TEXAS
Health and Human Services

Texas Department of State Health Services

# Inpatient Claim Entry

## (Formerly WebClaim)

**Revised April 2024**

Document #: 25-15005

# Background Information

- Chapter 108 of the Texas Health and Safety Code established and authorizes THCIC to collect and report on outpatient/inpatient discharge data.
  - http://www.statutes.legis.state.tx.us/Docs/HS/word/HS.108.doc
  - http://www.statutes.legis.state.tx.us/Docs/HS/pdf/HS.108.pdf

# THCIC Rules

## Title 25. Health Services

- **Subchapter A –** Collection and Release of Hospital Discharge Data

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

- http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=421

# 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 Dee Roes at email Dee.Roes@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.

# 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

# Data Reporting Schedule

When are my submissions due?

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

dshs.texas.gov/texas-health-care-information-collection/facility-repor

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Home / Texas Health Care Information Collection / Facility Reporting Requirements / Data Reporting Schedule

Center for Health Statistics

Facility Reporting Requirements

- Revenue Codes
- Inpatient Data Reporting Requirements
- Outpatient Data Reporting Requirements
- Emergency Department Data Reporting Requirements
- **Data Reporting Schedule**
- Training
- Texas Health Care Information Collection Numbered Letters
- Health Maintenance Organization (HMO) Data Reporting Requirements

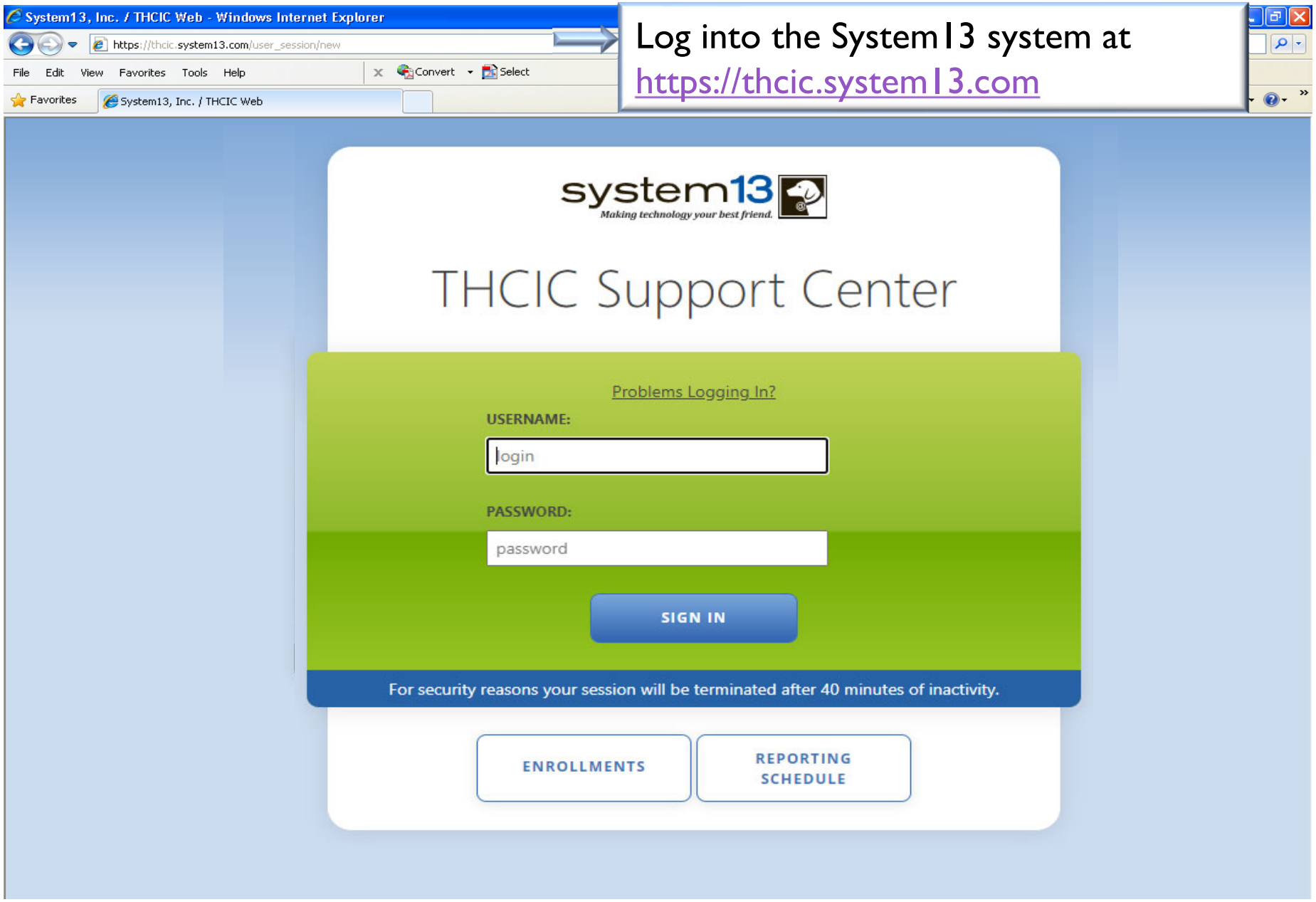
## Data Reporting Schedule

### Texas Health Care Information Collection
### Center for Health Statistics

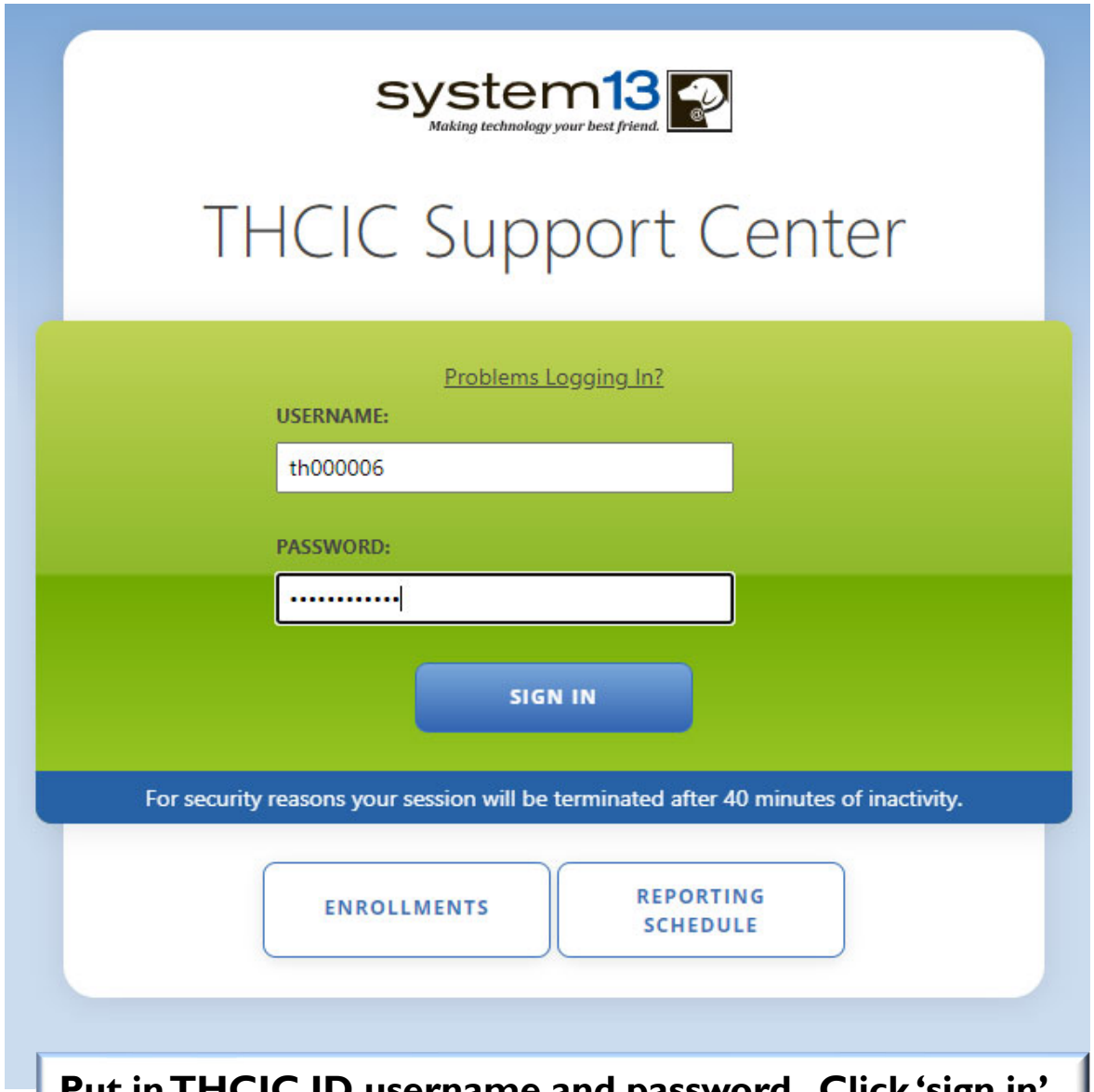
| Activity | Q4 2023 | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 |
|---|---|---|---|---|---|---|---|
| Cutoff for initial submission | 3-1-24 | 6-3-24 | 9-2-24 | 12-2-24 | 3-3-25 | 6-2-25 | 9-1-25 |
| Cutoff for corrections | 5-1-24 | 8-1-24 | 11-1-24 | 2-3-25 | 5-1-25 | 7-15-25 | 10-15-25 |
| Facilities retrieve certification files | 6-3-24 | 9-2-24 | 12-2-24 | 3-3-25 | 6-2-25 | 9-1-25 | 12-1-25 |
| Certification/ comments due | 7-15-24 | 10-15-24 | 1-15-25 | 4-15-25 | 7-15-25 | 10-1-25 | 1-2-26 |

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

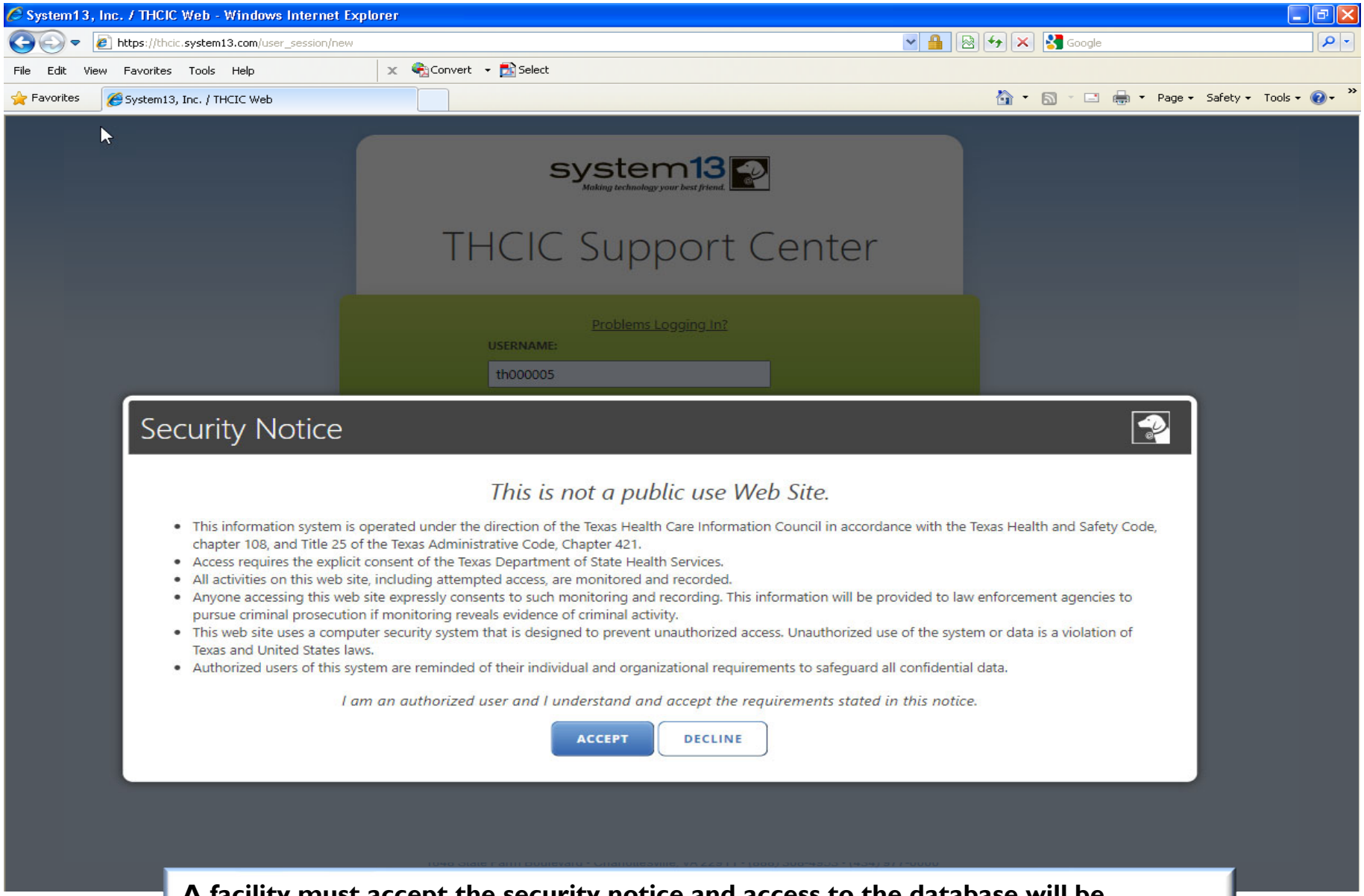


# Log In the System as a Provider



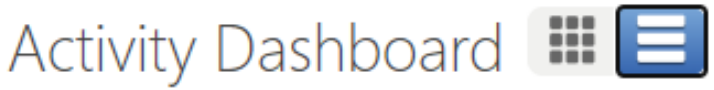

**Put in THCIC ID username and password. Click 'sign in'.**

# Security Notice

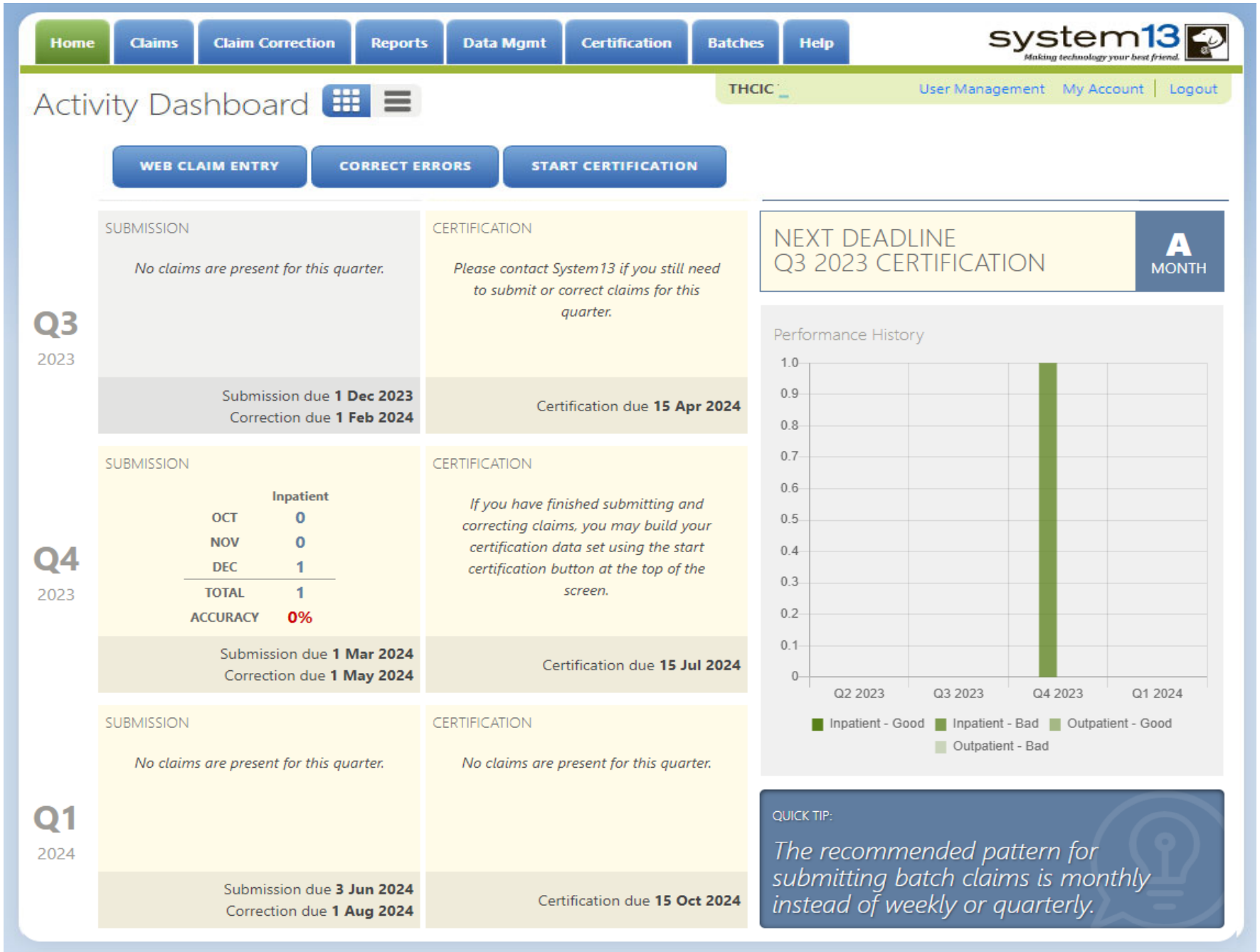



**A facility must accept the security notice and access to the database will be provided. If a facility declines this notice, access will not be granted to the database.**

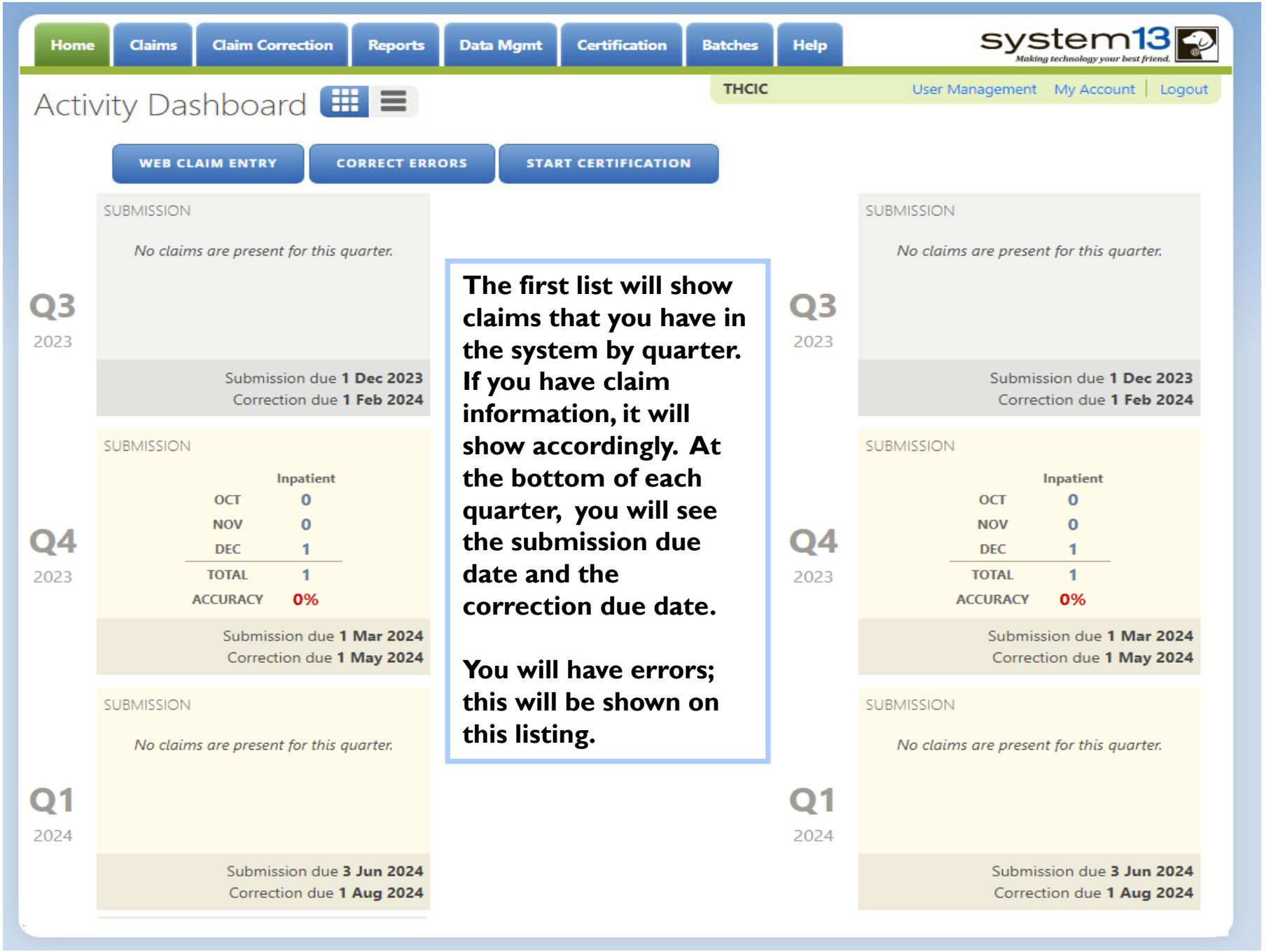
# New Provider Dashboard

- The new 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.
- Two views. 

