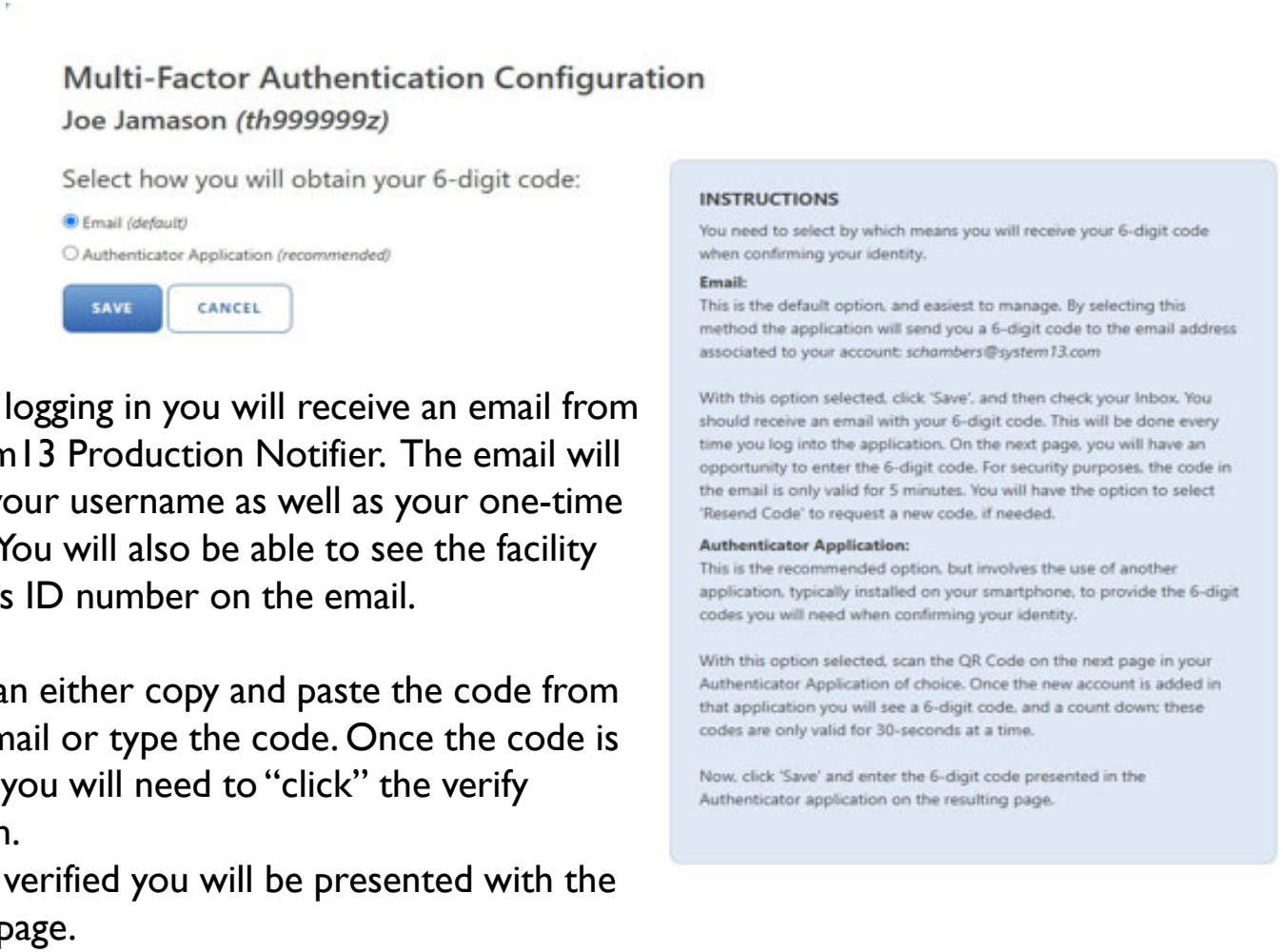
Email: Will send your code via Email, this is the easier option and does
not require additional update.

Authenticator App: Requires an App where your 6-digit code will cycle every 30 seconds. This will help if your facilities email filter takes too long for email.

Details and Instructions for both settings are available to read under the "Instructions".

MFA Configuration – Email

Email: Is the default and is easier to manage. You will be sent a 6 -digit code to the email address associated to the user's account. Once the code is sent it will be valid for 5 minutes. You will have the option to resend a new code.



Upon logging in you will receive an email from System13 Production Notifier. The email will have your username as well as your one-time code. You will also be able to see the facility and it's ID number on the email.

You can either copy and paste the code from the email or type the code. Once the code is there you will need to "click" the verify button.
Once verified you will be presented with the homepage.

Log In the System (Email)

Upon logging in you will receive an email from System13 Production Notifier.

The email will have your username as well as your one-time code. You will also be able to see the facility and it's ID number on the email.

You can either copy and paste the code from the email or type the code. Once the code is there you will need to "click" the verify button.

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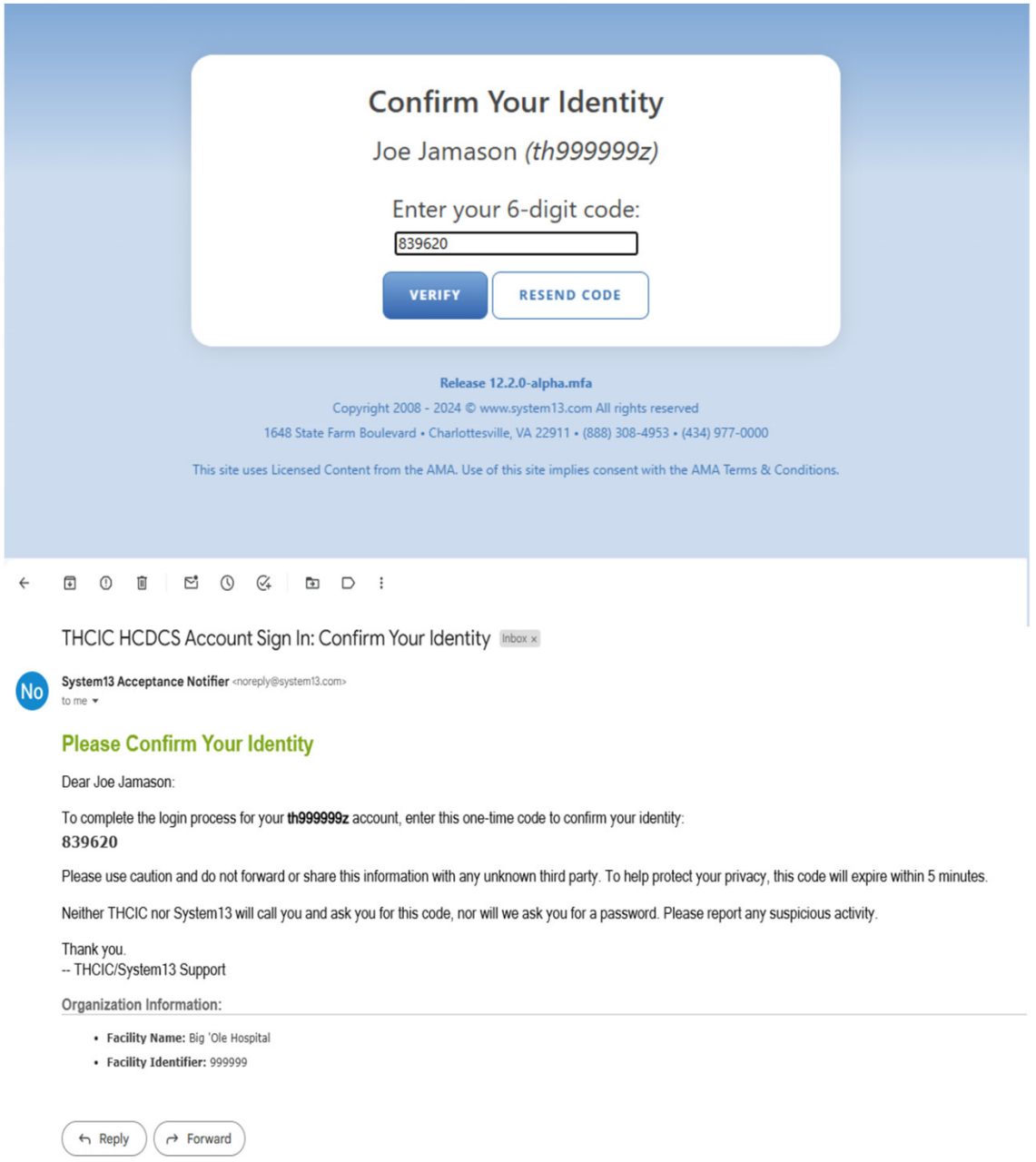
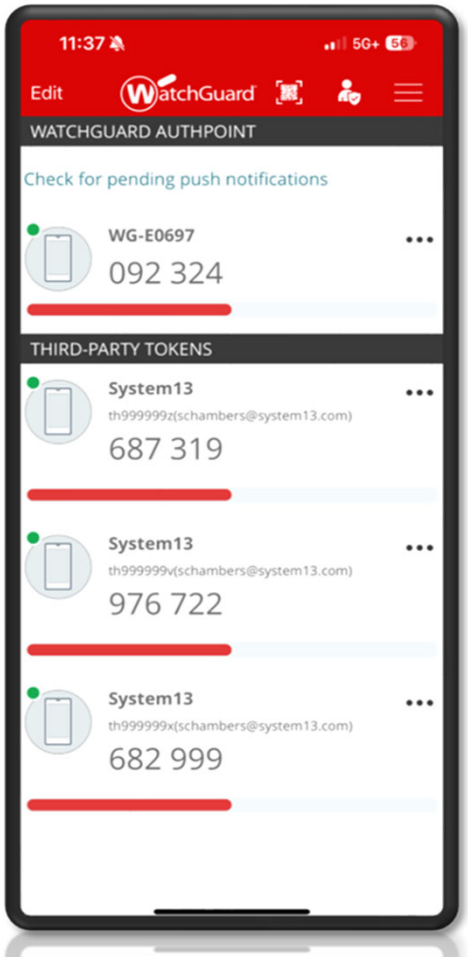


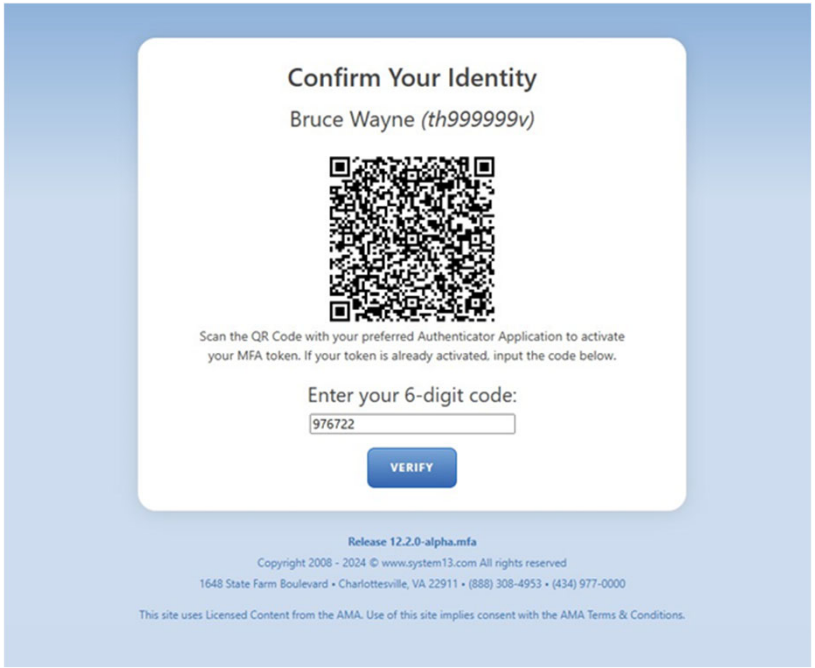
Log In the System (Auth App)

When challenged for your 6-digit code, you will need to look for the code in your authenticator app.

(Remember this code changes every 30-seconds.)

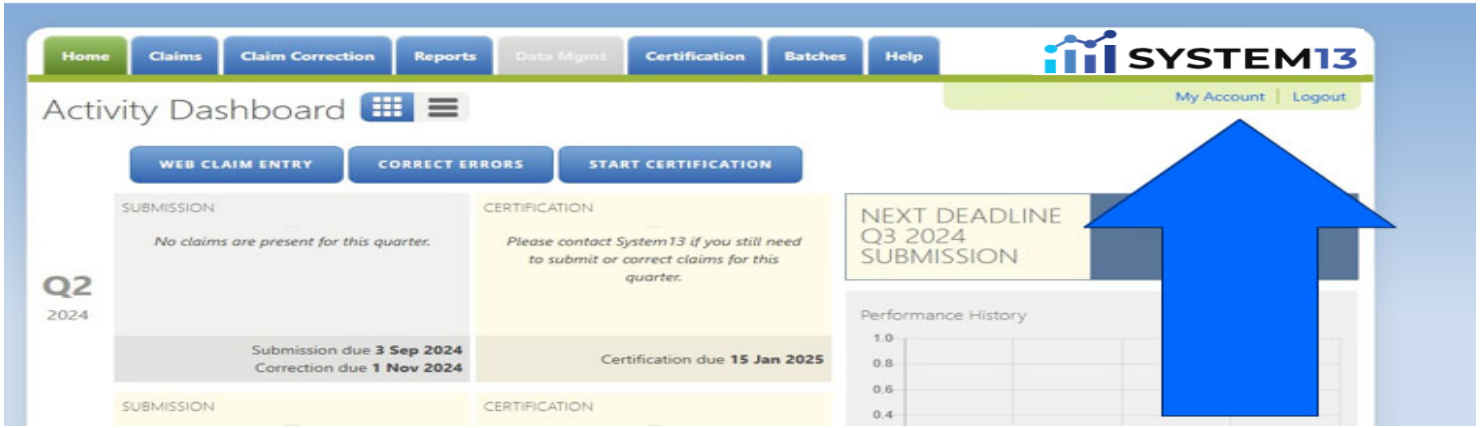
For users with multiple accounts your username will be over/under the code that you are looking for.





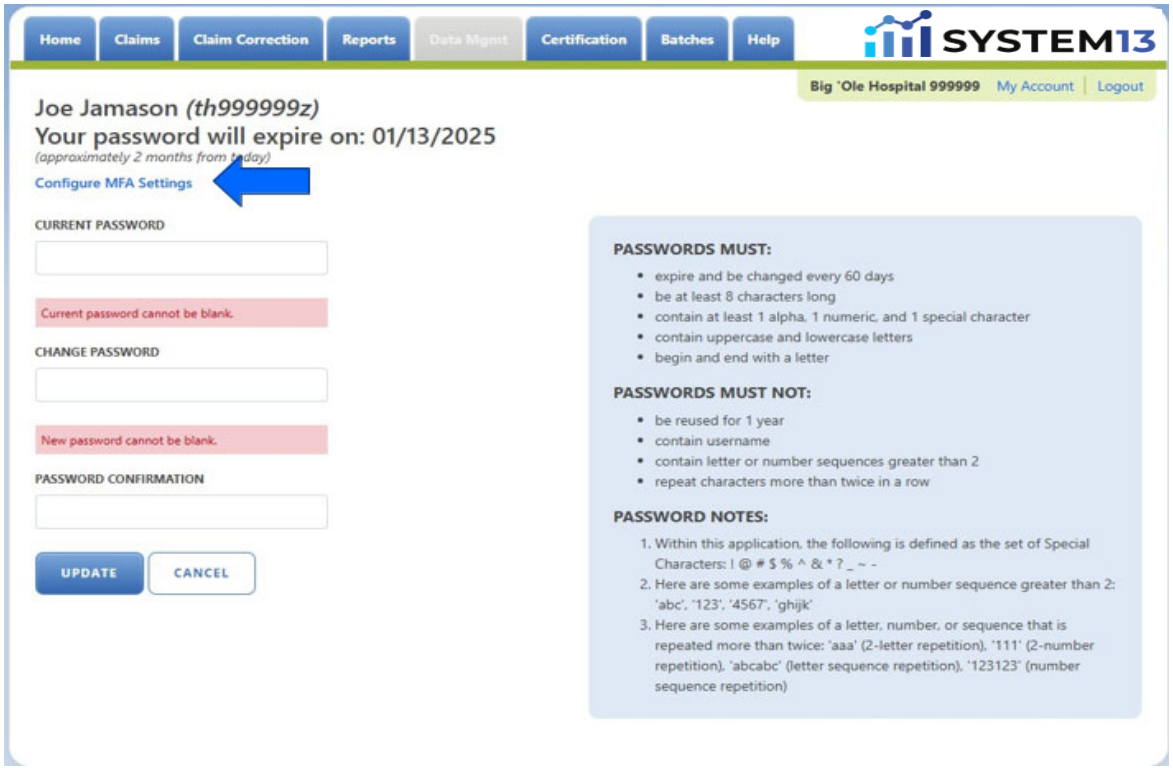
Updating MFA Settings

To change your MFA settings, you will need to go to "My account".



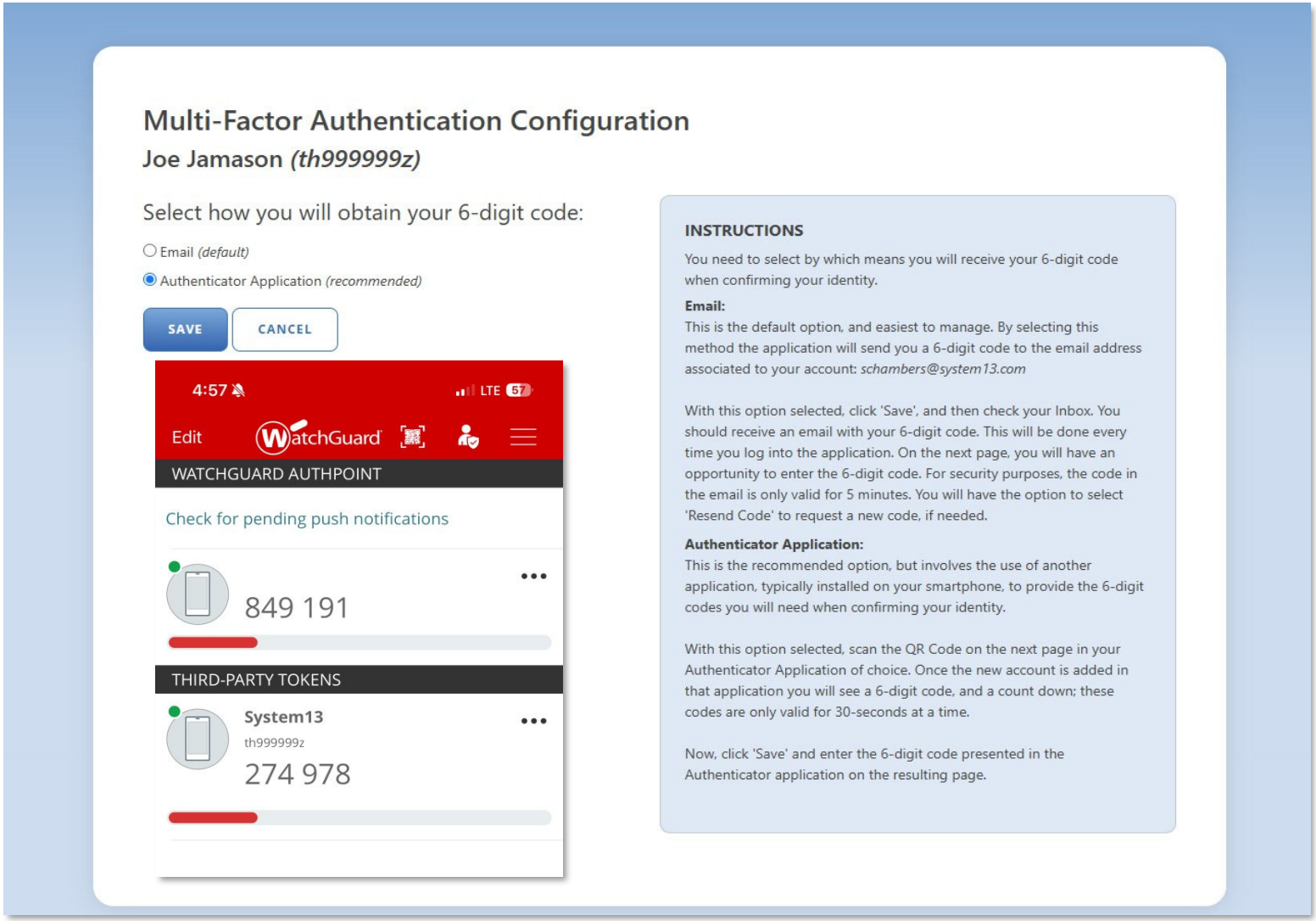
Then click "Configure MFA Settings".

For Authenticator Application you will need an Authenticator App on your smartphone to provide the 6-digit code. The codes on your app will only be valid for 30-seconds at a time.



Updating MFA Settings

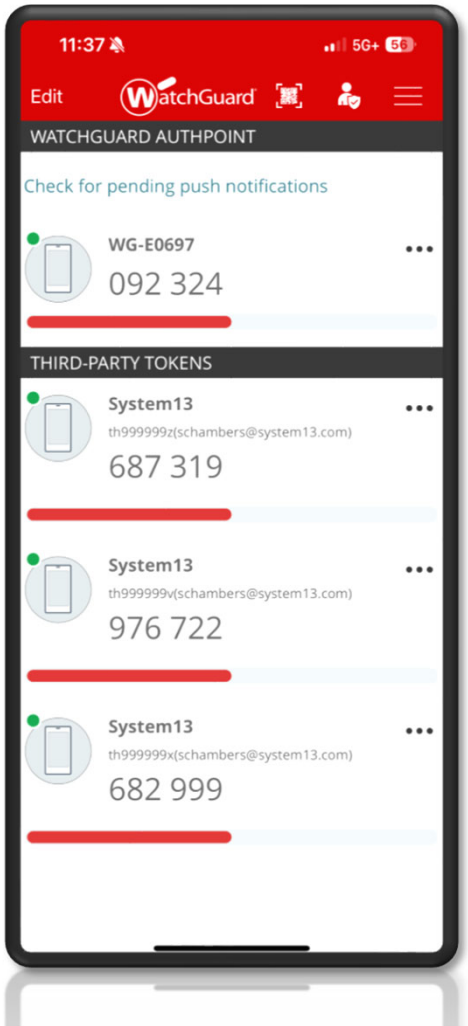
To update the MFA settings, click the preferred settings then click save.

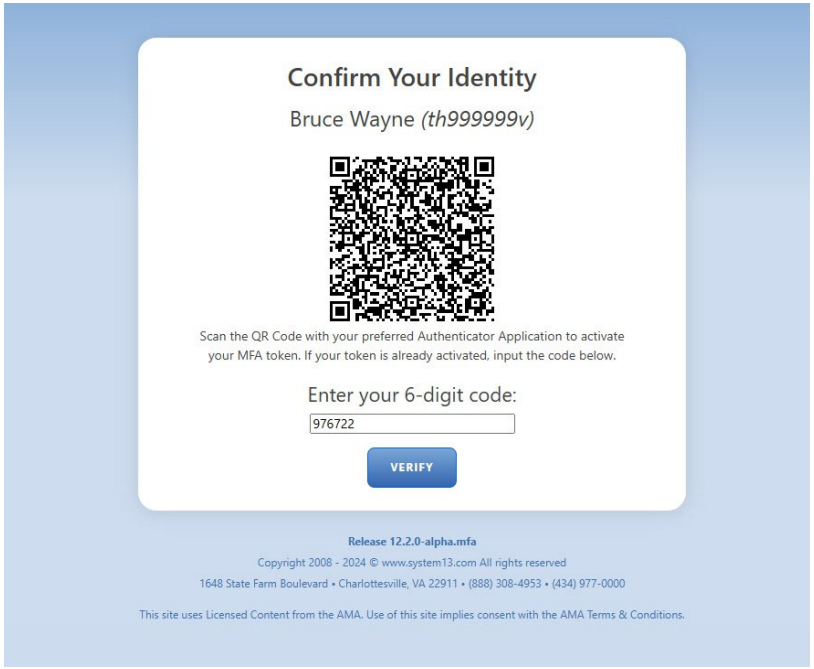


Log In the System (Auth APP)

When challenged for your 6-digit code, you will need to look for the code in your authenticator app. (Remember this code changes every 30-seconds.)

For users with multiple accounts your username will be over/under the code that you are looking for.





Troubleshooting the MFA Process

If the email code is not being received, double check that the email that was entered is correct.

Please only use one Authentication APP.

Make sure that you only have that specific login on your app once.

Double check the username on the app/email and the username for the site.

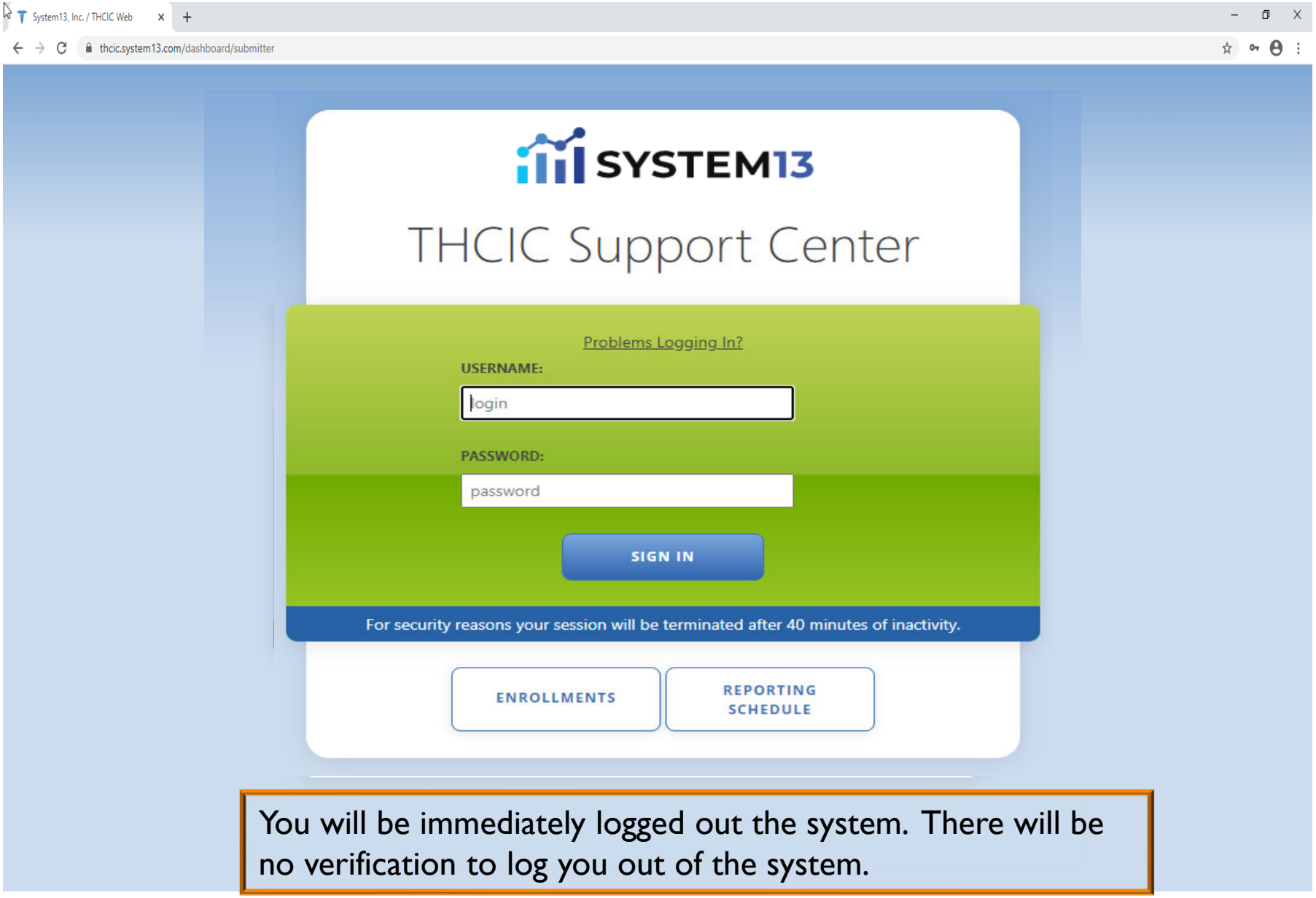
More information about this process can be in the THCIC numbered letter, Volume 27, number 5 available at https://www.dshs.texas.gov/sites/default/files/thcic/hospitals/numberedletters/2024/Vol27No5.pdf

Issues with the MFA process, please contact System13 at 888-308-4953 or email thcichelp@system13.com.

