Data Reporting Schedule

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 Provider

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

Username: TH40000b34c
Password: ********

For security reasons your session will be terminated after 40 minutes of inactivity.
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.
Provider Home Page

THCIC Support Center
Login successful!

- Reports
- WebCorrect
  Claim Correction
- WebCert
  Certification
- WebClaim
  New Claim
- New Claims in Progress
- Batches
Data Management/Primary Contact
Provider Home Page

THCIC Support Center
Login successful!

Reports
WebCorrect
WebCert
WebClaim
New Claims in Progress
Batches

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

**Provides a listing of all claims that need correction.**

**Various reports available for facility to view and documentation.**

**Various reports available for facility to view and documentation.**

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.

**Facilities can view current and historical certification data.**

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

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.
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, 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

4Q2012 Data Analysis Report (Inpatient)
Report Date: 18-Apr-2013
THCIC ID: 000004 MB - THCIC Acceptance Outpatient Pro

Quarter Analysis

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<th>xx0</th>
<th>xx1</th>
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<th>xx3</th>
<th>xx4</th>
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Quarter Comparison

<table>
<thead>
<tr>
<th>Qtr</th>
<th>Total</th>
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<tbody>
<tr>
<td>4q12</td>
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<td>3q12</td>
<td>0</td>
</tr>
<tr>
<td>2q12</td>
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</table>

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.
Modify/Replace/Remove Report

- Remove duplicate claims
- Replace certain bill types

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.
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 corresponding months
  - 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/Cancel

Duplicate Remove Process (DR)
- Match claims with the same key values:
  - Patient Control Number
  - Medical Record Number
  - Admission Start of Care
  - Admission Hour
  - Eliminate duplicate claims in the corresponding months

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 order
- Apply late charges (xx5 bill types)
- Apply corrections to claims (xx6 bill types)
- Apply the replacement information (xx9 bill types)
- Remove claims that match a Void/Clear

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 duplicate claims in the correct order
- Report the type of claim that is more recent

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

THCIC Support Center

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 timeframe
- Apply late charges (xx5 bill types)
- Apply corrections to claims (xx6 bill types)
- Apply the replacement information (xx8 bill types)
- Remove claims that match a Void/Clear

**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
- Actions: Process submitted. The most recently submitted claim is the correct record.

**Process Submitted**

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)
The Modify/Replace/Remove Claims (MRR) process has completed for provider 000004

From: DSHS - Center for Health Statistics
[mailto:dschs_cert_mail@system13.com]

To: To: Data Administrator/ Facility Primary Contact
Subject: The Modify/Replace/Remove Claims (MRR) process has completed for provider 000004

The Modify/Replace/Remove Claims (MRR) process has completed for provider 000004. The process reviewed 7 active claims, eliminated 0 claims due to applying updates to an original claim, leaving 7 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
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
- 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/Canc

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
- 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

<table>
<thead>
<tr>
<th>Select Claim Type</th>
<th>Select Action</th>
<th>Modify/Replace/Remove Process (MRR)</th>
<th>Duplicate Remove Process (DR)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The MRR function will:</td>
<td>The DR function will:</td>
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<tr>
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<td>- Match claims with the same key</td>
<td>- Match claims with the same key values:</td>
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<td>values:</td>
<td>- Control Number</td>
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<tr>
<td></td>
<td></td>
<td>- Patient Control Number</td>
<td>- Medical Record Number</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Medical Record Number</td>
<td>- Admission Start of Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Admission Hour</td>
<td>- Admission Hour</td>
</tr>
<tr>
<td></td>
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<td>- Eliminate duplicate claims in the</td>
<td>- Eliminate duplicate claims in the</td>
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<td></td>
<td>original data set</td>
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</tr>
<tr>
<td></td>
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<td>- Apply late charges (xx1 bill types)</td>
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<td></td>
<td></td>
<td>- Apply corrections to claims (xx1)</td>
<td>- Apply corrections to claims (xx1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Apply the replacement information</td>
<td>- Apply the replacement information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Remove claims that match a Void</td>
<td>- Remove claims that match a Void</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 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***
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 year
- Apply late charges (x5 bill types)
- Apply corrections to claims (x8 bill types)
- Apply the replacement information (x8 bill types)
- 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
  - Bill Type
- Remove the replacement claim and identify 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.
The Duplicate Claim Removal (DR) process has completed for provider 000004

From: DSHS - Center for Health Statistics
[mailto:dshs_cert_mail@system13.com]