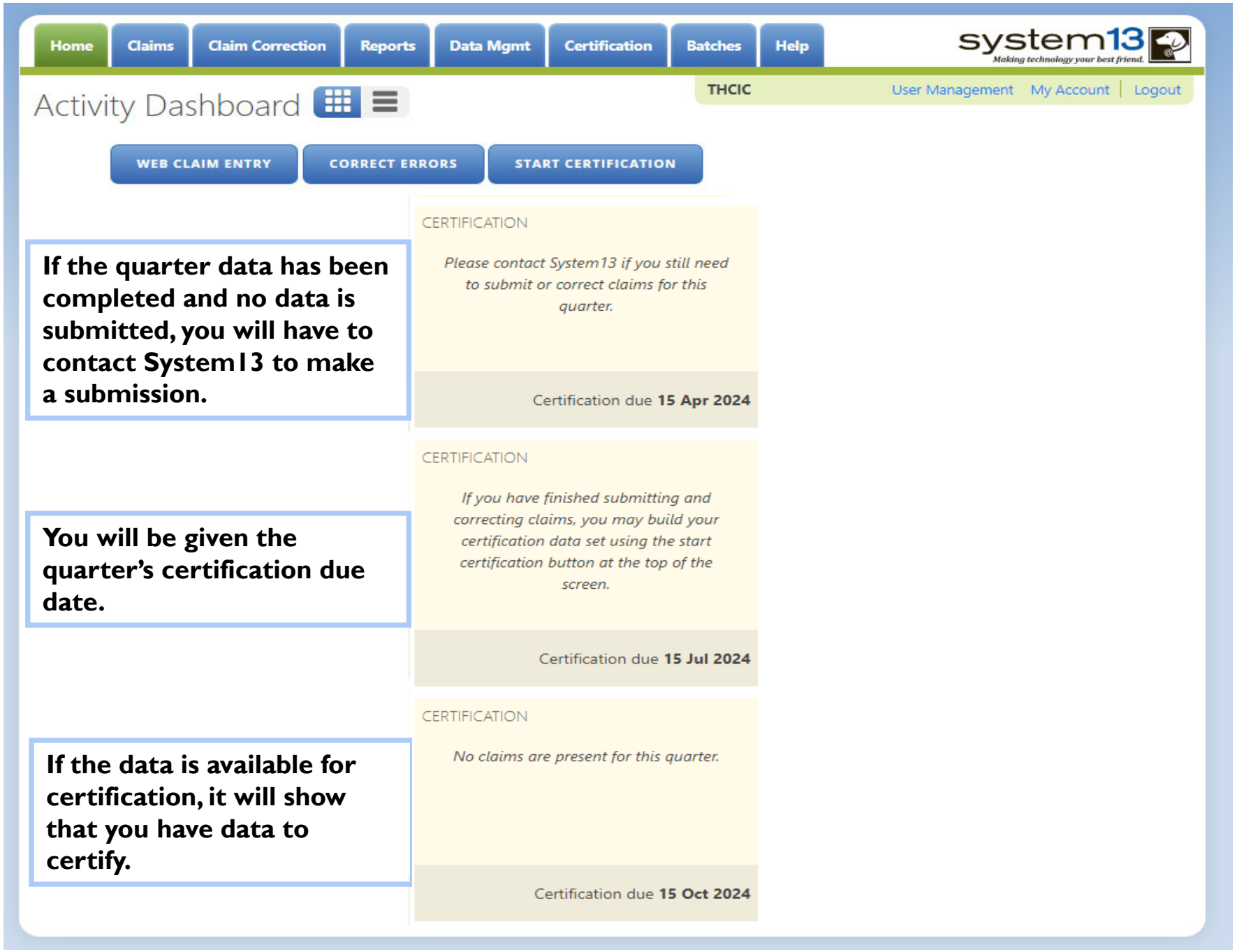
# Provider Home Page – Grid View



# Provider Home Page – 1st Row



# Provider Home Page – 2nd Row

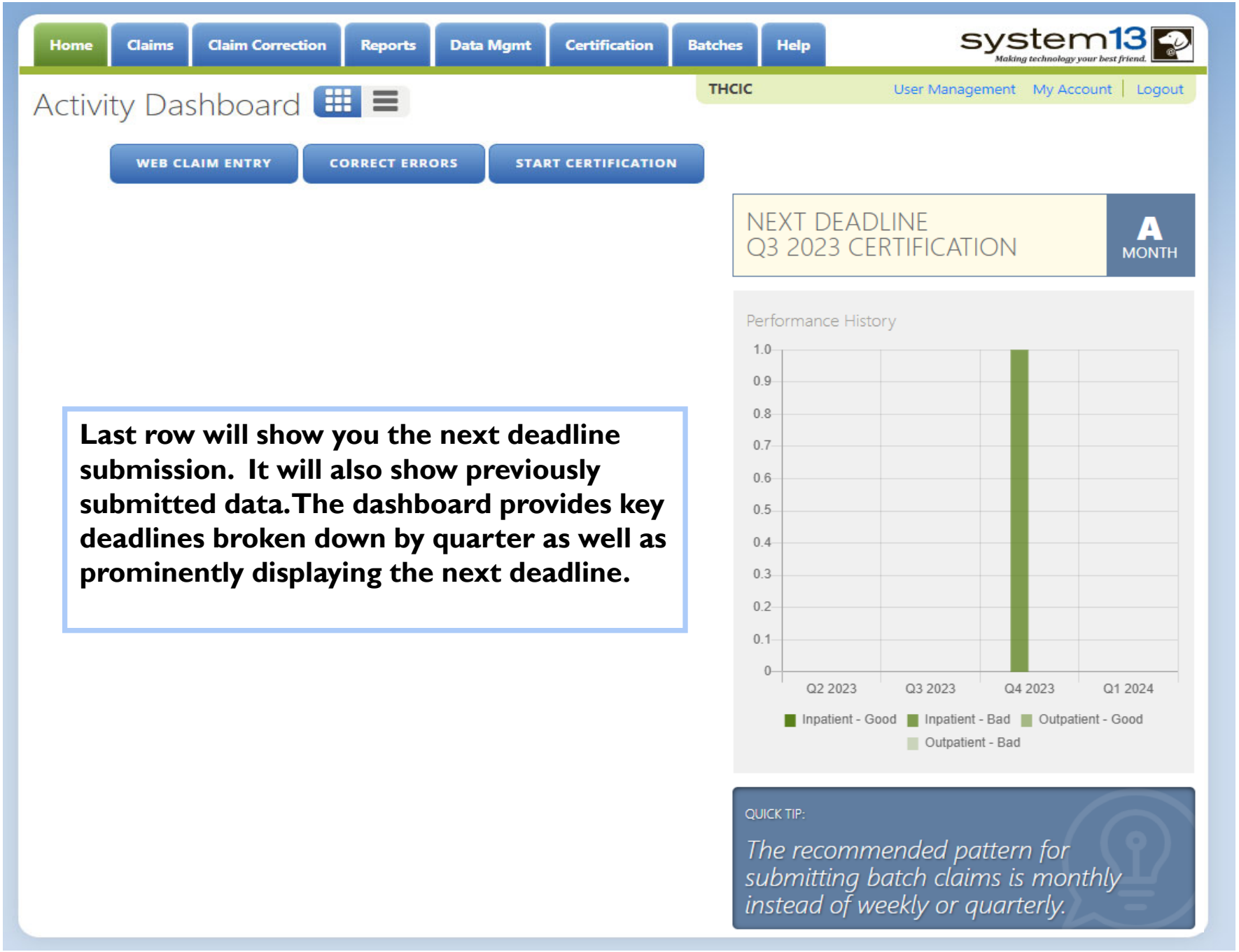



**If the quarter data has been completed and no data is submitted, you will have to contact System13 to make a submission.**

**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.**

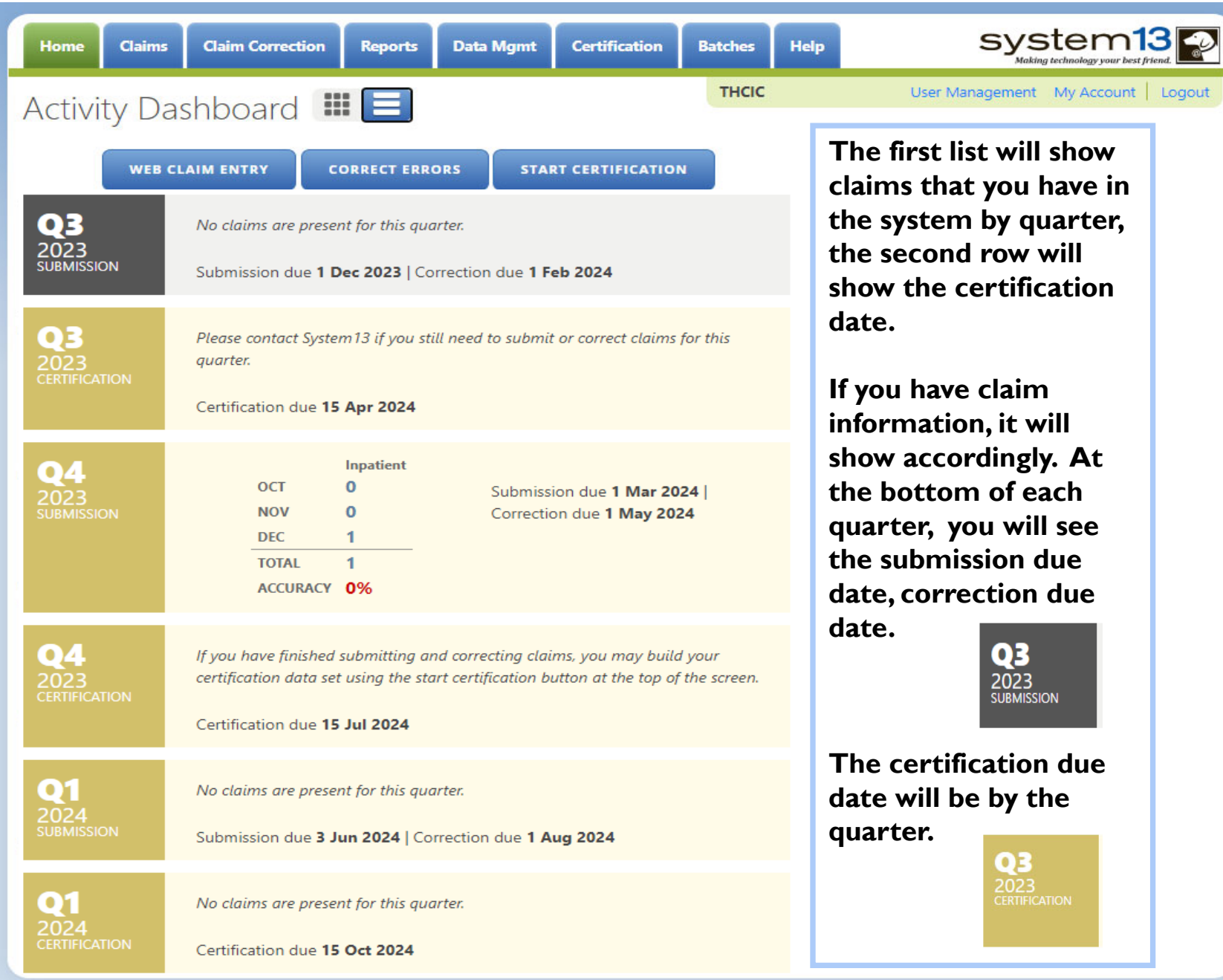
# Provider Home Page – 3rd Row




**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



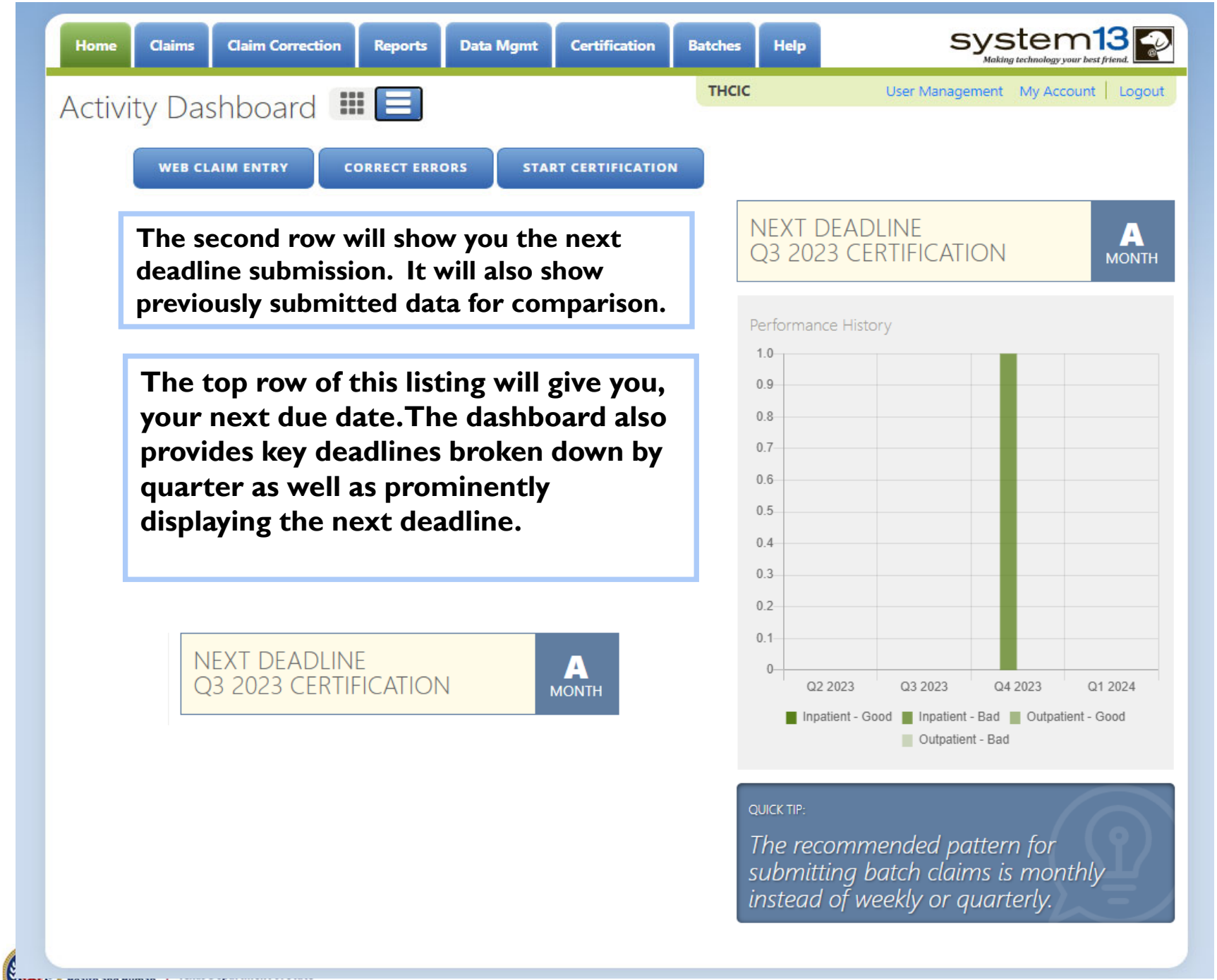

**The first list will show claims that you have in the system by quarter, the second row will show the certification date.**

**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.**

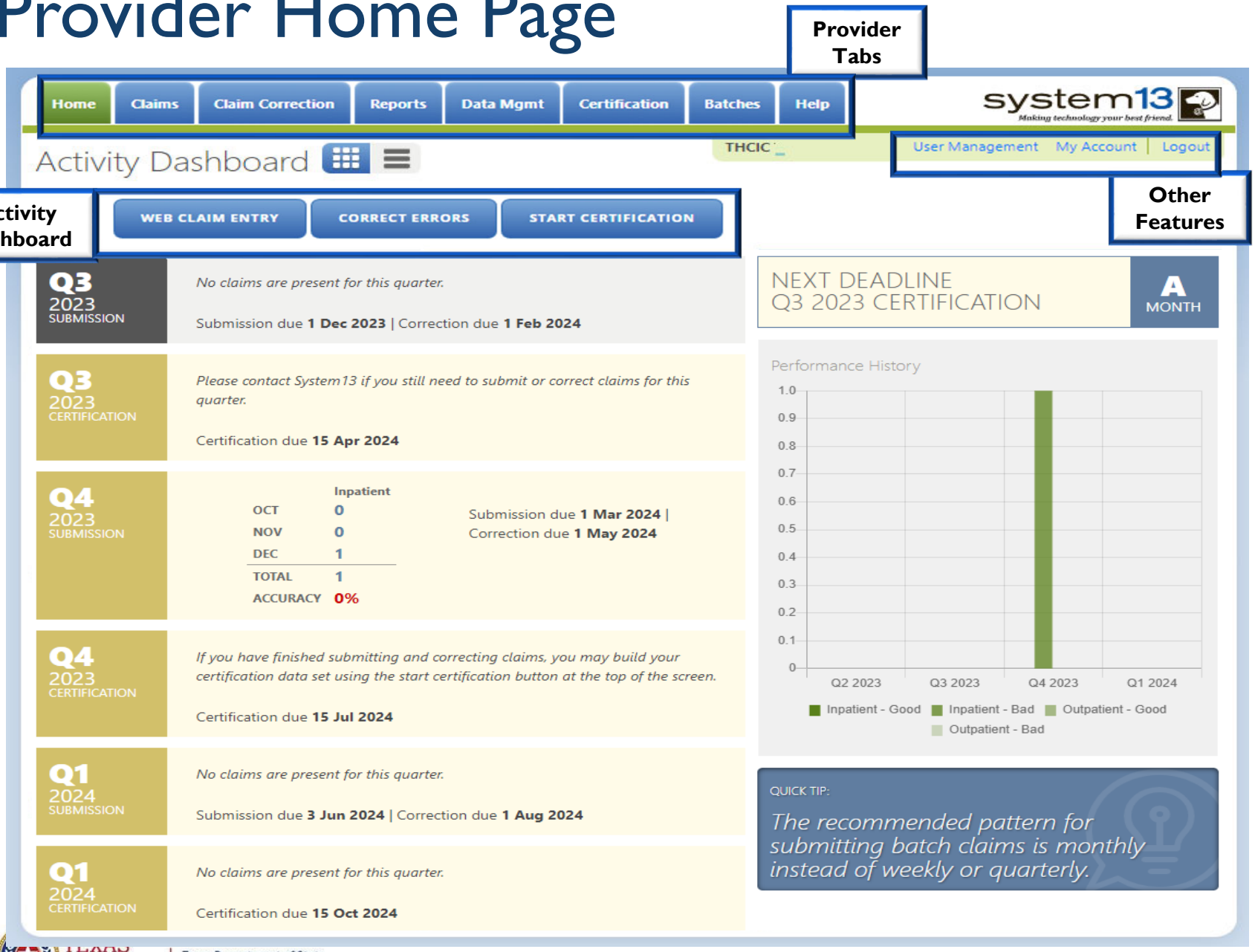



**The certification due date will be by the quarter.**

# Provider Home Page – 2nd Row



# Data Management/Primary Contact Provider Home Page



# Data Certifier Provider Home Page

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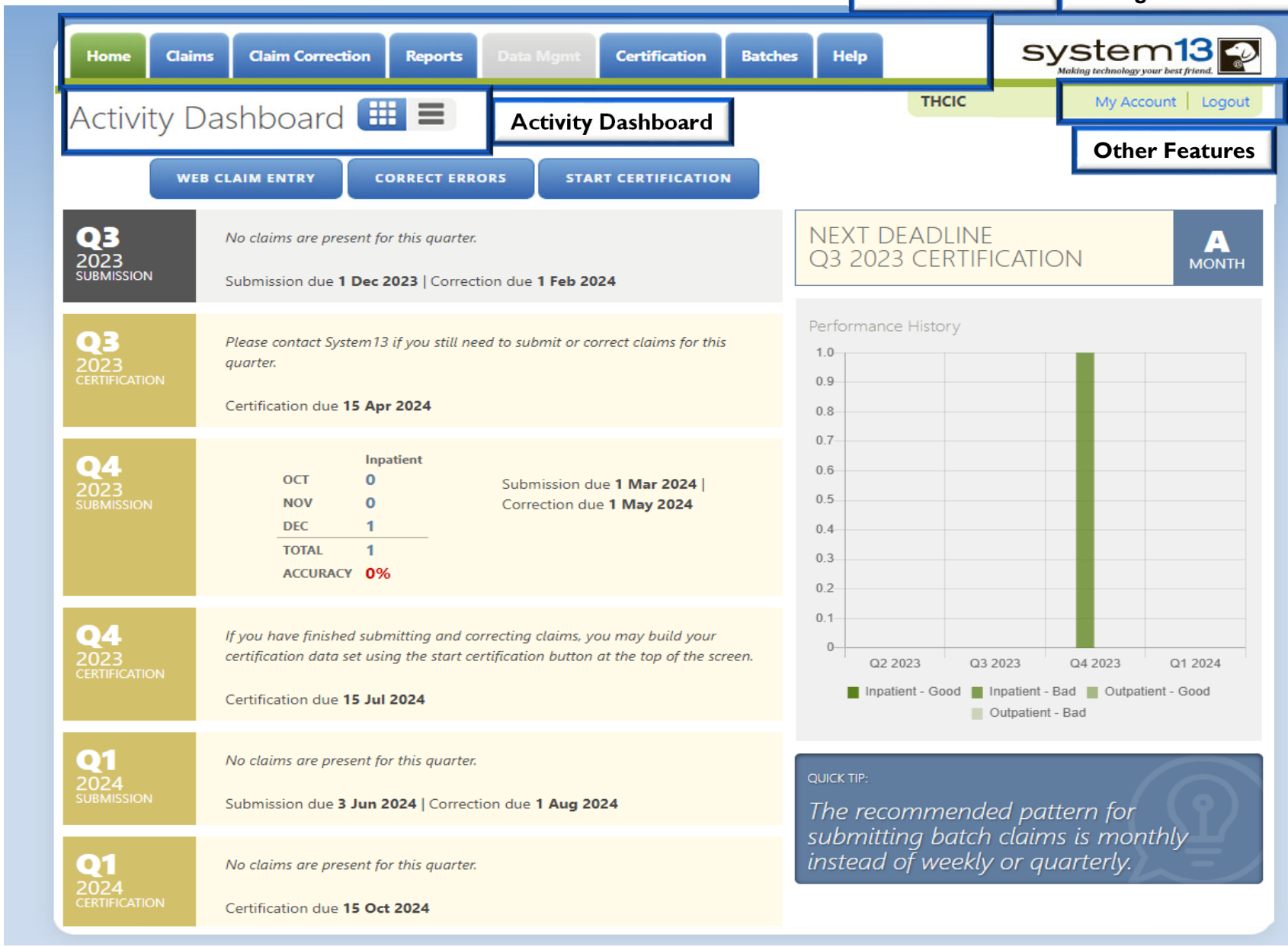
**Data certifier do not have access to the data management tab.**