Other Features - Logout

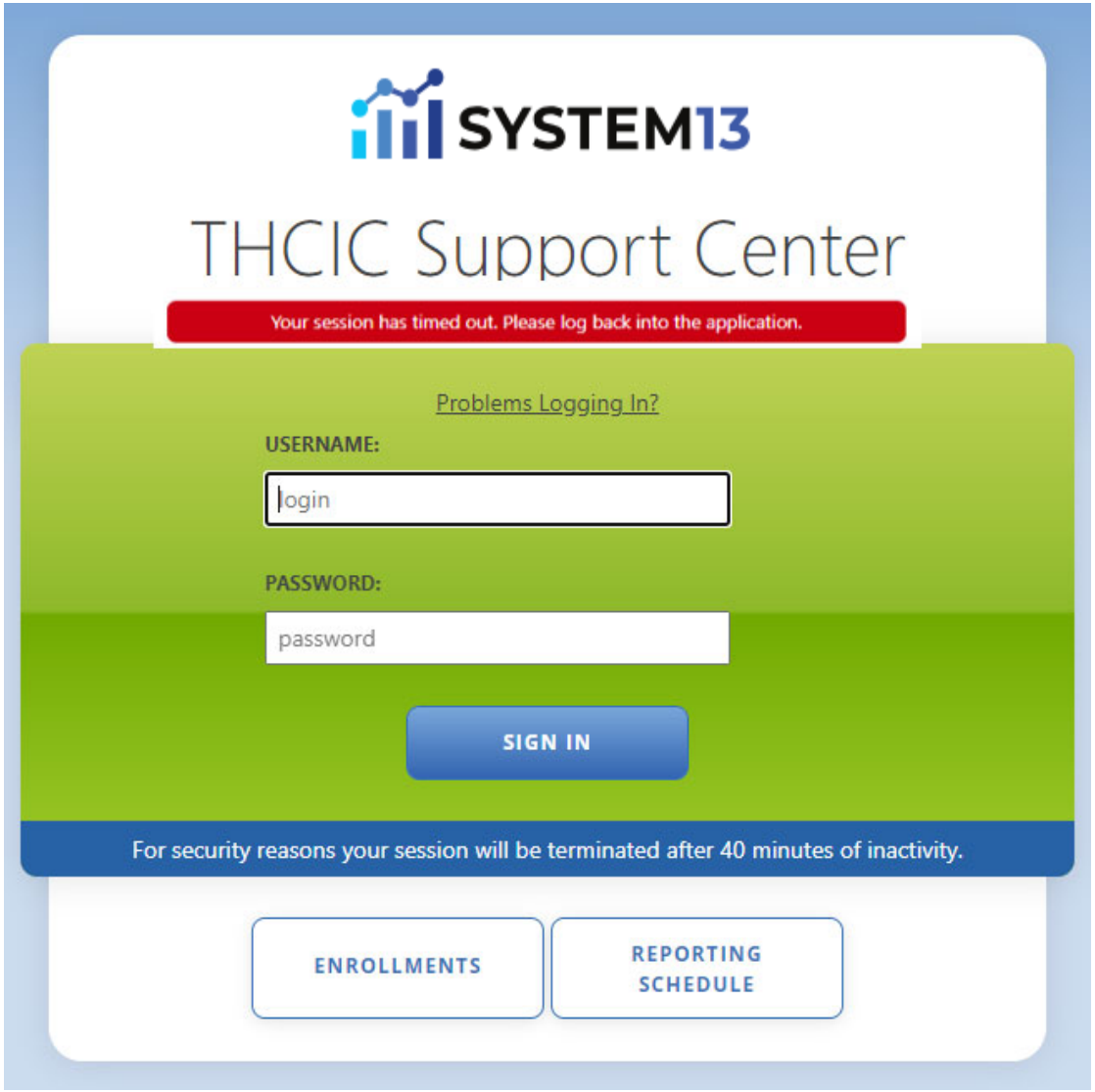
Logout logs you out of the system.

Other Features - Logout



You will be immediately logged out the system. There will be no verification to log you out of the system.

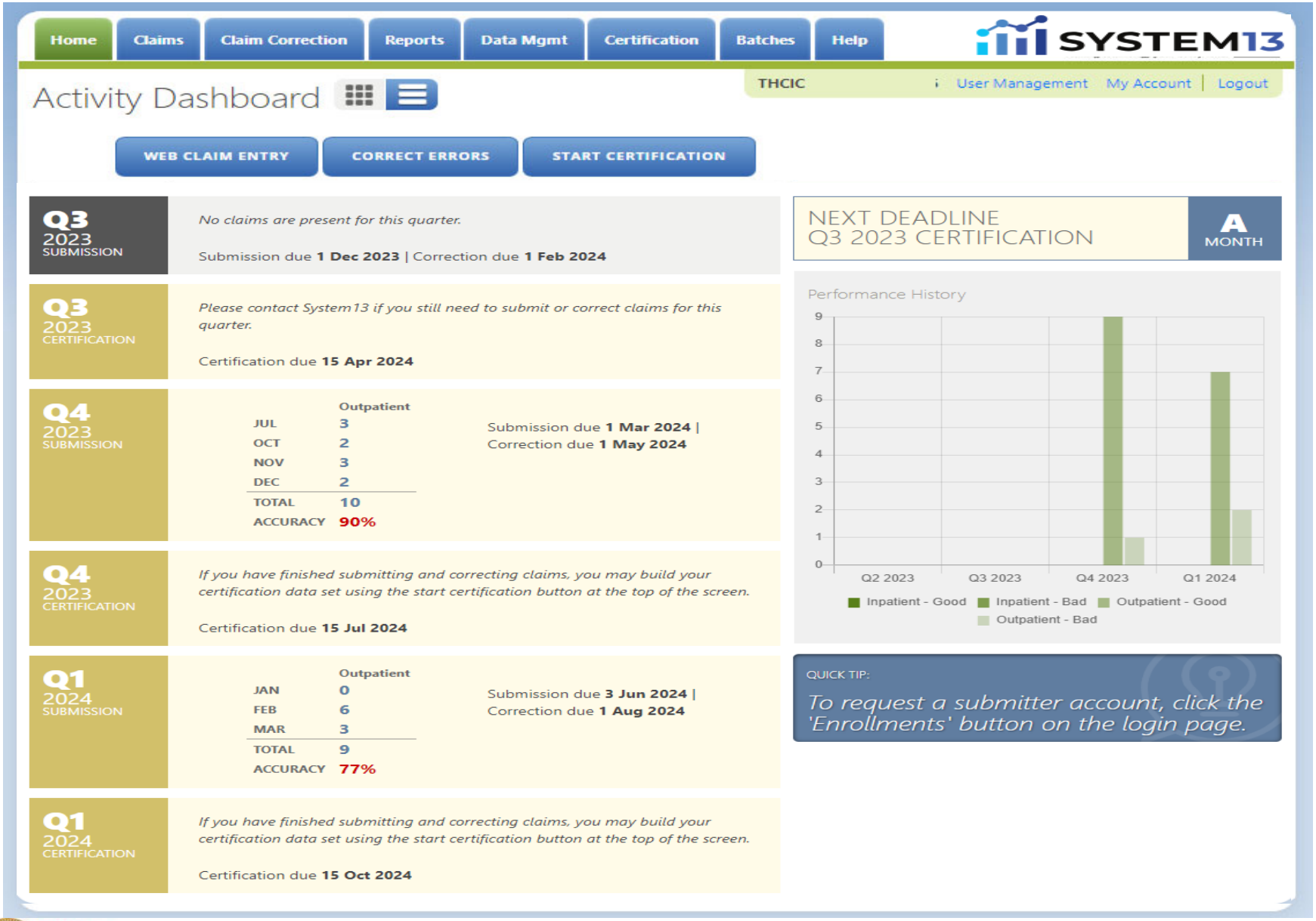
Inactivity



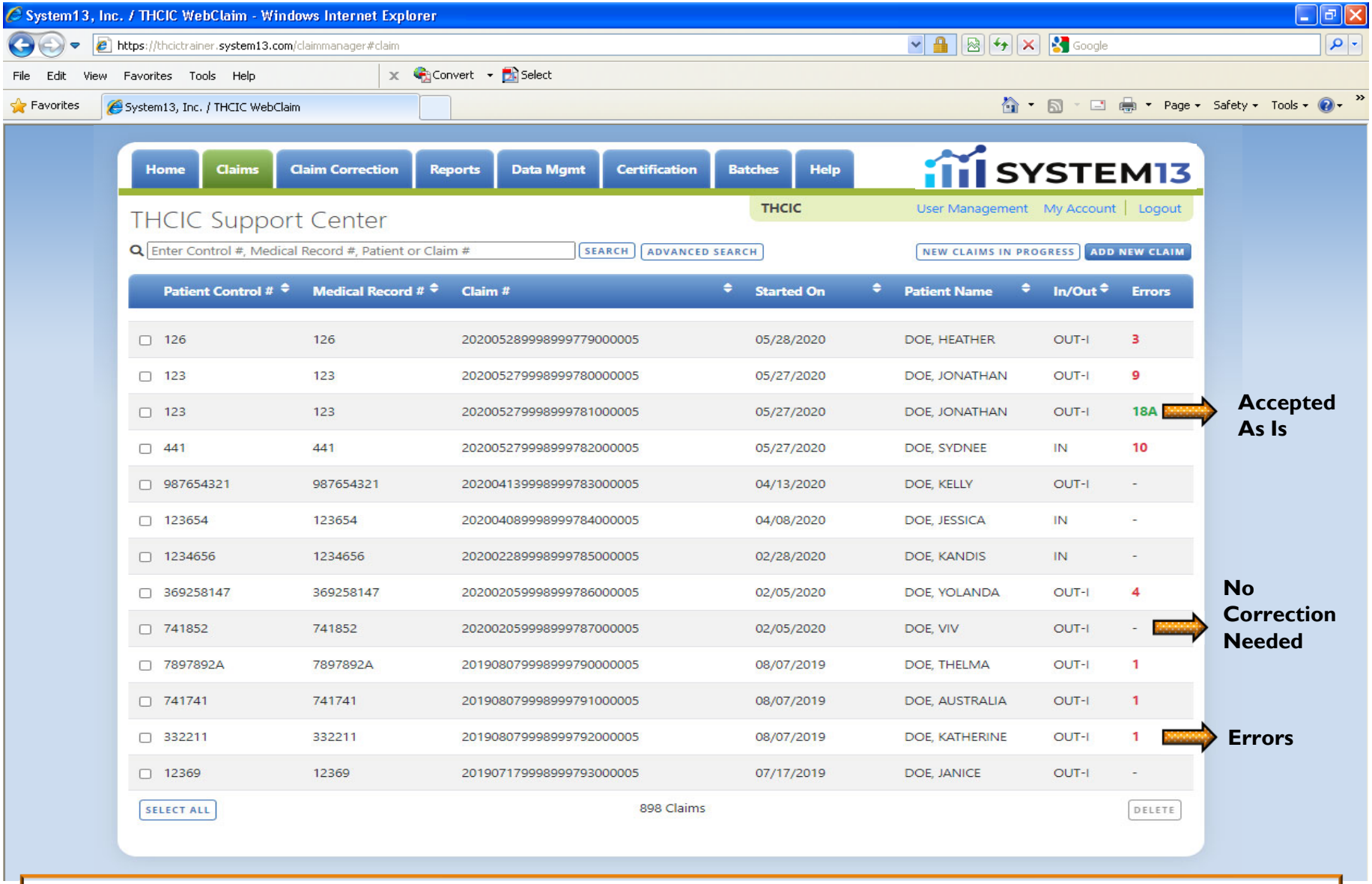
If you have been idle in the system for 40 minutes, you will be logged out of the system and will have to log back in.

Data Management/Primary Contact Provider Home Page – Grid View

Data Management/Primary Contact Provider Home Page – List View



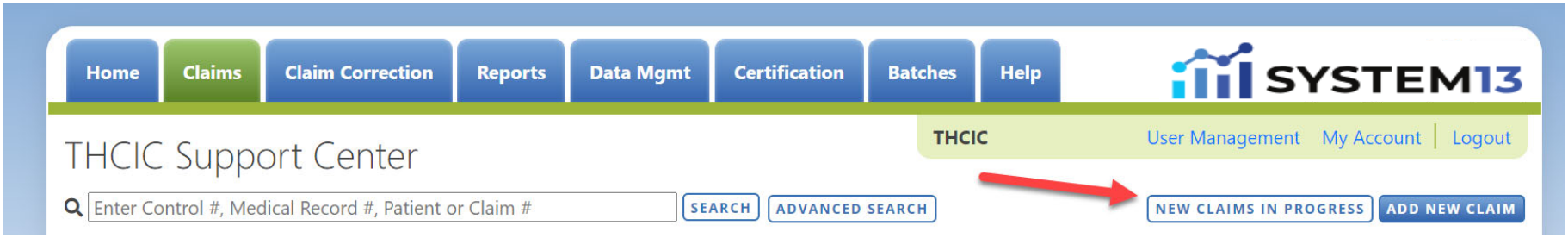
Provider Tab Claims Claims



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.

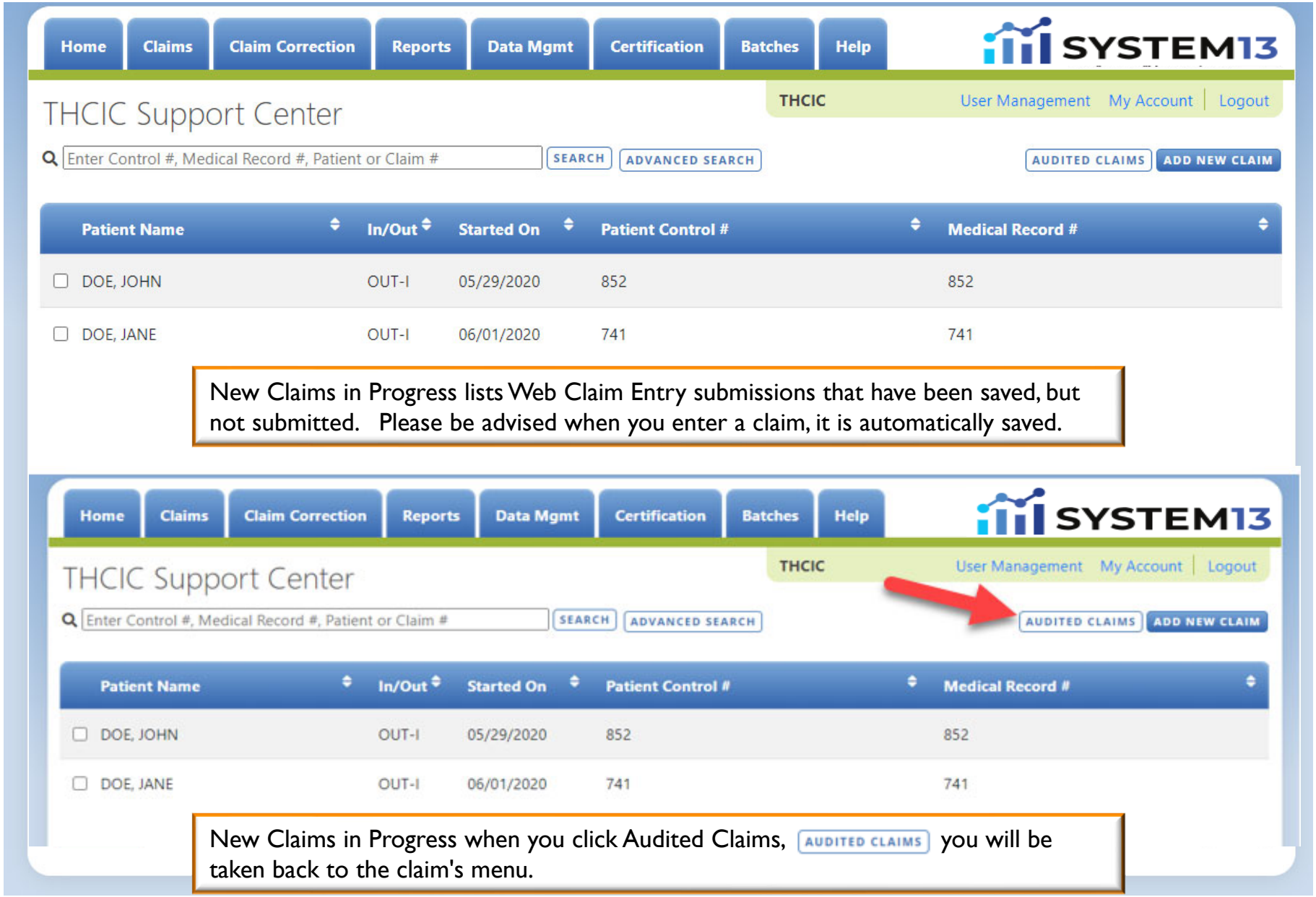
New Claims in Progress

NEW CLAIMS IN PROGRESS

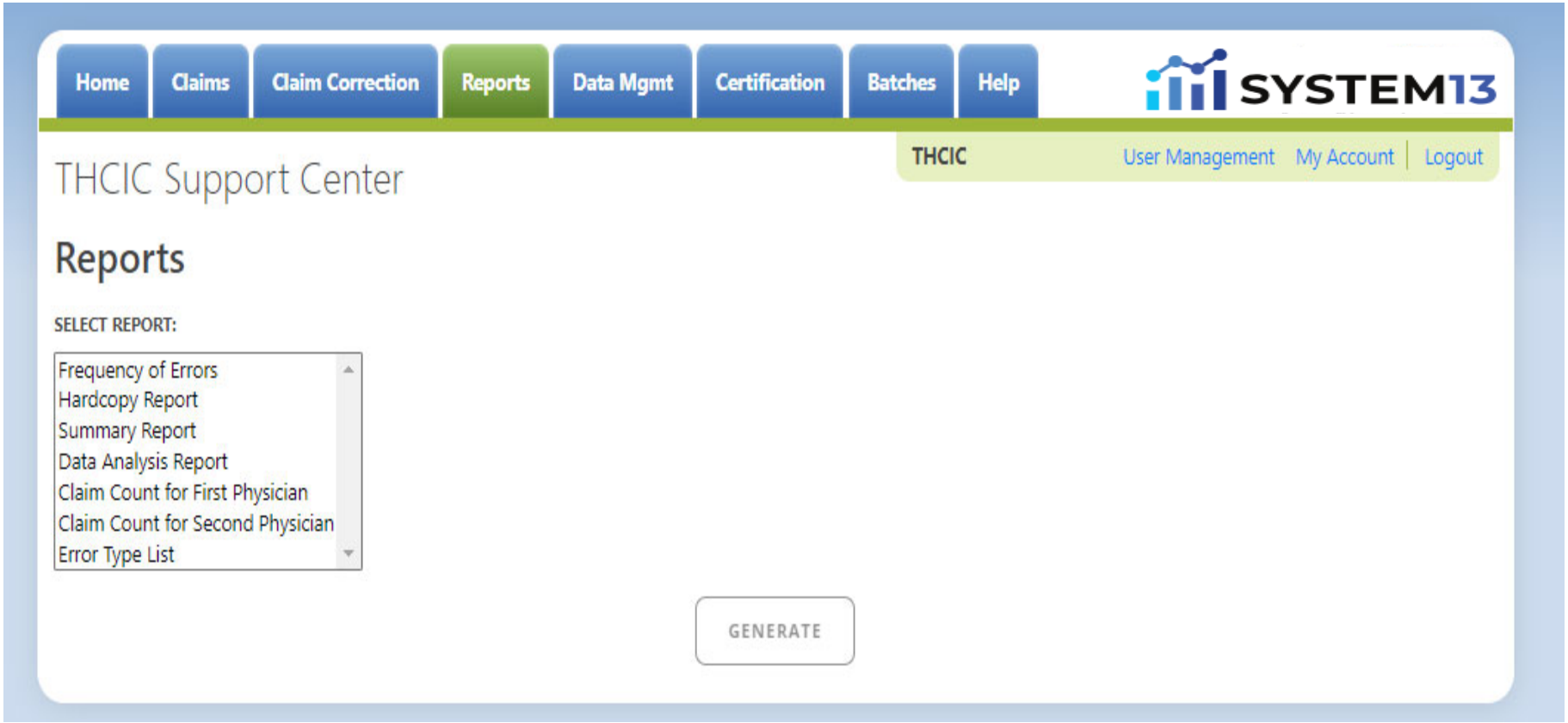


New Claims in Progress – Through the Claims tab, this feature allows facilities to continue completing claims that you have started entering using Web Claim Entry.

New Claims in Progress



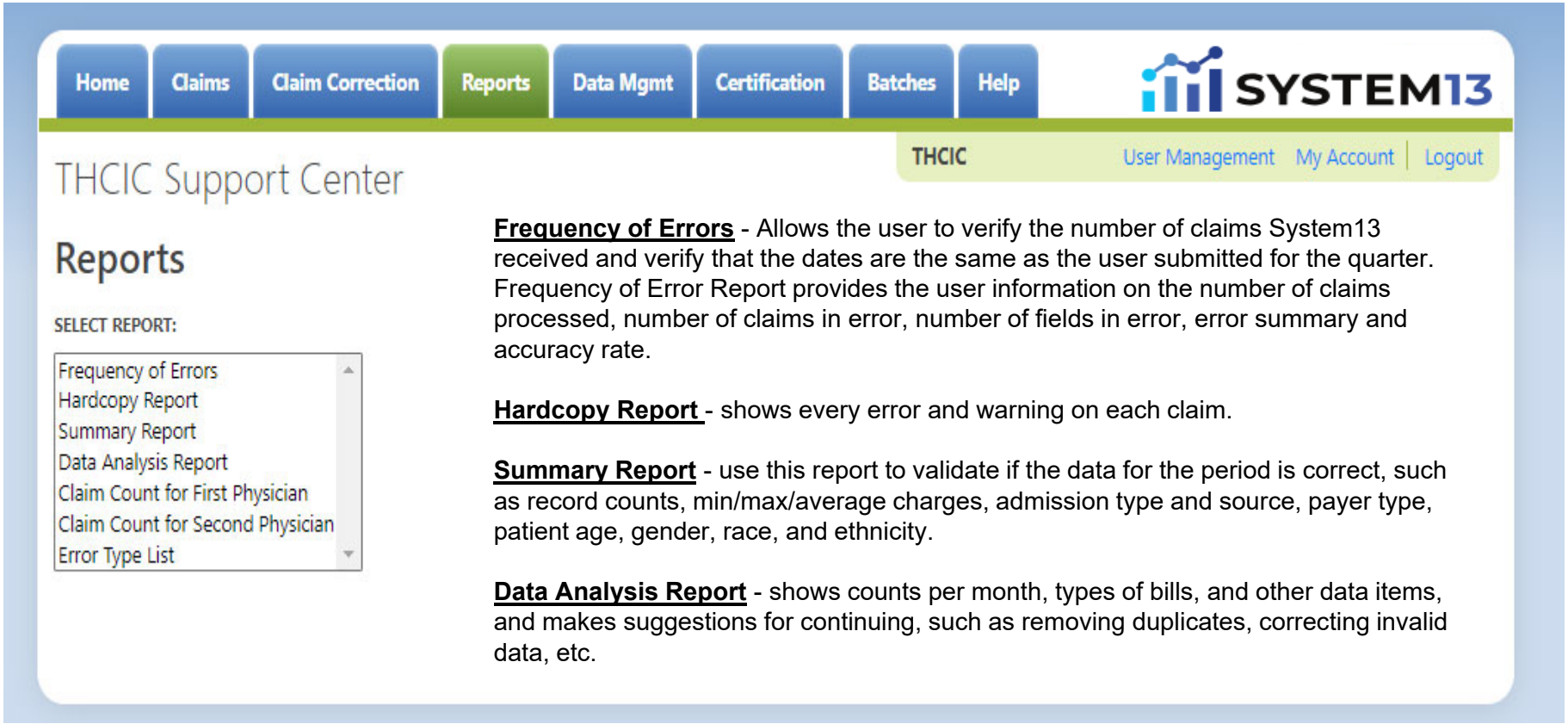
Reports Reports



Reports allows the user to get various reports on data that is currently in the system. The data currently in the systems includes data that has been submitted and not removed due to the cutoff for corrections.

Reports Available

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.

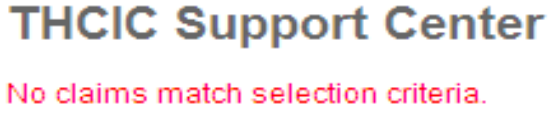
Claim Count for Second Physician - Use this to determine if the second physicians (attending, operating, other) who utilize your facility are represented correctly. This report will give a claim count by second physician name, sorted by name. It will also include the physician ID but will not include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

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

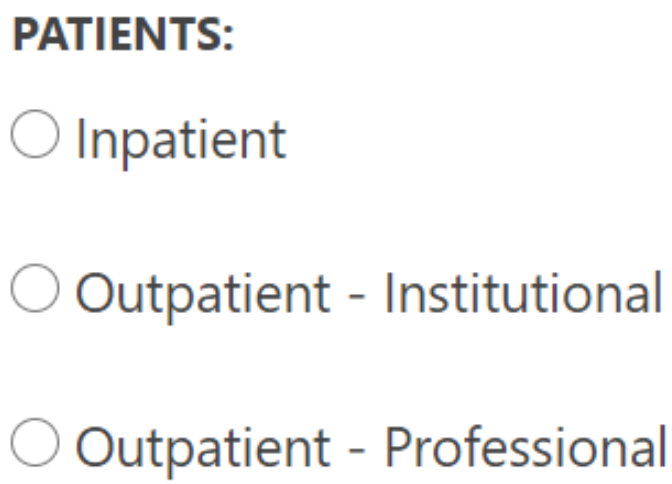
Reports Functionality

- The GENERATE button will remain disabled until the user selects the report type, filter by and type of patients. Then GENERATE will become an option.

- If no data matches your request, a message will be indicated on the top left corner.



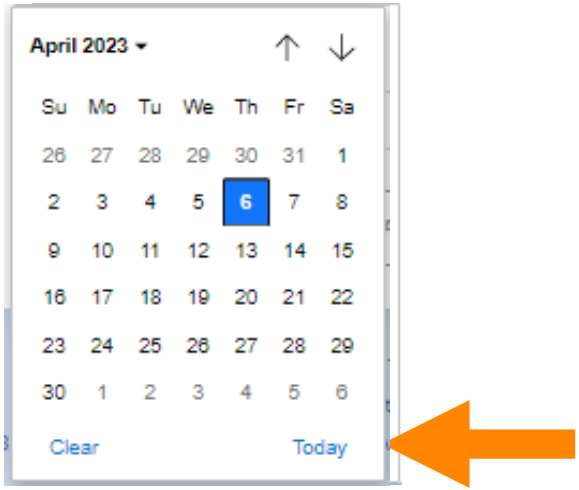
Type of Claims



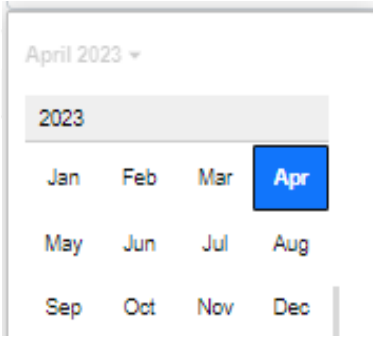
<u>Only one type of claim can be chosen to review patient data at a time</u>.
If batch number is chosen the type of claim within the batch is automatically selected, since it's already predetermined in the batch as to type of claims, type of patients is not an option.