To: Data Administrator/ Facility Primary Contact

Subject: The Duplicate Claim Removal (DR) process has completed for provider 000004

The Duplicate Claim Removal (DR) process has completed for provider 000004. The DR reviewed 10 active claims, eliminated 3 duplicate claims, leaving 7 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 that 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](http://www.dshs.state.tx.us/thcic/hospitals/numberedletters/2012/Vol15No3.pdf)
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

**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 (regen) 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.
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>
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<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>
<td></td>
<td></td>
</tr>
<tr>
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<td>OVERTON, TIFFANY</td>
<td>(512) 776-2352</td>
<td><a href="mailto:tiffany.overton@dshs.state.tx.us">tiffany.overton@dshs.state.tx.us</a></td>
<td>th000002o</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2 users
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.)
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.
Other Feature Logout

THCIC Support Center

Reports

WebCert
Certification

WebClaim
New Claim

New Claims in Progress
0 claims in progress

Batches
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 was in WebCorrect or WebClaim and have not saved before you went idle in the system, you will lose these changes.
Provider Dashboard
The user can go to Reports by the provider tab or by the provider dashboard icon.
The only data a facility can run seven 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.

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

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.
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.*

<table>
<thead>
<tr>
<th>Batch Number</th>
<th>Processed Date</th>
<th>Total Claims</th>
<th>Claims with Errors</th>
<th>In/Out</th>
</tr>
</thead>
<tbody>
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<td>73</td>
<td>In</td>
</tr>
<tr>
<td>201507140031</td>
<td>07/14/2015</td>
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<td>27</td>
<td>Out</td>
</tr>
<tr>
<td>201507140090</td>
<td>07/14/2015</td>
<td>134</td>
<td>20</td>
<td>Out</td>
</tr>
</tbody>
</table>
WebCorrect/ Claim Correction

The user can go to data corrections by provider tab the tab or the dashboard icon.

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

WebCorrect

Reporting Schedule

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.)

- Data Analysis Report/Modify/Replace/Remove/Duplicate

- Vendor’s Correction Mechanism – Reload the file
**Correction Due Dates**

**Inpatient and Outpatient Data Reporting Schedule**
Texas Health Care Information Collection
Center for Health Statistics

<table>
<thead>
<tr>
<th>Key Activity Due Dates by Quarter</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>
<th>Q4 2019</th>
<th>Q1 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cutoff for initial submission</td>
<td>9-3-18</td>
<td>12-3-18</td>
<td>3-1-19</td>
<td>6-3-19</td>
<td>9-3-19</td>
<td>12-2-19</td>
<td>3-2-20</td>
<td>6-1-20</td>
</tr>
<tr>
<td><strong>Cutoff for corrections (Free)</strong></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>
<td>5-1-20</td>
<td>8-3-20</td>
</tr>
<tr>
<td>Facilities retrieve certification files</td>
<td>12-3-18</td>
<td>3-1-19</td>
<td>6-3-19</td>
<td>9-3-19</td>
<td>12-2-19</td>
<td>3-2-20</td>
<td>6-1-20</td>
<td>9-1-20</td>
</tr>
<tr>
<td><strong>Cutoff for corrections at time of certification (Associated Fees)</strong></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>
<td>7-1-20</td>
<td>10-1-20</td>
</tr>
</tbody>
</table>

‘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.
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 the user is on the home page and click the claim tab, claim correction and when the user chooses data for data certification.
List of all the claims that are in the system and needs corrections.
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 which will determine the direction of the listing. (Example below modified by patient name.)
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.

![Dropdown List Example](image-url)
Search for Claims

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.
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 pencil, 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 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

Claim has been successfully submitted, but still contains errors.
Review Errors Next Claim