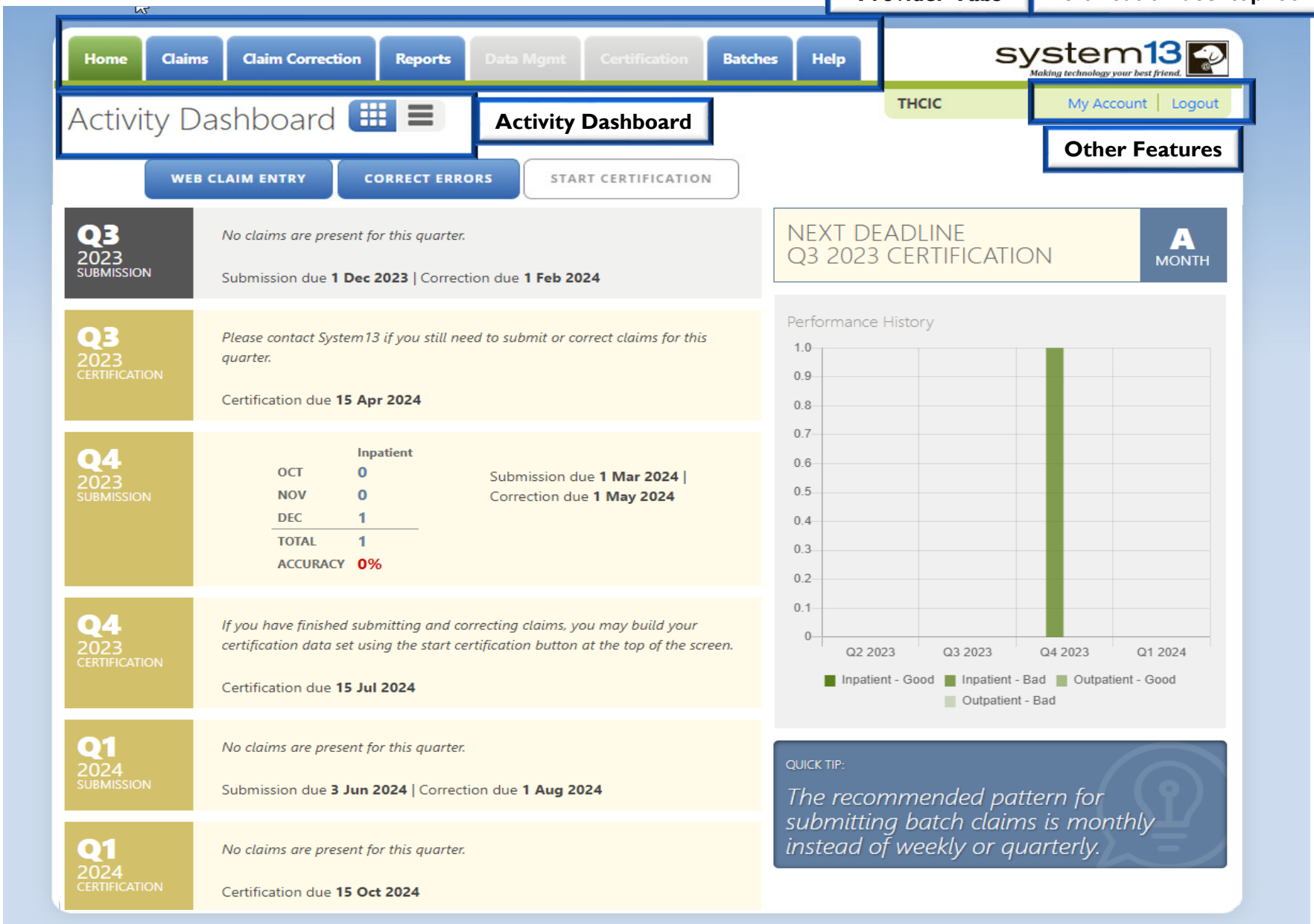
**Provider Tabs**



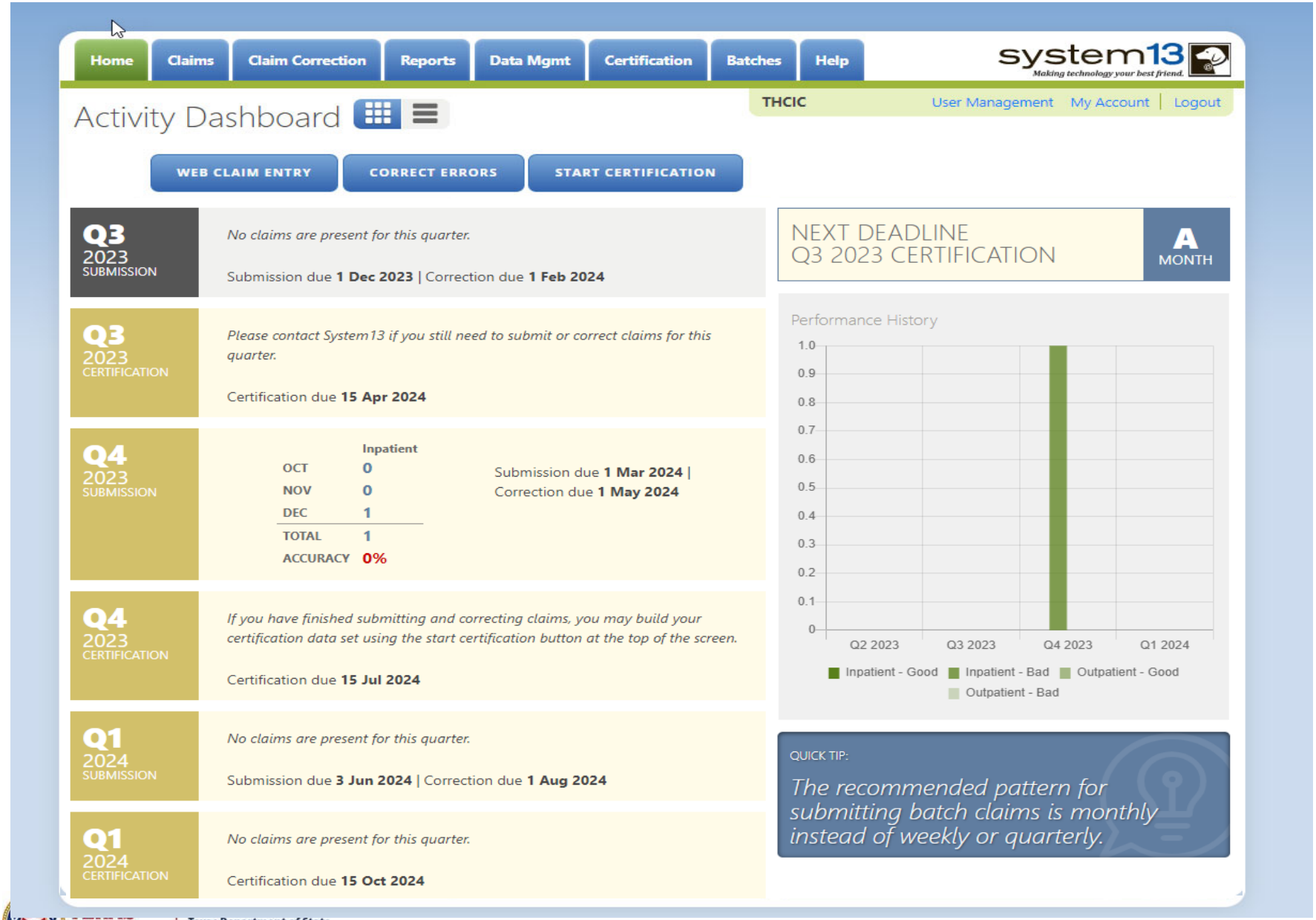
# Data Manager Provider Home Page

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

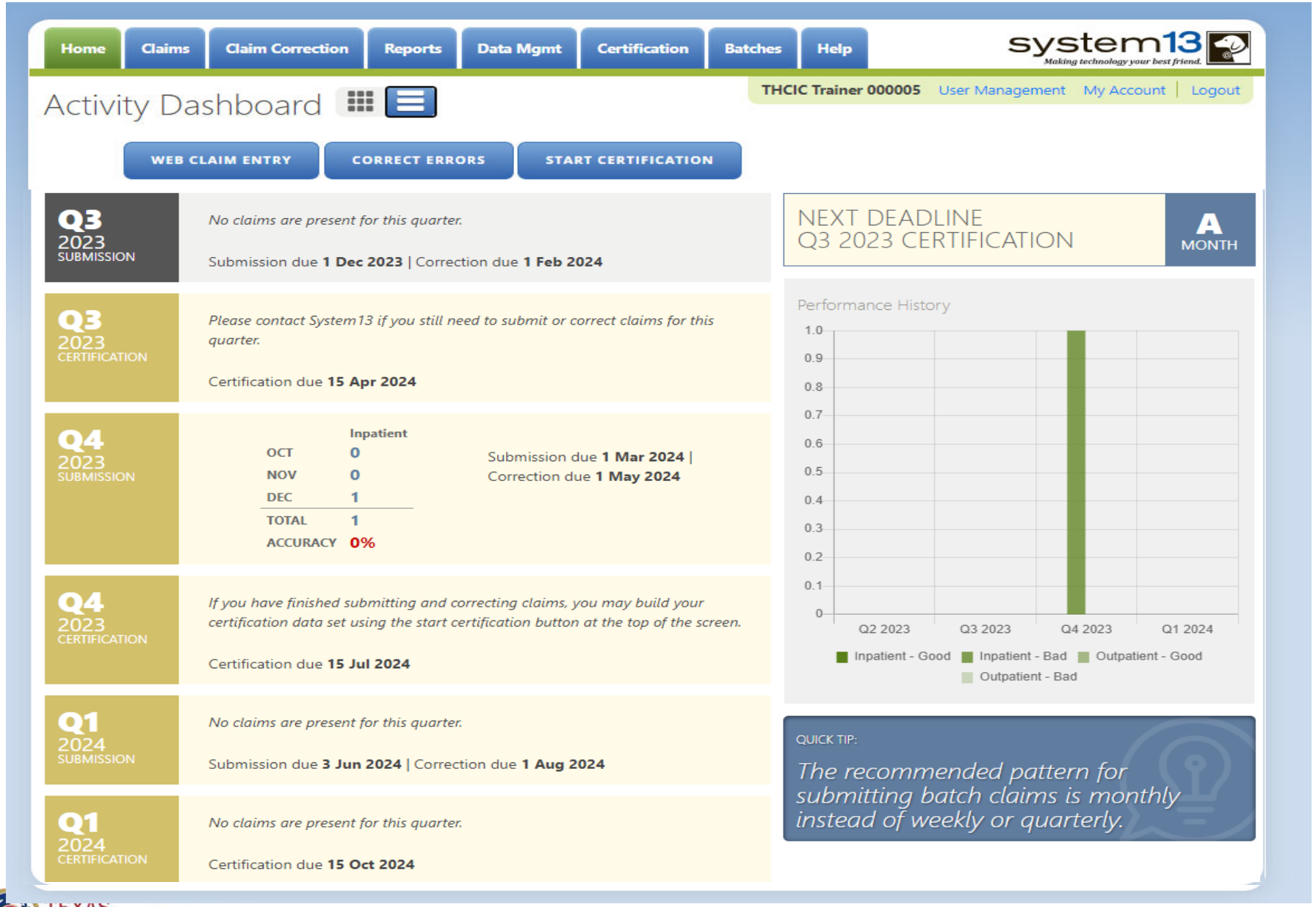
**Data managers do not have access to the data management tab and certification tab and Certification desktop icon.**



# Data Management/Primary Contact Provider Home Page – Grid View



# Data Management/Primary Contact Provider Home Page – List View



# 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.

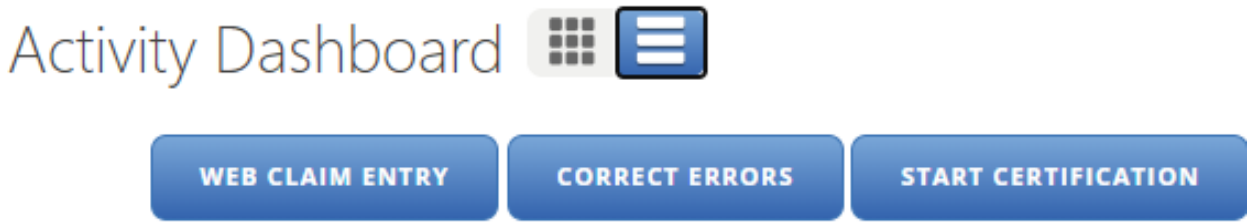
**Reports** — Various reports available for facility to view and documentation.

**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 Certification – Allows facilities to certify their data.

# Web Claim Entry

WEB CLAIM ENTRY

ADD NEW CLAIM

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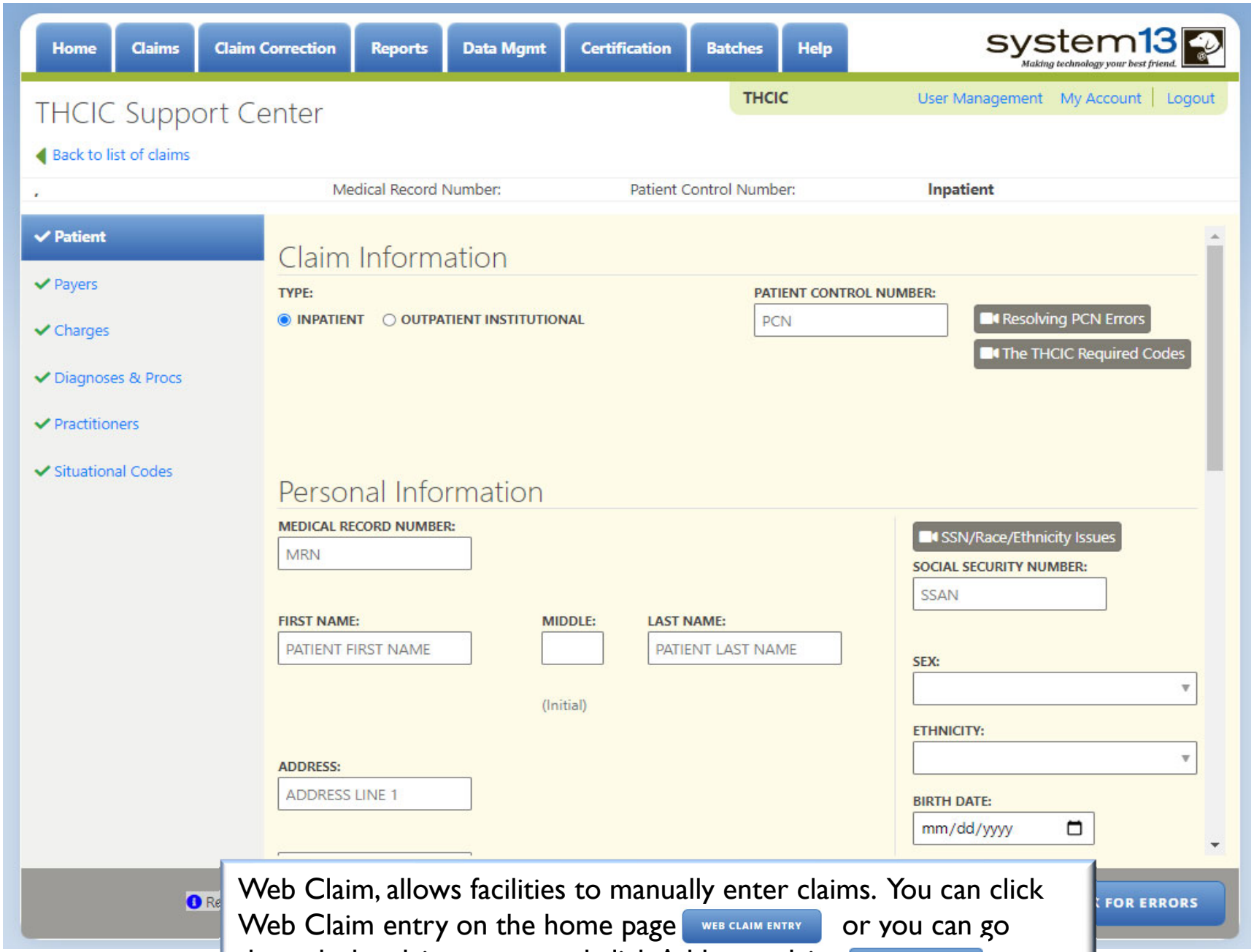
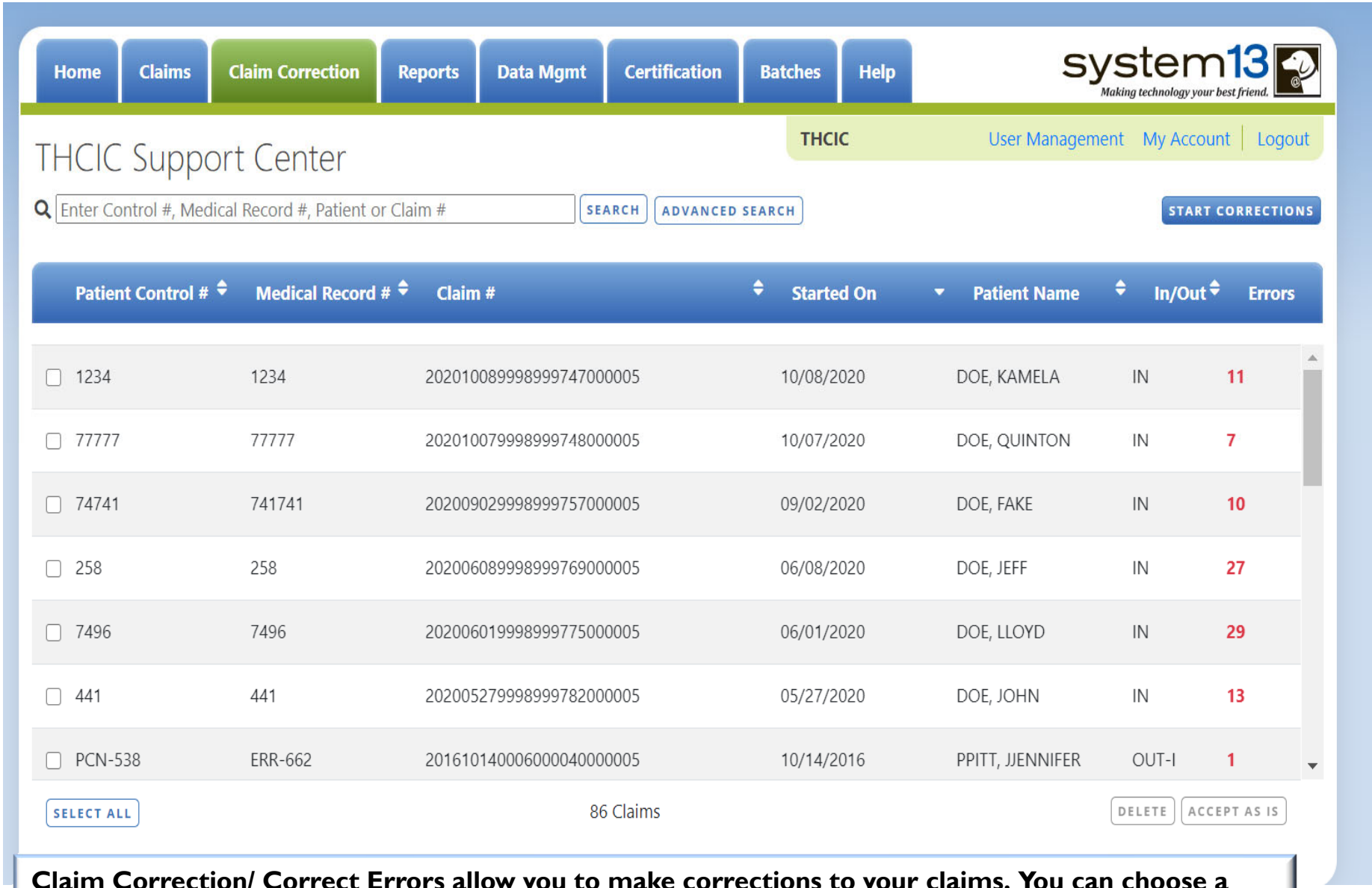



Web Claim, allows facilities to manually enter claims. You can click Web Claim entry on the home page WEB CLAIM ENTRY or you can go through the claims menu and click Add new claim ADD NEW CLAIM

# Claim Corrections / Correct Errors

CORRECT ERRORS

Claim Correction

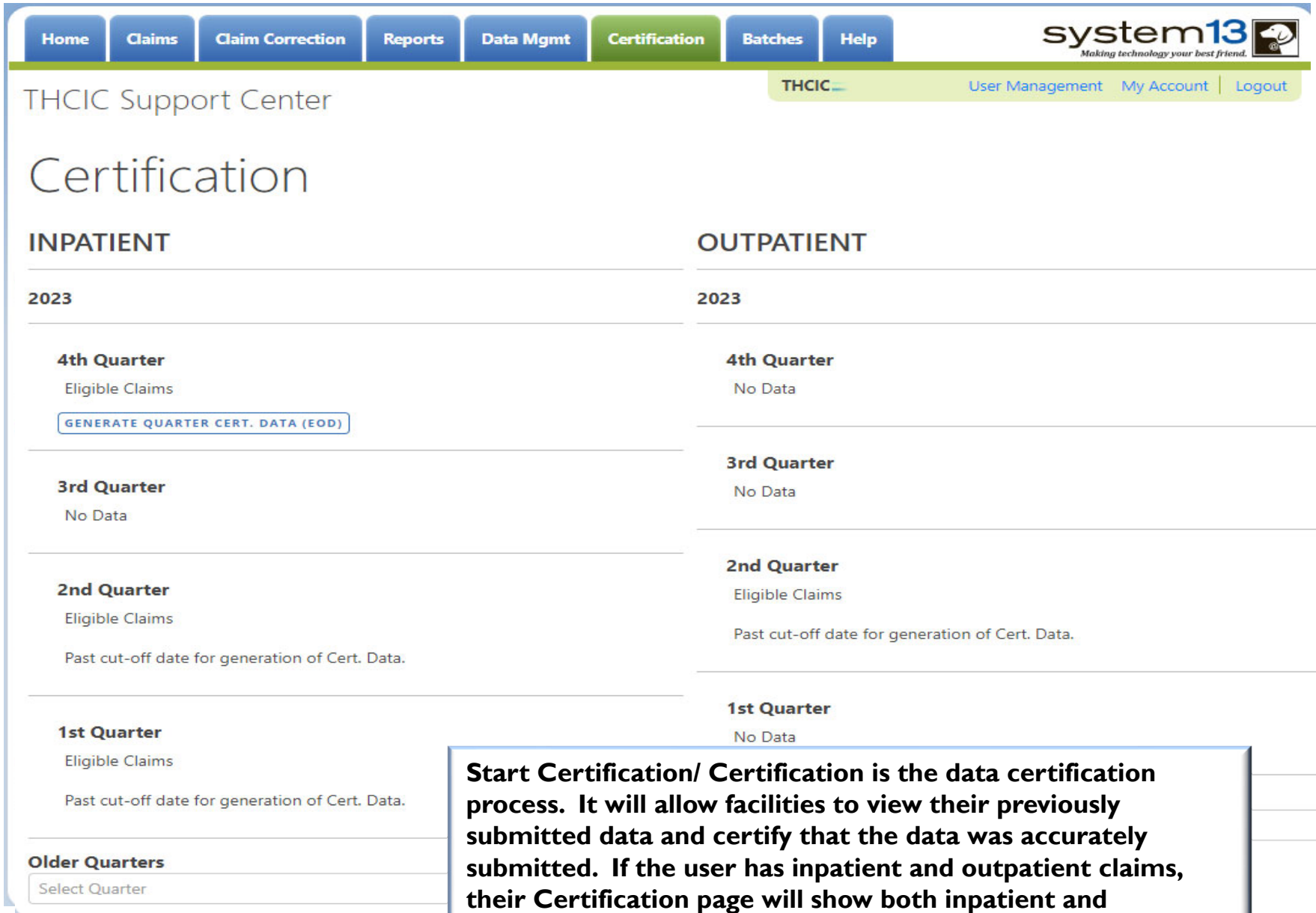



**Claim Correction/ Correct Errors allow you to make corrections to your claims. You can choose a claim from the listing, modify your listing or click start corrections** START CORRECTIONS **which opens the first claim on your listing.**

# Start Certification /Certification

START CERTIFICATION

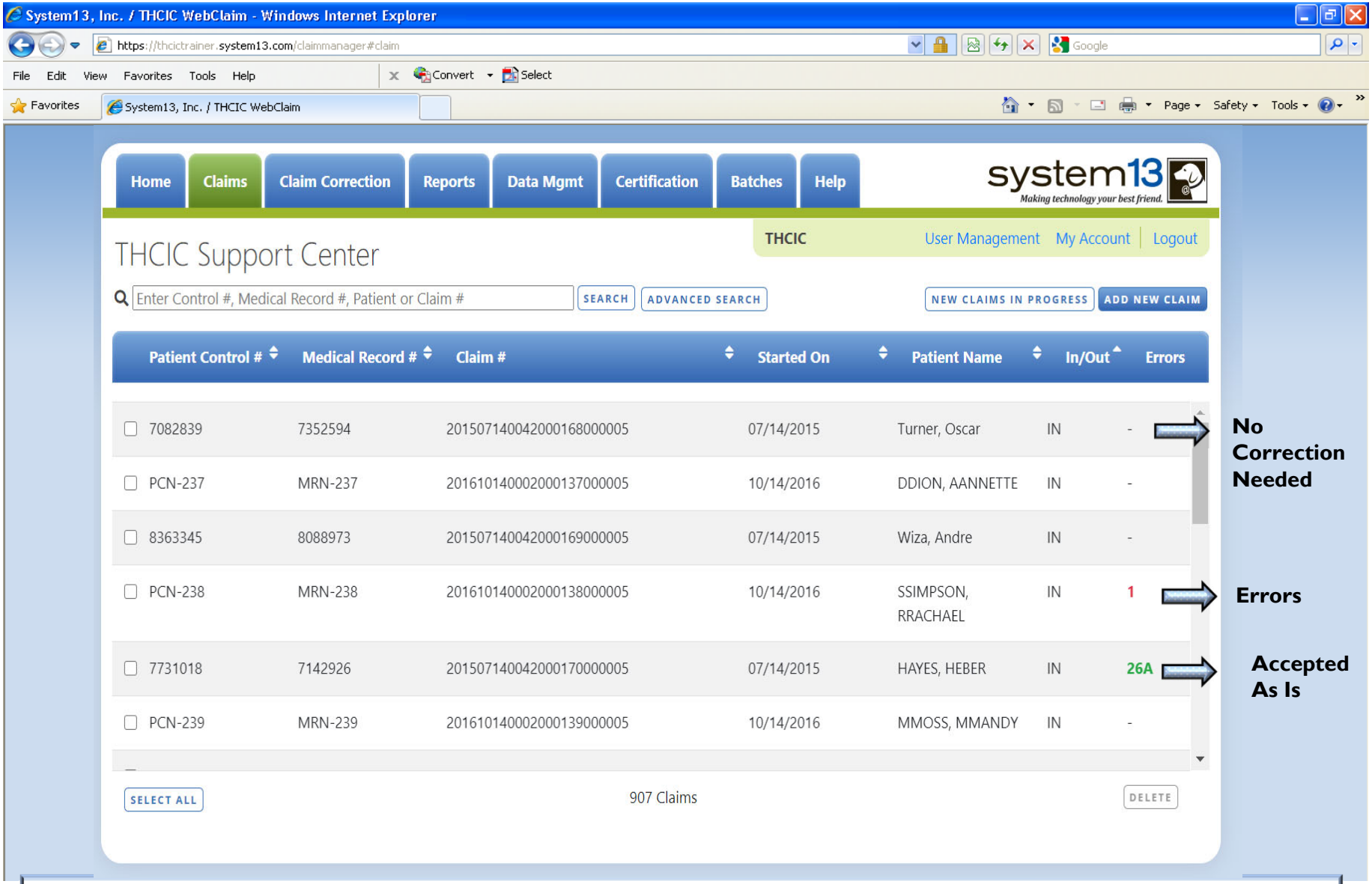
Certification




**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 Certification page will show both inpatient and outpatient data. If the facility only submits outpatient data, it will only show outpatient data.**

# Provider Tab Claims

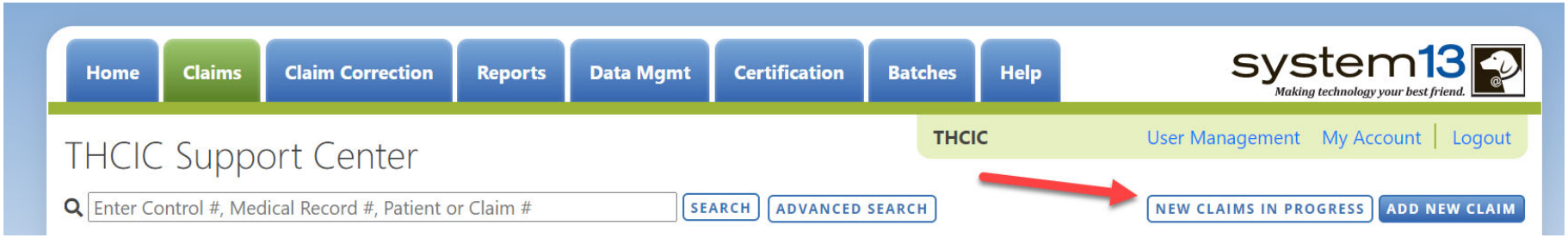
Claims




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.