Functionality of the Calendar Feature

- Feature of the calendar



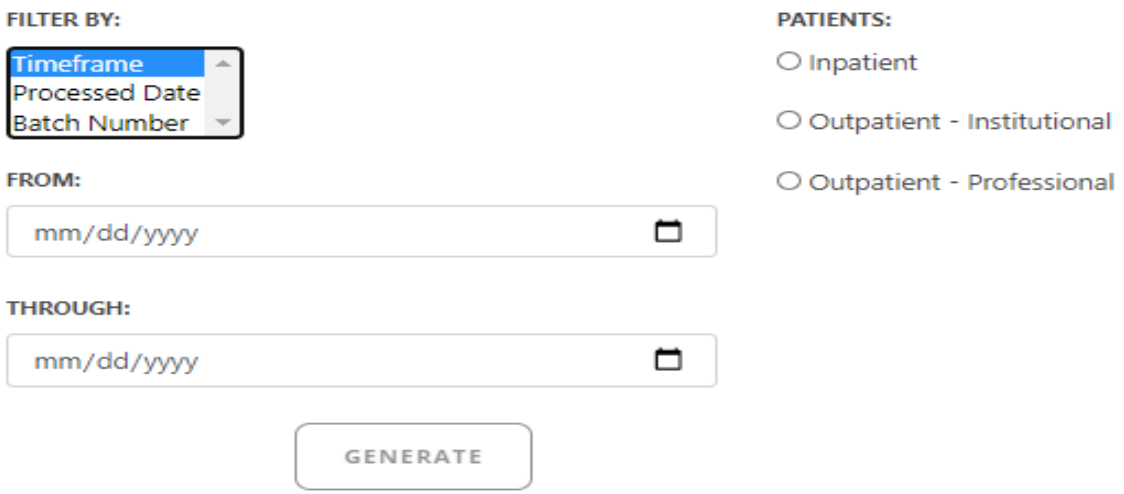
- The icon will open choosing the current date.
  - ↑ ↓ will move the calendar back a month.
  - Choosing the month's drop-down menu will change the month



  - Choosing the sidebar will change the year

Filter Report By Timeframe

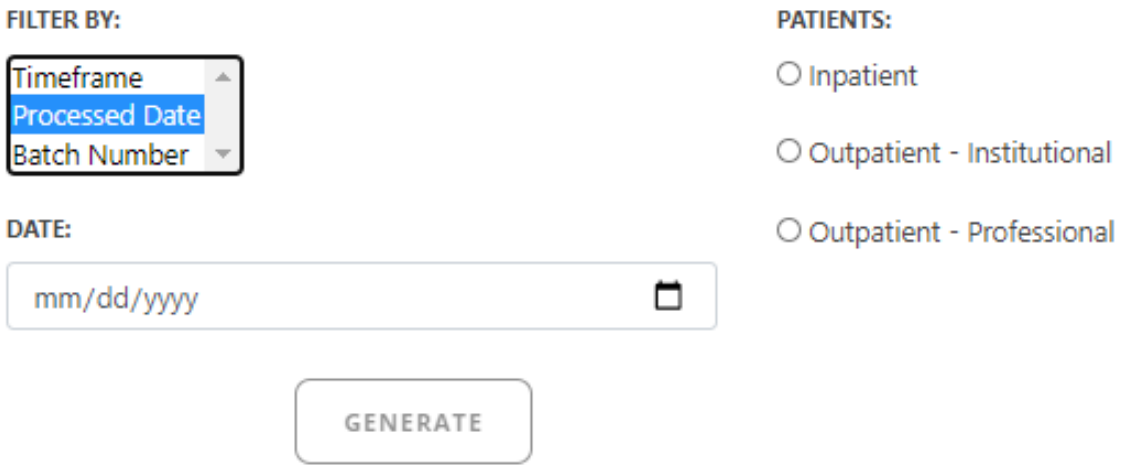
- To create by timeframe.



- The icon will open a calendar to choose dates.
- You can choose any dates, even through separate quarters.
- Choose type of claims.

Filter Report By Processed Date

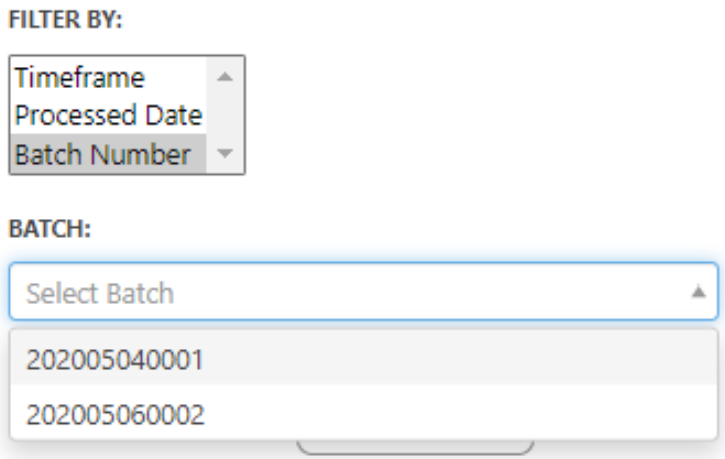
- To create a report, filter by processed date.



- To filter by the processed date, you must choose a certain date.
- Choose the type of claims and click generate.

Filter Report By Batch Number

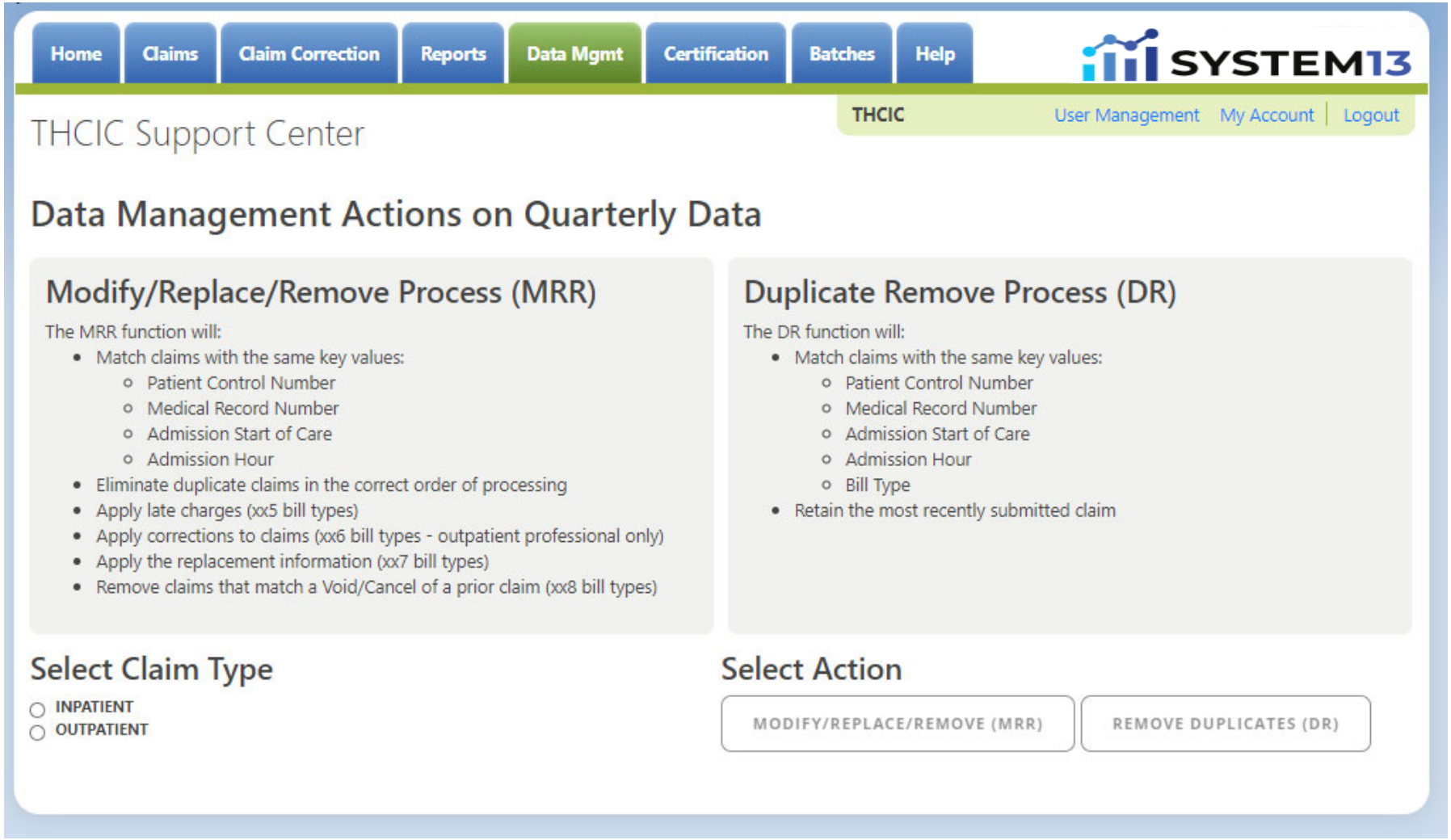
- To create a report by batch number, you have to choose a batch from the batch listing in the system.



- If 'batch number' is chosen, it's automatically determined the type of claims, outpatient or inpatient. Choosing the type of patients is not an option.

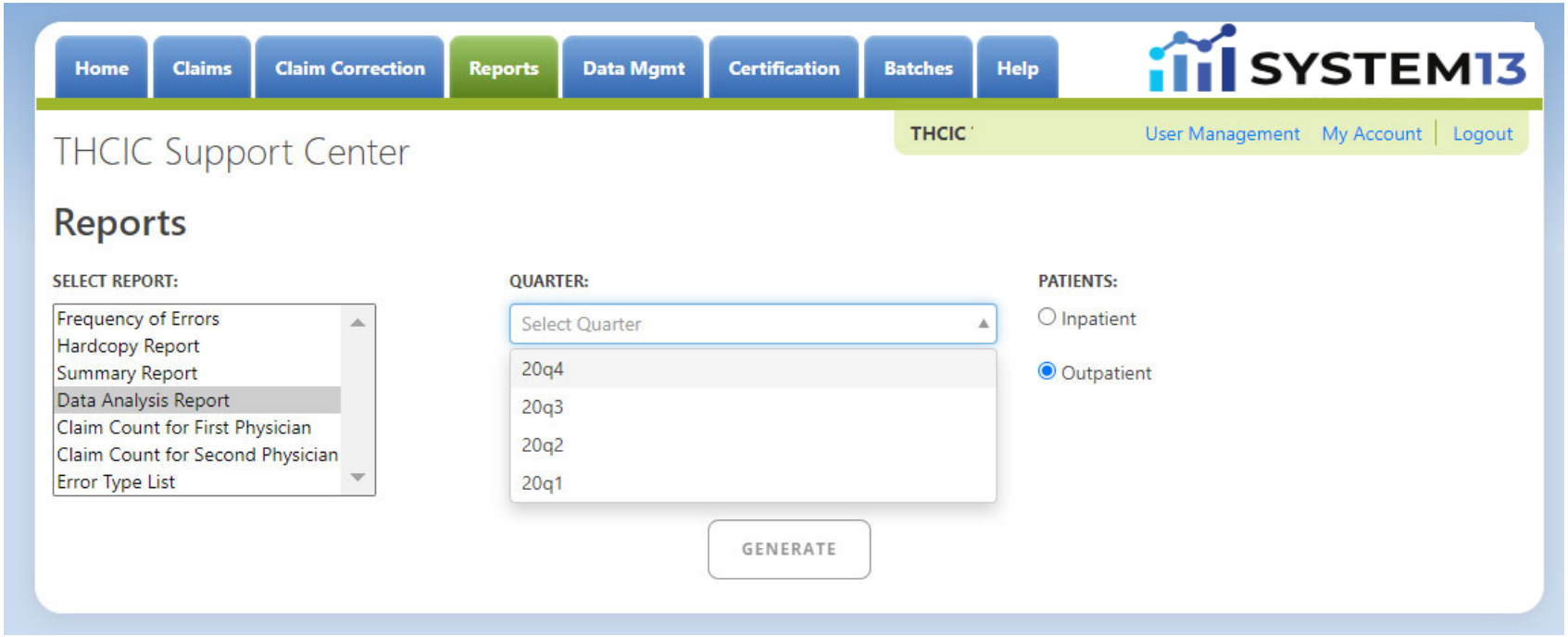
Provider Tab Data Management

Data Mgmt



This tab is only available to the data administrator/primary contact of the facility. Before the modify/replace/remove and duplicate removal is run, 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

2Q2020 Data Analysis Report (Outpatient)
Report Date: 09-Oct-2020
THCIC ID:

Quarter Analysis

Month	Total	xx0	xx1	xx2	xx3	xx4	xx5	xx6	xx7	xx8	???
Jan	0	0	0	0	0	0	0	0	0	0	0
Feb	0	0	0	0	0	0	0	0	0	0	0
Mar	0	0	0	0	0	0	0	0	0	0	0
Apr	5	0	5	0	0	0	0	0	0	0	0
May	2	0	2	0	0	0	0	0	0	0	0
Jun	0	0	0	0	0	0	0	0	0	0	0

Quarter Comparison

Qtr	Total
2q20	7

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; patient control number, medical record number, admission start of care and admission hour.

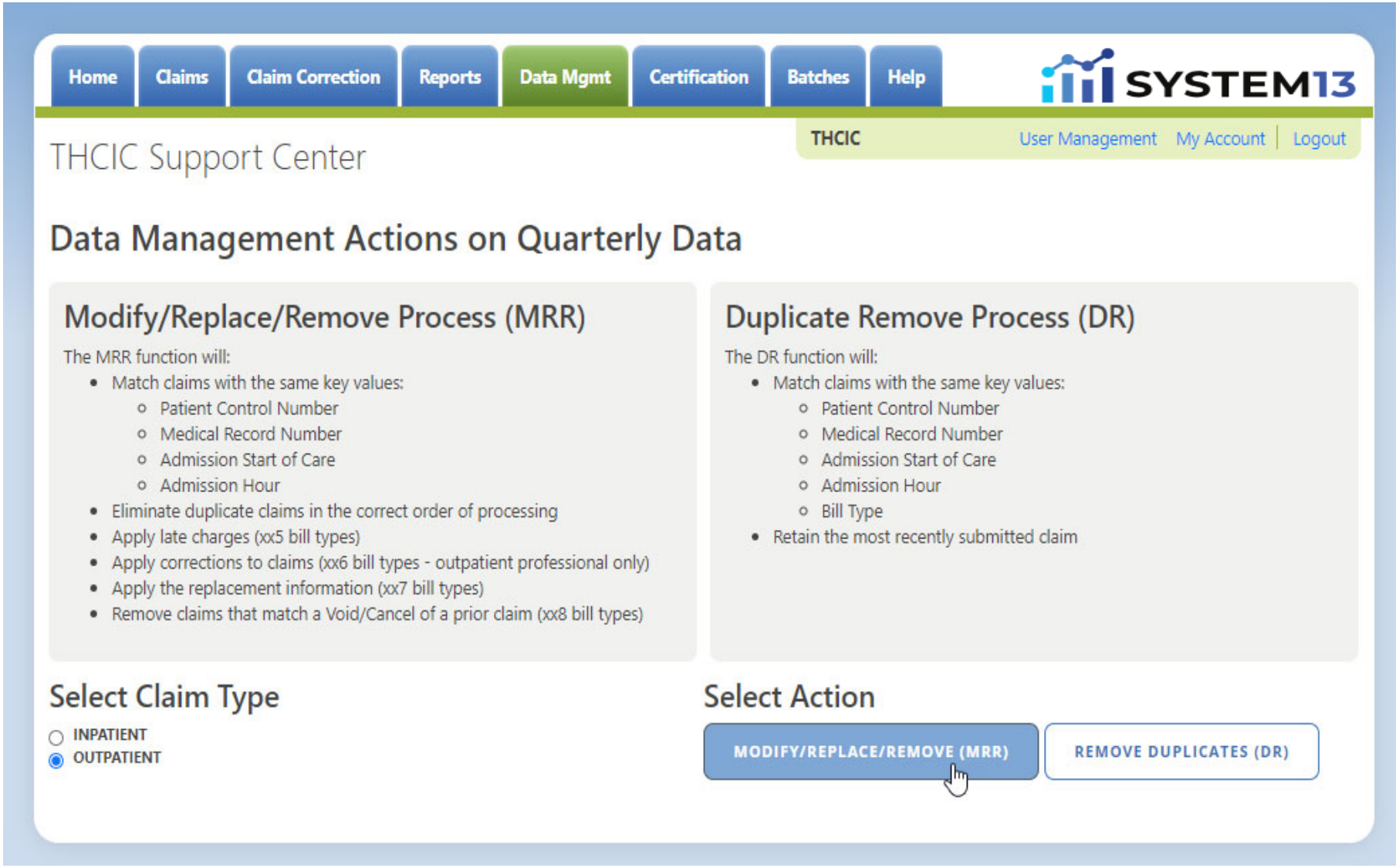
The MRR process will:

- 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.

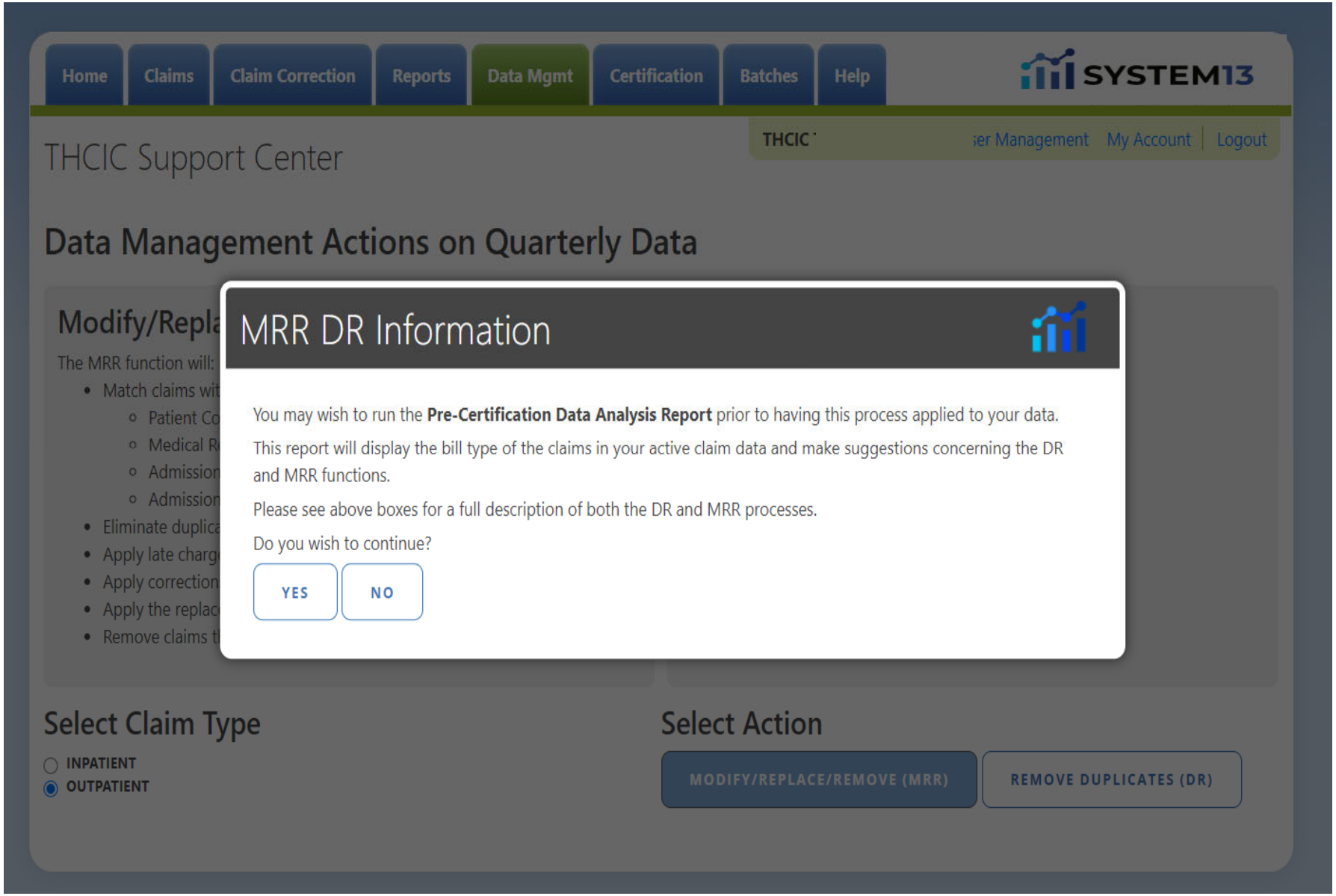
After the provider completes all of the prompts, the MRR or DR process is submitted to run in the background. When the process is completed, the Data Manager is sent an email describing the number of records that were analyzed and any that fit each category of removal.

Provider Tab Data Management – Modify/ Replace/ Remove Process (MRR)