Claim has been successfully submitted.
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.
### 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>87654321</td>
<td>12345678</td>
<td>2015010599389999</td>
<td>01/06/2015</td>
<td>DOE, SELFIE</td>
<td>In</td>
<td>27</td>
</tr>
<tr>
<td>6978369</td>
<td>7321818</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>Bartell, Marilou</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>7065325</td>
<td>6262241</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>DOE, Angie</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>8569928</td>
<td>7101000</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>DOE, Christian</td>
<td>In</td>
<td>2</td>
</tr>
<tr>
<td>5525739</td>
<td>7527230</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>O’Kon, Mara</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>8443928</td>
<td>860265</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>Erdman, Alyson</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>5676918</td>
<td>708009</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>Marquardt, Kane</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>6268192</td>
<td>8312242</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>Ziemann, Marcella</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>6452853</td>
<td>5791765</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>Ankunding, Edgar</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>8711428</td>
<td>7020028</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>Reichert, Heaven</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>5970885</td>
<td>5776112</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>Torphy, Clifford</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>8787790</td>
<td>7707449</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>Pollich, Korbin</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>8499808</td>
<td>7283434</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>Erdman, Devan</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>7179519</td>
<td>8209565</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>Rau, Koby</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>5538287</td>
<td>8283870</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>Moen, Myra</td>
<td>In</td>
<td>1</td>
</tr>
<tr>
<td>5918017</td>
<td>6238018</td>
<td>201507140042000000</td>
<td>07/14/2015</td>
<td>Sipes, Ashley</td>
<td>In</td>
<td>1</td>
</tr>
</tbody>
</table>

121 claims
**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

Start Corrections
WebCorrect...Errors in the Claim

27 errors in this claim
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 27.
Open part of claim to make corrections...

When you open up the part of the claim, the errors will be indicated by pink with red lettering. If you click in the field with the error, a brief description of what the error is.
Click Save

After making corrections, clicking ‘Save’ only saves the changes made. The user will have to click ‘submit claim’ to have another audit ran. Once ‘save’ is chosen ‘submit claim’ will be an option.
Error in the Claim

Which tabs the errors are on now.

Number of errors in the claim goes down from 27 to 9. When the user makes the change, this field will turn green.
Next Error in the Claim
Make Change

If the user clicks, the error field that has the error the user will be able to see what the error is. It’ll have a **pink tint**.

Clicking a **red X** will close the tab.

Once a change has been made, it will show in a **green tint**. That indicates a change has been made. It does not mean that the claim is now correct. Click ‘save’ to save these changes or save next error, which will save the data and go to the next error.

If the user chooses ‘**ZZ – Mutually defined, or Self Pay, or Unknown, or Charity**’ as the payer, do not identify the payer’s name as the ‘payer name’. Payer name should also be Self Pay, as pictured above.
Next Error in Claim

THCIC Support Center

SELFIE DOE

Medical Record Number: 12345678
Patient Control Number: 87654321

Inpatient

Revenue Code: Qualifier:
Procedure Code:
Modifiers:
Rate: Qty: Unit: Charge:
Non covered charge: 

Total Charges: $0.00

667-Missing Total Claim Charges

7 errors in this claim
Make changes to claim
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.
Present On Admission (POA) for inpatient facilities required to submit this data will show an error if the data is not submitted on data on/after January 29, 2011.
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.

- Present on Admission (POA) for inpatient facilities required to submit this data will show an error if the data is not submitted on data on/after January 29, 2011.
Make Necessary Change

THCIC Support Center

SELRIE DOE

Medical Record Number: 12345678

Patient Control Number: 87654321

Inpatient

Diagnosis

Principal:
7841 - THROAT PAIN

POA:

Admit:
7848 -

E-Code:

POA:

Other Diagnosis Codes:

Procedures

Principal

Other Procedure Codes

7 errors in this claim

Cancel  Save  Save, Next Error
‘Save, next error’ will take the user to the next error in this claim. The user can make the necessary change.
Make Changes

THCIC Support Center

SELFE DOE

Medical Record Number: 12345678
Patient Control Number: 87654321

Inpatient

Attending Physician

ID Type: XX - NPI - National Provider Identifier
ID Number: 123456789

First Name: PATRICK
Middle: (initial)
Last Name: MORGAN

Operating Physician

ID Type: 
ID Number: 

First Name: 
Middle: (initial)
Last Name: 

Click ‘Save’ to save this change.
Submit Claim

Once the claim has been saved. The user will be able to submit claim.
Claim Submitted

If the claims was submitted and no longer has errors the user will get the message above. The user can click ‘Back To List of Claims’ to go back to the list of corrections or click ‘Next Claim’ and the user will go to the next claim for correction from the WebCorrect listing. If the claims still has errors, the user will get the message below, with a list of errors on that claim. The user can review the errors, go to the next claim or go back to the list of claims.

Claim has been successfully submitted, but still contains errors.

- 633 - Missing Patient Gender
- 635 - Missing Patient Ethnicity
- 630 - Missing Patient Birth Date
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 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.

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.

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

Address:
System13, Inc
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