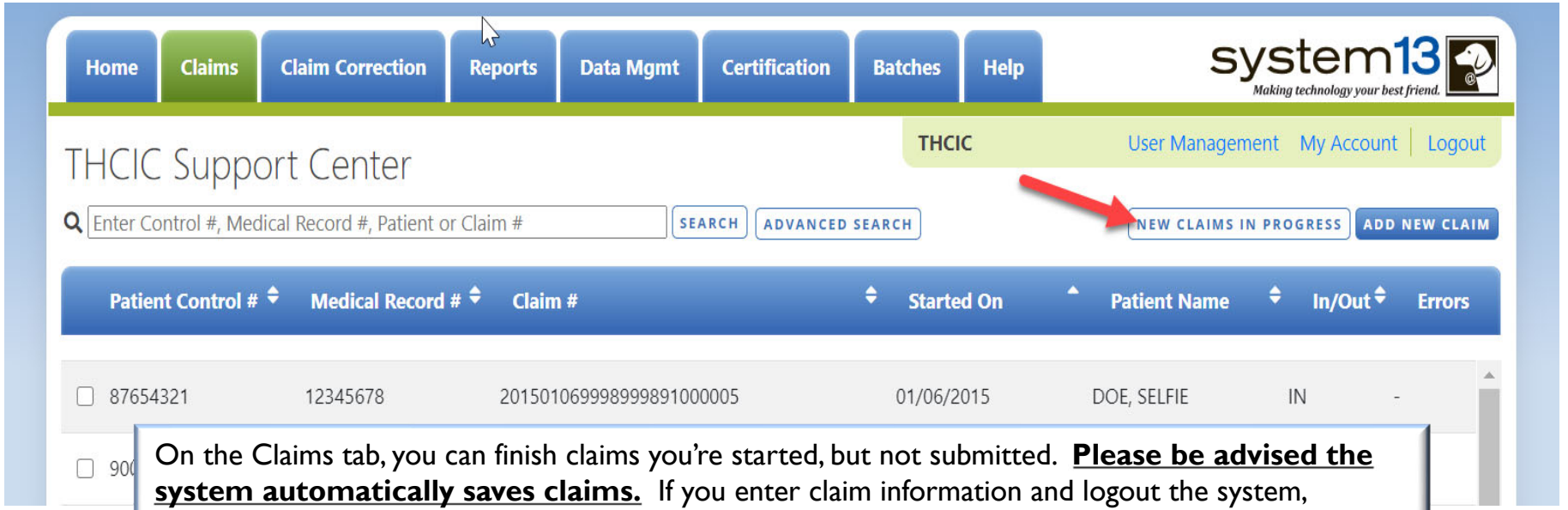
# New Claims in Progress

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.

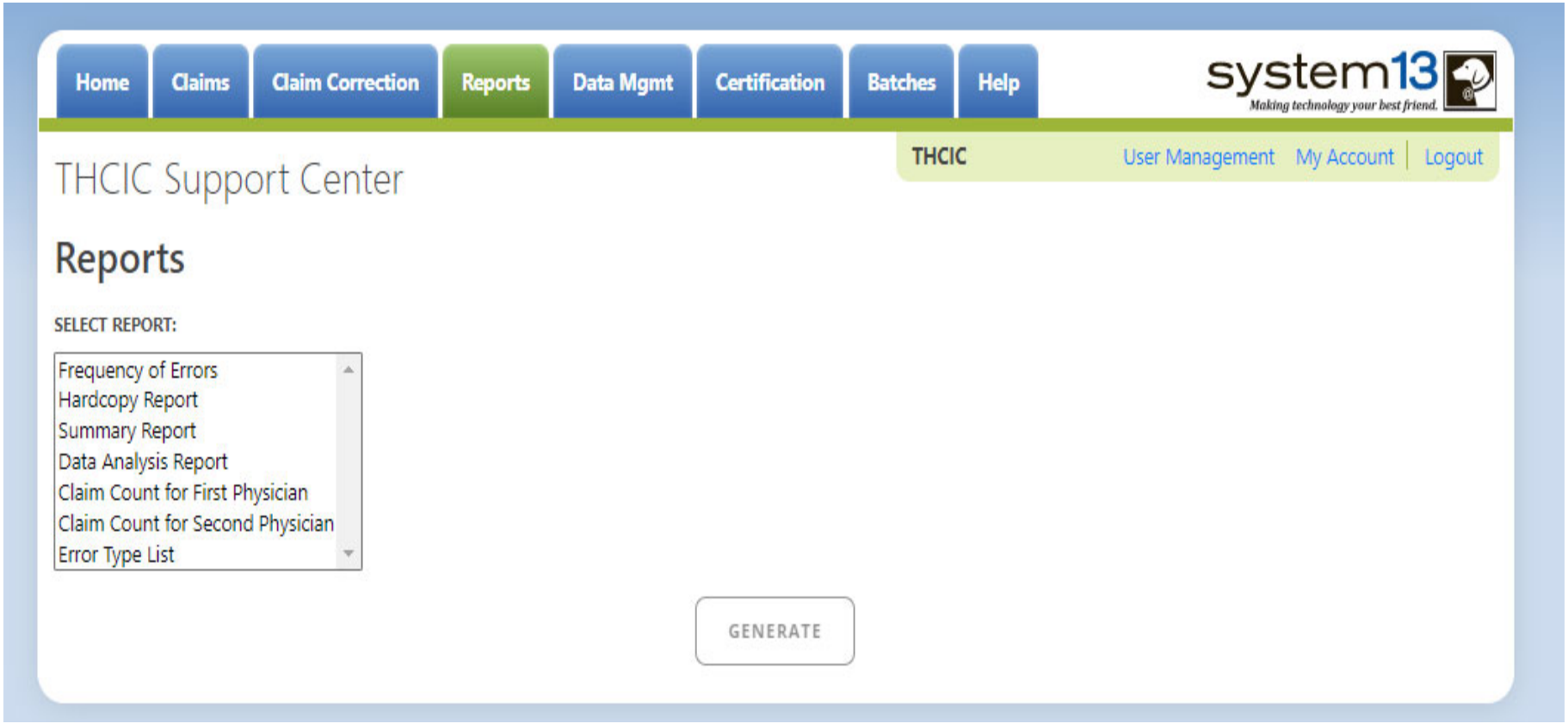
# New Claims in Progress




On the Claims tab, you can finish claims you're started, but not submitted. **Please be advised the system automatically saves claims.** If you enter claim information and logout the system, whatever you entered will be saved. These claims can be located by clicking New Claims in Progress through the claims tab. These claims can also be deleted by choosing the check box next to the claim and delete will come as an option on the bottom right .

Audited Claim AUDITED CLAIMS is a list of claims that can be completed or deleted.

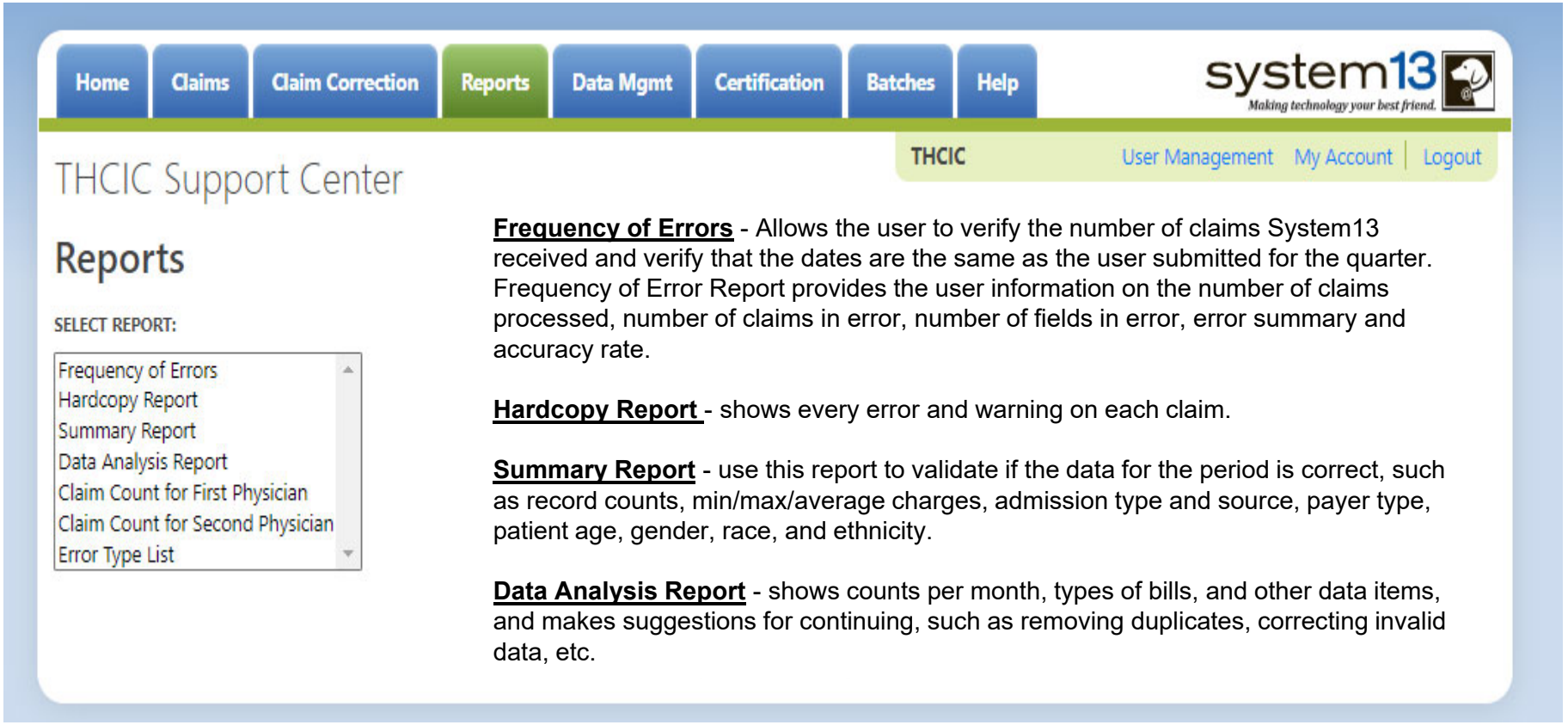
# Reports




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.

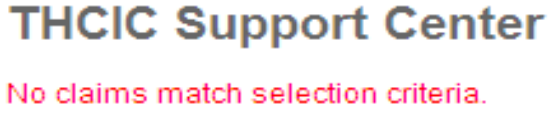
**Claim Count for Second Physician** - Use this to determine if the second physicians (attending, operating, other) who utilize your facility are represented correctly. This report will give a claim count by second physician name, sorted by name. It will also include the physician ID, but will not include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

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

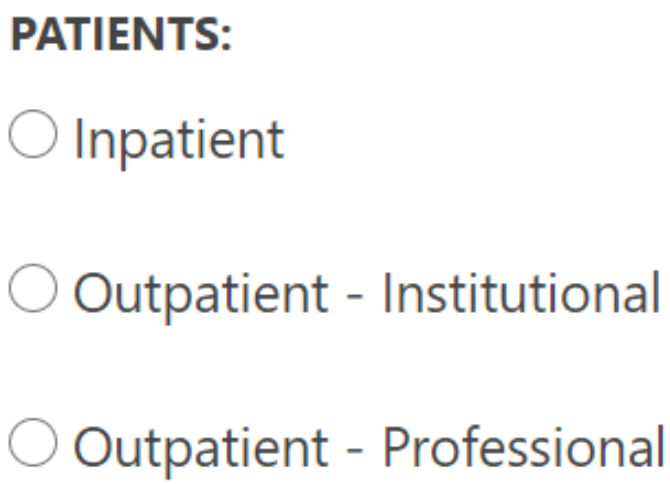
# Reports Functionality

- 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.



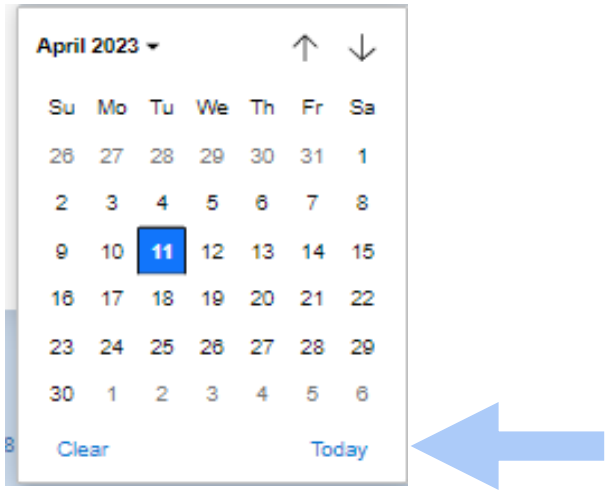
# Type of Claims



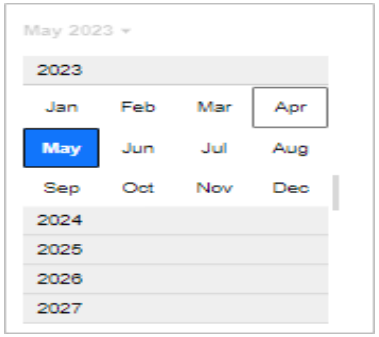

**<u>Only one type of claim can be chosen to review patient data at a time</u>.**
If batch number is chosen the type of claim within the batch is automatically selected, since it's already predetermined in the batch as to type of claims, type of patients is not an option.

# Functionality of the Calendar Feature

- Feature of the calendar



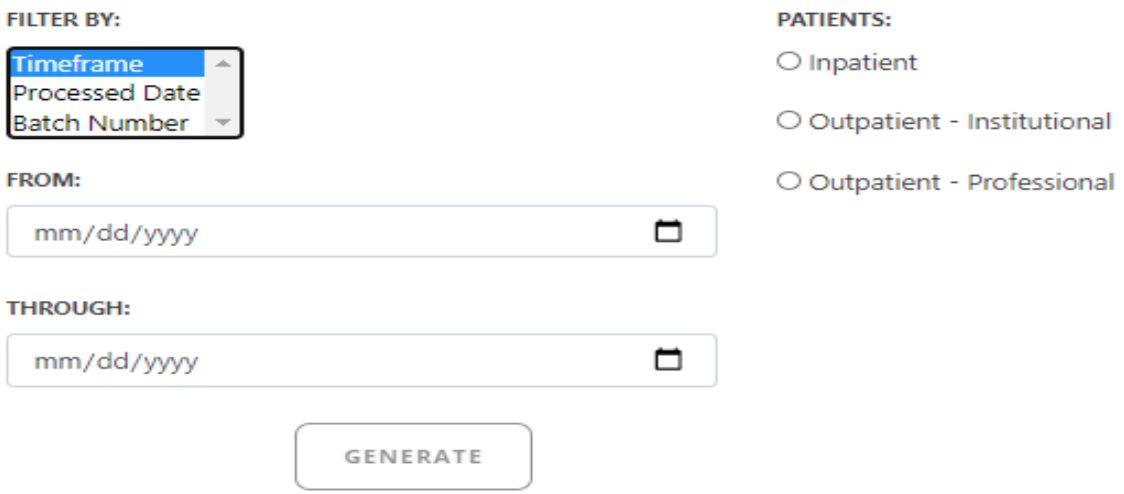

- The icon will open choosing the current date.
  - ↑ ↓ will move the calendar back a month.
  - Choosing the month's drop-down menu will change the month




  - Choosing the sidebar will change the year

# Filter Report By Timeframe

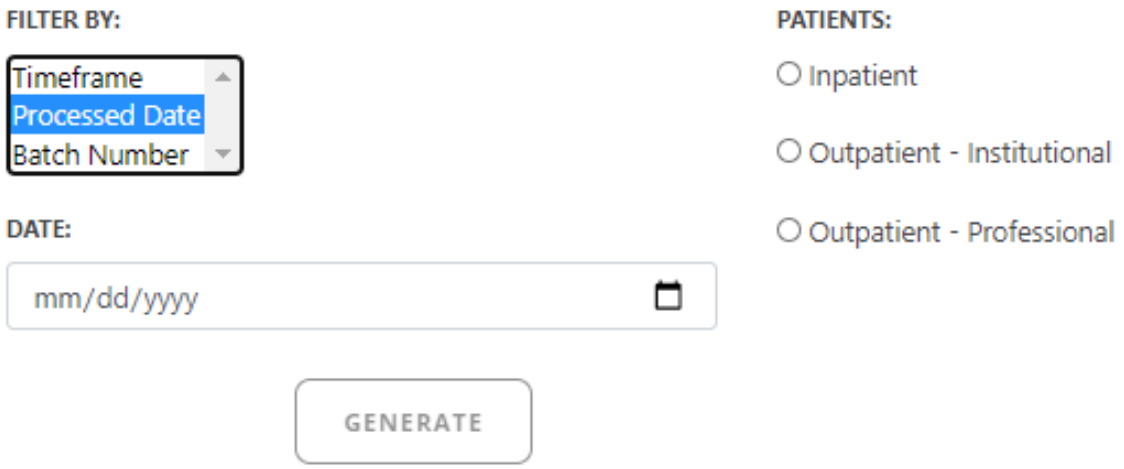
- To create by timeframe.




- 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

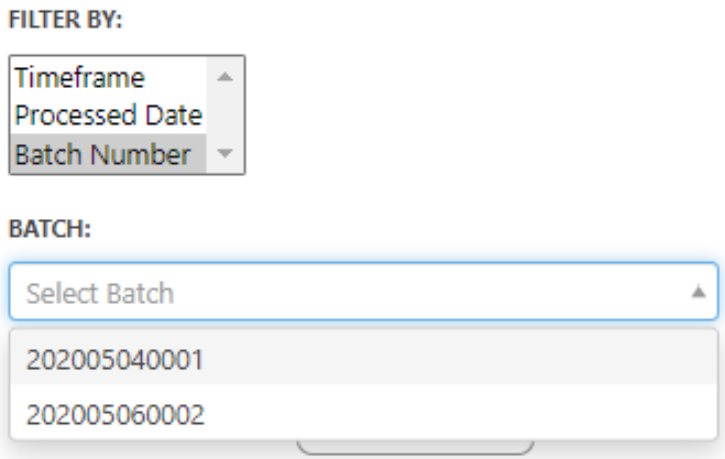
- To create a report, filter by processed date.




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

# Filter Report By Batch Number

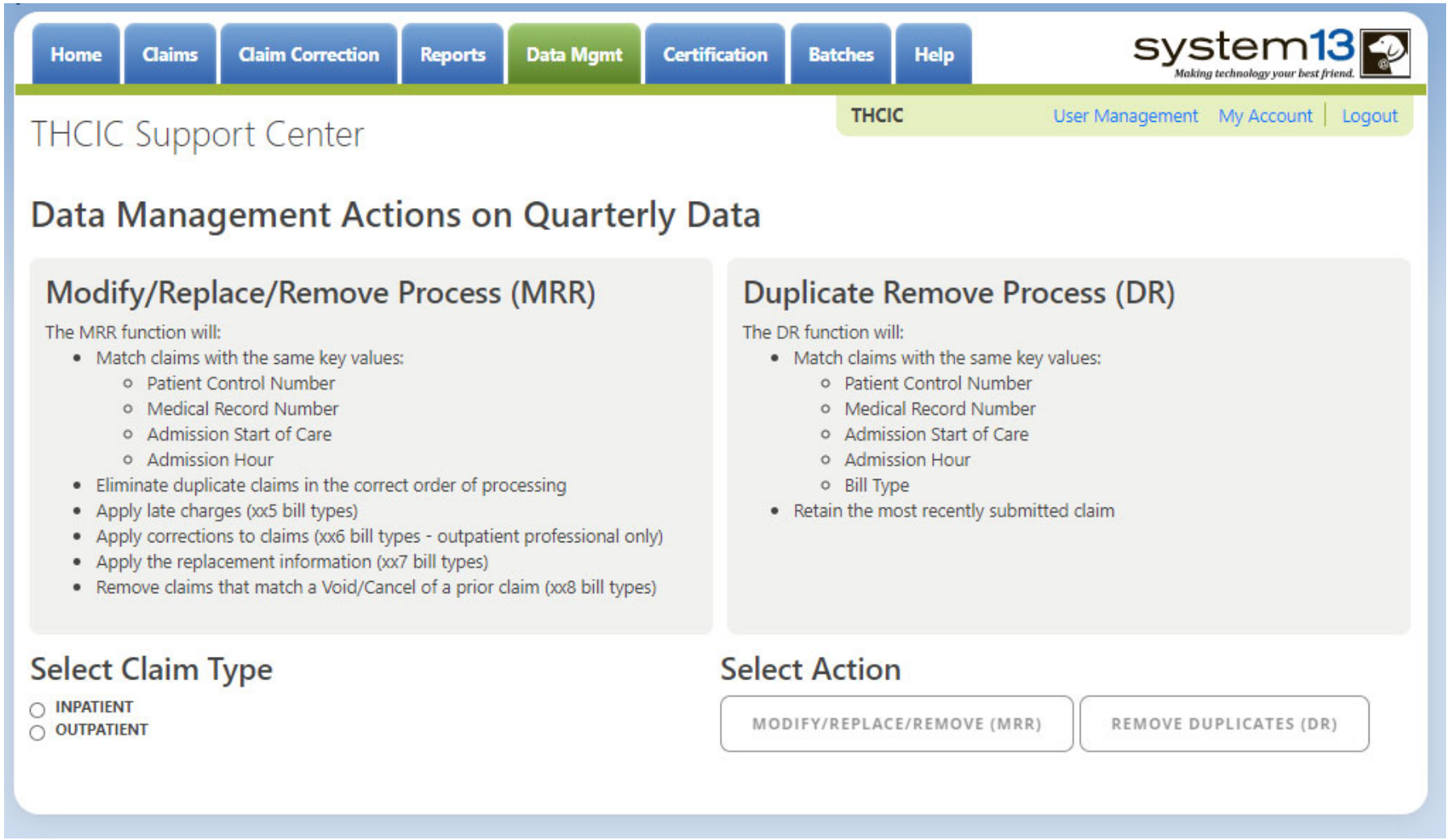
- To create a report by batch number, you have to choose a batch from the batch listing in the system.




- 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.

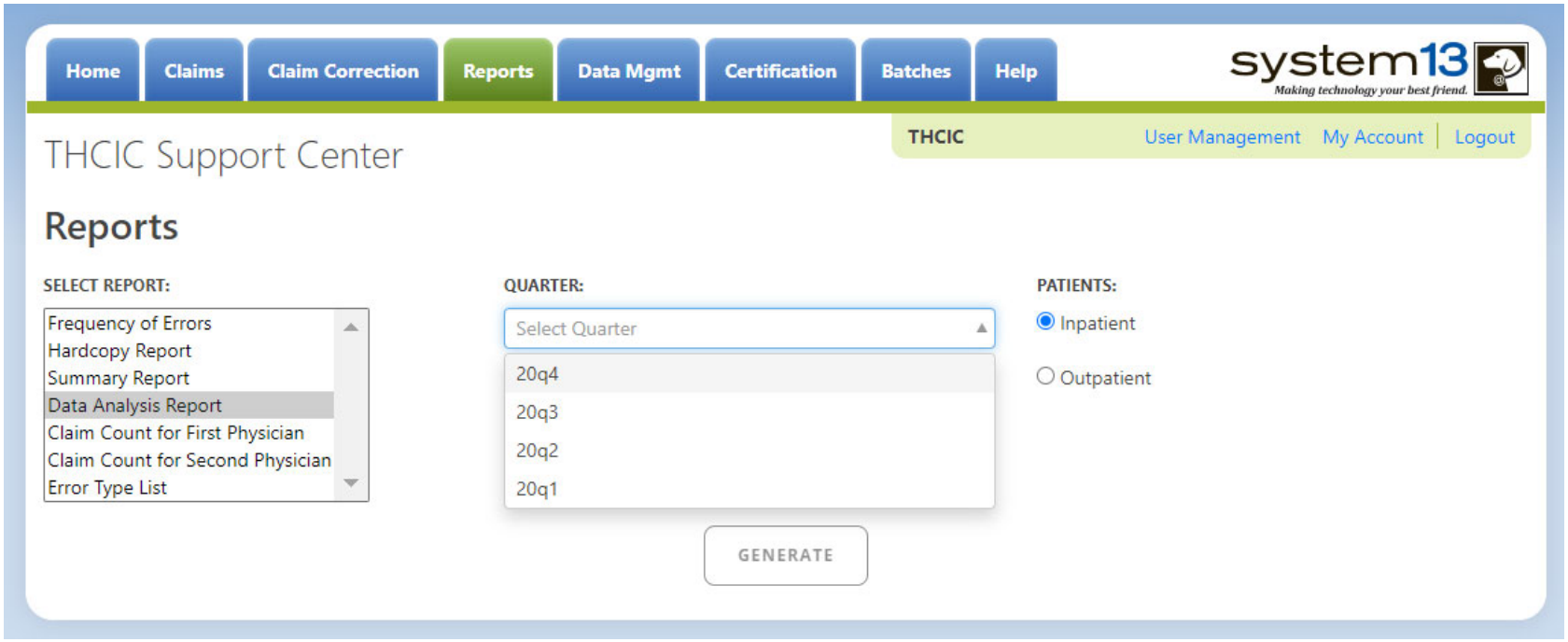
# Provider Tab Data Management

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 ran, it is recommended that the data analysis report is ran through the reports tab.