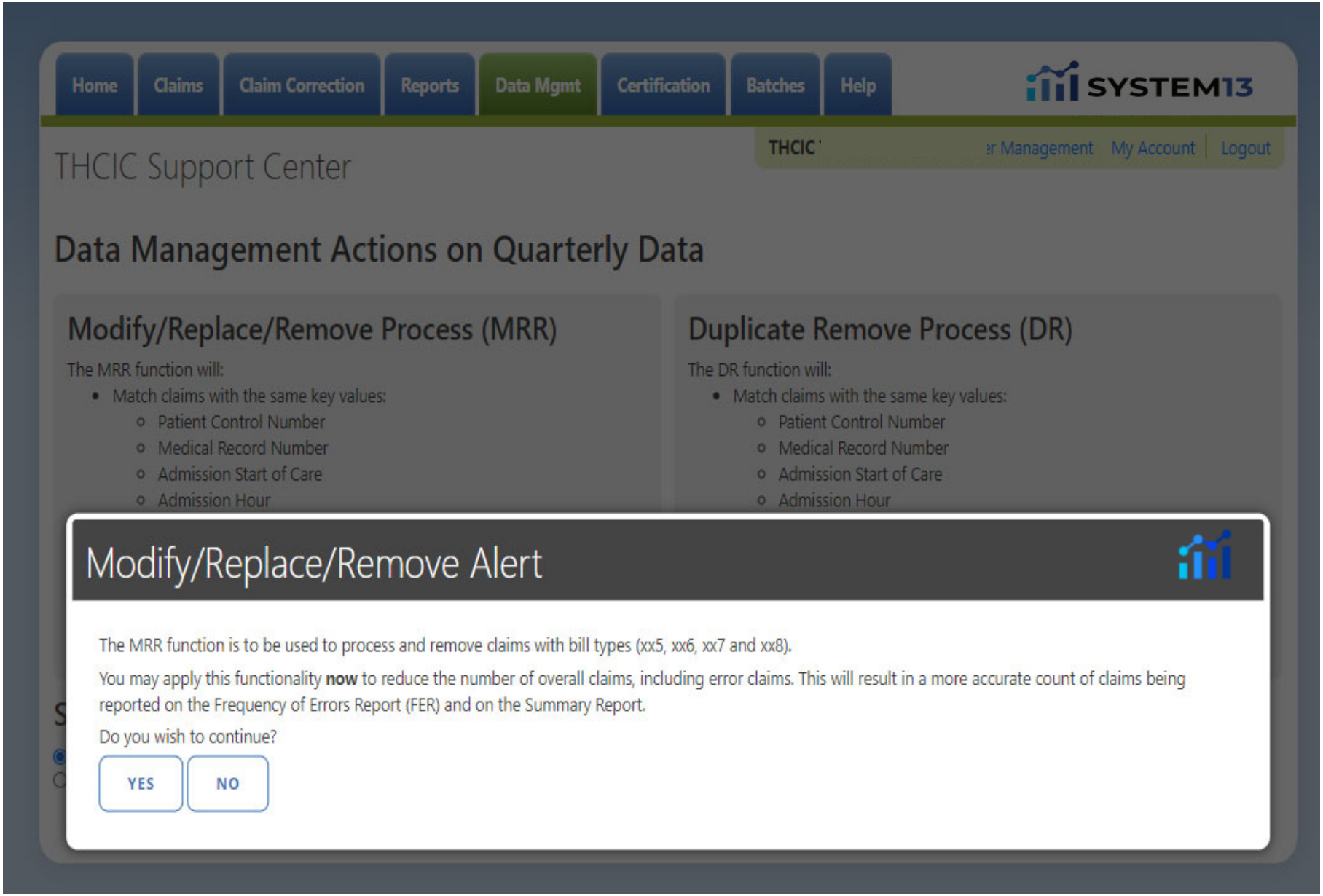
Provider Tab Data Management

Data Mgmt



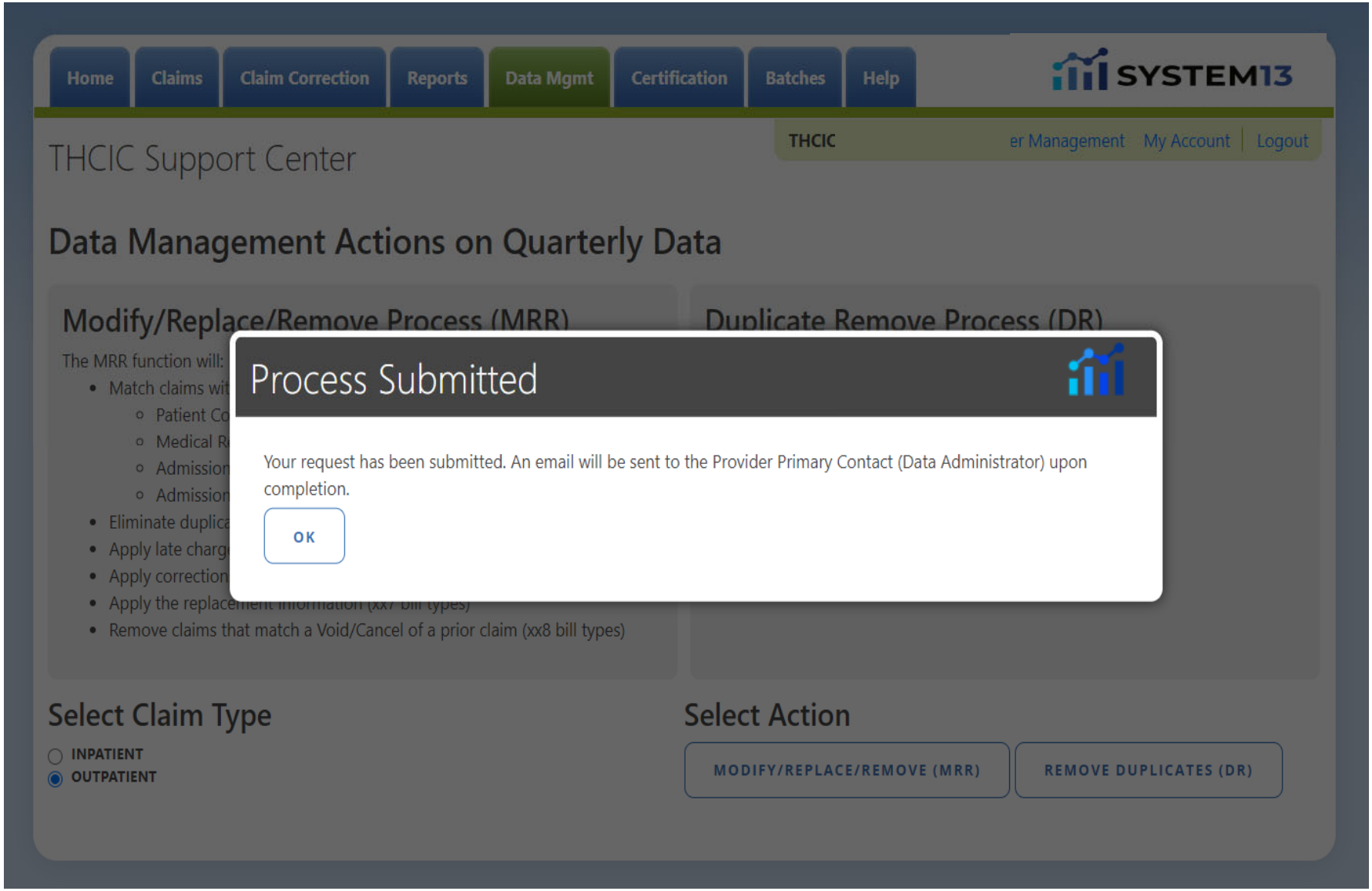
Provider Tab Data Management

Data Mgmt



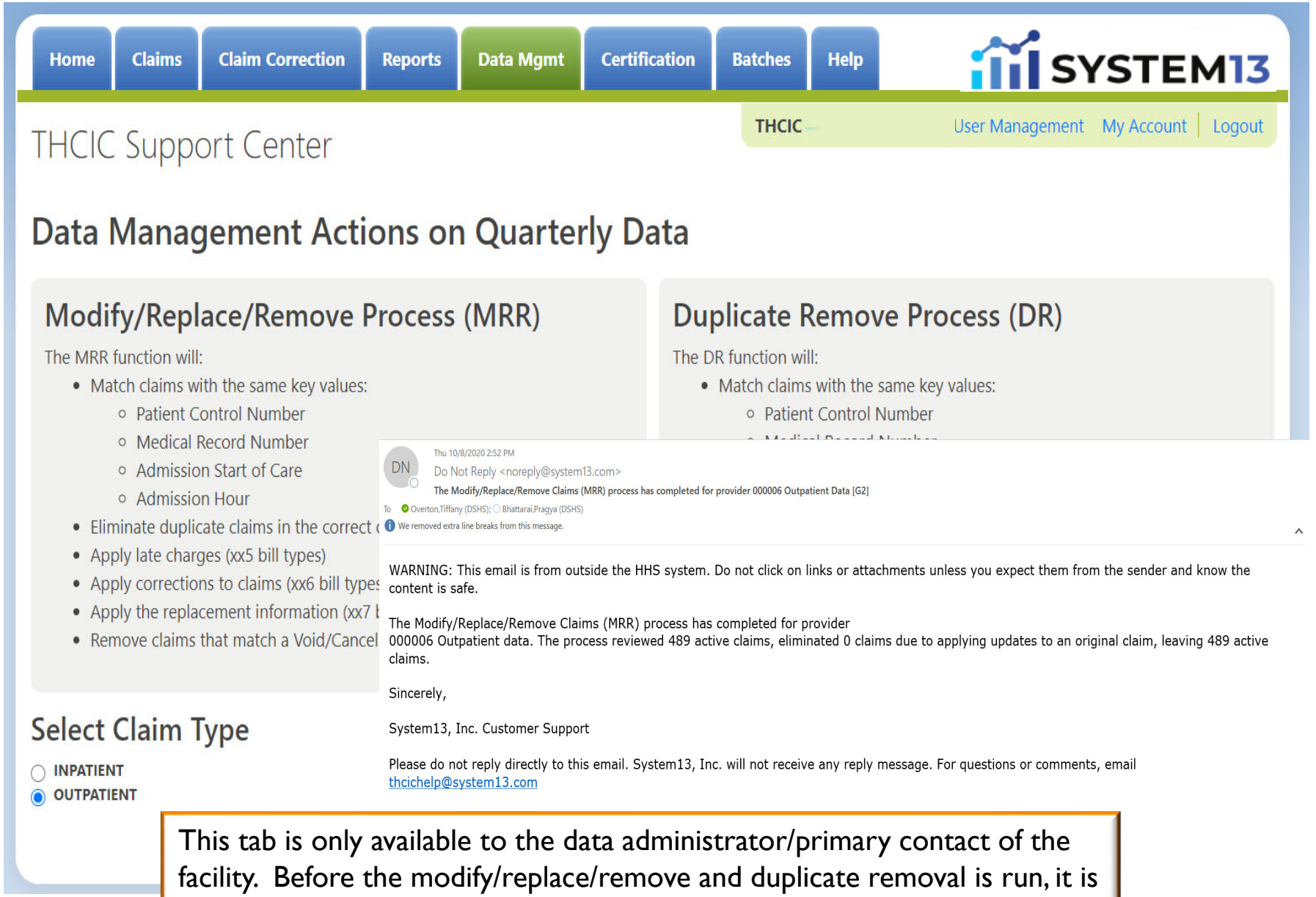
Provider Tab Data Management

Data Mgmt



Data Management Emails

Data Mgmt



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

Provider Tab Data Management

Data Mgmt

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)** must match with the same key values patient control number, medical record number, admission start of care, admission hour, 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.

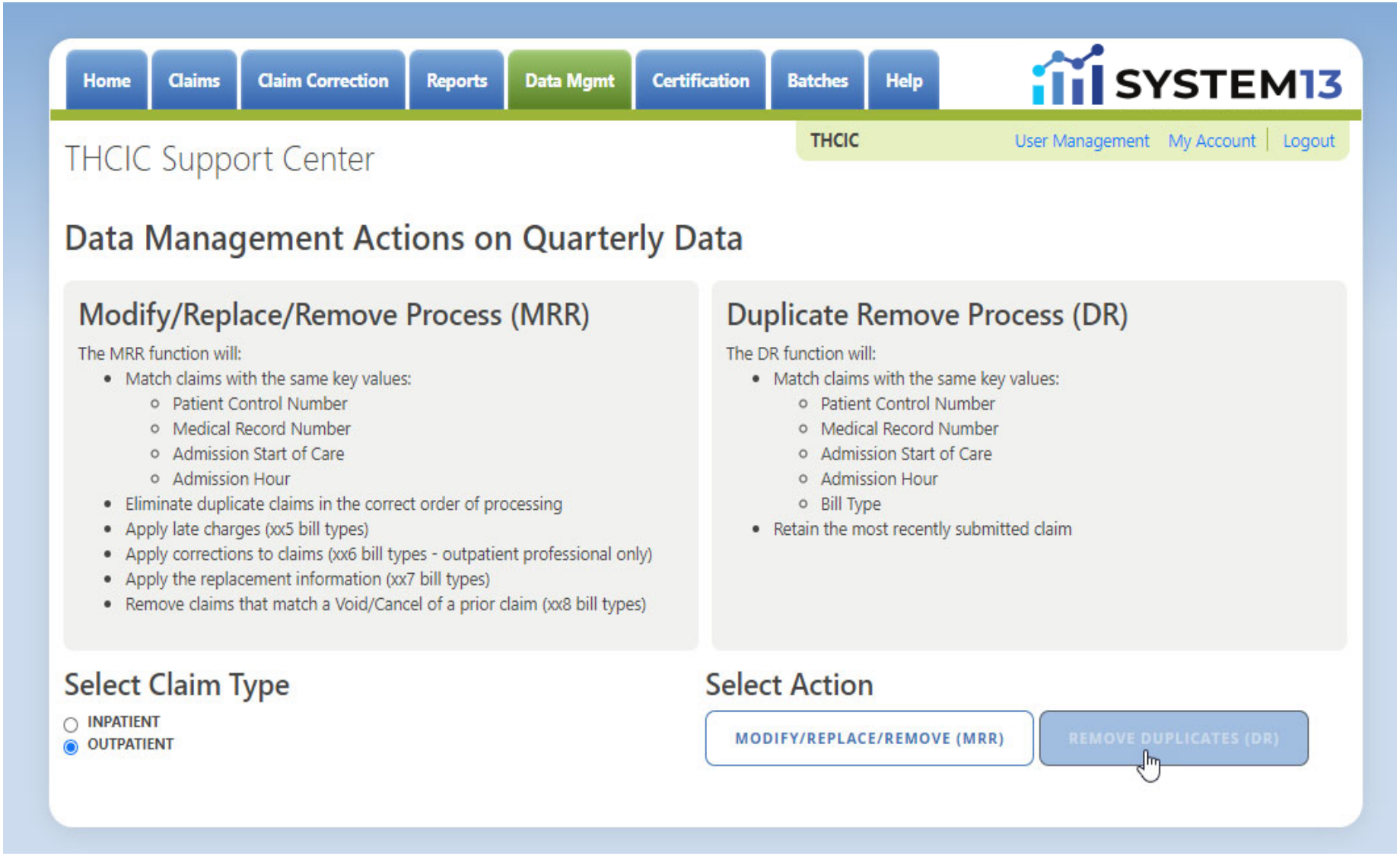
After the provider completes all of the prompts, the MRR or DR process is submitted to run in the background. When the process is completed, the Data Manager is sent an email describing the number of records that were analyzed and any that fit each category of removal.

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.

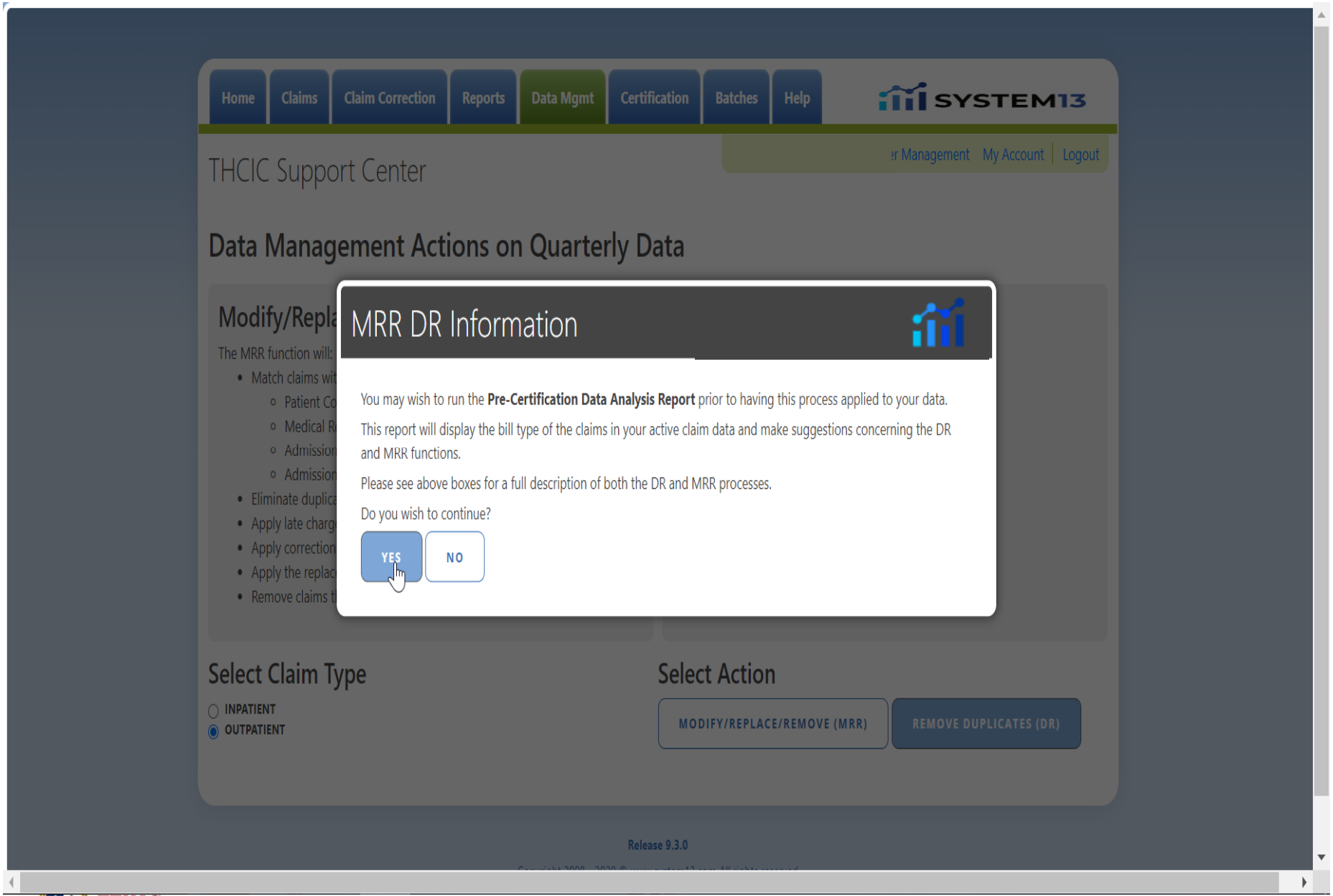
This report will open as a PDF as shown below.

Provider Tab Data Management – Duplicate Removal Process (DR)



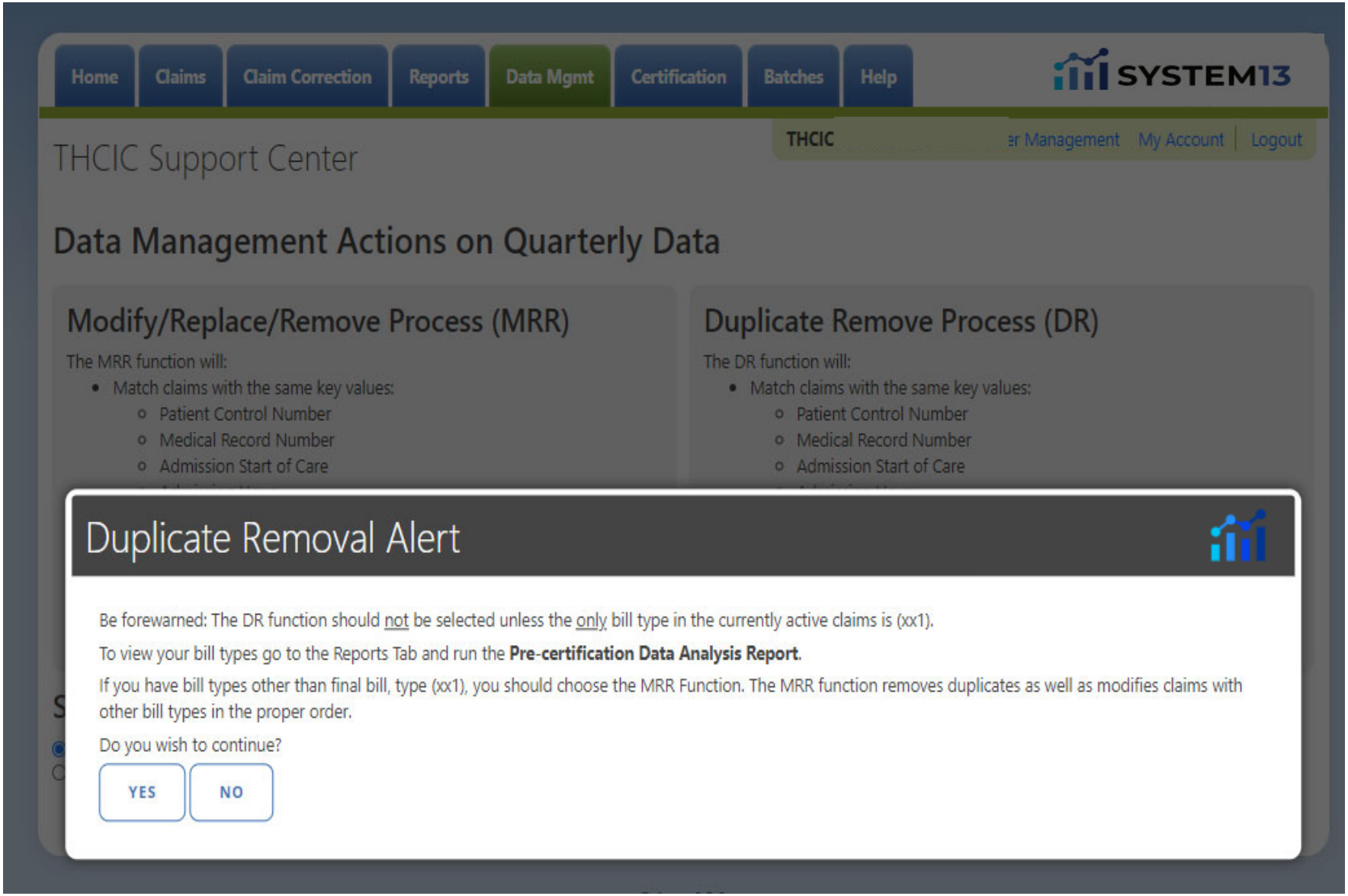
Provider Tab Data Management

Data Mgmt



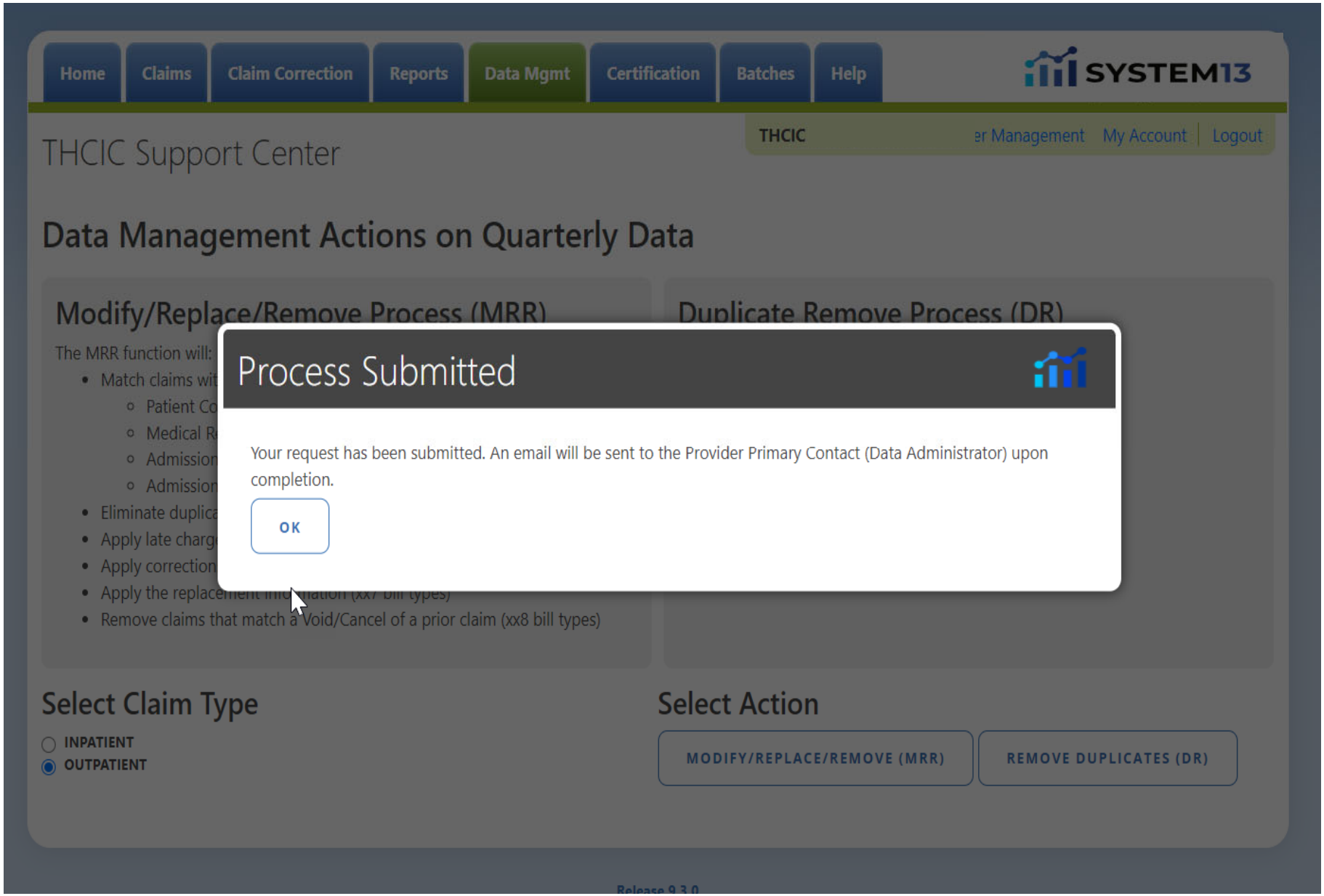
Provider Tab Data Management

Data Mgmt



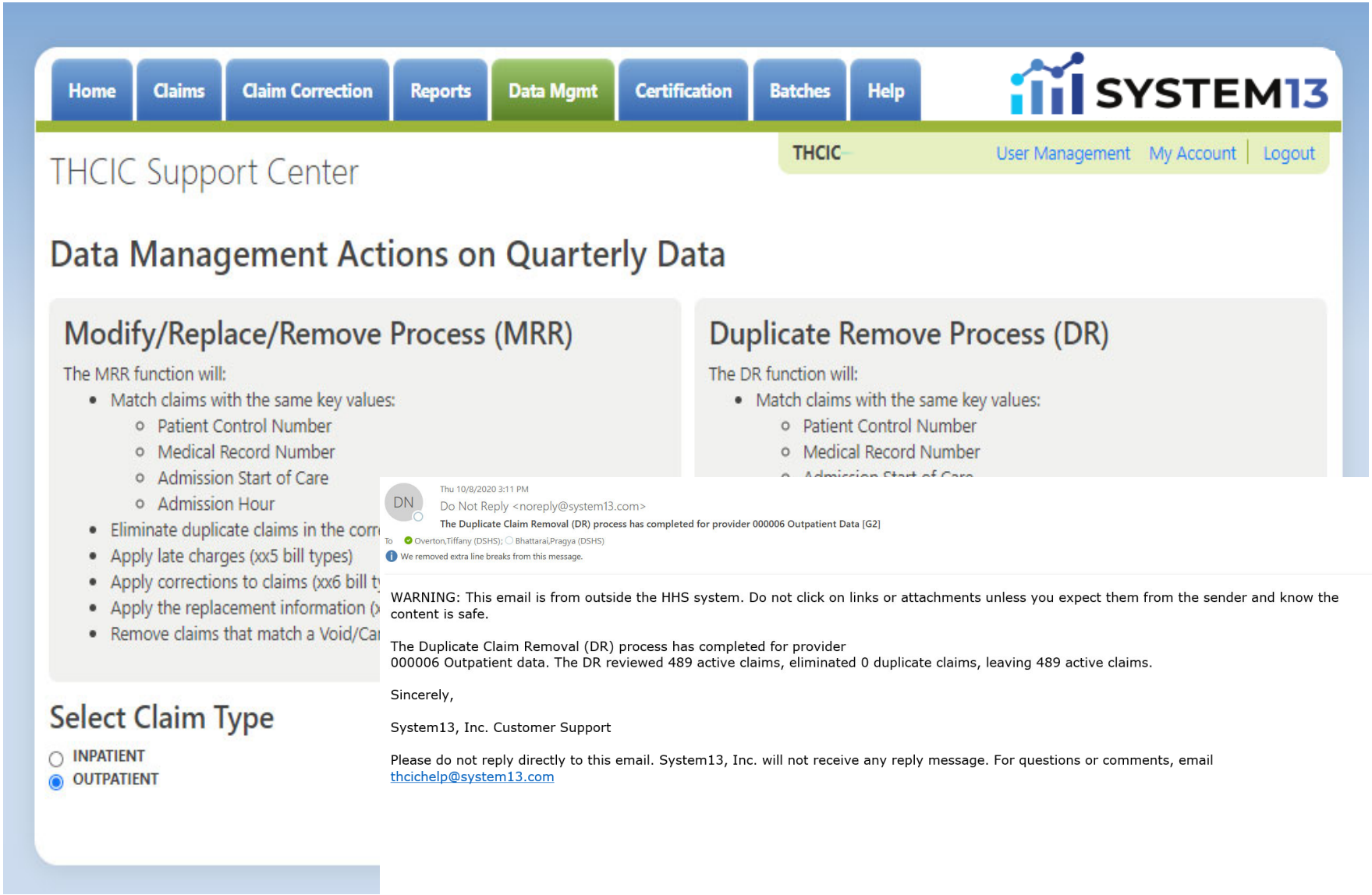
Provider Tab Data Management

Data Mgmt



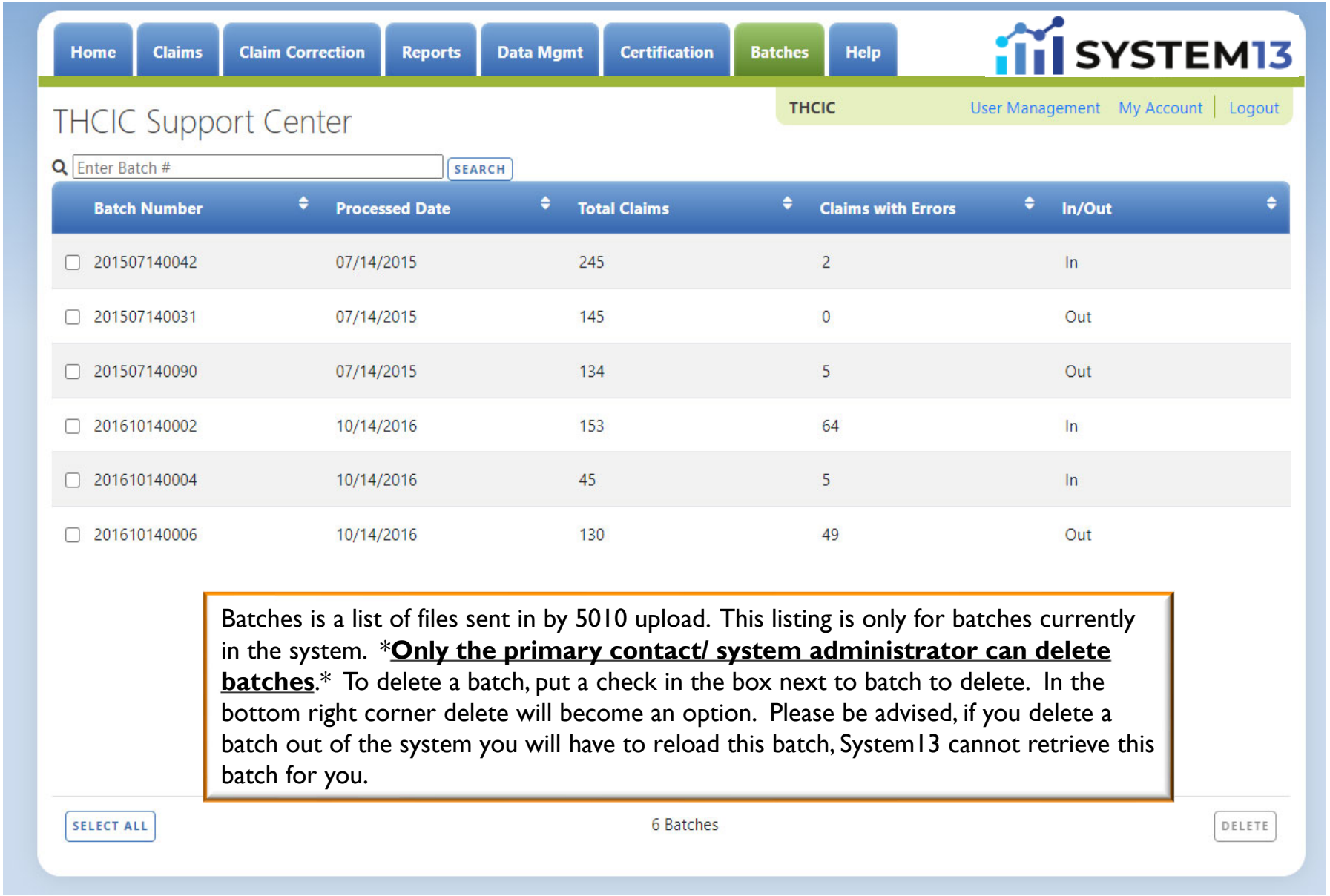
Data Management Email

Data Mgmt

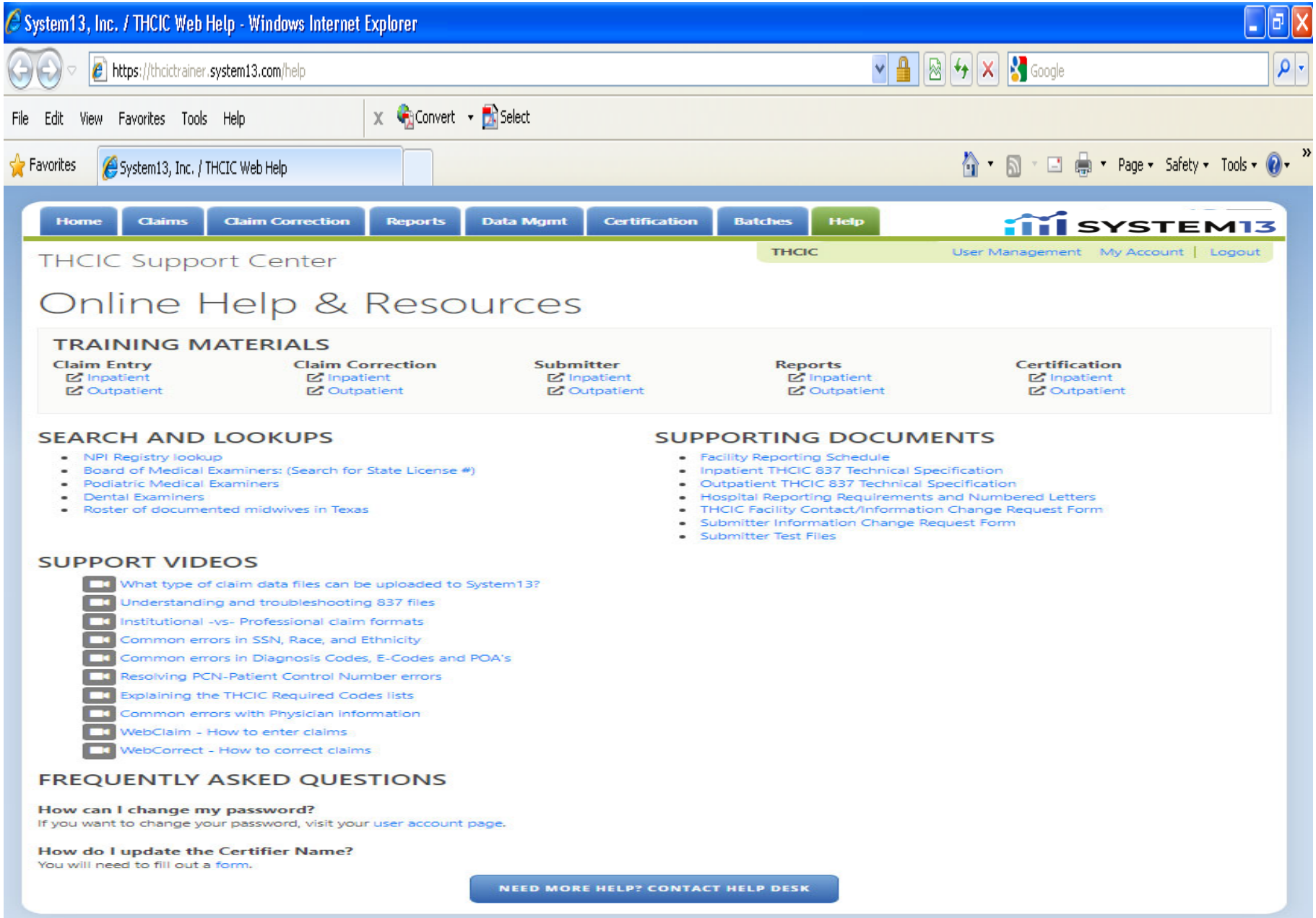


Batches

Batches



Provider Tab Help



Outpatient Web Claim Entry Training

- Data Reporting Schedule
- System Feature
- Web Claim Entry
  - Submitting claims manually using Web Claim Entry
  - New Claims in Progress
- Outpatient Institutional
- Outpatient Professional

Initial Submission Due Dates

Data Reporting Schedule

Texas Health Care Information Collection Center for Health Statistics

Activity	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Q1 2026	Q2 2026	Q3 2026	Q4 2026
Cutoff for initial submission	6-2-25	9-2-25	12-1-25	3-2-26	6-1-26	9-1-26	12-1-26	3-1-27
Cutoff for corrections	8-1-25	11-3-25	2-2-26	5-1-26	8-3-26	11-2-26	2-1-27	5-3-27
Facilities retrieve certification files	9-2-25	12-1-25	3-2-26	6-1-26	9-1-26	12-1-26	3-1-27	6-1-27
Certification/ comments due	10-15-25	1-15-26	4-15-26	7-15-26	10-15-26	1-15-27	4-15-27	7-15-27

The reporting schedule is a rule driven schedule, under Chapter 421, Title 25, Part 1 of the Texas Administrative Code, Subchapter D, RULE §421.66. The due dates are either the 1st or the 15th of the month, if these dates are on a weekend or state observed holiday, the data is due the next business day.

System Feature

After the *Cutoff for initial submission the Data Manager (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.

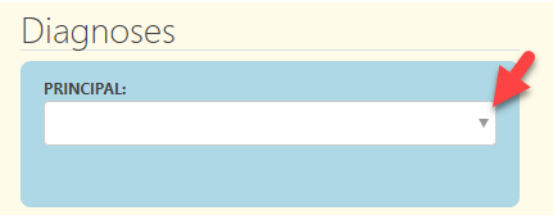
*Cutoff for initial submission is the date when the submission data is due in the system.

Various Options for Entering Web Claim Entry

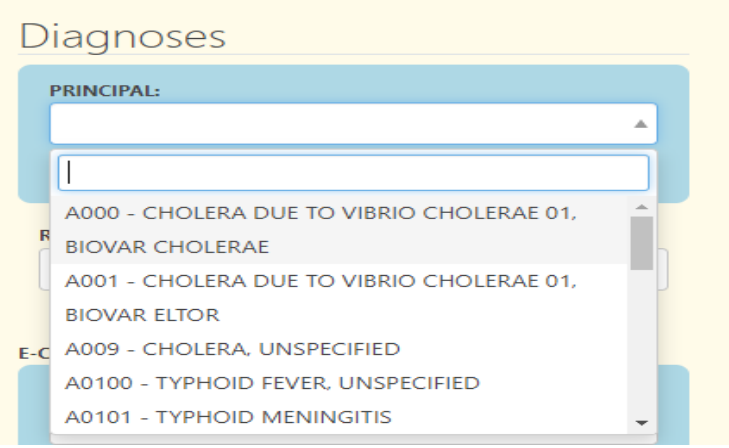
- You can enter Web Claim Entry from:
  - Provider Home page – click WEB CLAIM ENTRY
  - Claims Listing – click ADD NEW CLAIM
  - To continue a claim in process click NEW CLAIMS IN PROGRESS

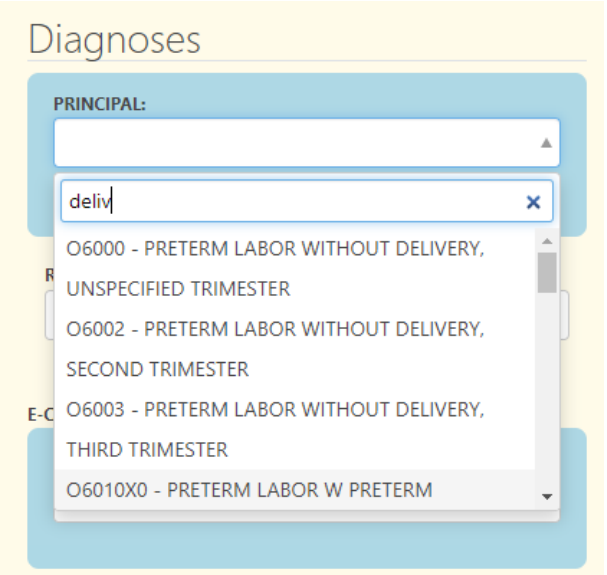
Dropdown Lists

- **The user can tell if a field has a drop down list by the arrow on the field.**



- **Typing into a text box with a dropdown list will search the list for matches and display the list to the user.**





- **Use the up and down arrow keys to move to the value.**

- **Press ENTER** 

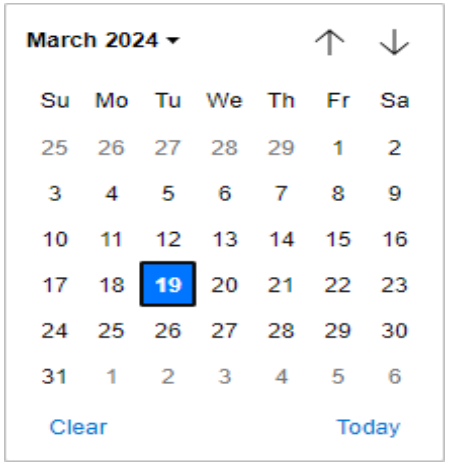
when the highlighted selection is on the correct choice.

- **Press TAB** 

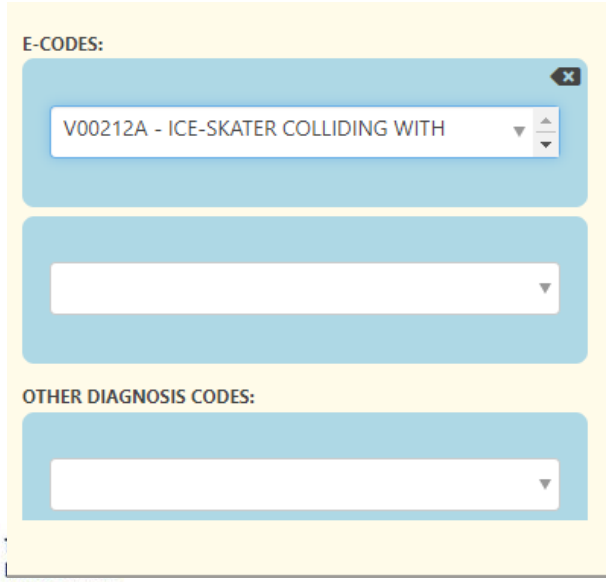
to move to the next field on the screen.

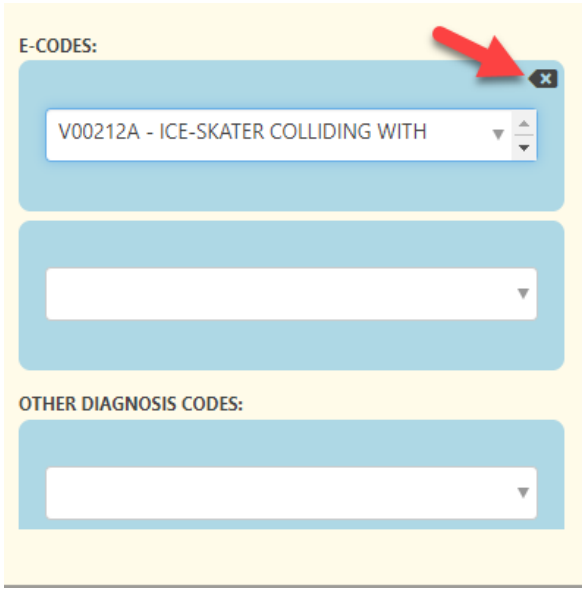
Calendars/ Adding or Deleting Choices

- **The user can tell if a field has a calendar, indicated by** 🗔



- **Some fields allow you to have multiple codes, once a code is enter another box will become available, to delete an entry, click the X beside this choice.**

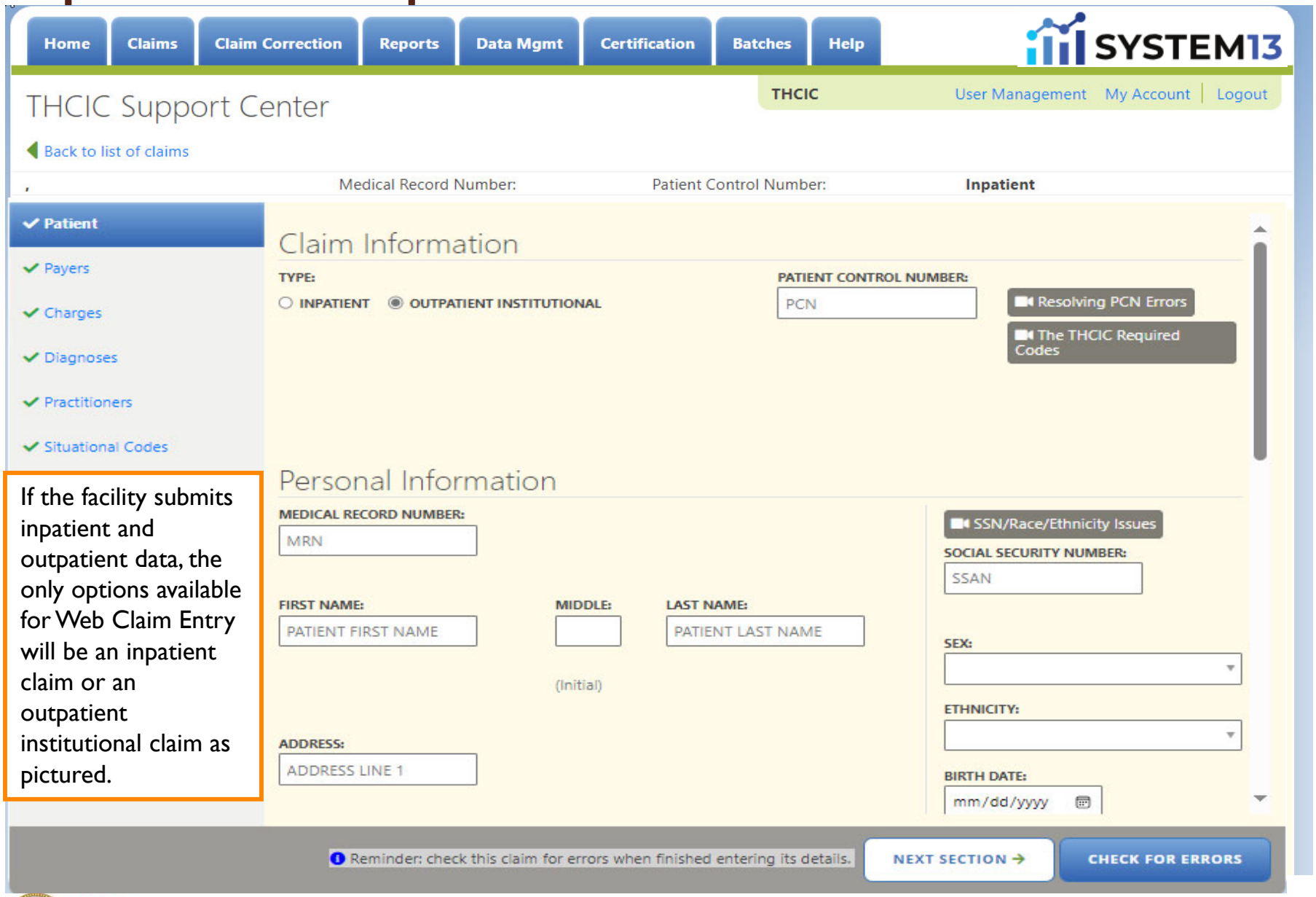




TEXAS Health and Human Services

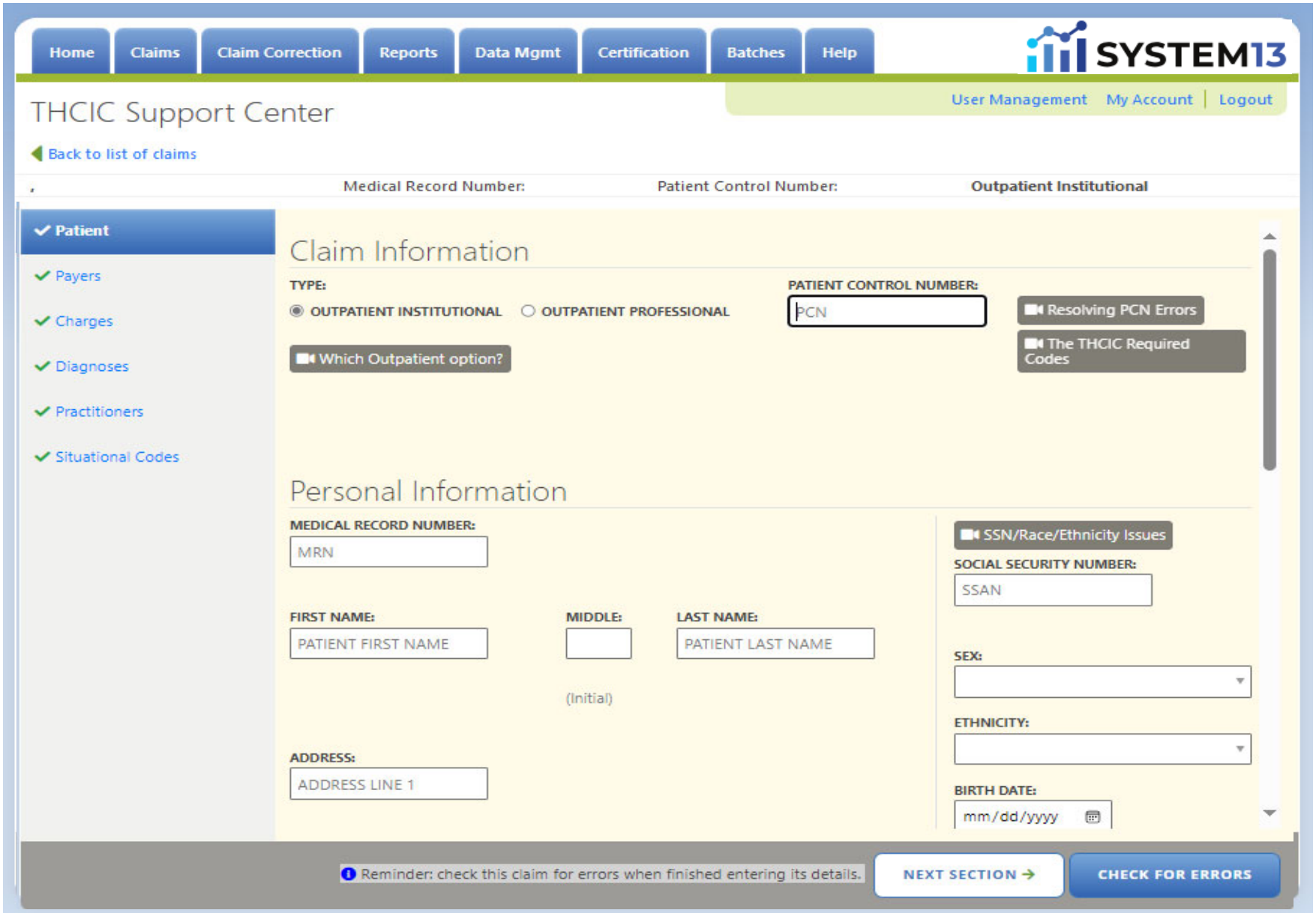
Outpatient Institutional

Opening Web Claim Entry for Inpatient/Outpatient Facilities

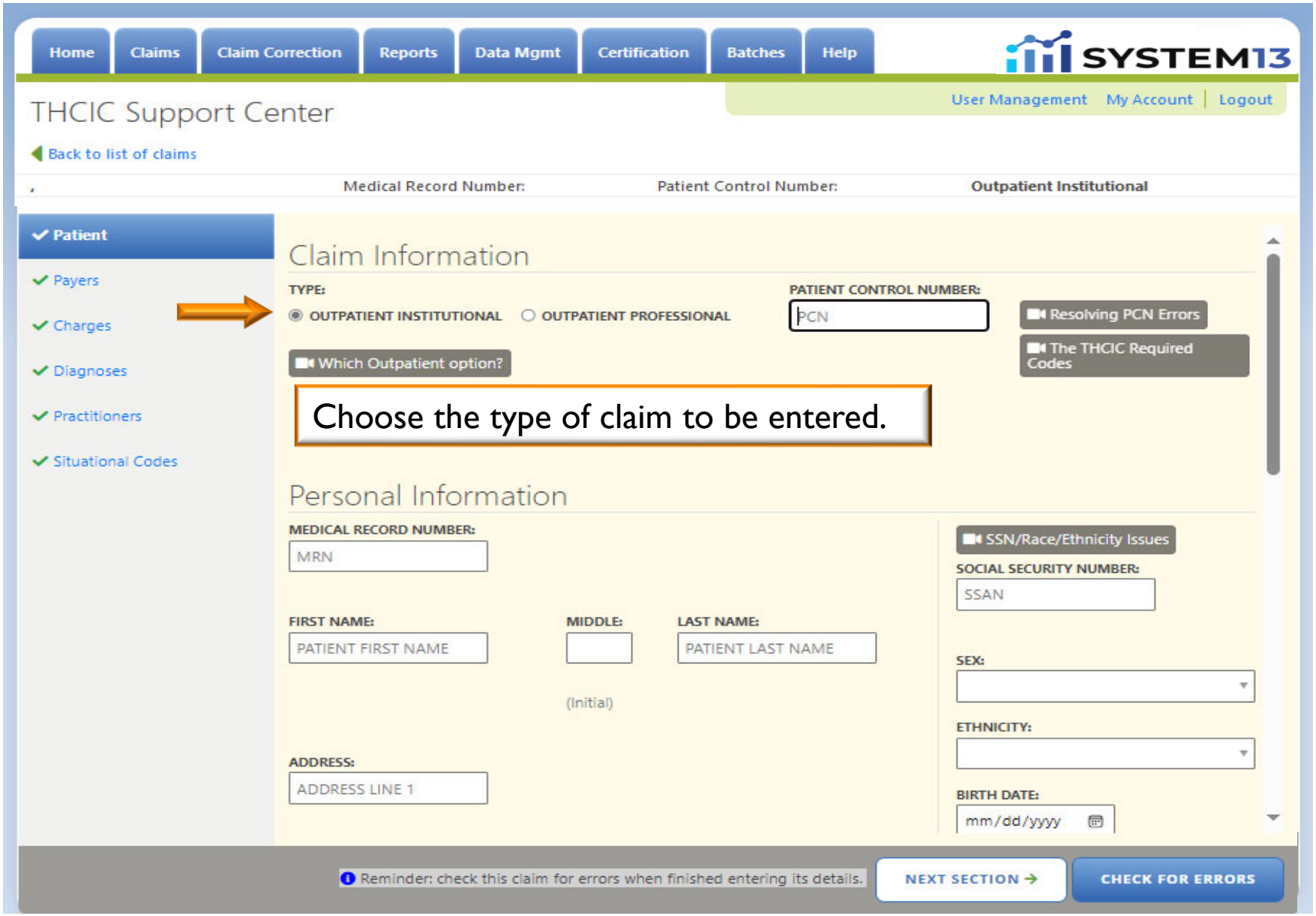


If the facility submits inpatient and outpatient data, the only options available for Web Claim Entry will be an inpatient claim or an outpatient institutional claim as pictured.

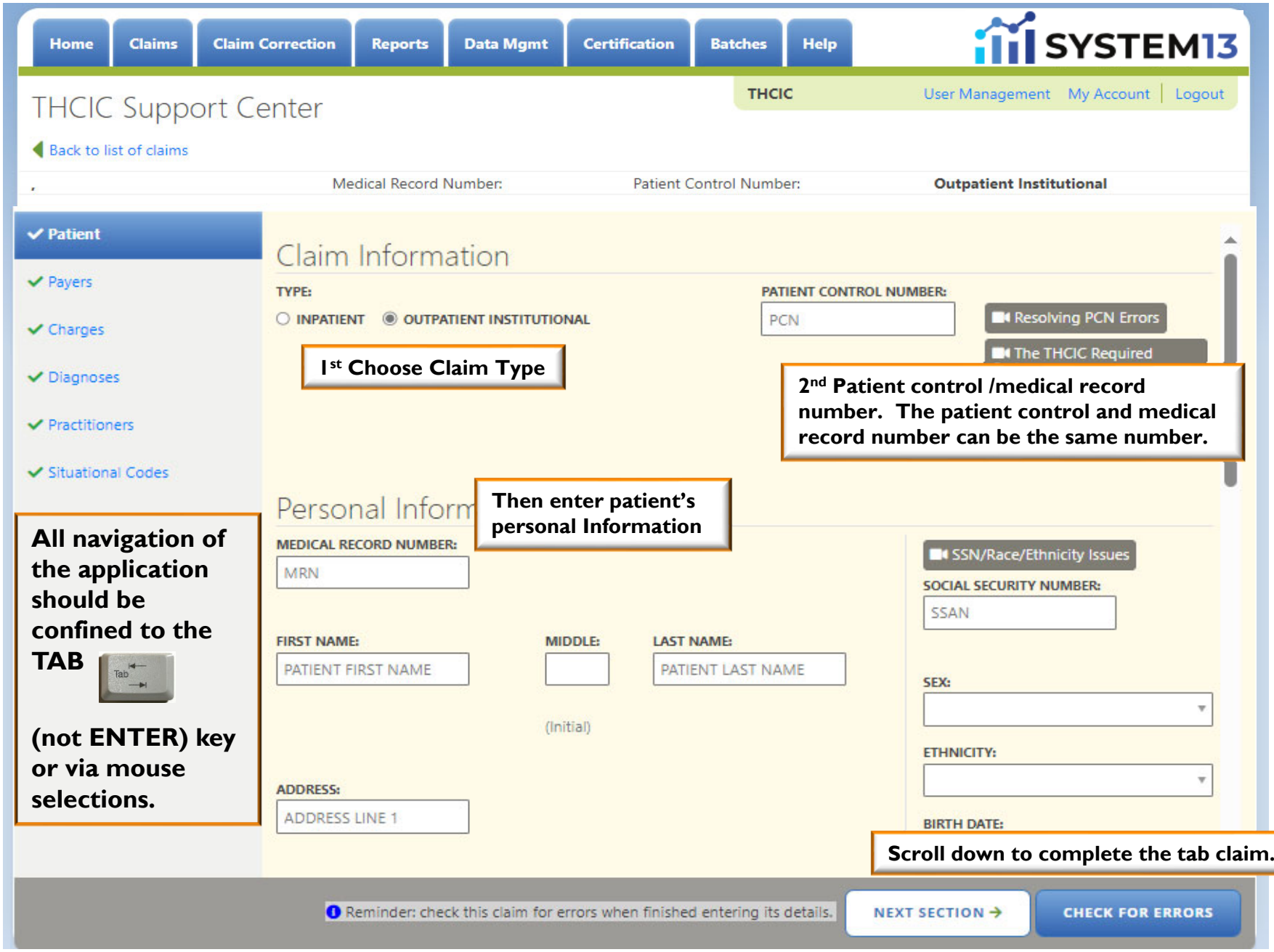
Opening Web Claim Entry Through Provider Home Page