# Data Management – Running 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

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.

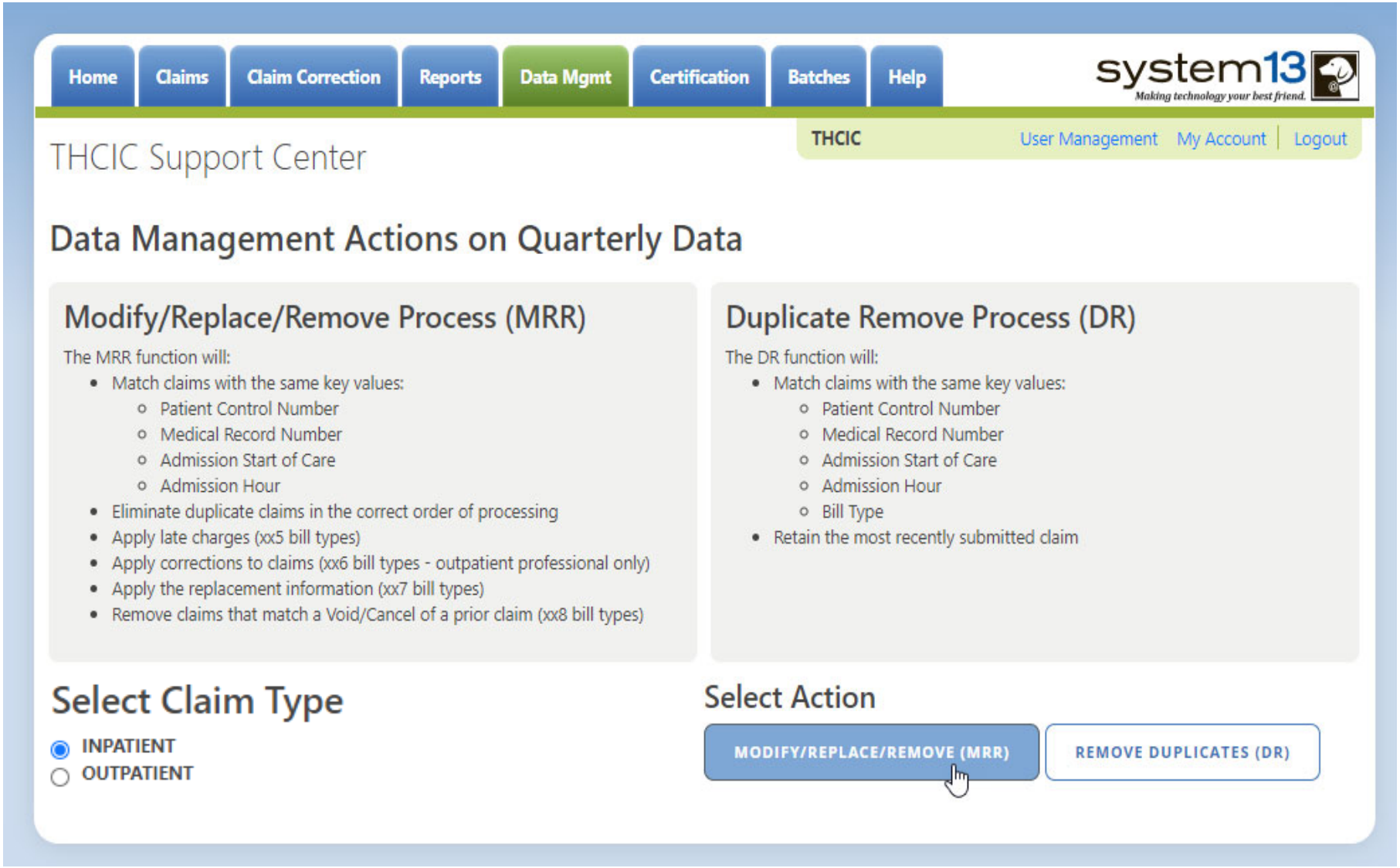
The MRR process will:

- 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.

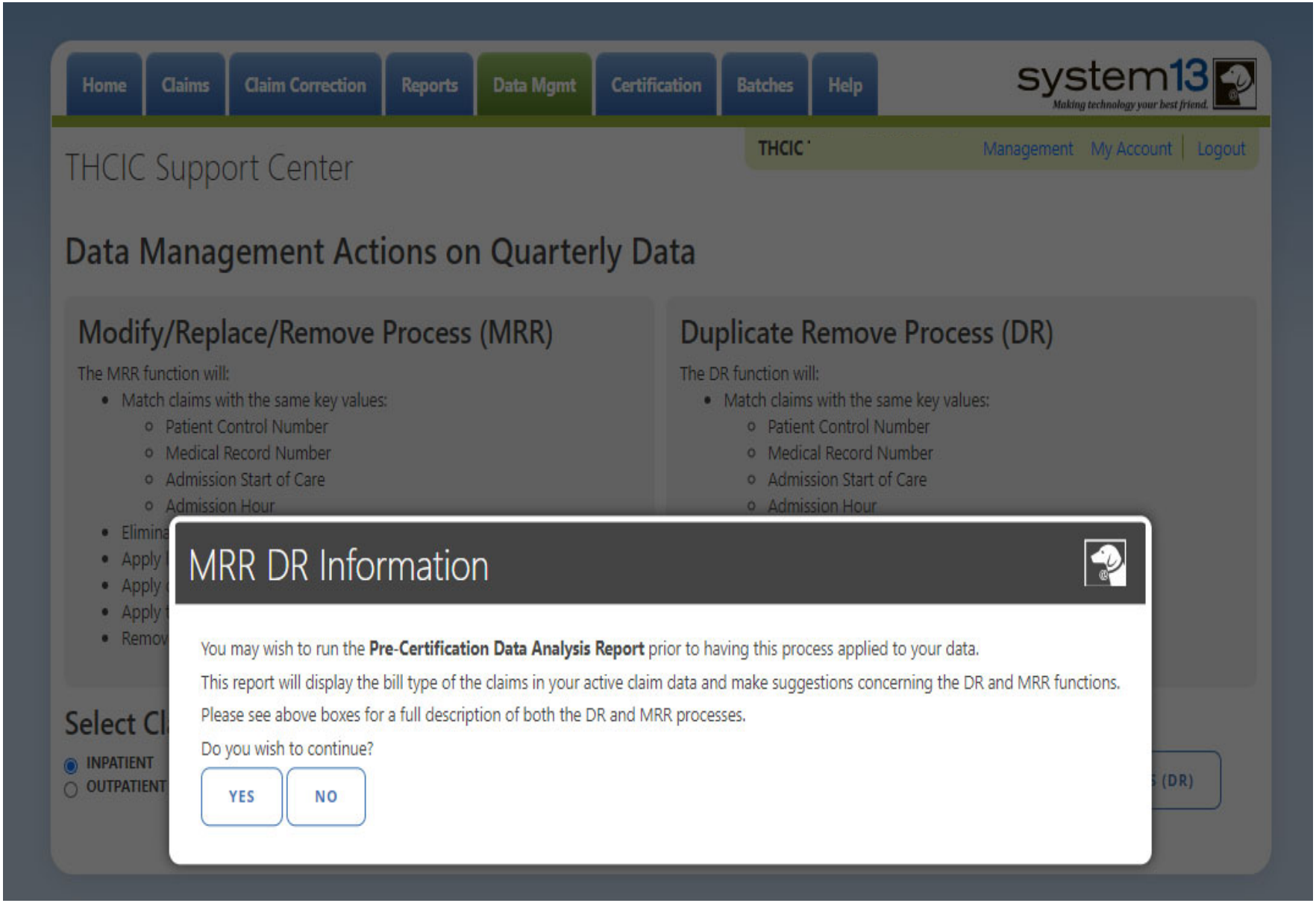
After the provider completes all of the prompts, the MRR or DR process is submitted to run in the background. When the process is completed, the data administrator is sent an email describing the number of records that were analyzed and any that fit each category of removal.

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



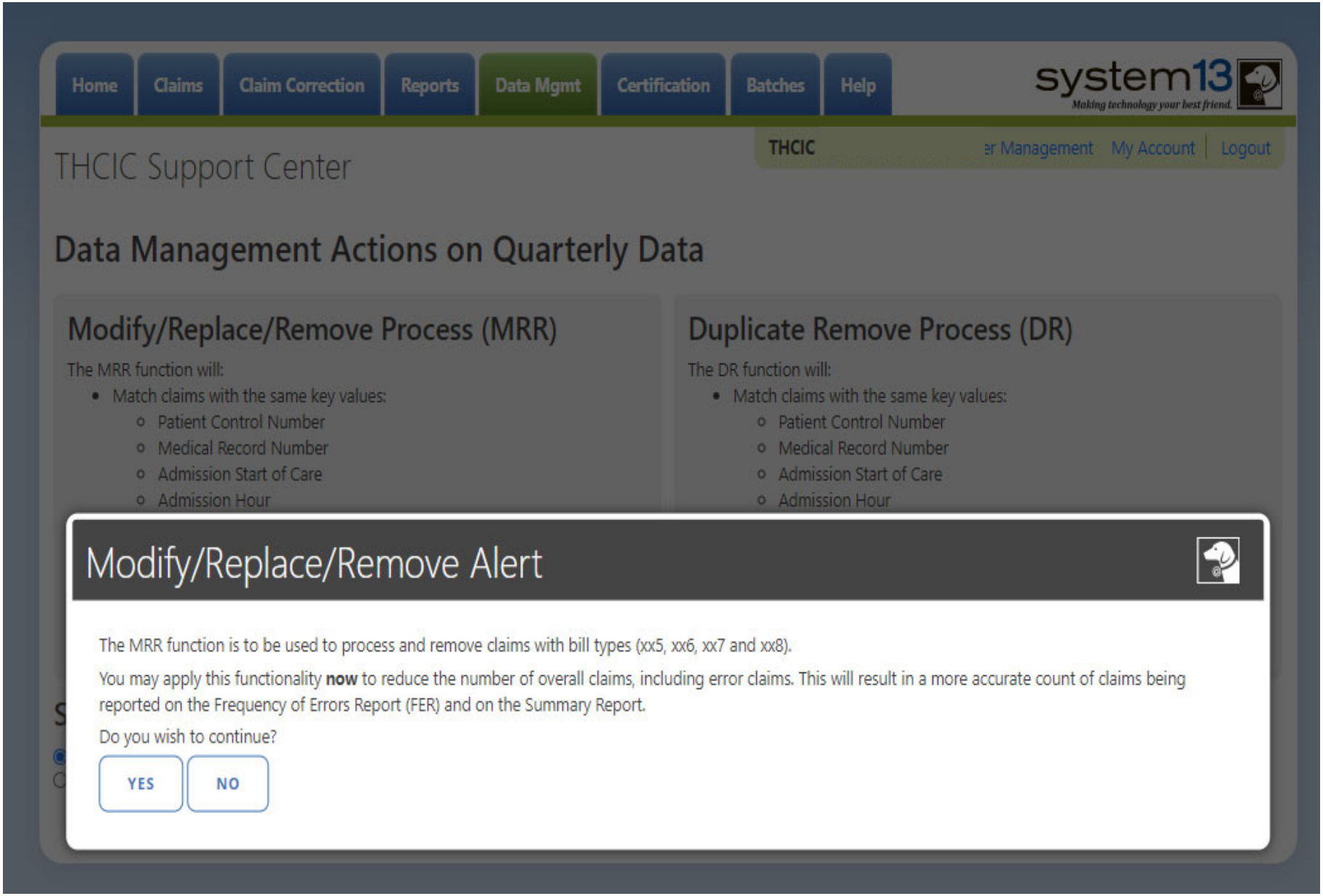
# Provider Tab Data Management

Data Mgmt



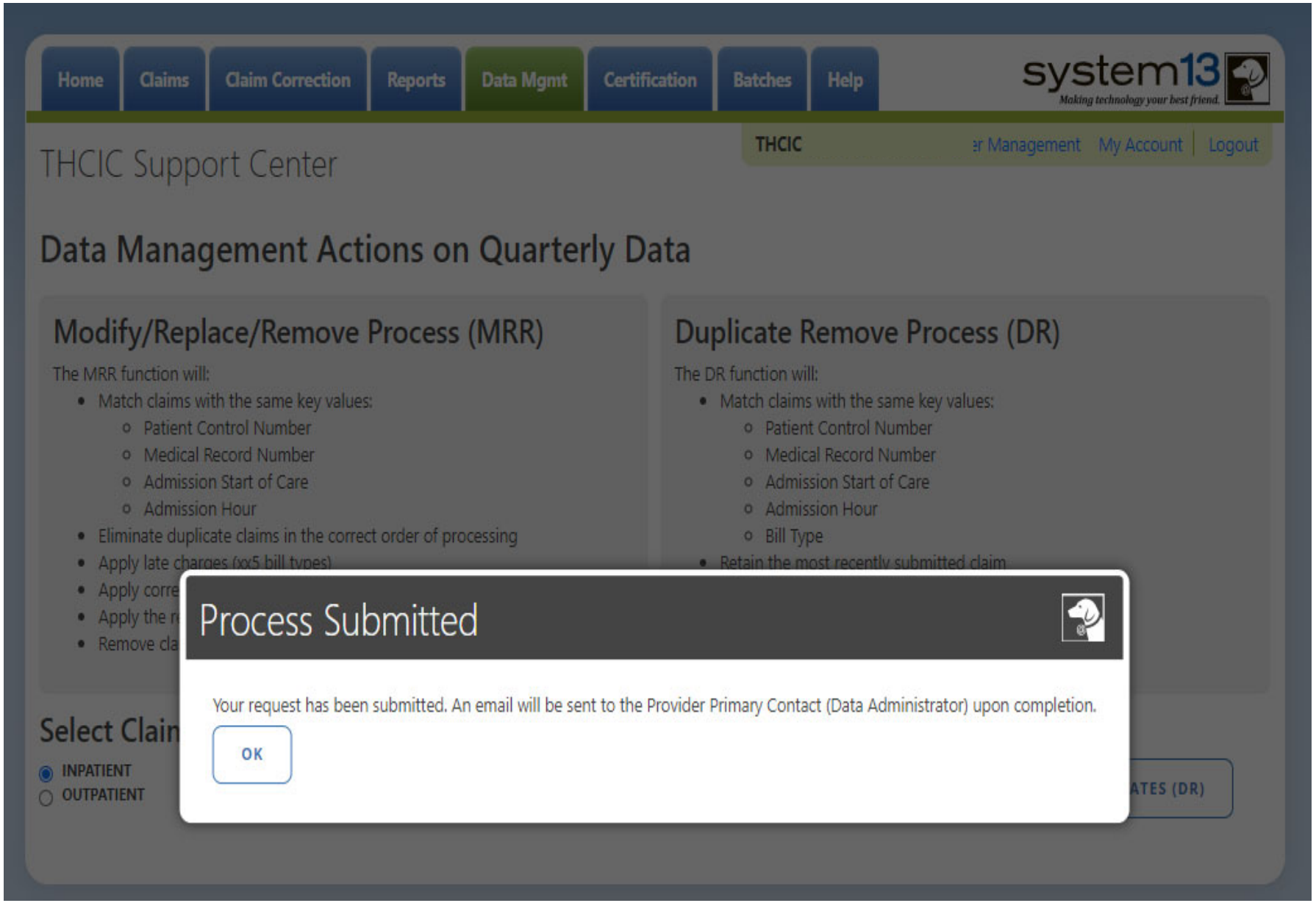
# Provider Tab Data Management

Data Mgmt



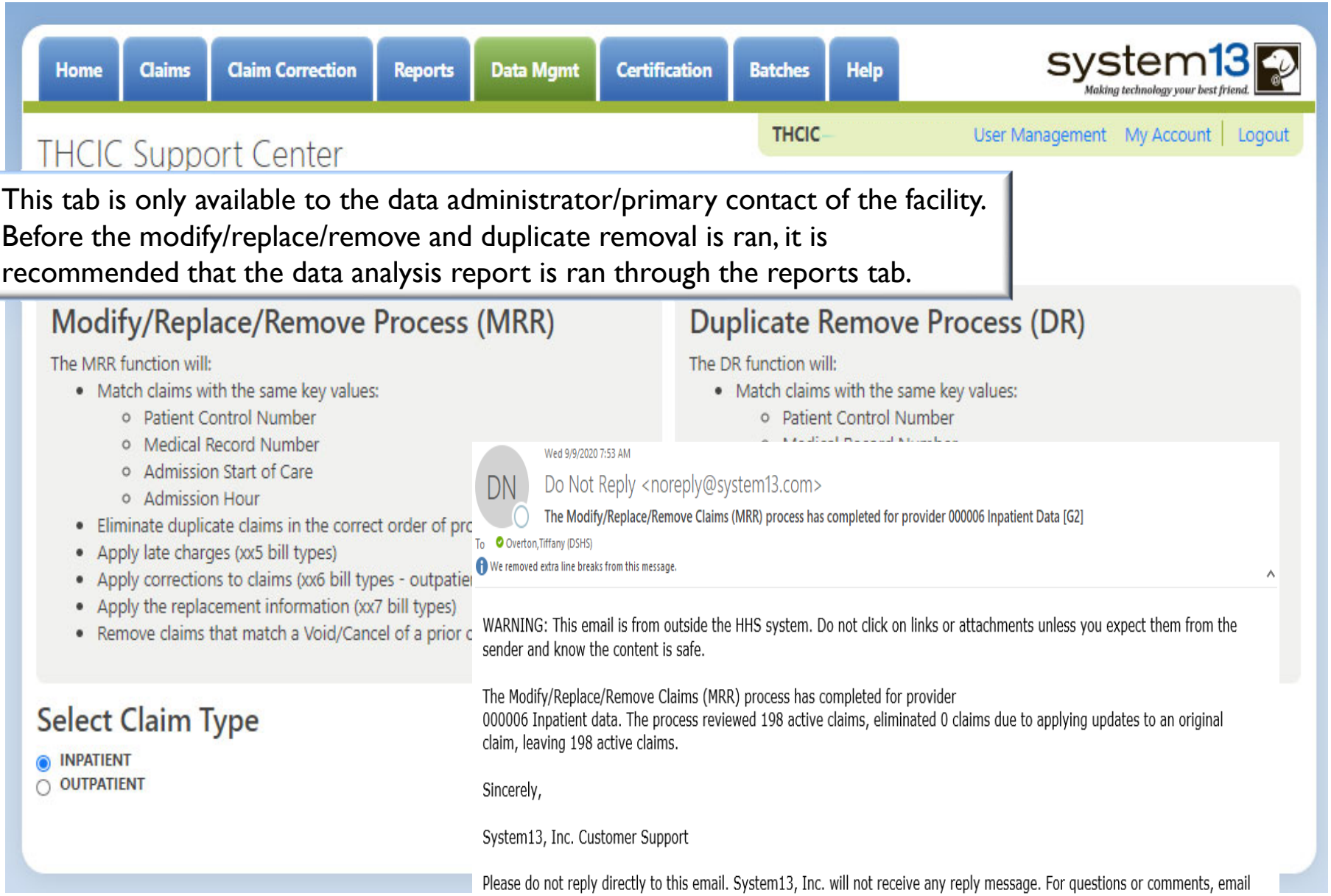
# Provider Tab Data Management

Data Mgmt



# Data Management Emails

Data Mgmt



# 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.

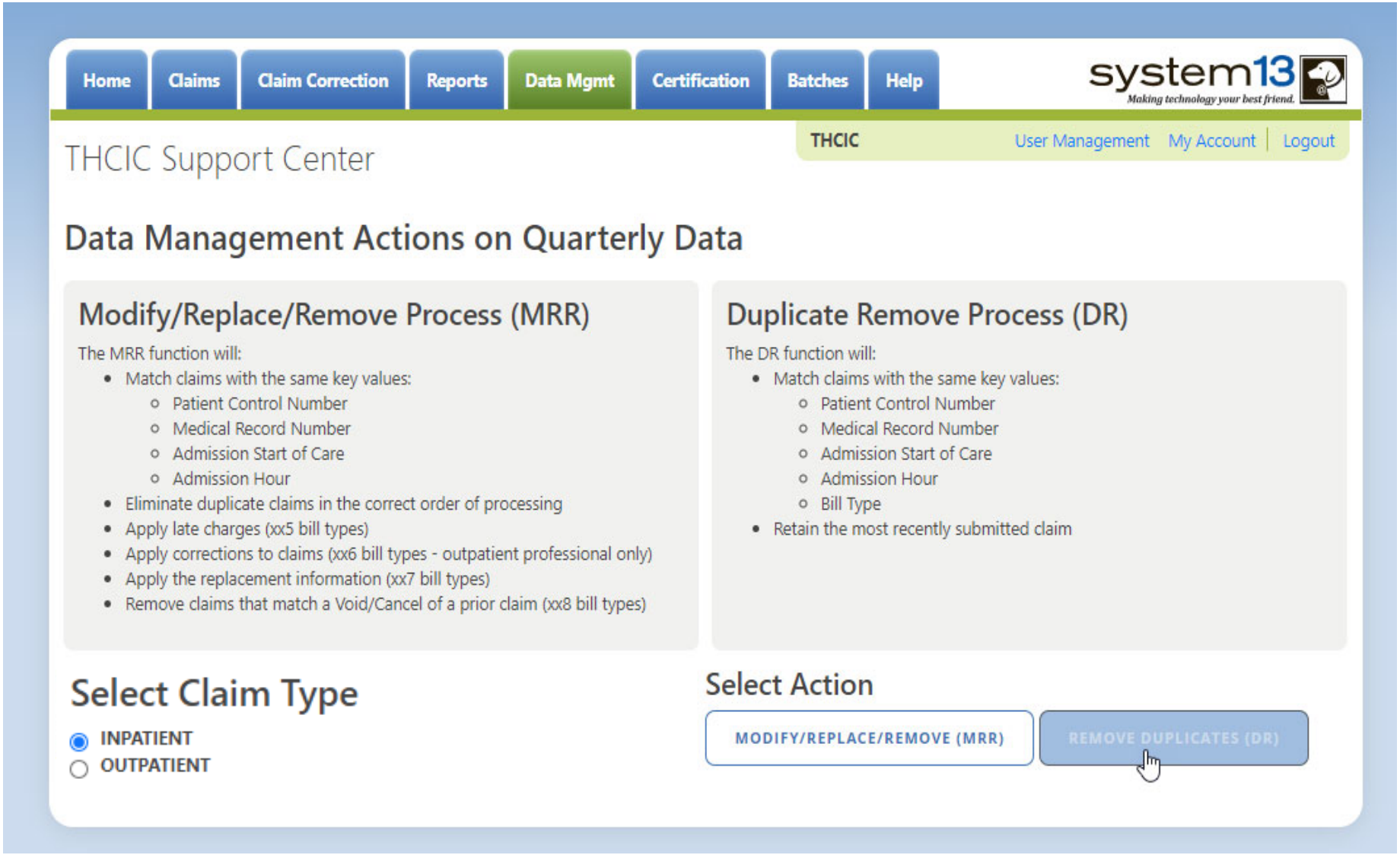
After the provider completes all of the prompts, the MRR or DR process is submitted to run in the background. When the process is completed, the data administrator is sent an email describing the number of records that were analyzed and any that fit each category of removal.

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.