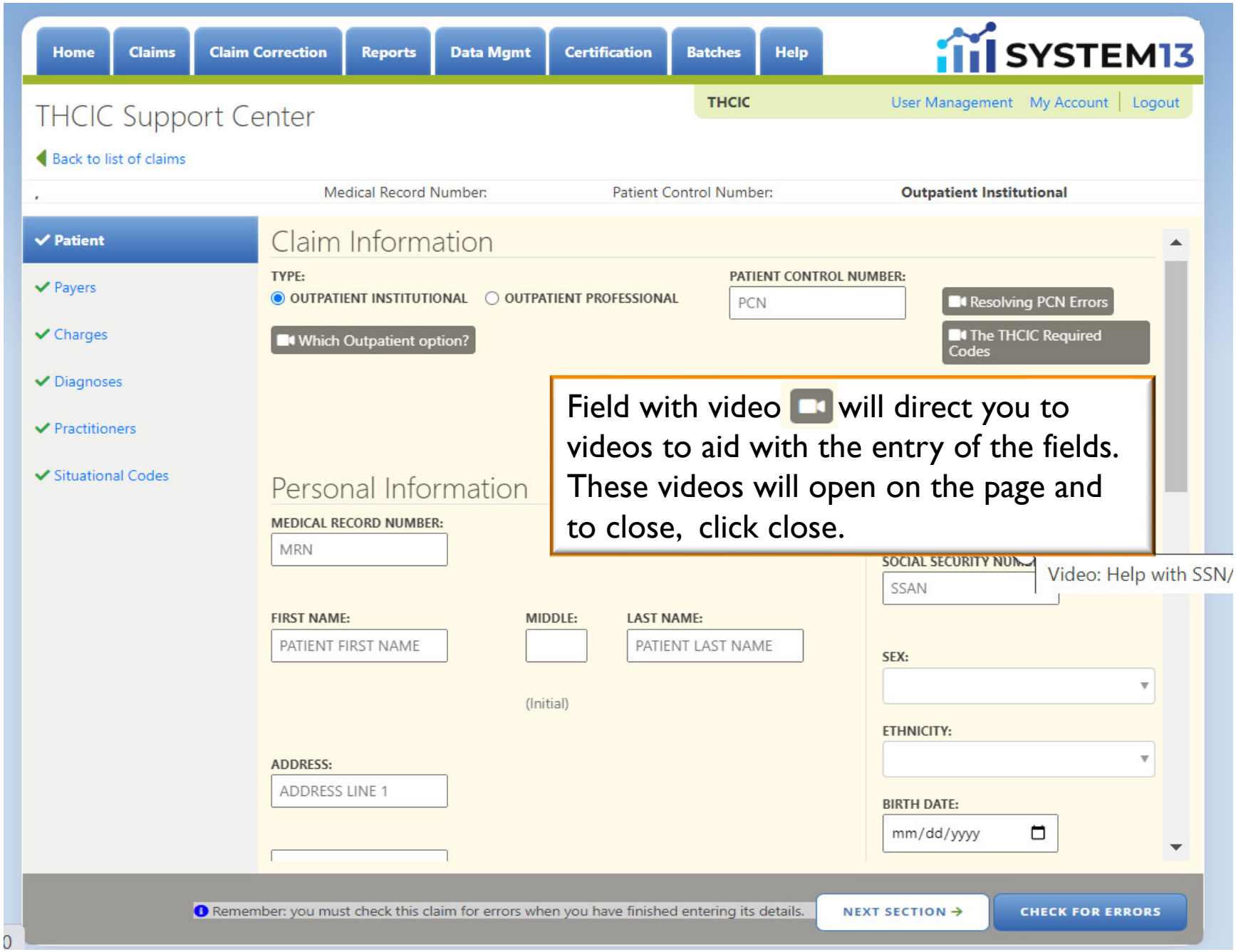
Patient Tab
Outpatient Institutional



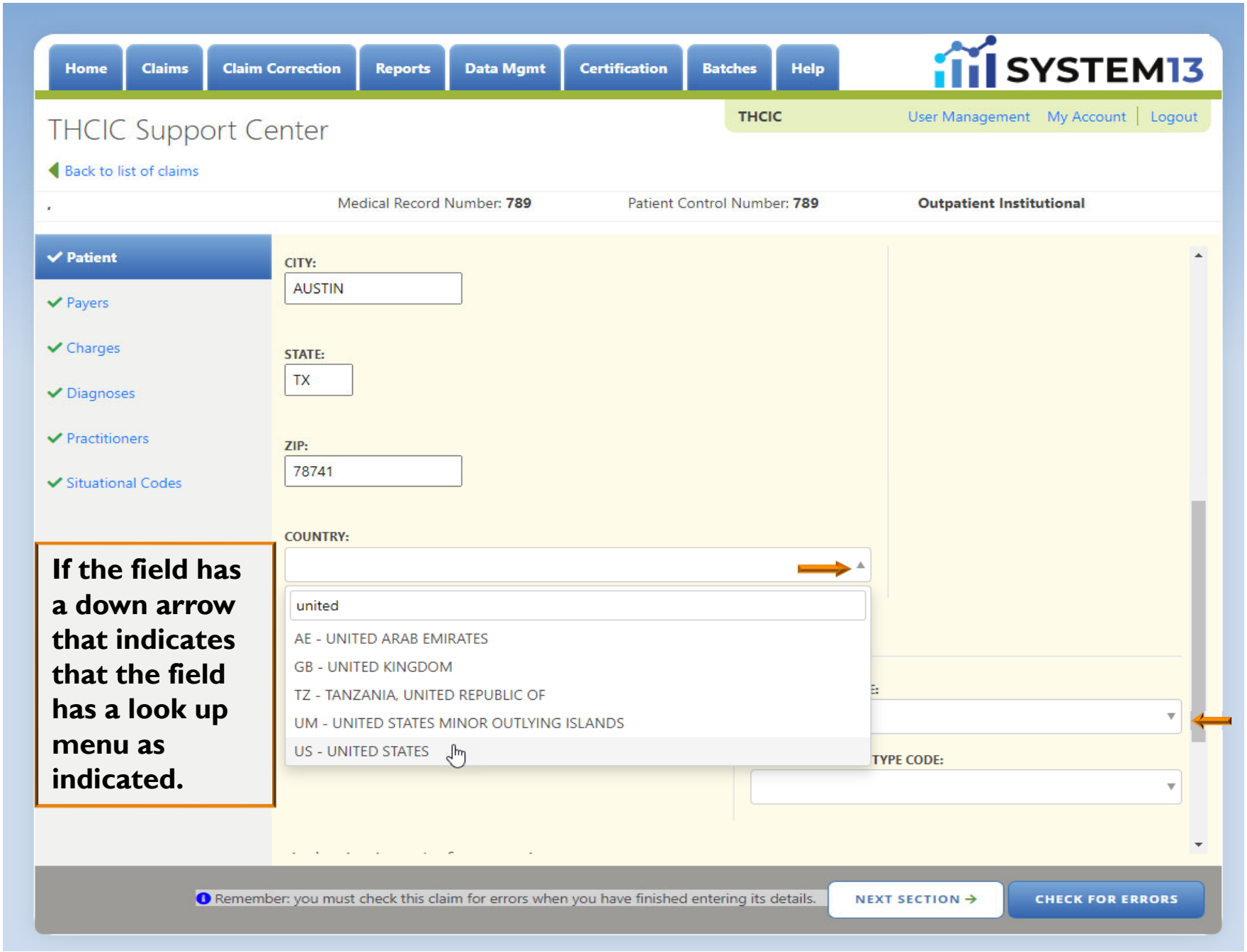
Web Claim Entry Data Input - Patient Tab



Patient Tab

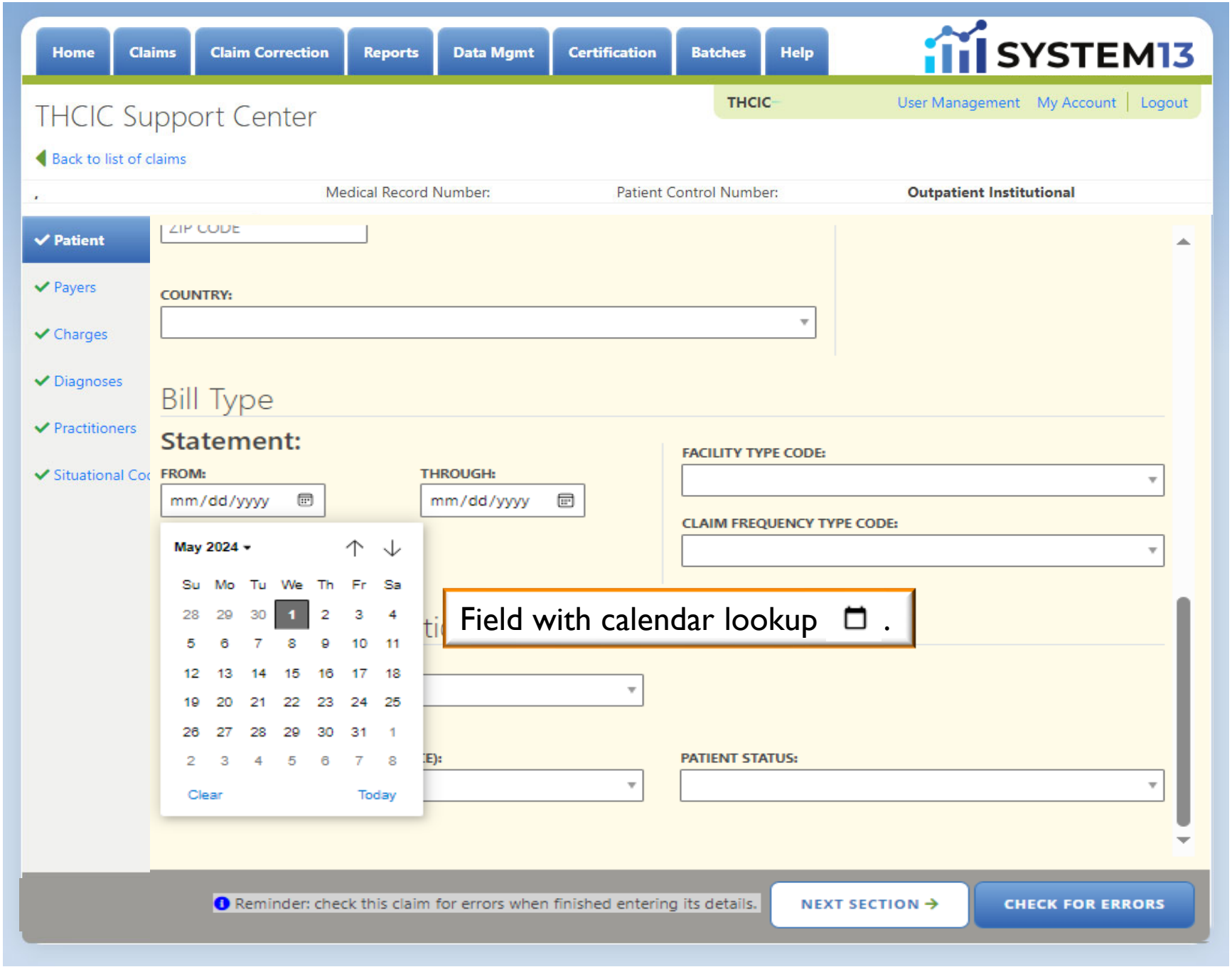

Home
Claims
Claim Correction
Reports
Data Mgmt
Certification
Batches
Help
SYSTEM13
THCIC Support Center
THCIC
User Management
My Account
Logout
Back to list of claims
Medical Record Number:
Patient Control Number:
Outpatient Institutional
Patient
Payers
Charges
Diagnoses
Practitioners
Situational Codes
Claim Information
TYPE:
OUTPATIENT INSTITUTIONAL
OUTPATIENT PROFESSIONAL
PATIENT CONTROL NUMBER:
PCN
Resolving PCN Errors
Which Outpatient option?
The THCIC Required Codes
Field with video will direct you to videos to aid with the entry of the fields. These videos will open on the page and to close, click close.
Personal Information
MEDICAL RECORD NUMBER:
MRN
SOCIAL SECURITY NUM
SSAN
Video: Help with SSN/
FIRST NAME:
PATIENT FIRST NAME
MIDDLE:
(Initial)
LAST NAME:
PATIENT LAST NAME
SEX:
ETHNICITY:
ADDRESS:
ADDRESS LINE 1
BIRTH DATE:
mm/dd/yyyy
Remember: you must check this claim for errors when you have finished entering its details.
NEXT SECTION →
CHECK FOR ERRORS

Entering Claim Information



If the field has a down arrow that indicates that the field has a look up menu as indicated.

Patient Tab


Home
Claims
Claim Correction
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THCIC
User Management
My Account
Logout
THCIC Support Center
Back to list of claims
Medical Record Number:
Patient Control Number:
Outpatient Institutional
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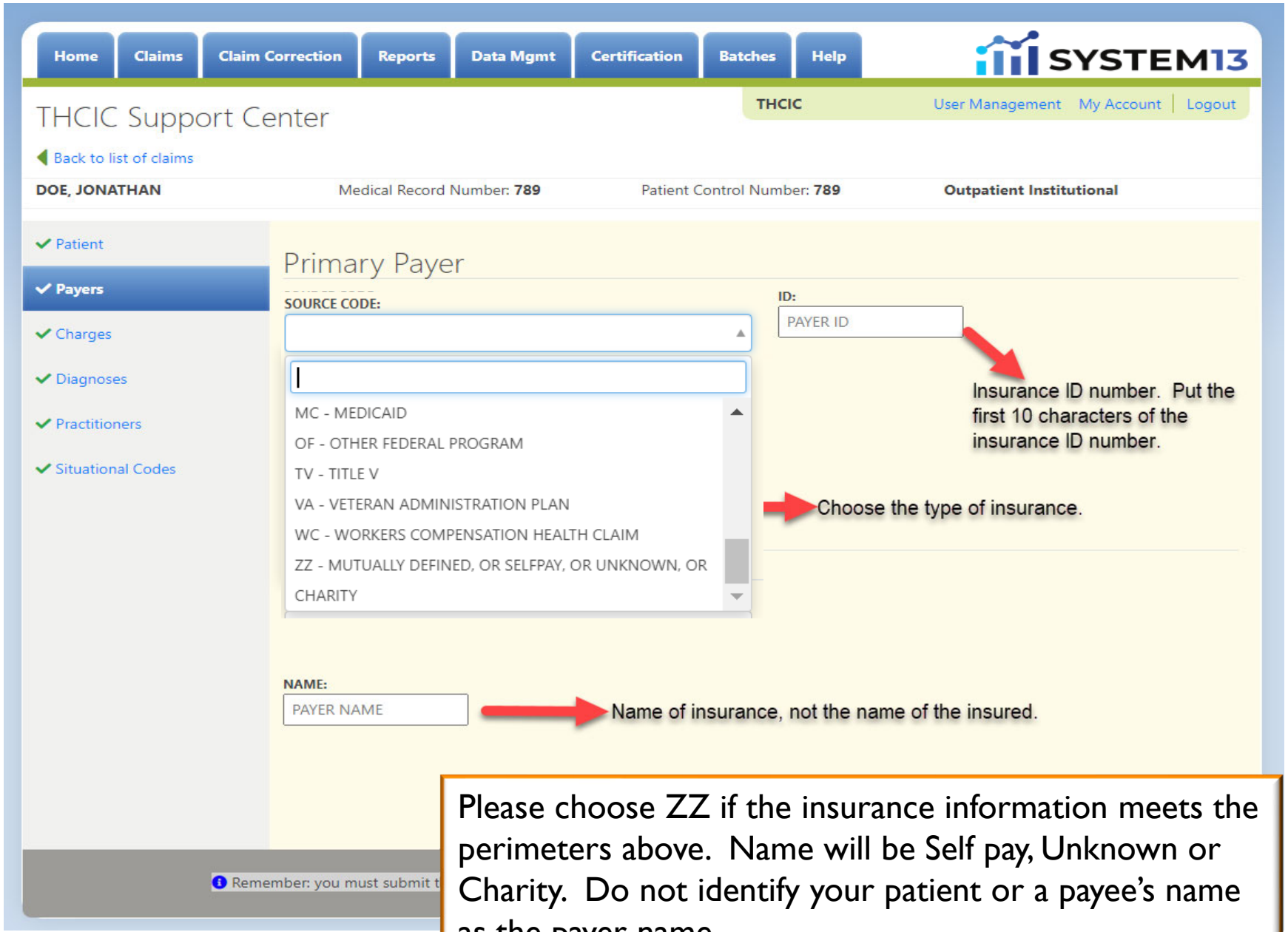
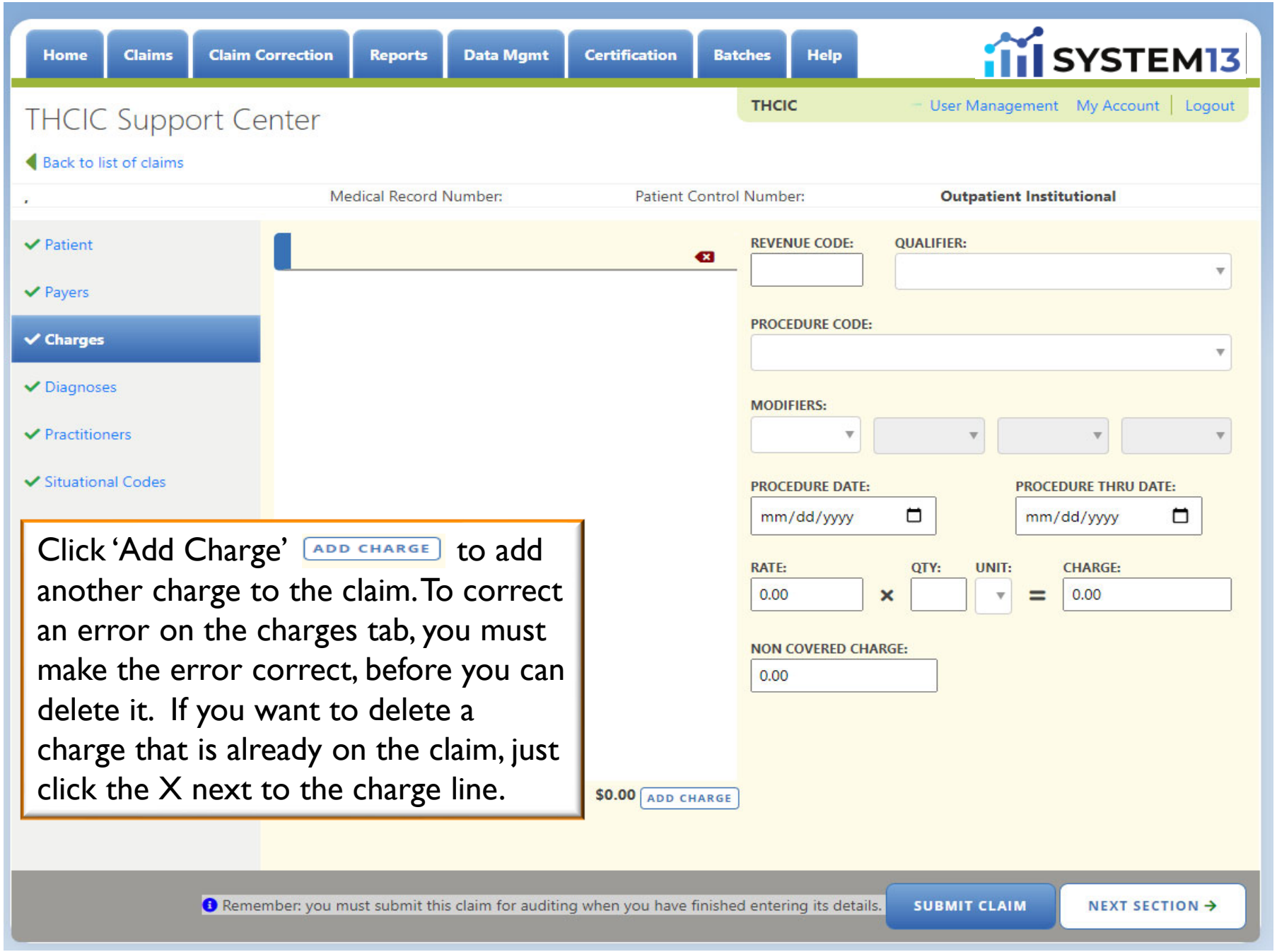
Payers
Charges
Diagnoses
Practitioners
Situational Co
COUNTRY:
Bill Type
Statement:
FROM:
mm/dd/yyyy
THROUGH:
mm/dd/yyyy
FACILITY TYPE CODE:
CLAIM FREQUENCY TYPE CODE:
May 2024
Su Mo Tu We Th Fr Sa
28 29 30 1 2 3 4
5 6 7 8 9 10 11
12 13 14 15 16 17 18
19 20 21 22 23 24 25
26 27 28 29 30 31 1
2 3 4 5 6 7 8
Clear
Today
Field with calendar lookup .
PATIENT STATUS:
Reminder: check this claim for errors when finished entering its details.
NEXT SECTION
CHECK FOR ERRORS

Payer Tab



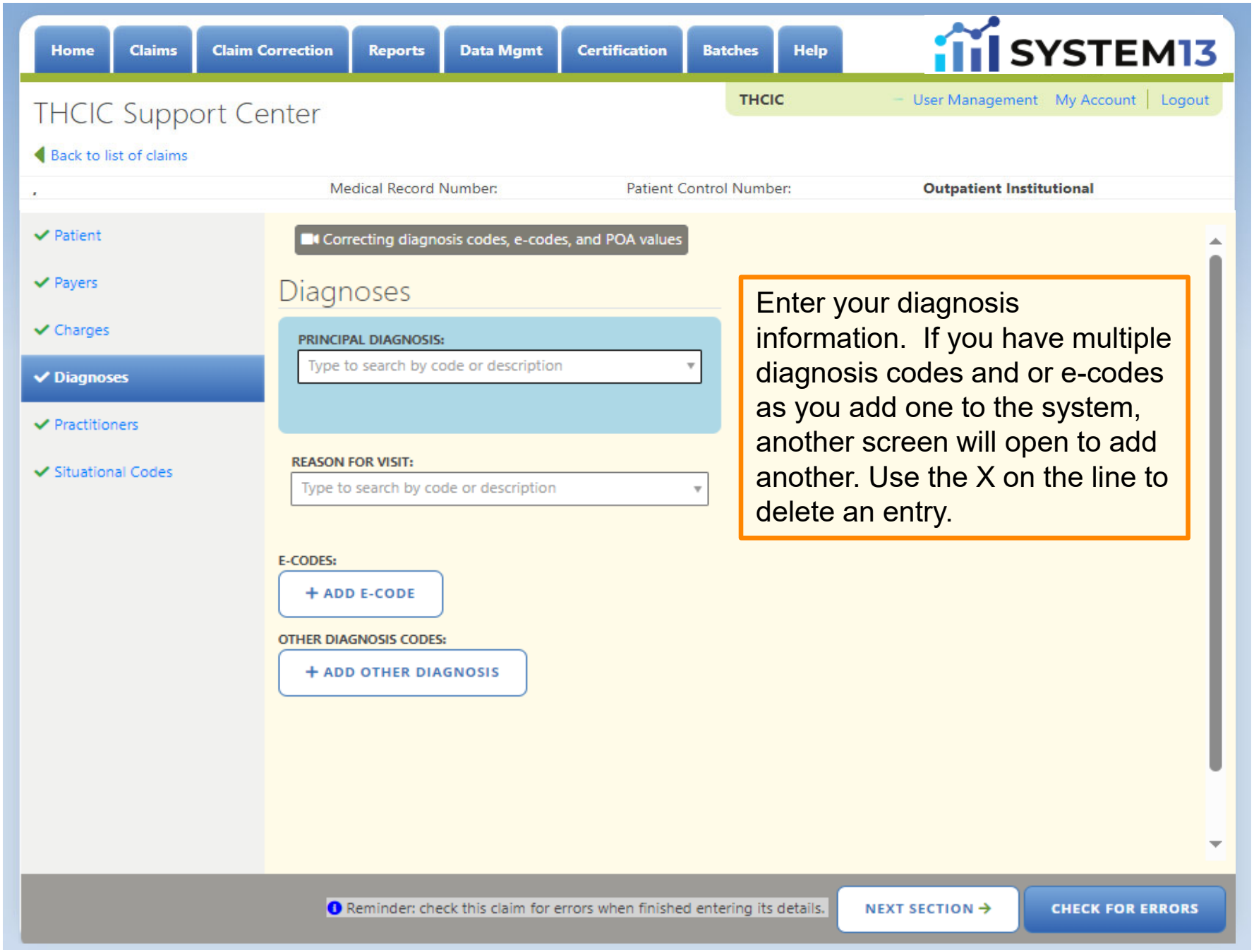
Please choose ZZ if the insurance information meets the perimeters above. Name will be Self pay, Unknown or Charity. Do not identify your patient or a payee's name as the payer name.

Charges Tab



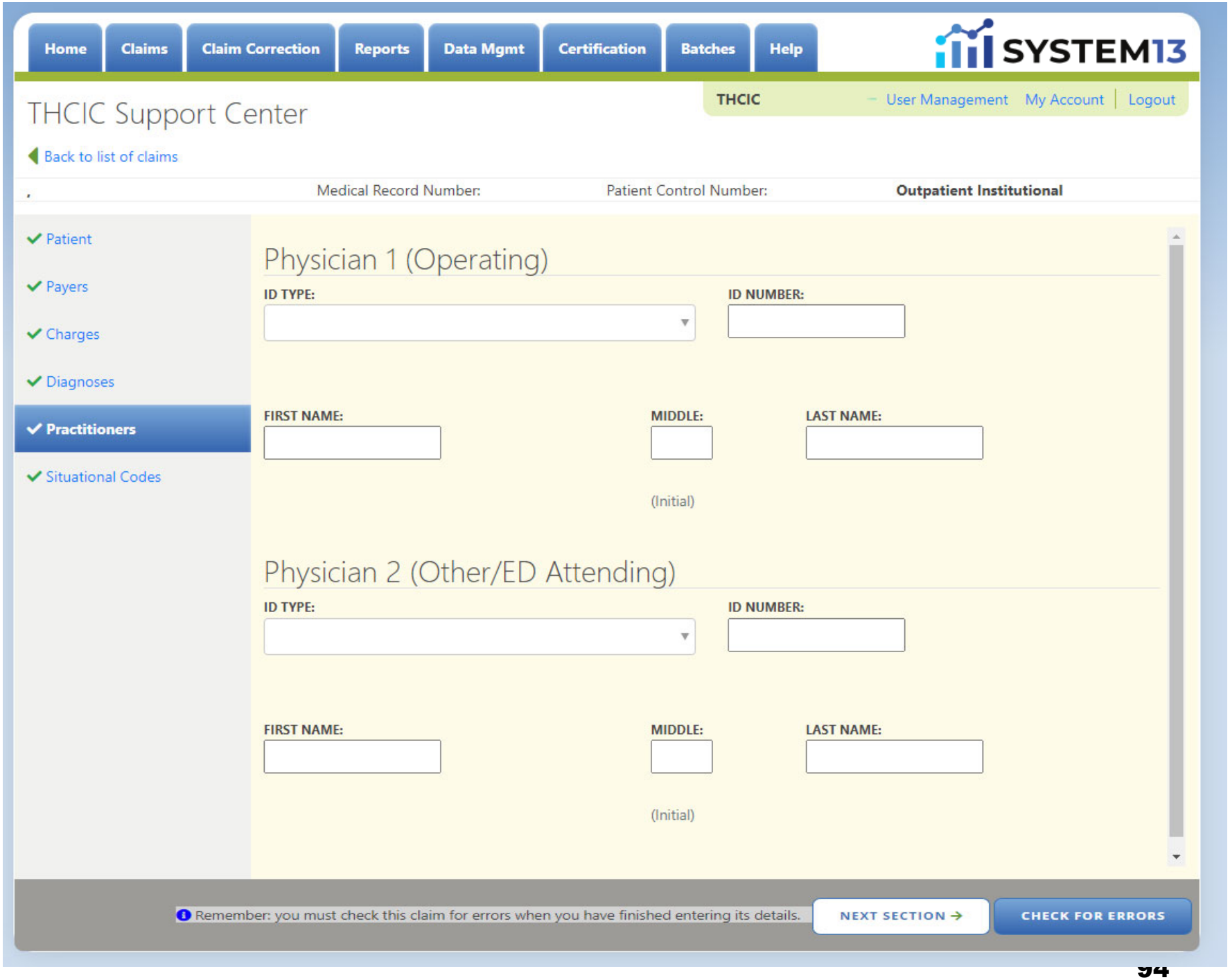
Click 'Add Charge' ADD CHARGE to add another charge to the claim. To correct an error on the charges tab, you must make the error correct, before you can delete it. If you want to delete a charge that is already on the claim, just click the X next to the charge line.

Diagnosis Tab

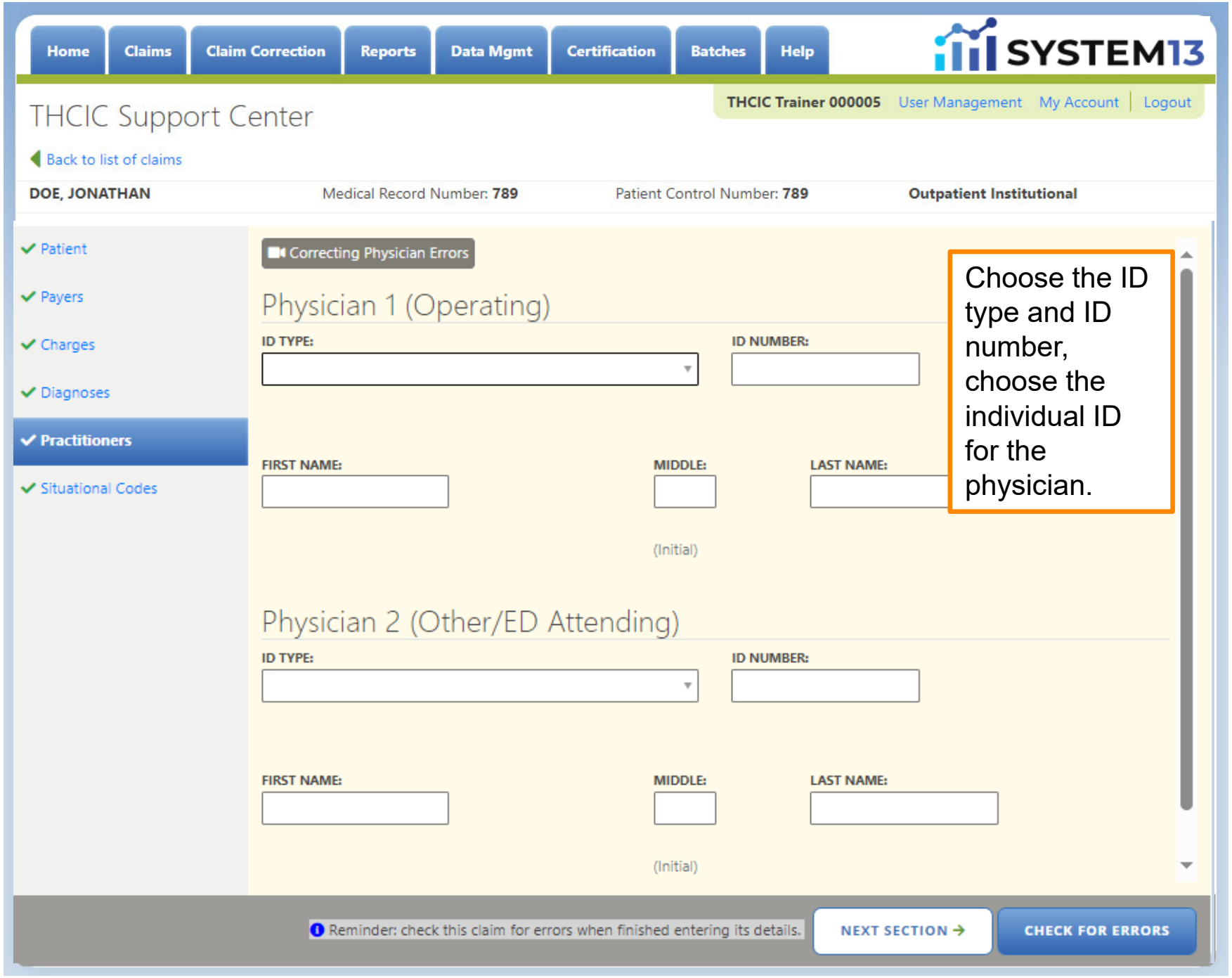


Enter your diagnosis information. If you have multiple diagnosis codes and or e-codes as you add one to the system, another screen will open to add another. Use the X on the line to delete an entry.

Practitioners Tab

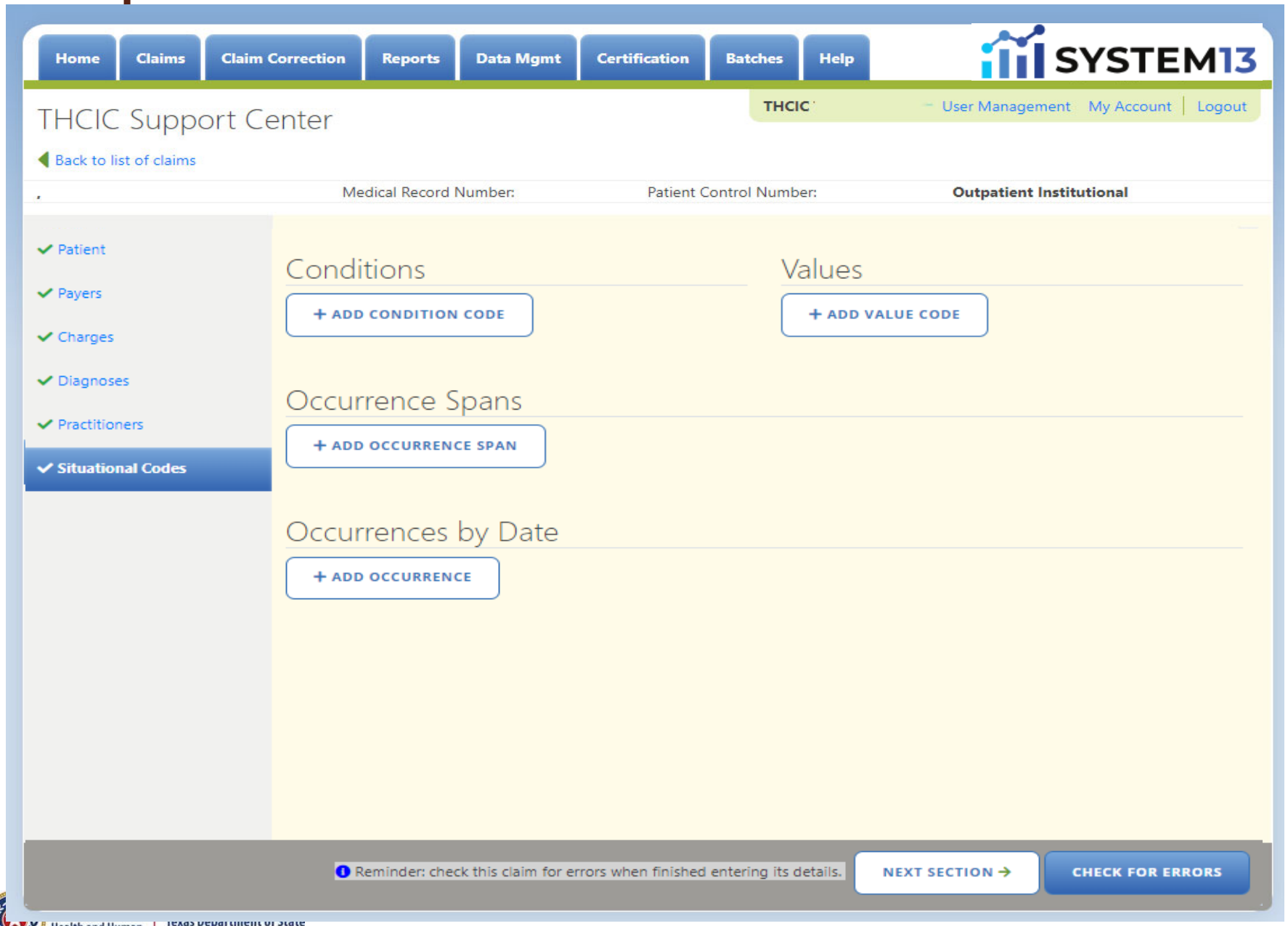


Practitioners Tab

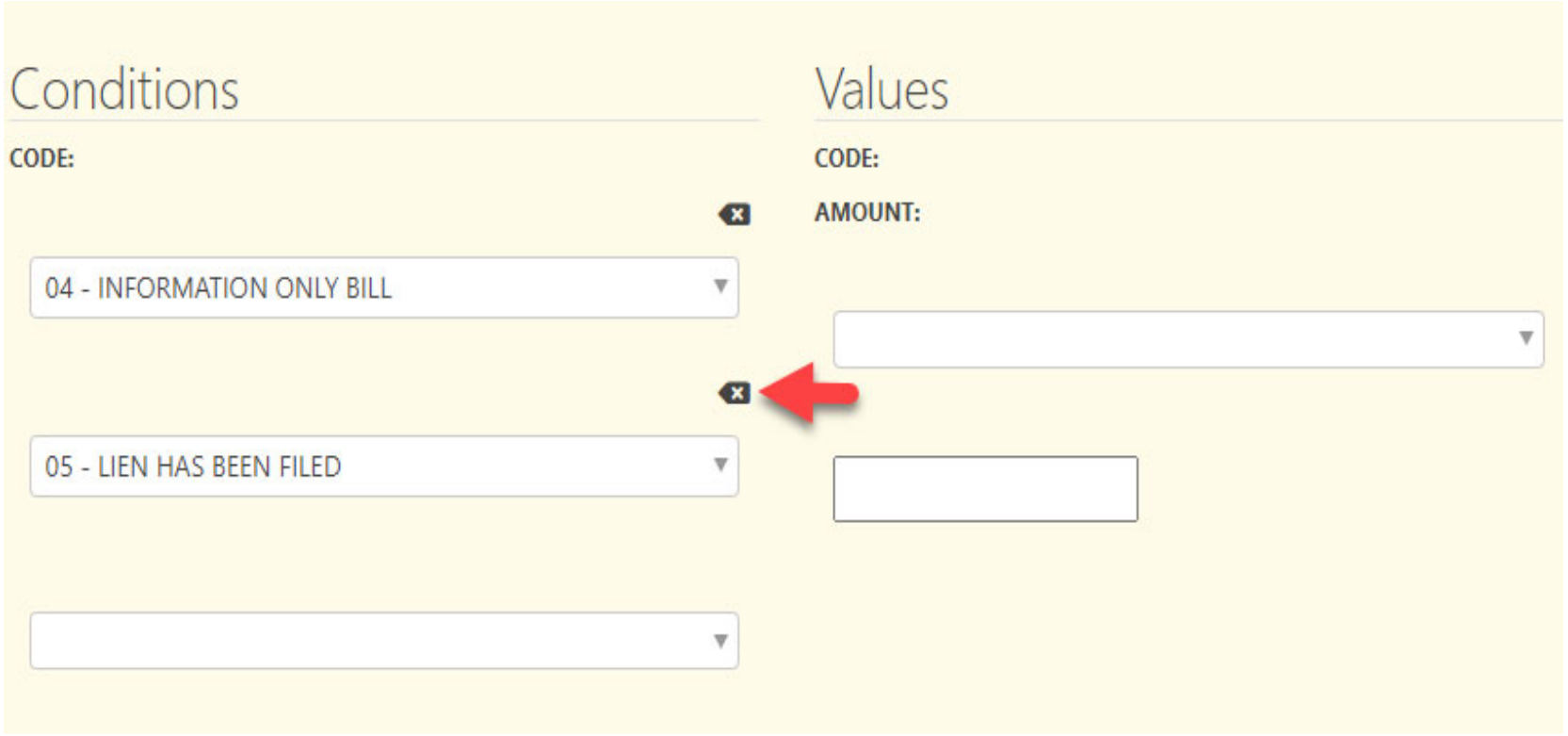


Choose the ID type and ID number, choose the individual ID for the physician.

Situational Codes Tab only available on Outpatient Institutional



Situational Codes Tab only available on Outpatient Institutional

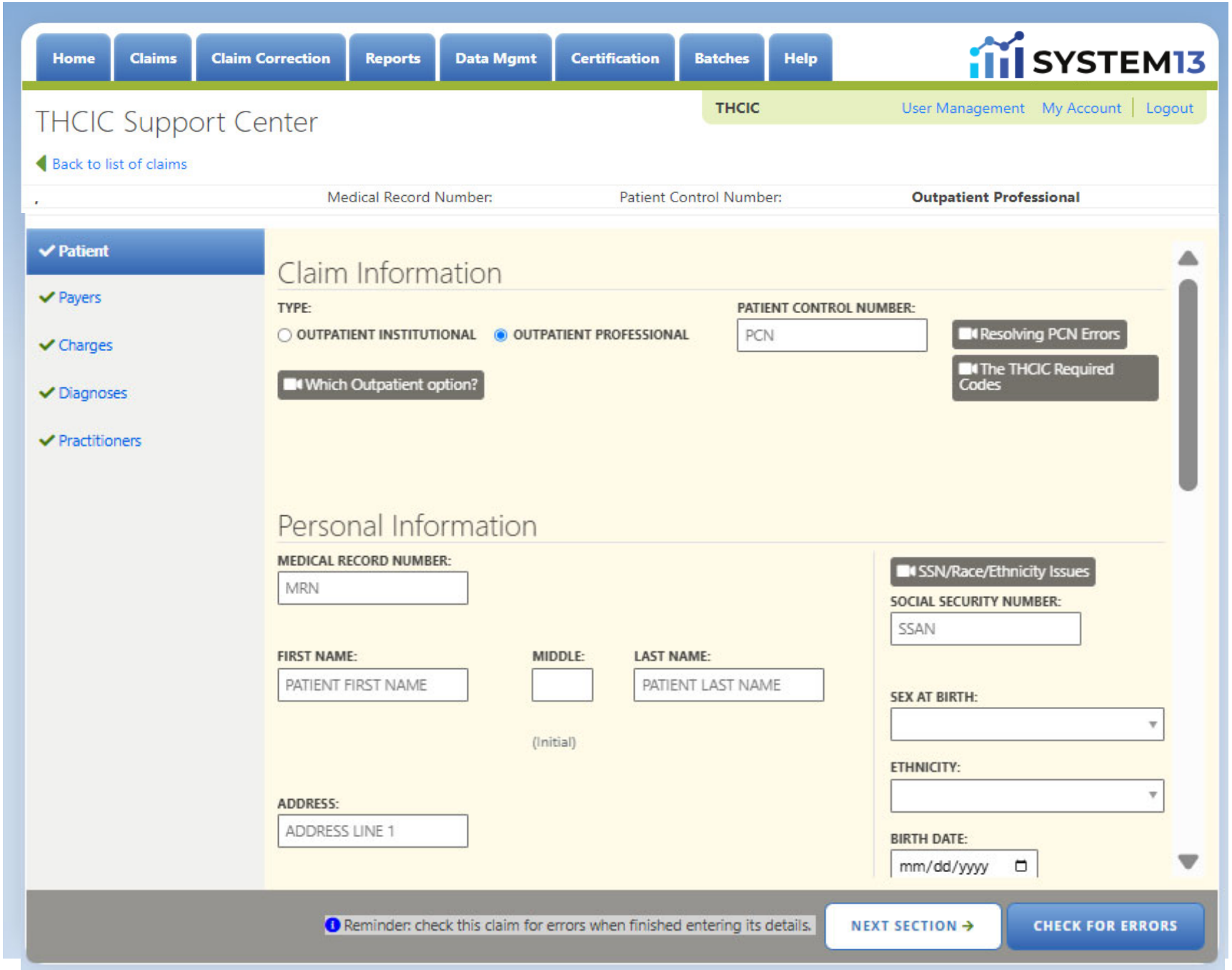


If you have multiple conditions to add to a claim, as you tab out of this screen you will be able to add another condition. If you want to delete a condition, click the box next to the claim information.

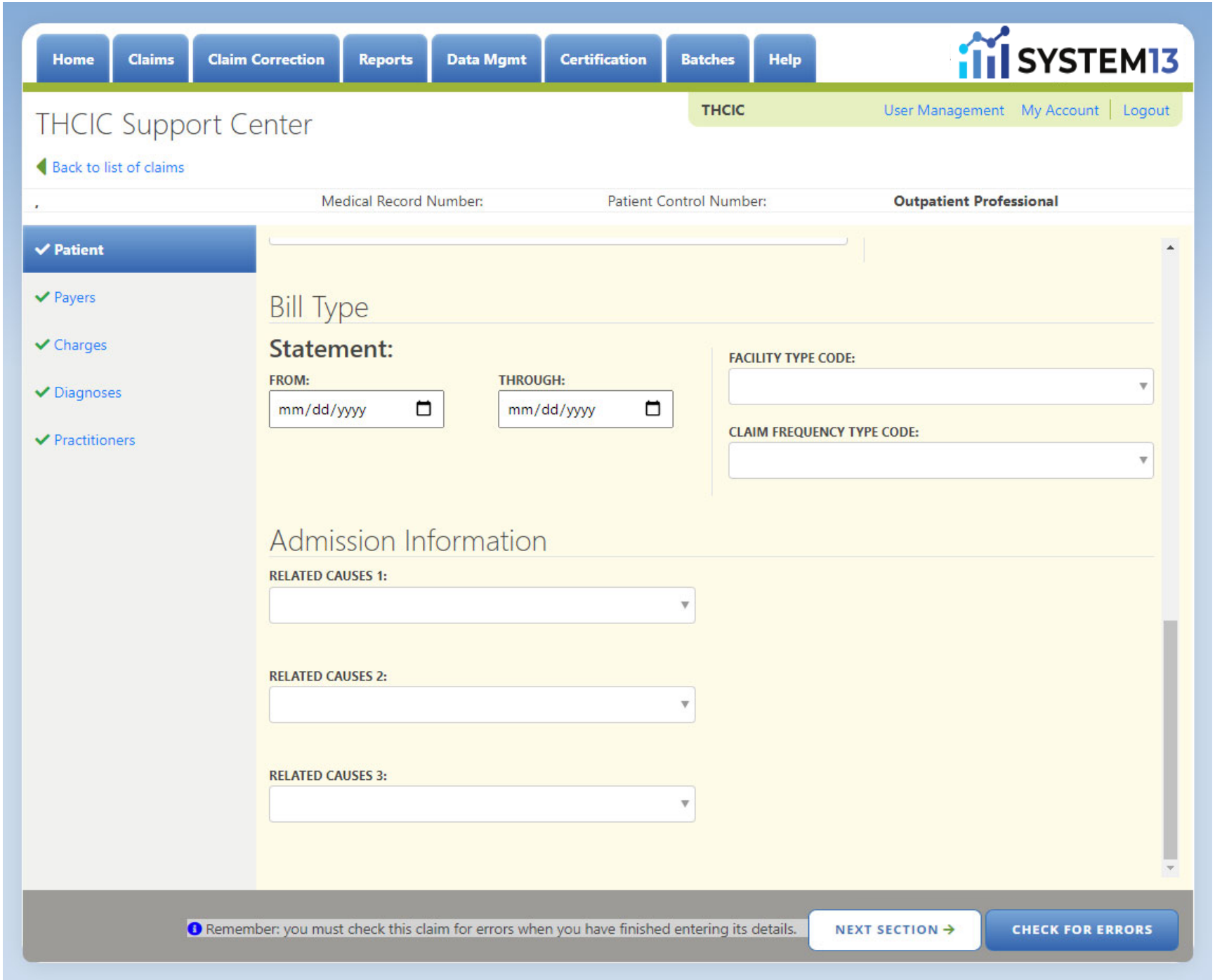
Outpatient Professional

Medicaid or Medicare Claims only. You can submit Medicare and Medicaid claims on the institutional claim, but **ONLY** Medicare and Medicaid can be professional.

Patient Tab


Home
Claims
Claim Correction
Reports
Data Mgmt
Certification
Batches
Help
SYSTEM13
THCIC Support Center
THCIC
User Management
My Account
Logout
Back to list of claims
Medical Record Number:
Patient Control Number:
Outpatient Professional
Patient
Payers
Charges
Diagnoses
Practitioners
Claim Information
TYPE:
OUTPATIENT INSTITUTIONAL
OUTPATIENT PROFESSIONAL
PATIENT CONTROL NUMBER:
PCN
Resolving PCN Errors
The THCIC Required Codes
Which Outpatient option?
Personal Information
MEDICAL RECORD NUMBER:
MRN
SSN/Race/Ethnicity Issues
SOCIAL SECURITY NUMBER:
SSAN
FIRST NAME:
PATIENT FIRST NAME
MIDDLE:
(Initial)
LAST NAME:
PATIENT LAST NAME
SEX AT BIRTH:
ETHNICITY:
ADDRESS:
ADDRESS LINE 1
BIRTH DATE:
mm/dd/yyyy
Reminder: check this claim for errors when finished entering its details.
NEXT SECTION →
CHECK FOR ERRORS

Patient Tab


Home
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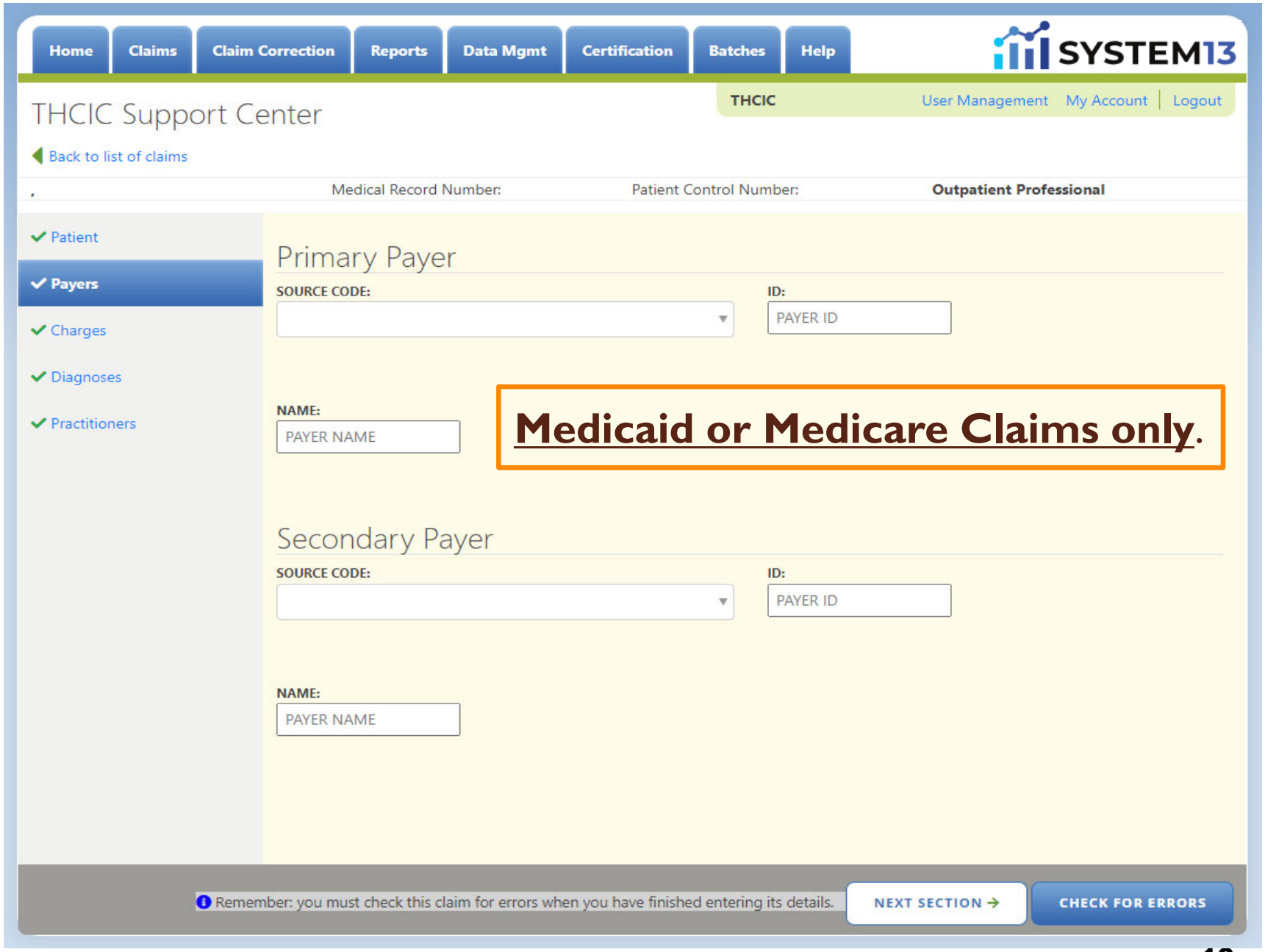
Diagnoses
Practitioners
Bill Type
Statement:
FROM:
mm/dd/yyyy
THROUGH:
mm/dd/yyyy
FACILITY TYPE CODE:
CLAIM FREQUENCY TYPE CODE:
Admission Information
RELATED CAUSES 1:
RELATED CAUSES 2:
RELATED CAUSES 3:
Remember: you must check this claim for errors when you have finished entering its details.
NEXT SECTION →
CHECK FOR ERRORS

Payer Tab


Home
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Back to list of claims
Medical Record Number:
Patient Control Number:
Outpatient Professional
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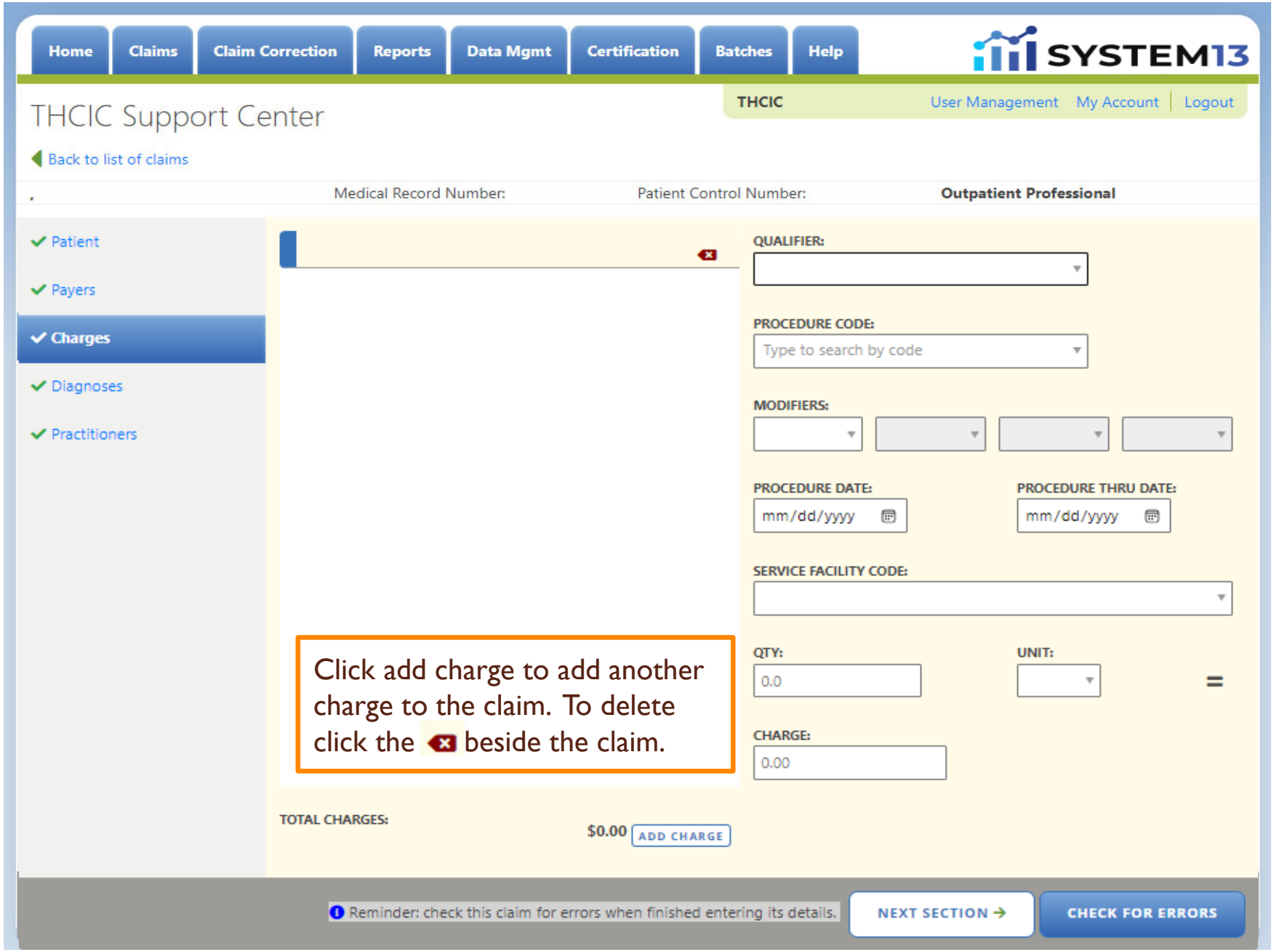
Payers
Charges
Diagnoses
Practitioners
Primary Payer
SOURCE CODE:
ID:
PAYER ID
NAME:
PAYER NAME
Medicaid or Medicare Claims only.
Secondary Payer
SOURCE CODE:
ID:
PAYER ID
NAME:
PAYER NAME
Remember: you must check this claim for errors when you have finished entering its details.
NEXT SECTION →
CHECK FOR ERRORS