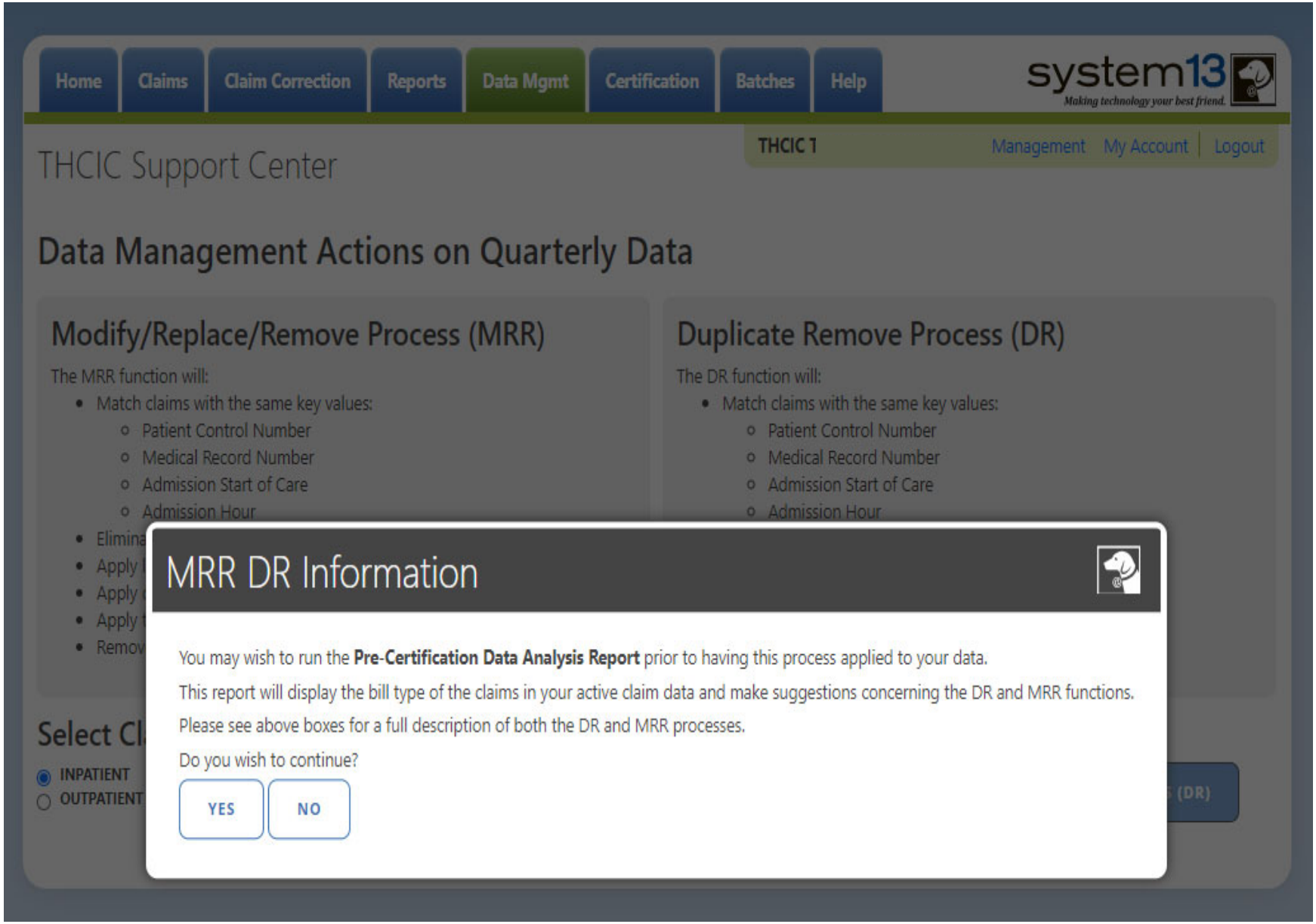
This report will open as a PDF as shown below.

# Provider Tab Data Management – Duplicate Removal Process (DR)



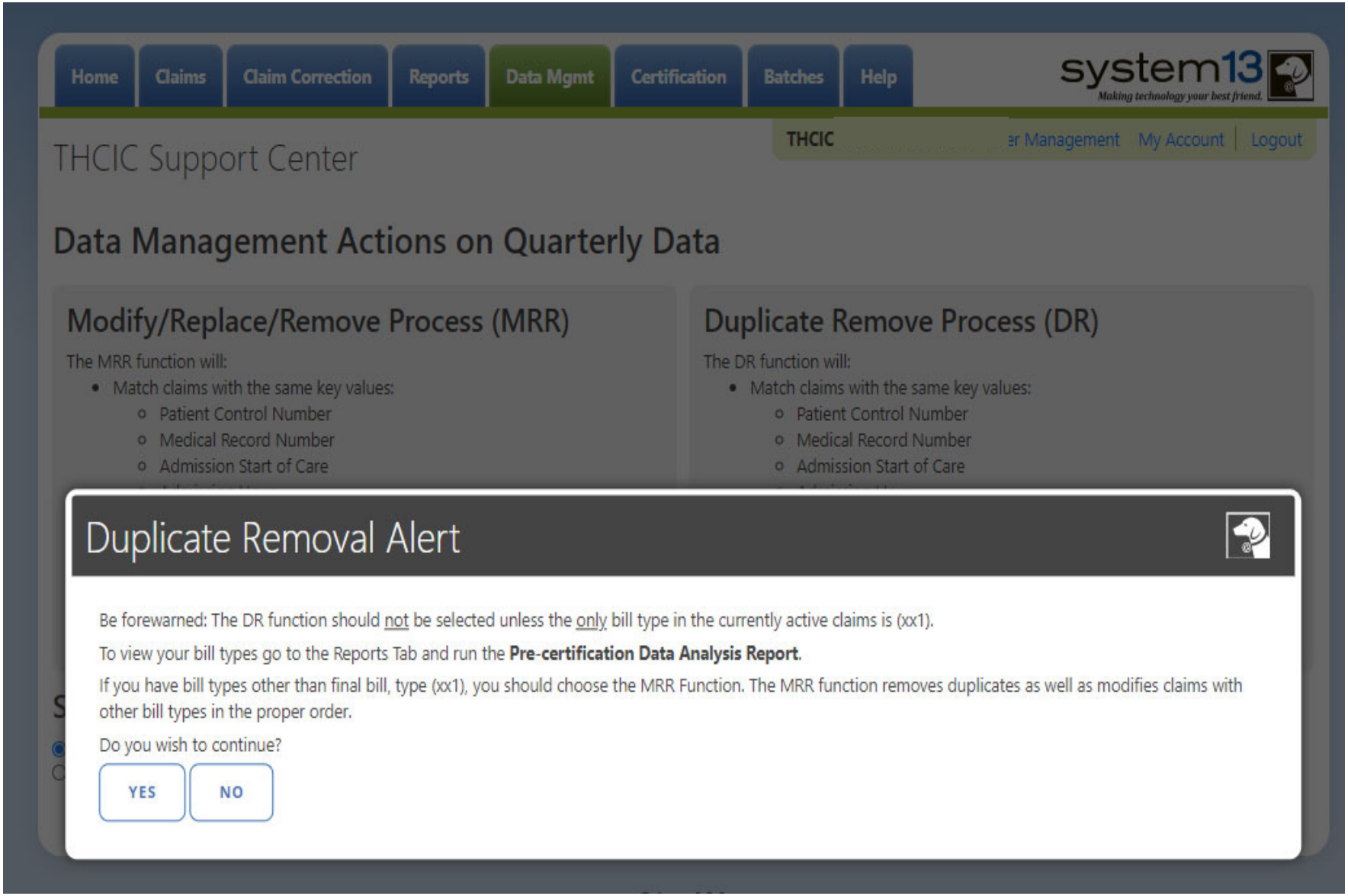
# Provider Tab Data Management

Data Mgmt



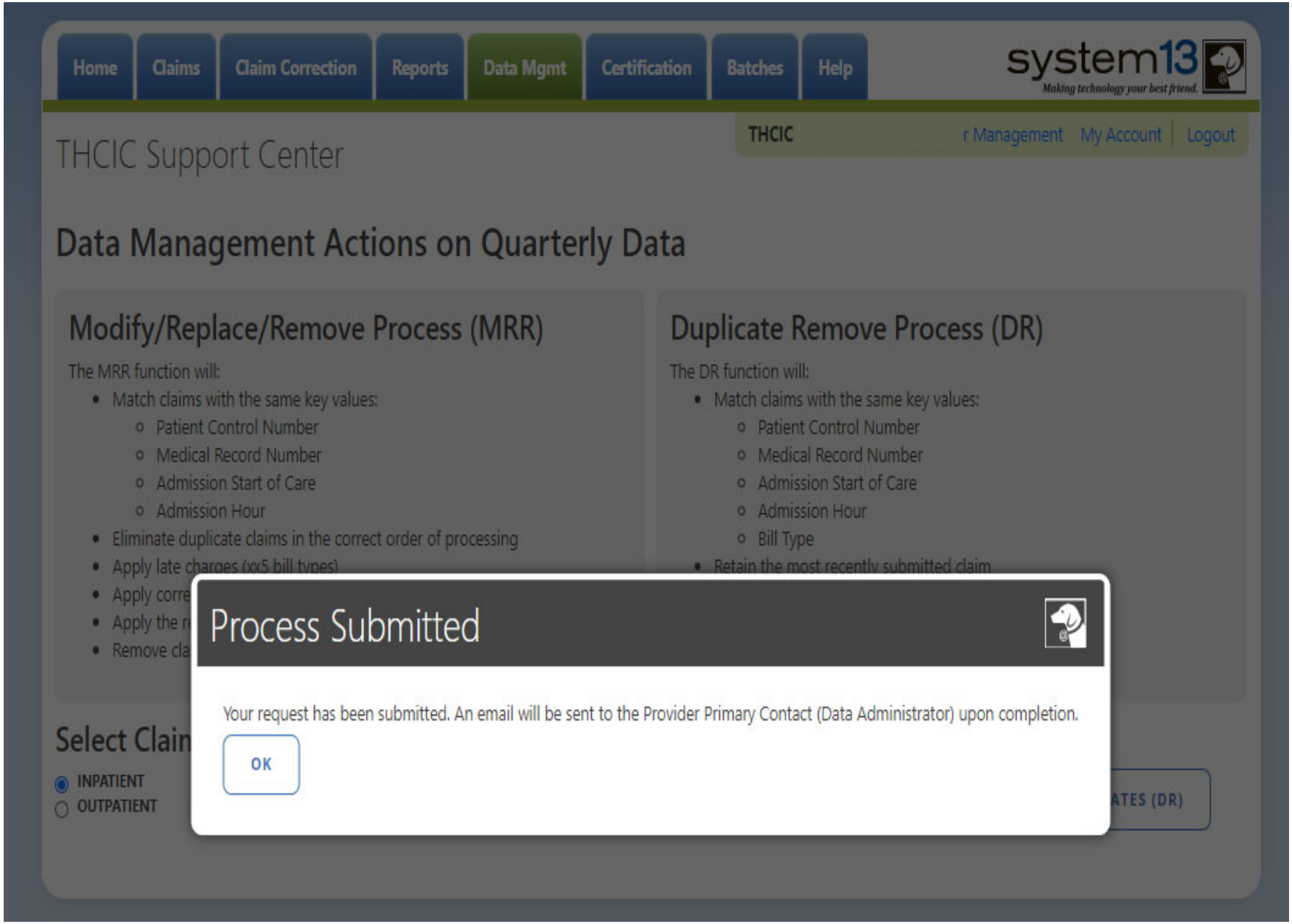
# Provider Tab Data Management

Data Mgmt



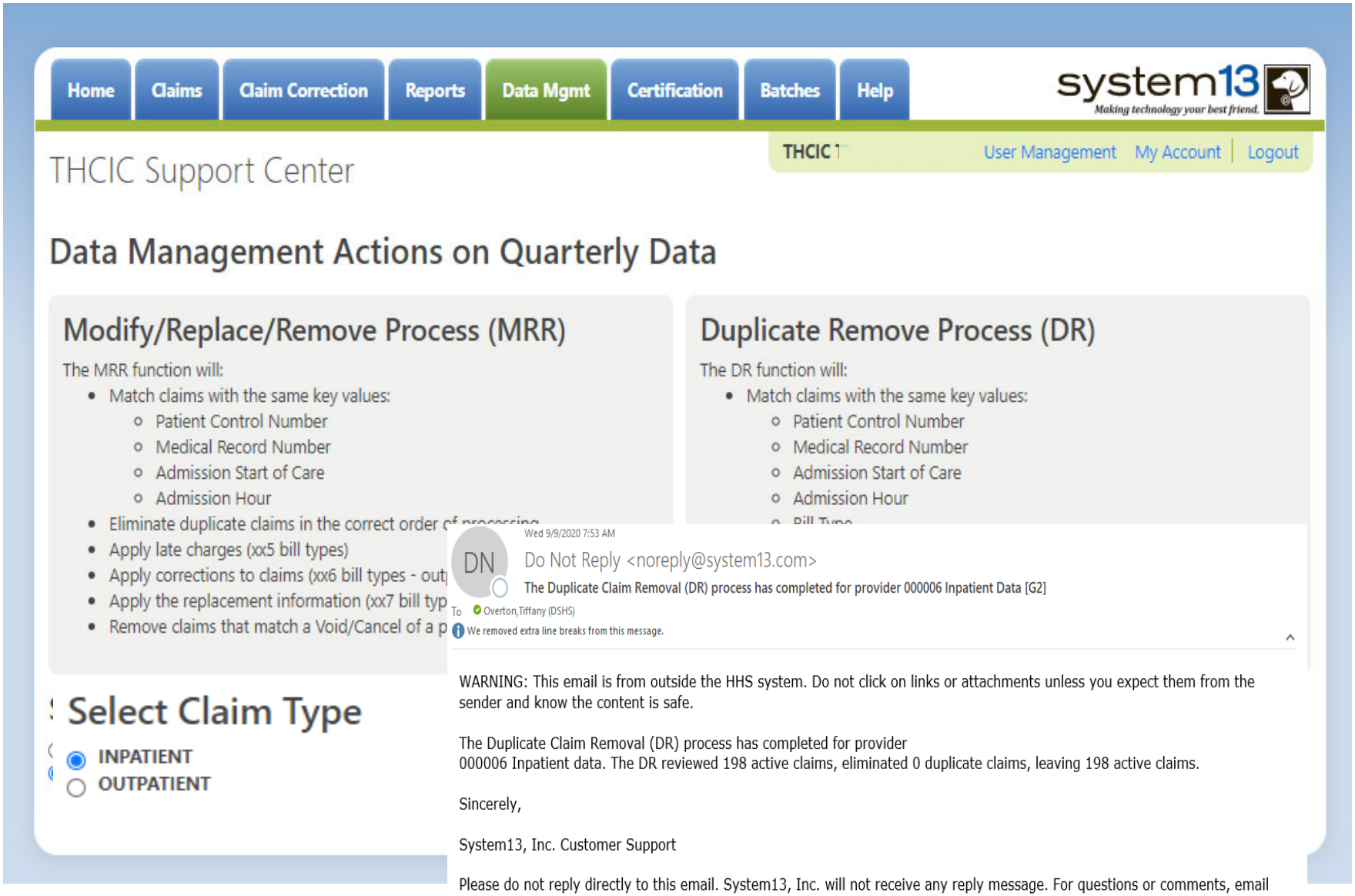
# Provider Tab Data Management

Data Mgmt



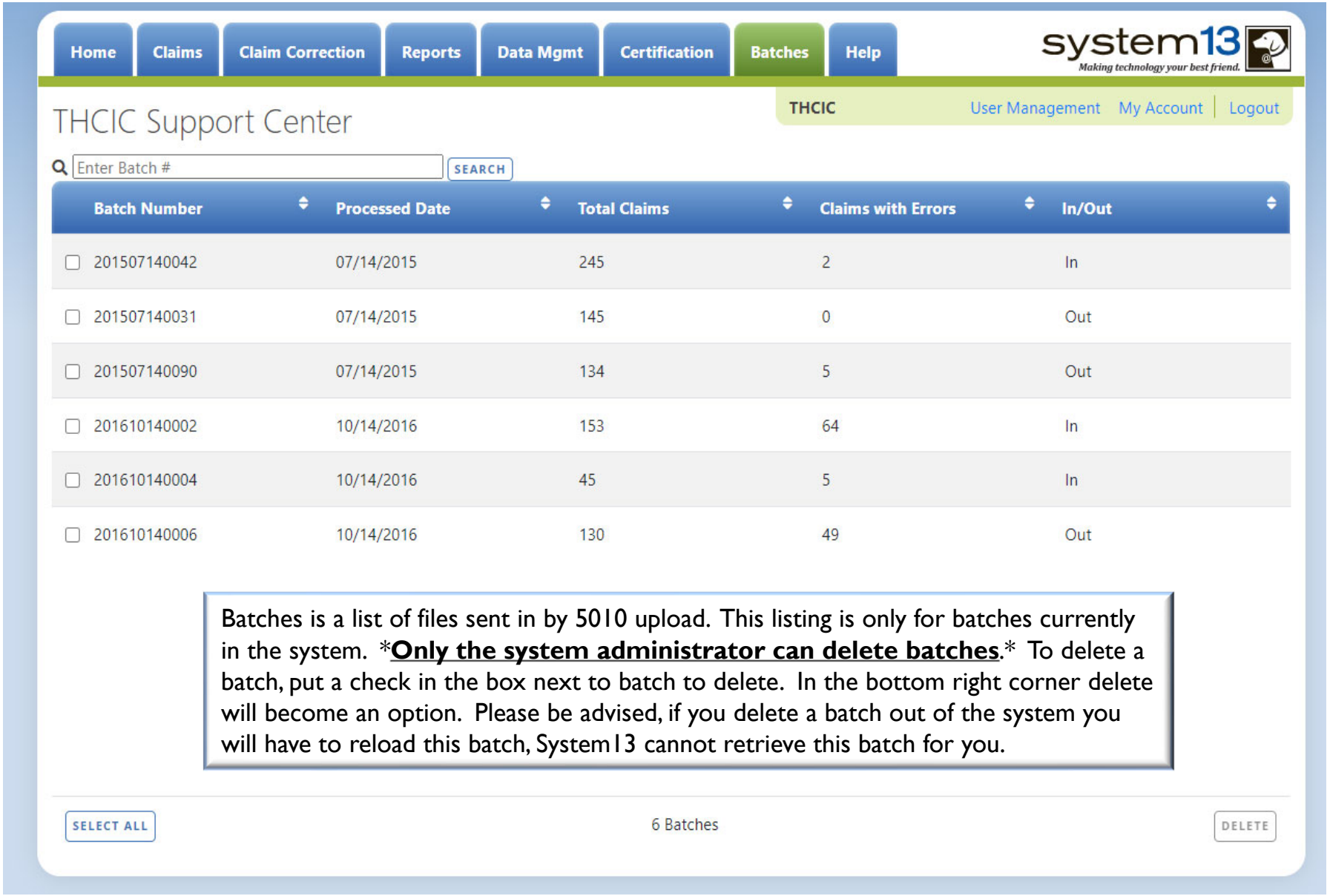
# Data Management Emails

Data Mgmt



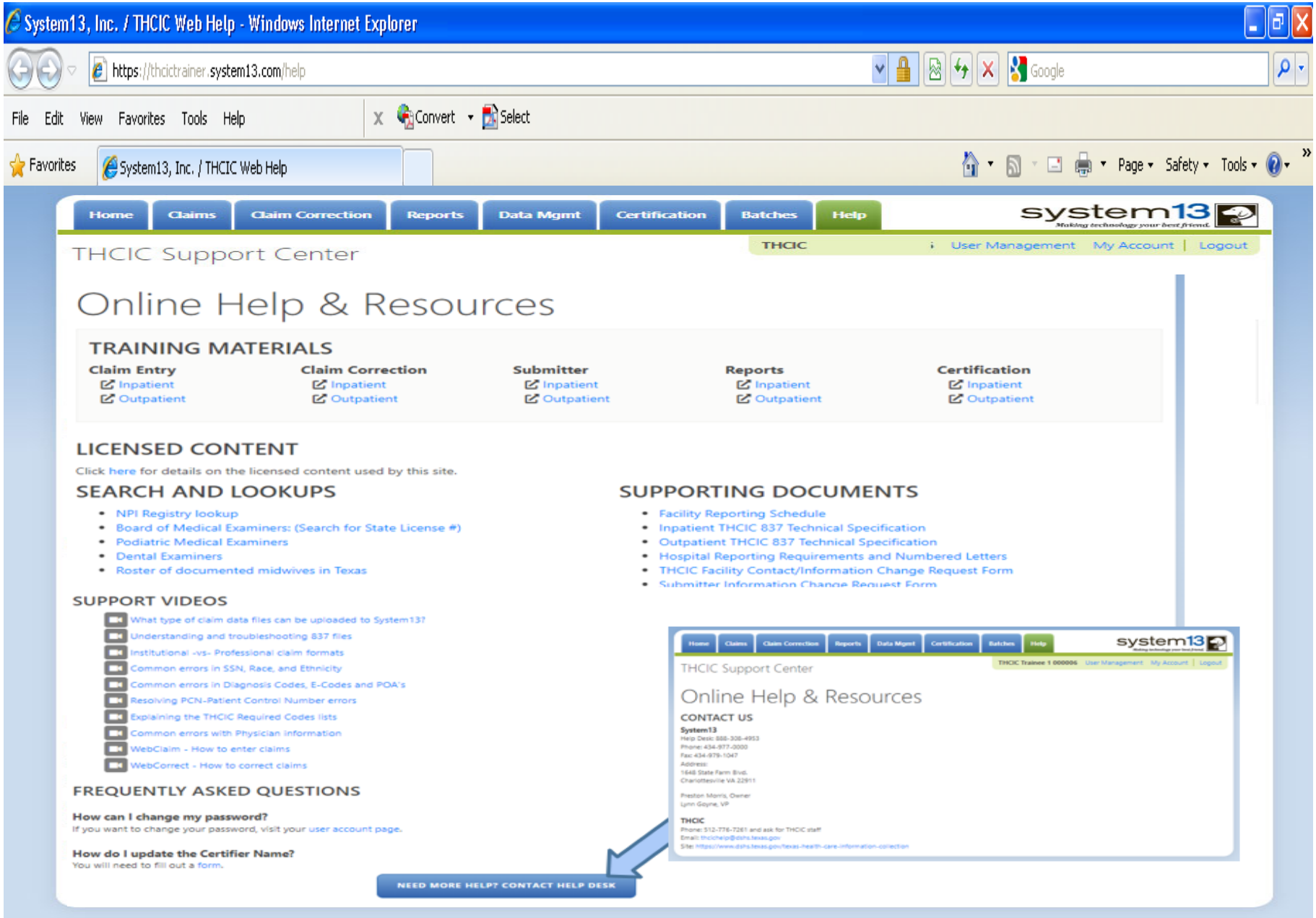
# Batches

Batches



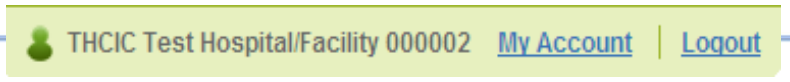
# Provider Tab Help

Help

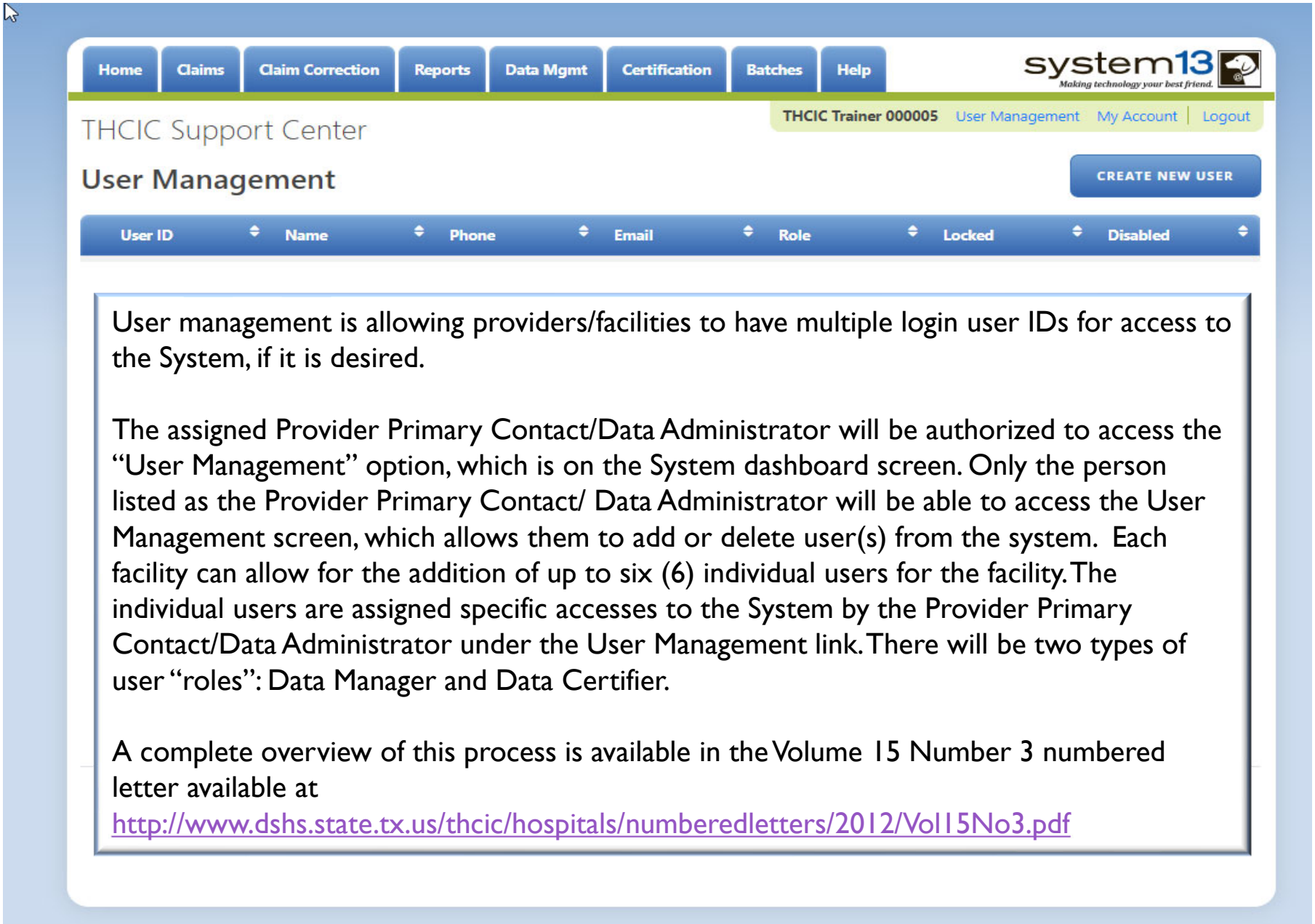


# Provider Other Features

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

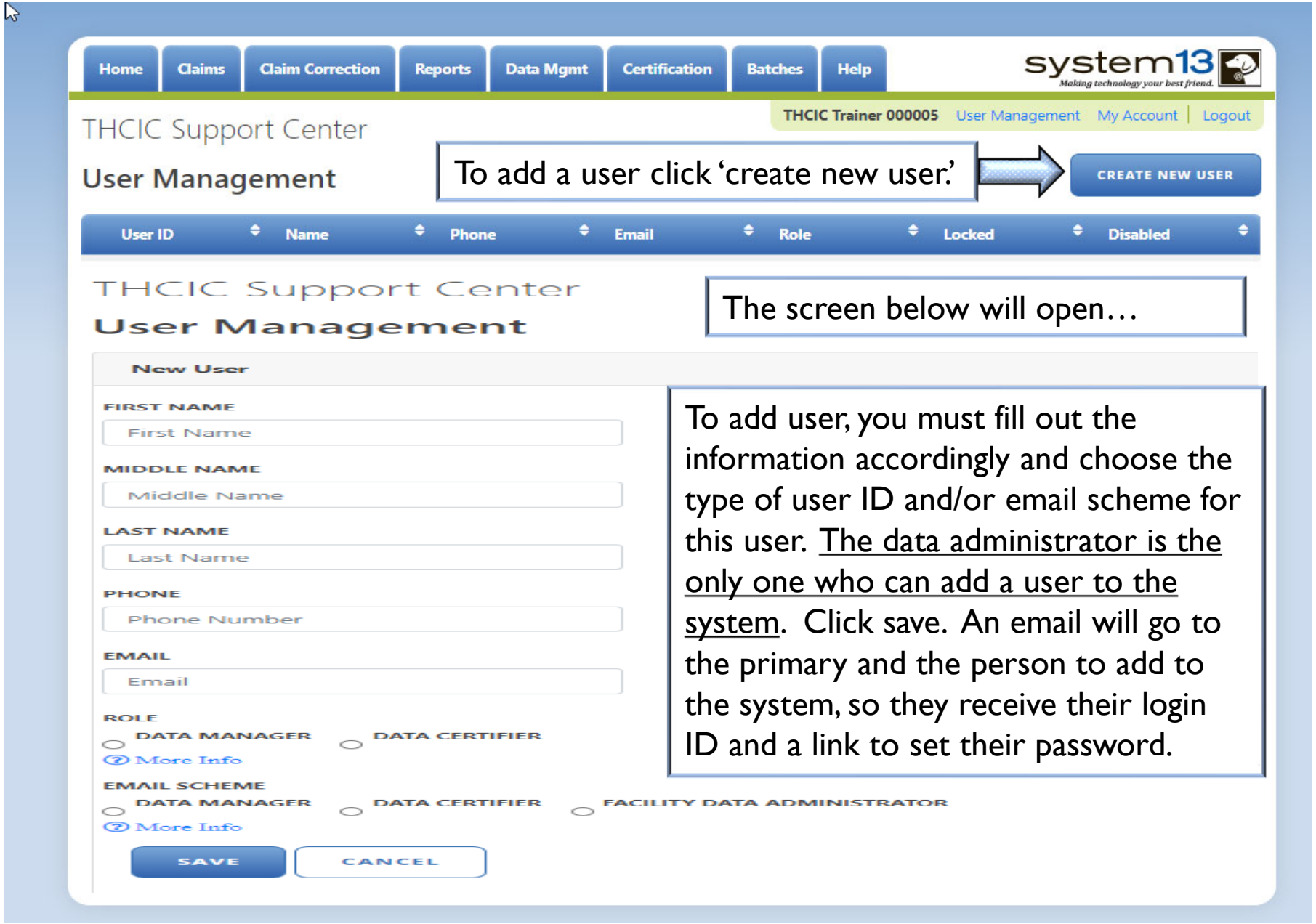



User management is allowing providers/facilities to have multiple login user IDs for access to the System, if it is desired.

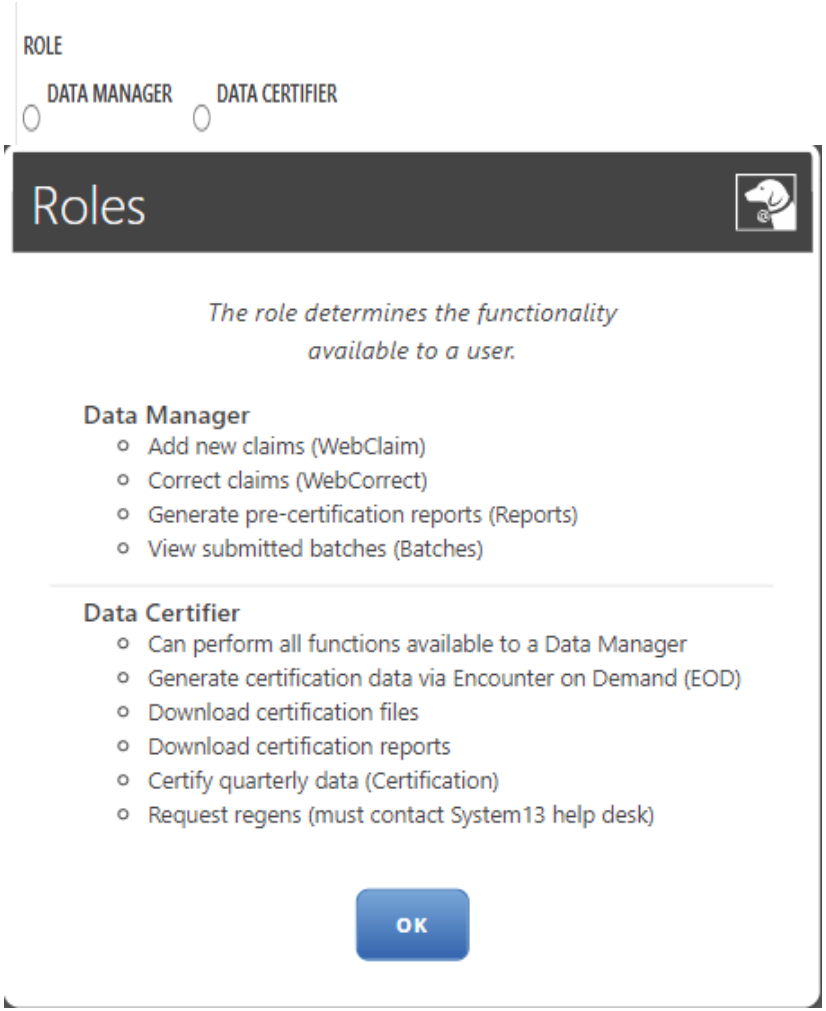
The assigned Provider Primary Contact/Data Administrator will be authorized to access the "User Management" option, which is on the System dashboard screen. Only the person listed as the Provider Primary Contact/ Data Administrator will be able to access the User Management screen, which allows them 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 Manager and Data Certifier.

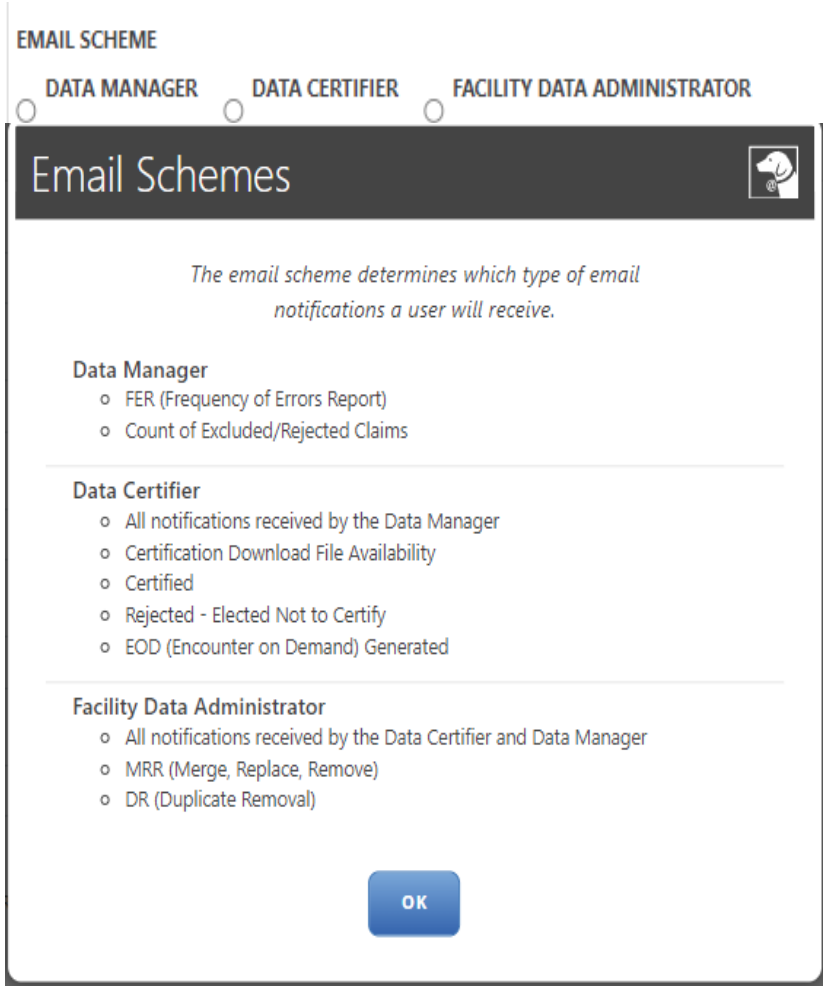
A complete overview of this process is available in the Volume 15 Number 3 numbered letter available at
http://www.dshs.state.tx.us/thcic/hospitals/numberedletters/2012/Vol15No3.pdf

# User Management – To Add User



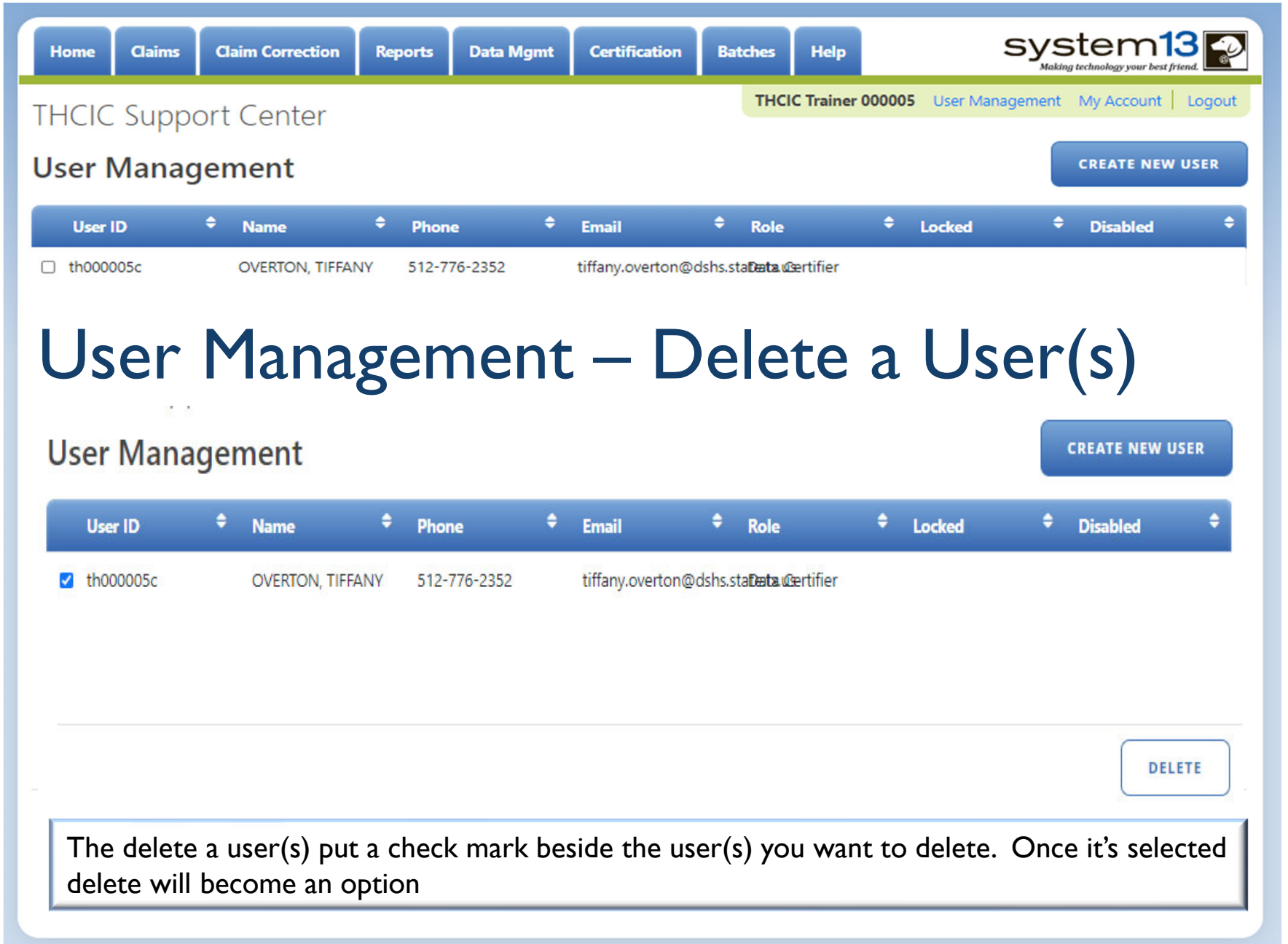
# User Management – User Roles / Email Schemes




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

# User Management – List of User(s)

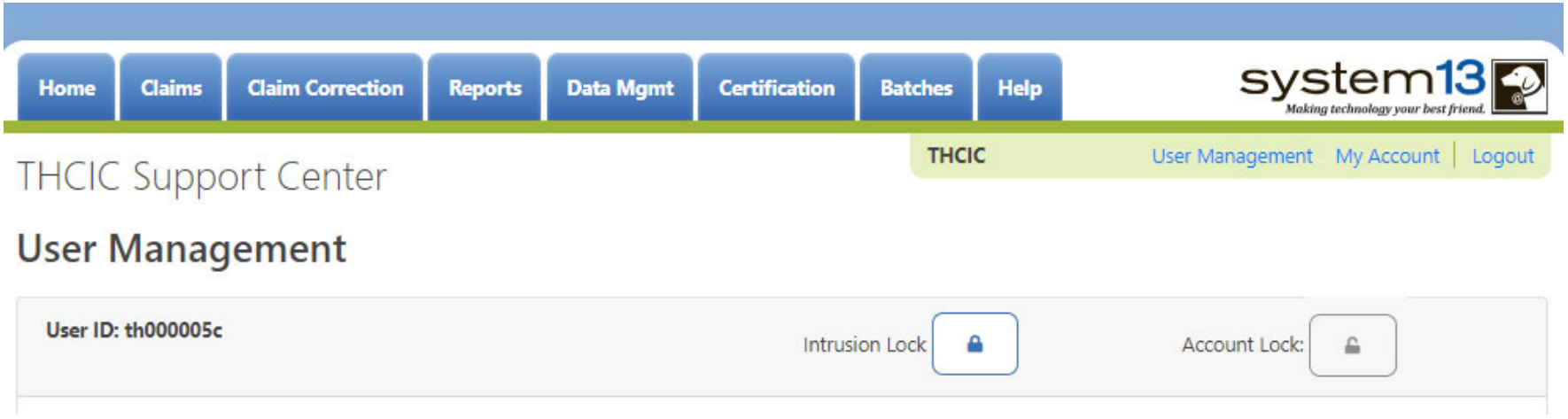



# User Management – Delete a User(s)

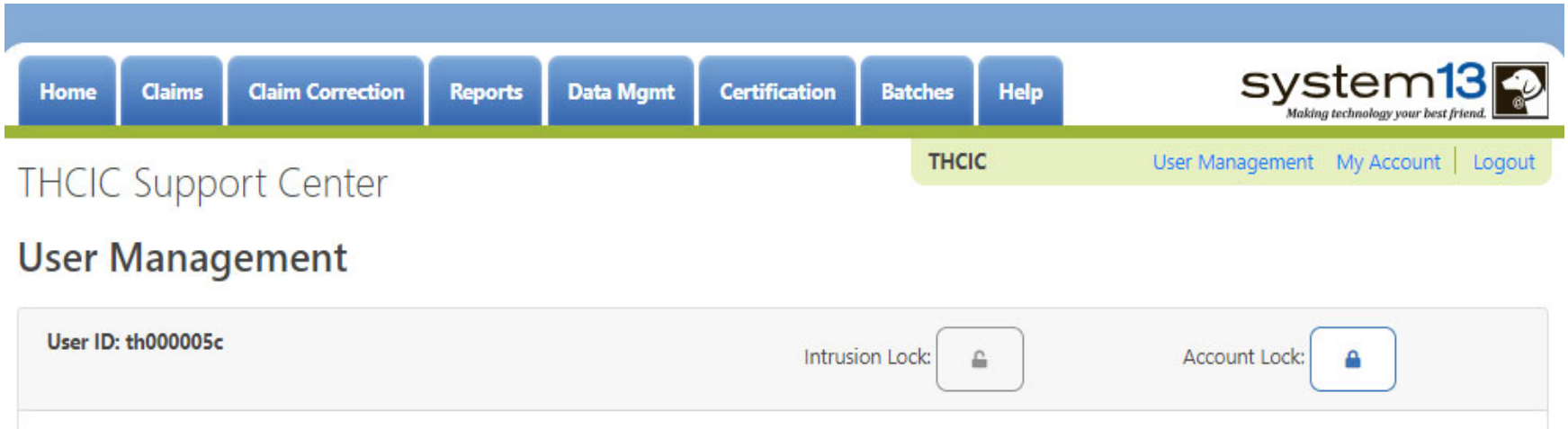



The delete a user(s) put a check mark beside the user(s) you want to delete. Once it's selected delete will become an option

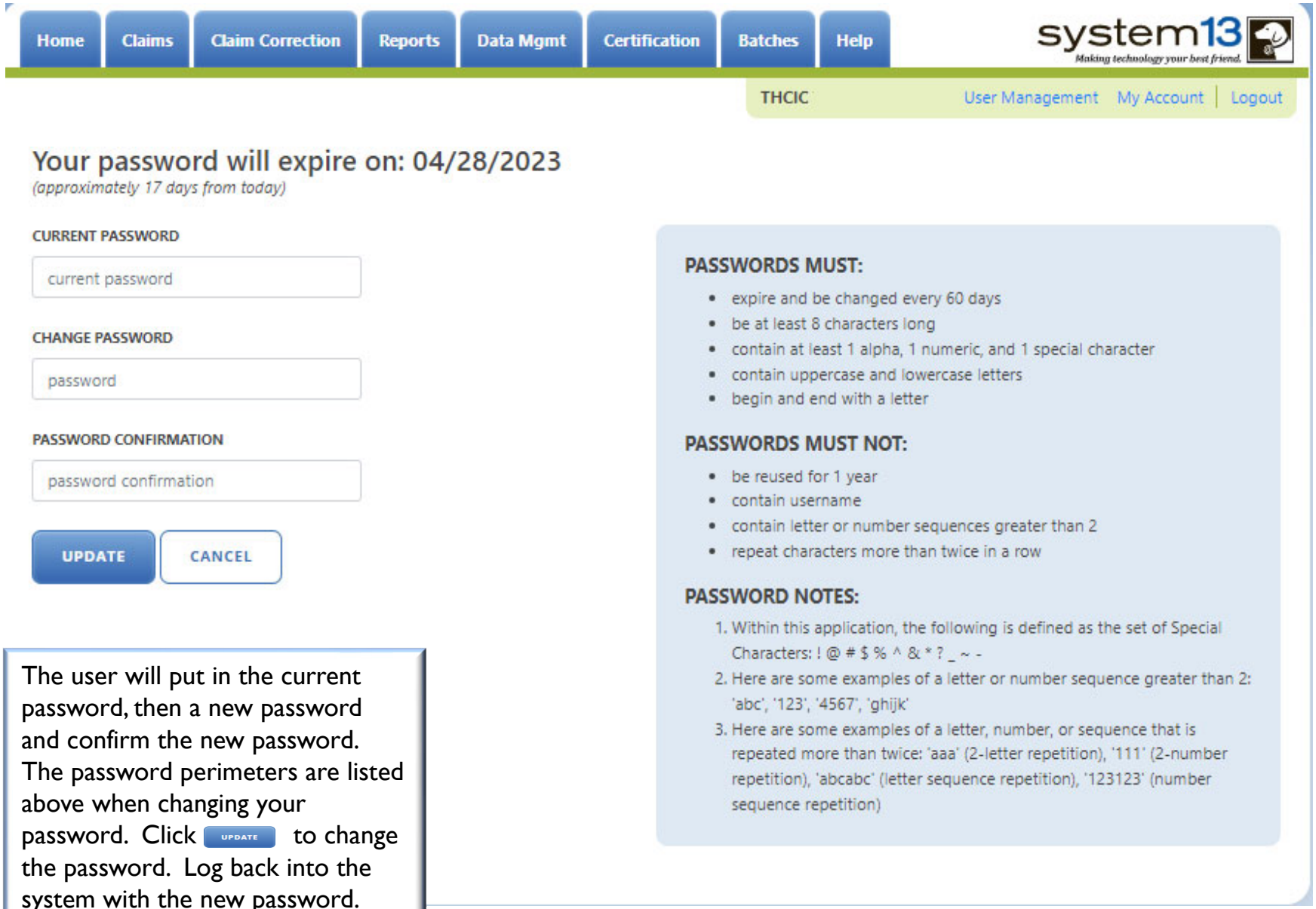
# User Management – Lock Features




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




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

# Password Process

**PASSWORDS MUST:**

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

**PASSWORDS MUST NOT:**

- be reused for 1 year
- contain username
- contain letter or number sequences greater than 2
- repeat characters more than twice in a row

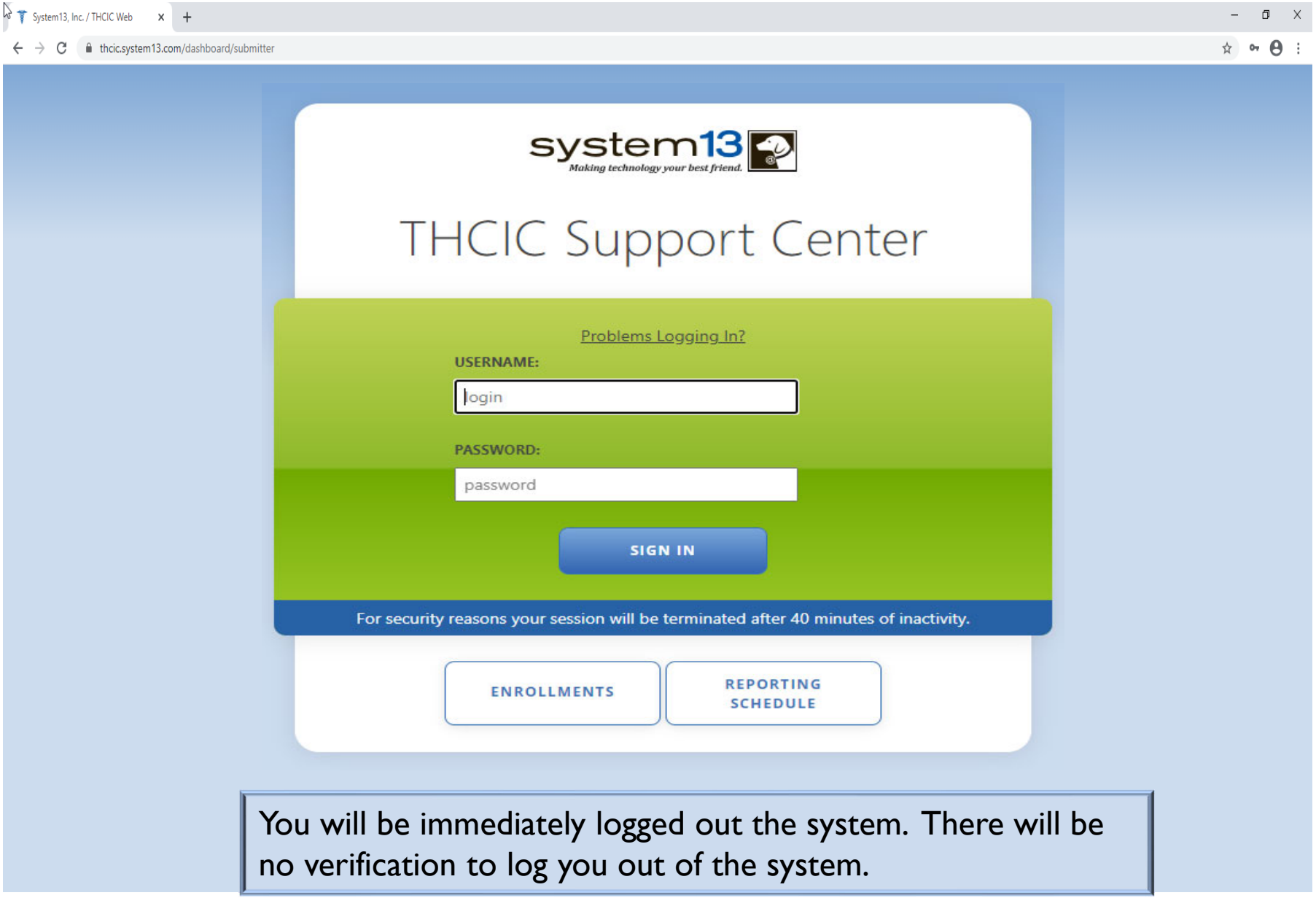
**PASSWORD NOTES:**

1. Within this application, the following is defined as the set of Special Characters: ! @ # $ % ^ & * ? _ ~ -
2. Here are some examples of a letter or number sequence greater than 2: 'abc', '123', '4567', 'ghijk'
3. Here are some examples of a letter, number, or sequence that is repeated more than twice: 'aaa' (2-letter repetition), '111' (2-number repetition), 'abcabc' (letter sequence repetition), '123123' (number sequence repetition)

# 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.**

# Outpatient Web Claim Training

- Data Reporting Schedule
- System Feature
- Web Claim Entry
  - Submitting claims manually using 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 | Q4 2023 | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 |
|---|---|---|---|---|---|---|---|
| Cutoff for initial submission | 3-1-24 | 6-3-24 | 9-2-24 | 12-2-24 | 3-3-25 | 6-2-25 | 9-1-25 |
| Cutoff for corrections | 5-1-24 | 8-1-24 | 11-1-24 | 2-3-25 | 5-1-25 | 7-15-25 | 10-15-25 |
| Facilities retrieve certification files | 6-3-24 | 9-2-24 | 12-2-24 | 3-3-25 | 6-2-25 | 9-1-25 | 12-1-25 |
| Certification/ comments due | 7-15-24 | 10-15-24 | 1-15-25 | 4-15-25 | 7-15-25 | 10-1-25 | 1-2-26 |

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 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.