Charges Tab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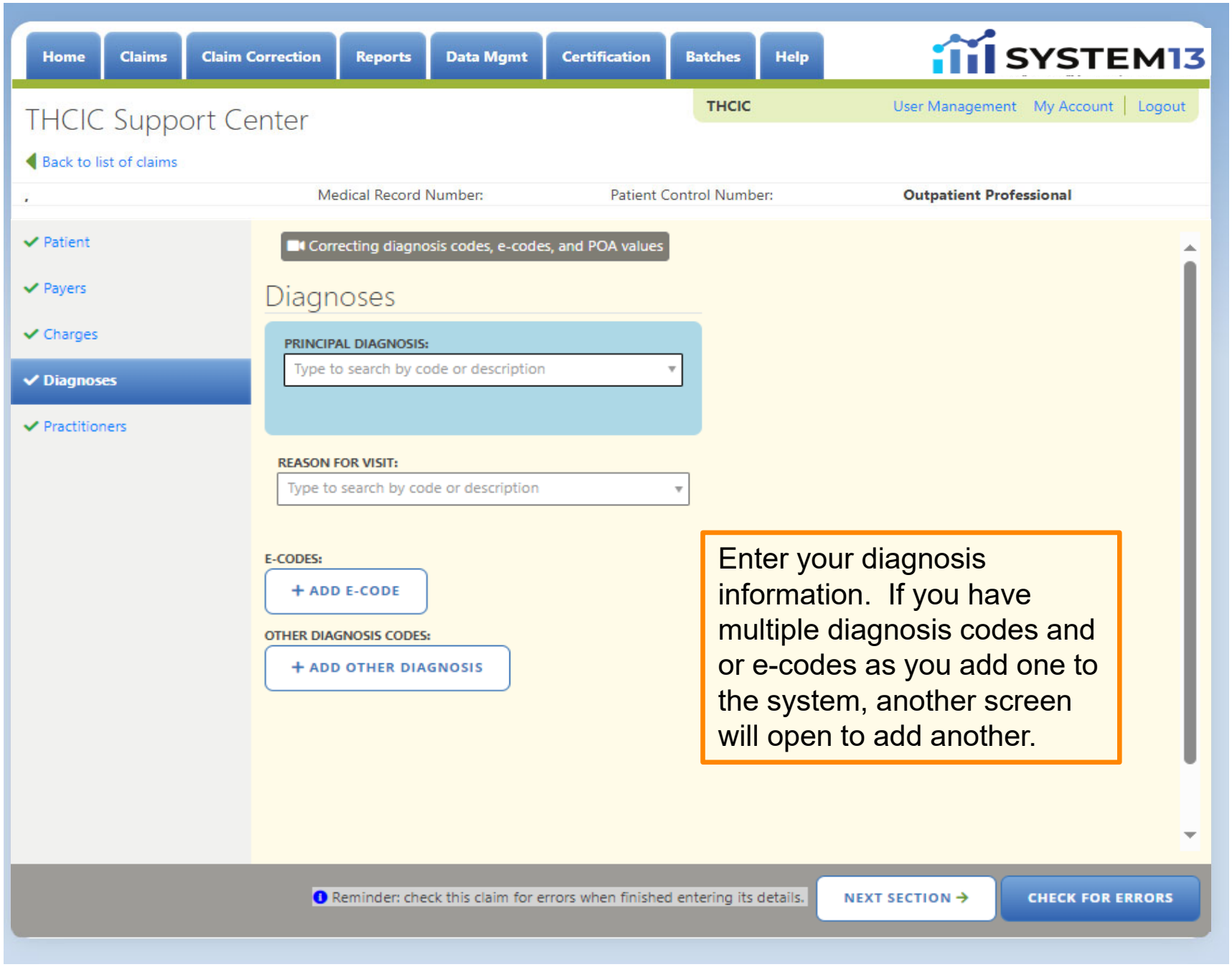
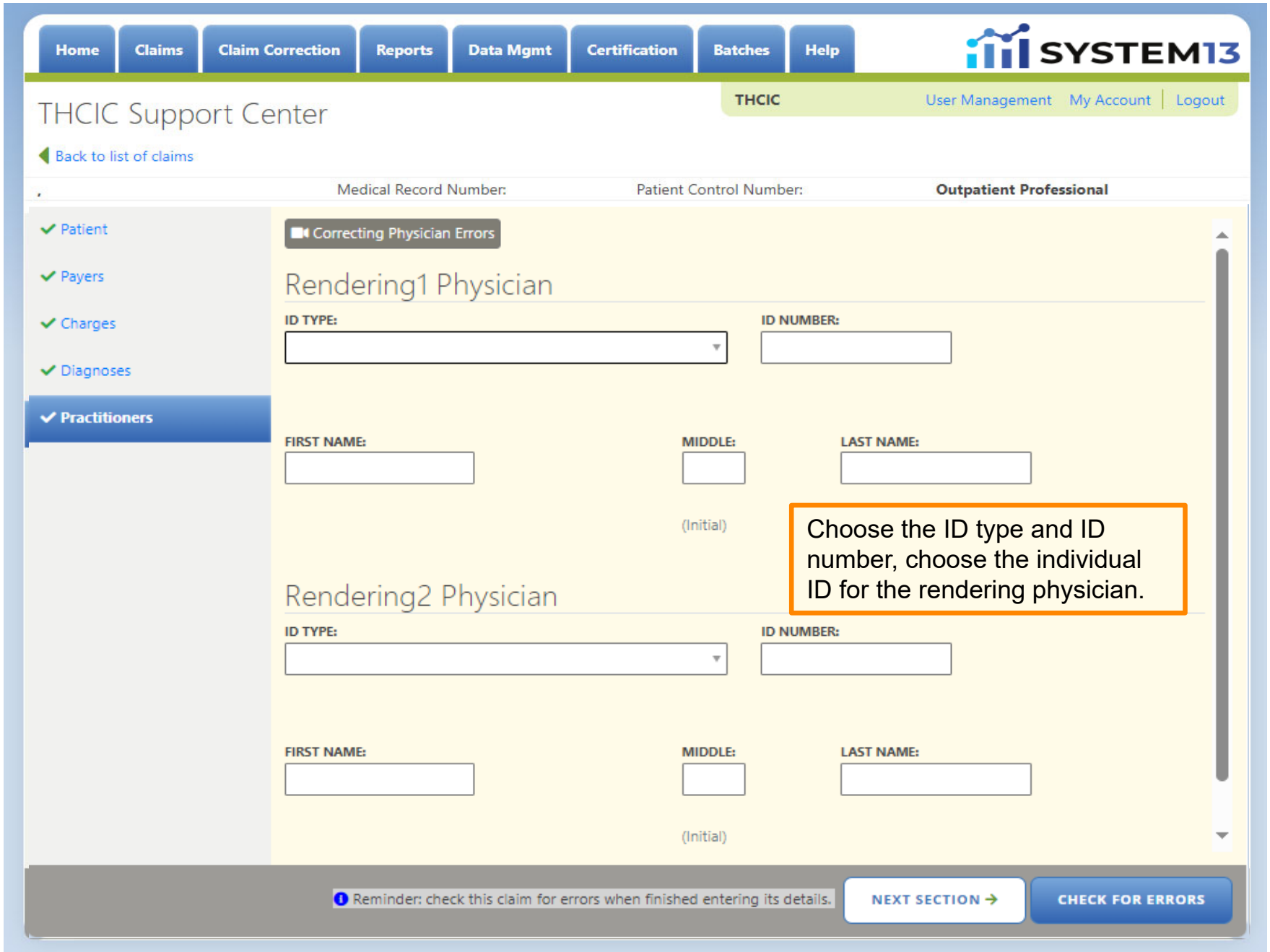
Logout
Back to list of claims
Medical Record Number:
Patient Control Number:
Outpatient Professional
Patient
Payers
Charges
Diagnoses
Practitioners
QUALIFIER:
PROCEDURE CODE:
Type to search by code
MODIFIERS:
PROCEDURE DATE:
mm/dd/yyyy
PROCEDURE THRU DATE:
mm/dd/yyyy
SERVICE FACILITY CODE:
QTY:
0.0
UNIT:
CHARGE:
0.00
Click add charge to add another charge to the claim. To delete click the beside the claim.
TOTAL CHARGES:
$0.00
ADD CHARGE
Reminder: check this claim for errors when finished entering its details.
NEXT SECTION
CHECK FOR ERRORS

Diagnosis Tab



Enter your diagnosis information. If you have multiple diagnosis codes and or e-codes as you add one to the system, another screen will open to add another.

Practitioners Tab



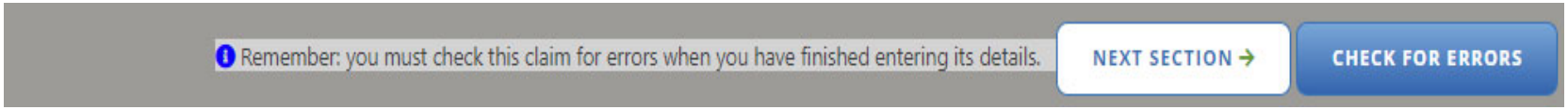
Submitting Your Claim

- The claims are automatically saved.
- You must submit claims for them to be entered in the system.

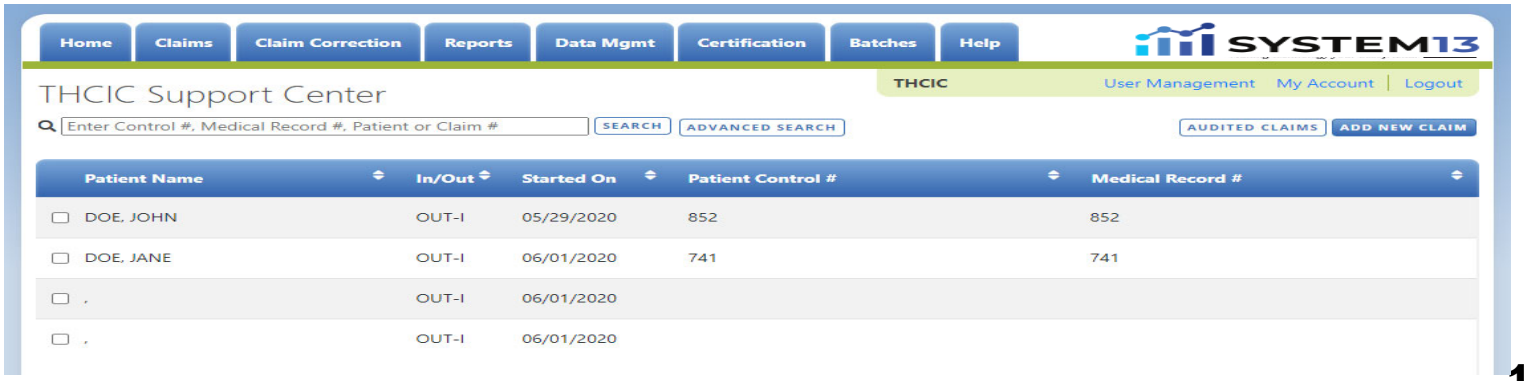
- If you do not submit the claim, it will go to new claims in progress through the claims tab, NEW CLAIMS IN PROGRESS . Once opened you can complete and submit the claim.

Check for Errors/ Submitting Your Claim

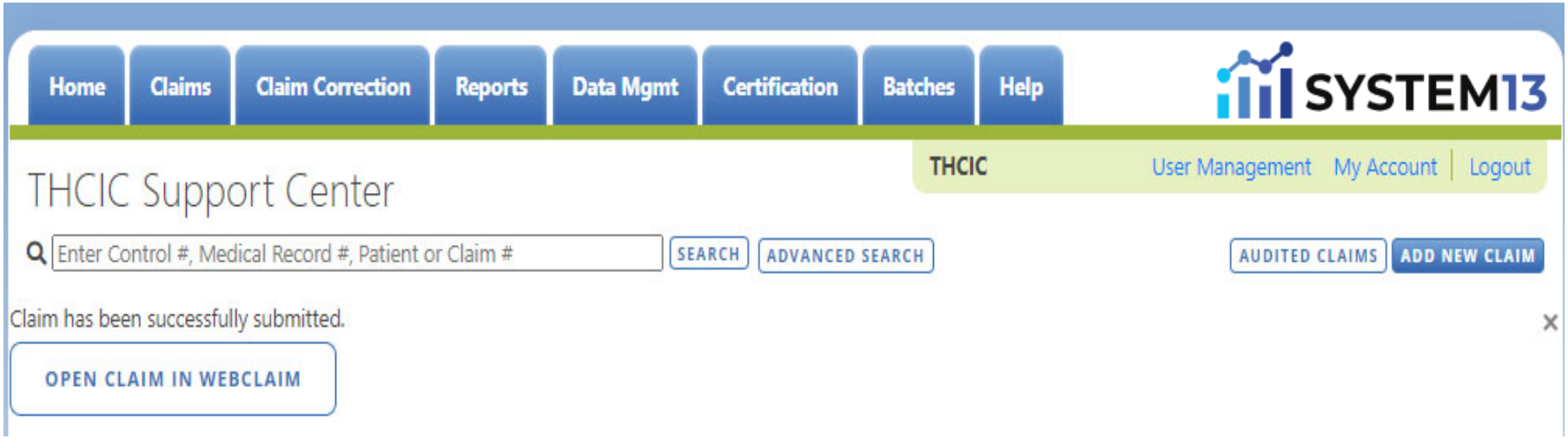
- The claims are automatically saved.
- You must click "check for errors" to submit claims entered in the system. The claims will be checked for errors and submitted.



- If you do not "check for errors" the claim, it will go to new claims in progress through the claims tab, NEW CLAIMS IN PROGRESS. Once opened you can complete and submit the claim.



Other Options



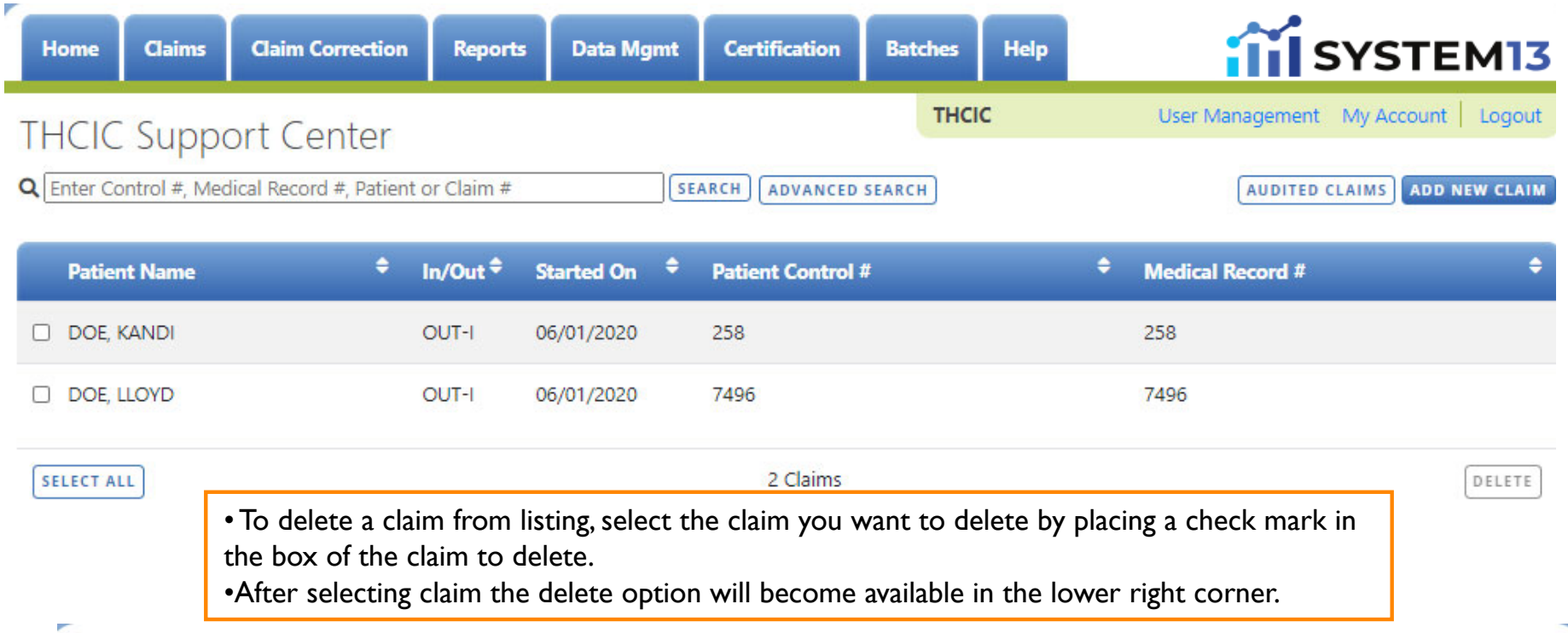
OPEN CLAIM IN WEBCLAIM will open the claim to update the information.

This listing is also the new claims in progress listing the user will get a listing of claims that has been entered without submitting.

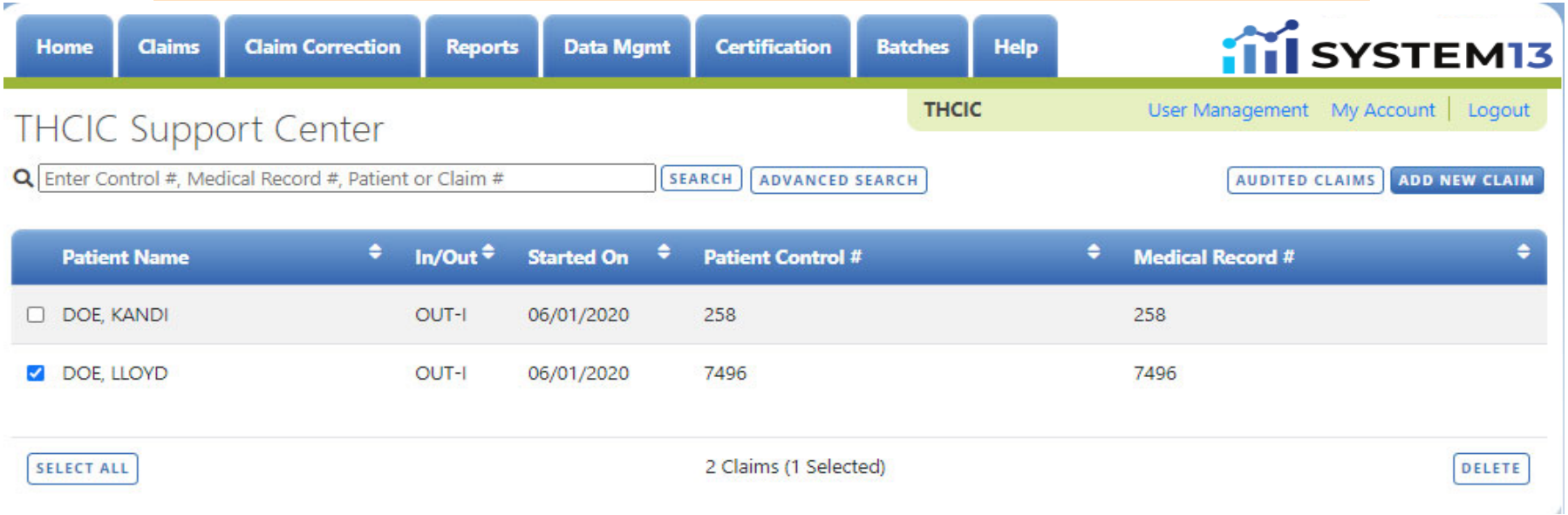
The user can click AUDITED CLAIMS and will be taken to the Claim Correction listing.

The user can add new claim by clicking ADD NEW CLAIM button.

Options…Delete Claim(s)



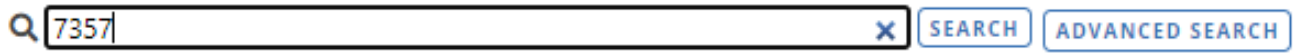
- To delete a claim from listing, select the claim you want to delete by placing a check mark in the box of the claim to delete.
- After selecting claim the delete option will become available in the lower right corner.



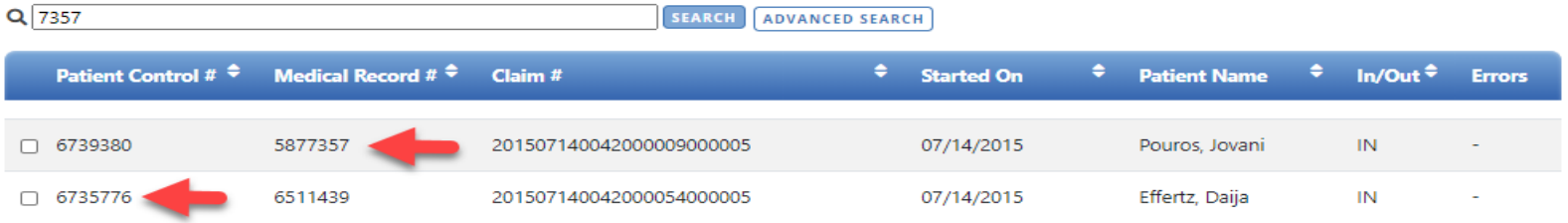
Options…Search for Claims

- You can search by Control #, Medical Record #, Patient or Claim #

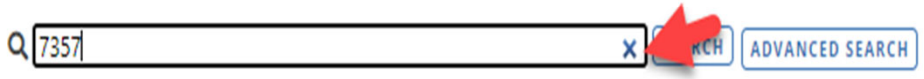
- Type in your search request.



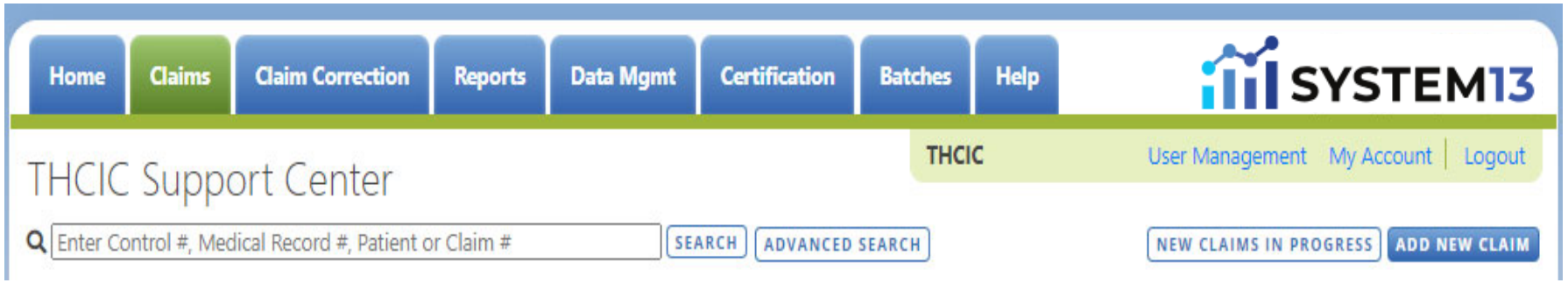
- Click search to sort your listing by search criteria requested.



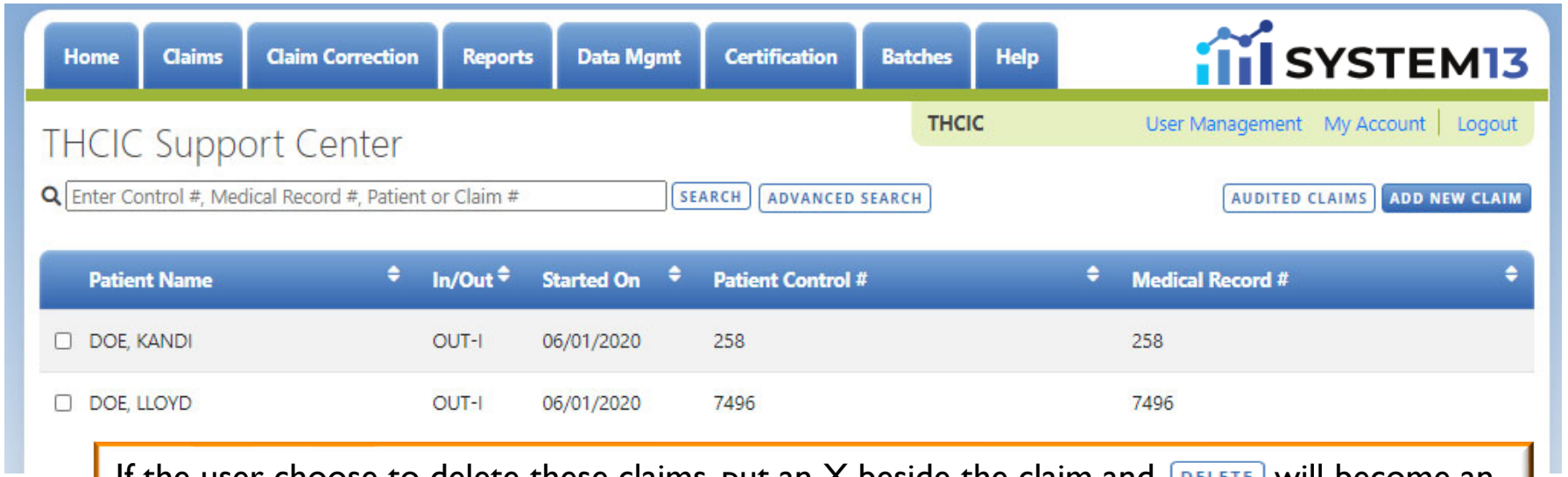
- Click clear to return to the unfiltered list of claims click the X.



Incomplete (Saved) Claims
New Claims in Progress



If the user does not submit a claim, it will be automatically saved. To complete this claim, the user will have to click the claims tab and click new claims in progress. A listing of the claims that have been saved, but not submitted will open. The user can complete entering these claims. If the user choose to delete these claims, put an X beside the claim and delete will become an option.



If the user choose to delete these claims, put an X beside the claim and DELETE will become an option.

Web Claim Entry

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

E-mail: THCIChelp@dshs.texas.gov

Web site: https://www.dshs.texas.gov/texas-health-care-information-collection

THCIC Contact

- Contact Adrianna Jackson at email Adrianna.Jackson@dshs.texas.gov if submitter test/production files reject due to a submission address or EIN/NPI number.

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

- For general questions or to request information about THCIC please e-mail to thcichelp@dshs.texas.gov.

SYSTEM13 Contact

Address:
System13
1648 State Farm Blvd.
Charlottesville, VA 22911

Phone: 1-888-308-4953

Fax: 434-979-1047

E-mail: THCIChelp@system13.com

Web site: https://thcic.system13.com