This email will only be sent to facilities that have a 100% accuracy rate on the date of initial submission. This 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.**

**Generate Quarter Cert. Data (EOD)**

# Various Options for Entering Web Claim

- You can enter Web Claim from:
  - Provider Home page – click

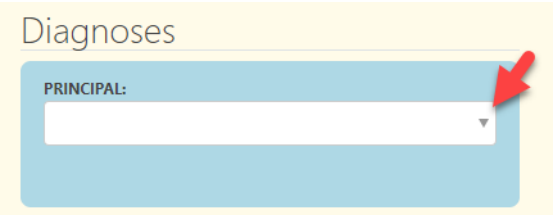
  -

 Listing – click

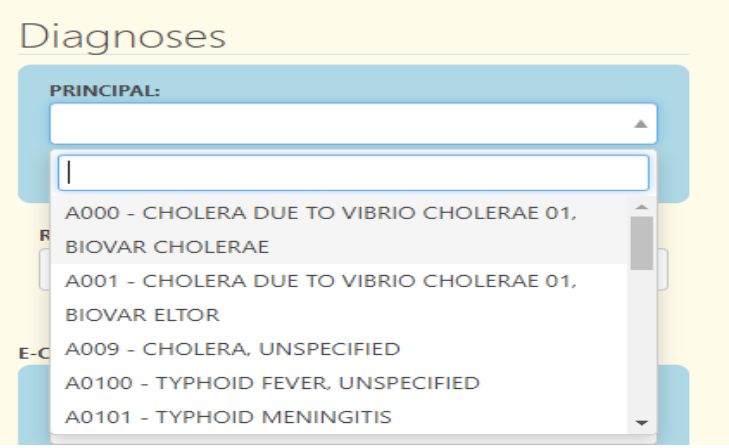
  - To continue a claim in process click

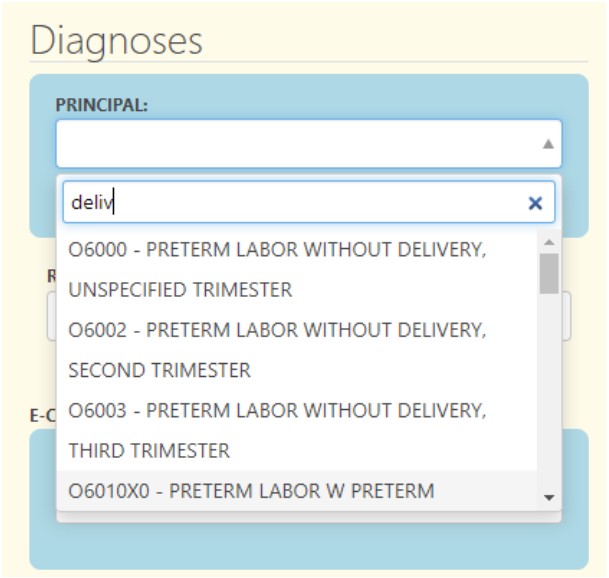
# Dropdown Lists

- **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**

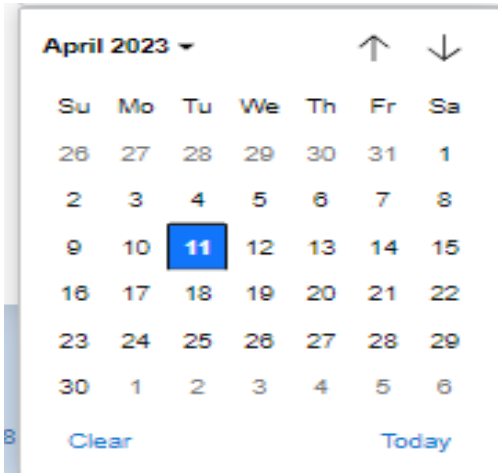
**when the highlighted selection is on the correct choice.**

- **Press TAB**

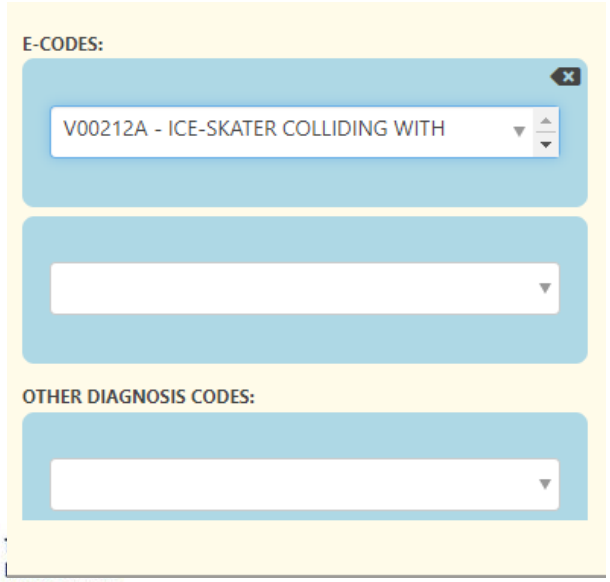
**to move to the next field on the screen.**

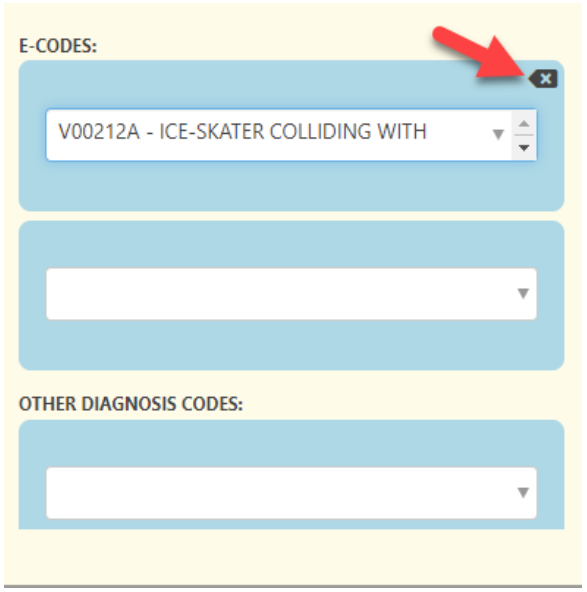
# Calendars/ Adding or Deleting Choices

- **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.**



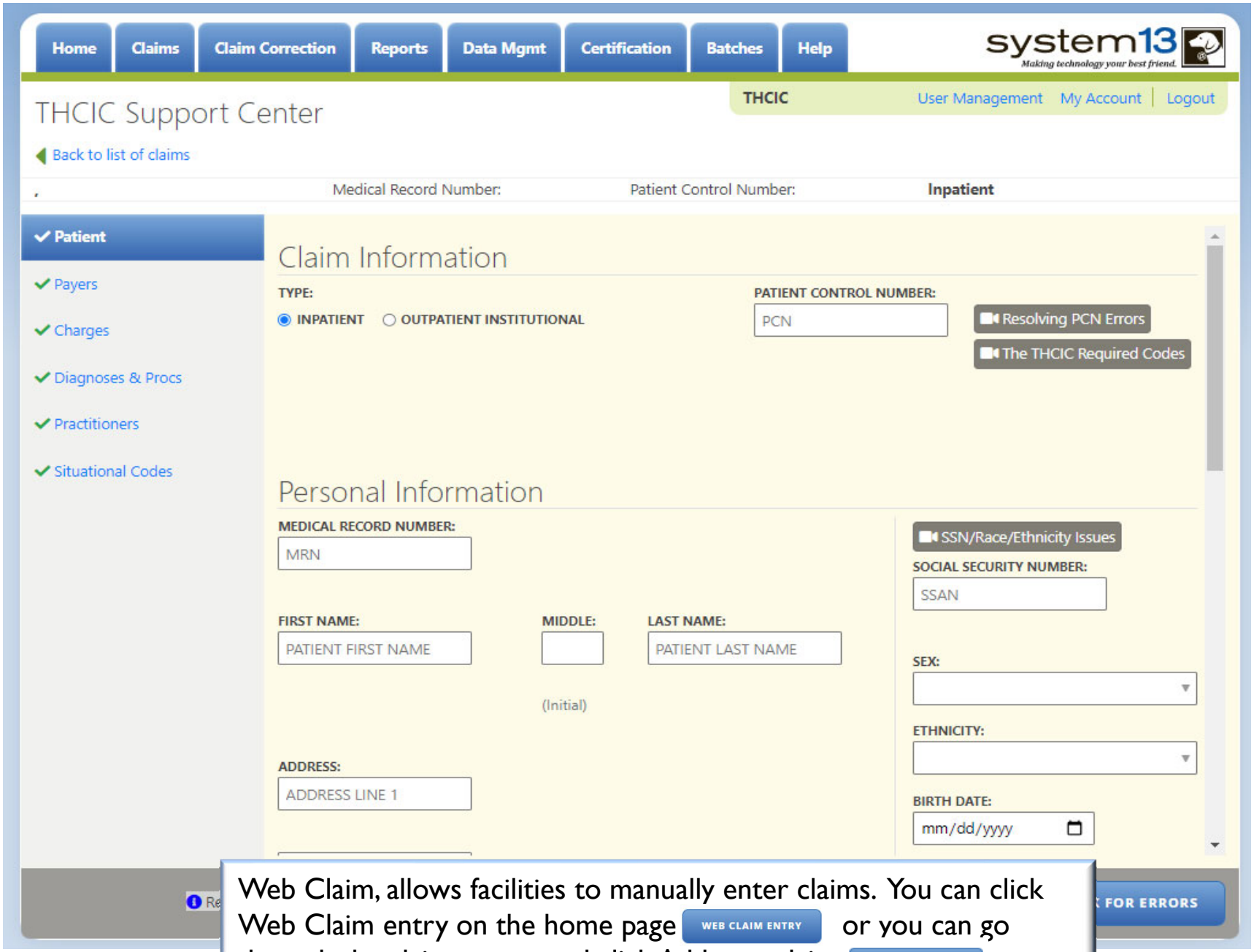



# Web Claim Entry

WEB CLAIM ENTRY

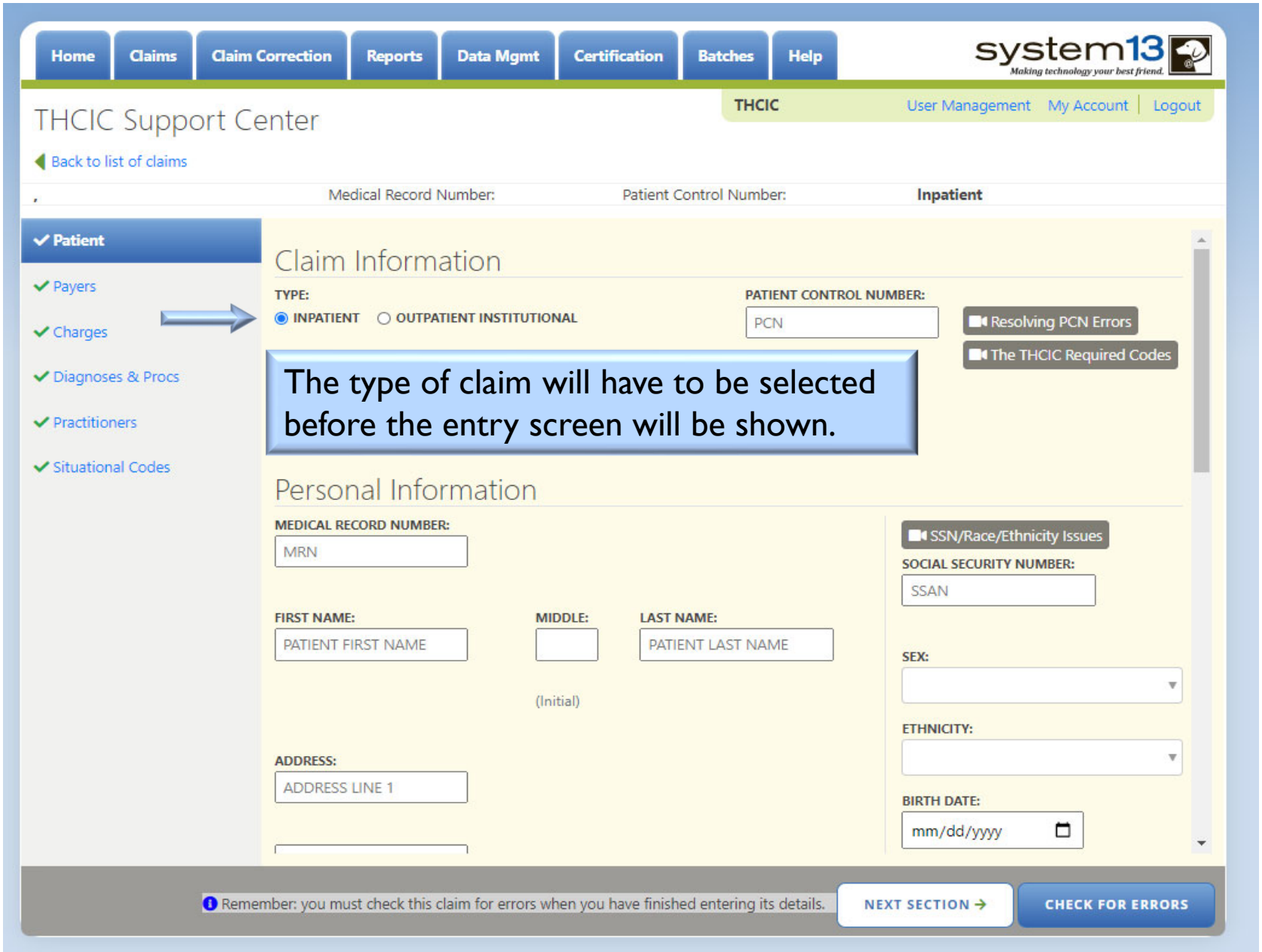
ADD NEW CLAIM

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

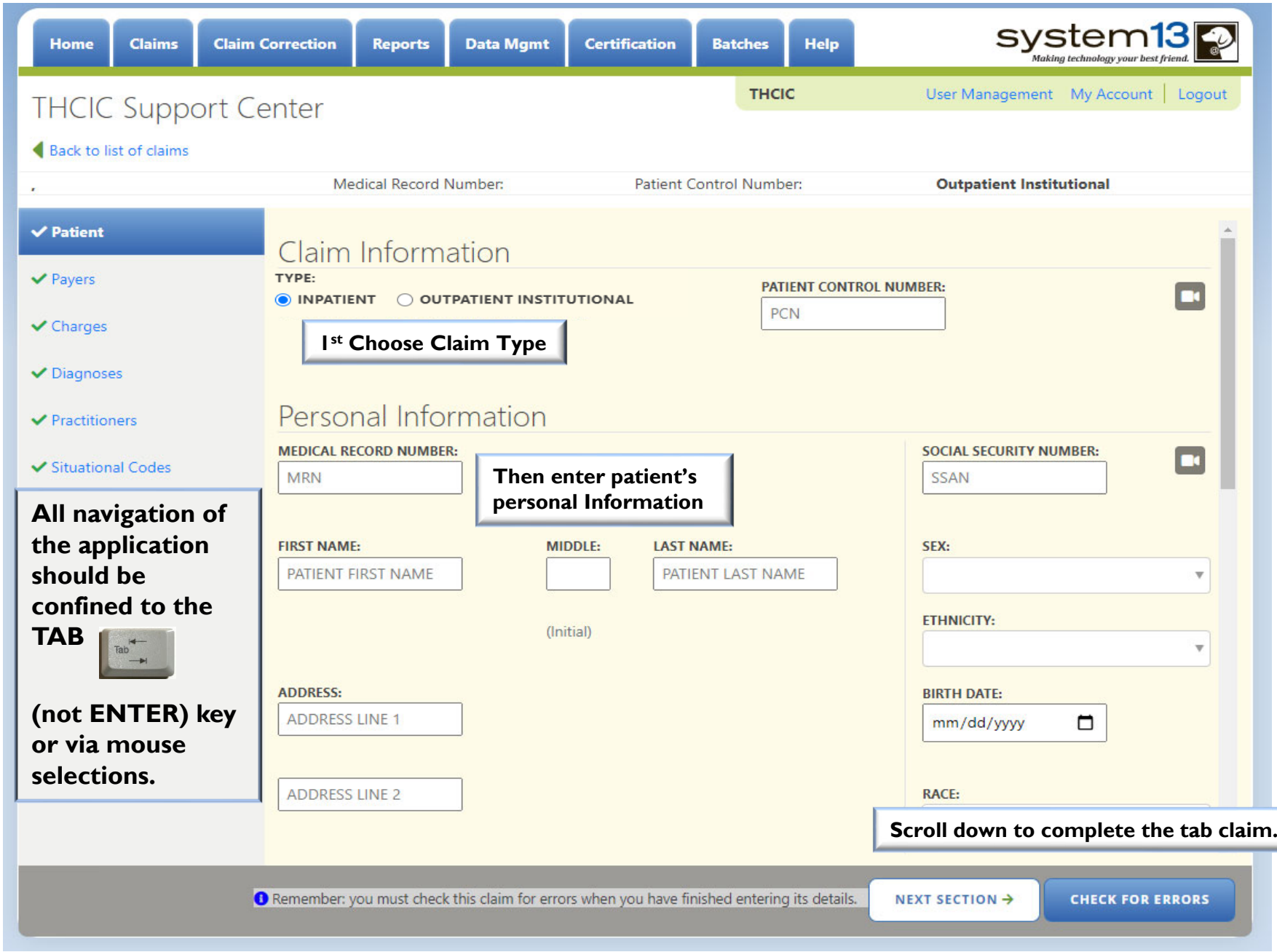



Web Claim, allows facilities to manually enter claims. You can click Web Claim entry on the home page WEB CLAIM ENTRY or you can go through the claims menu and click Add new claim ADD NEW CLAIM

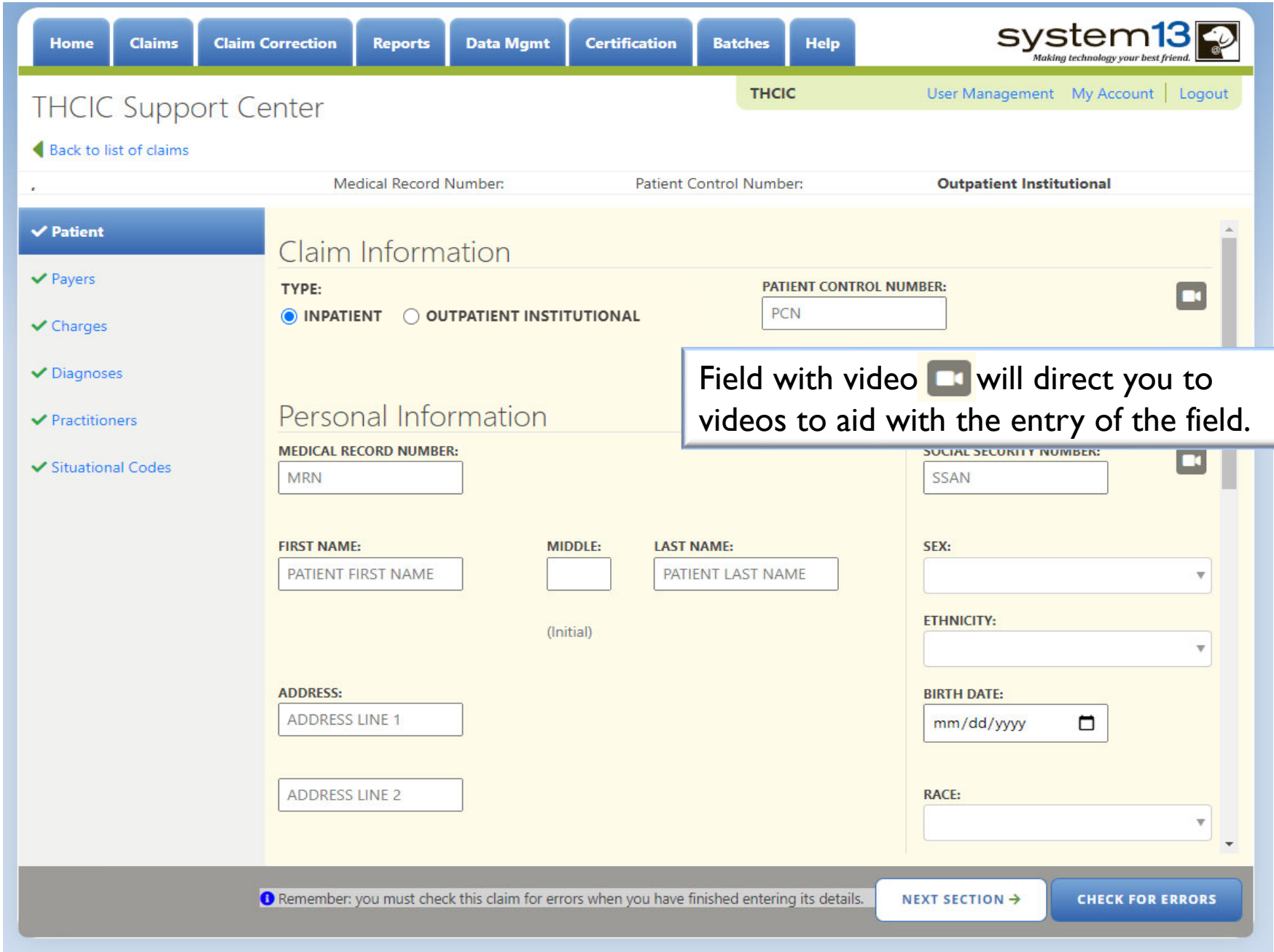
# Patient Tab


Home
Claims
Claim Correction
Reports
Data Mgmt
Certification
Batches
Help
system13
Making technology your best friend.
THCIC
User Management
My Account
Logout
THCIC Support Center
Back to list of claims
Medical Record Number:
Patient Control Number:
Inpatient
Patient
Payers
Charges
Diagnoses & Procs
Practitioners
Situational Codes
Claim Information
TYPE:
INPATIENT
OUTPATIENT INSTITUTIONAL
PATIENT CONTROL NUMBER:
PCN
Resolving PCN Errors
The THCIC Required Codes
The type of claim will have to be selected before the entry screen will be shown.
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:
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

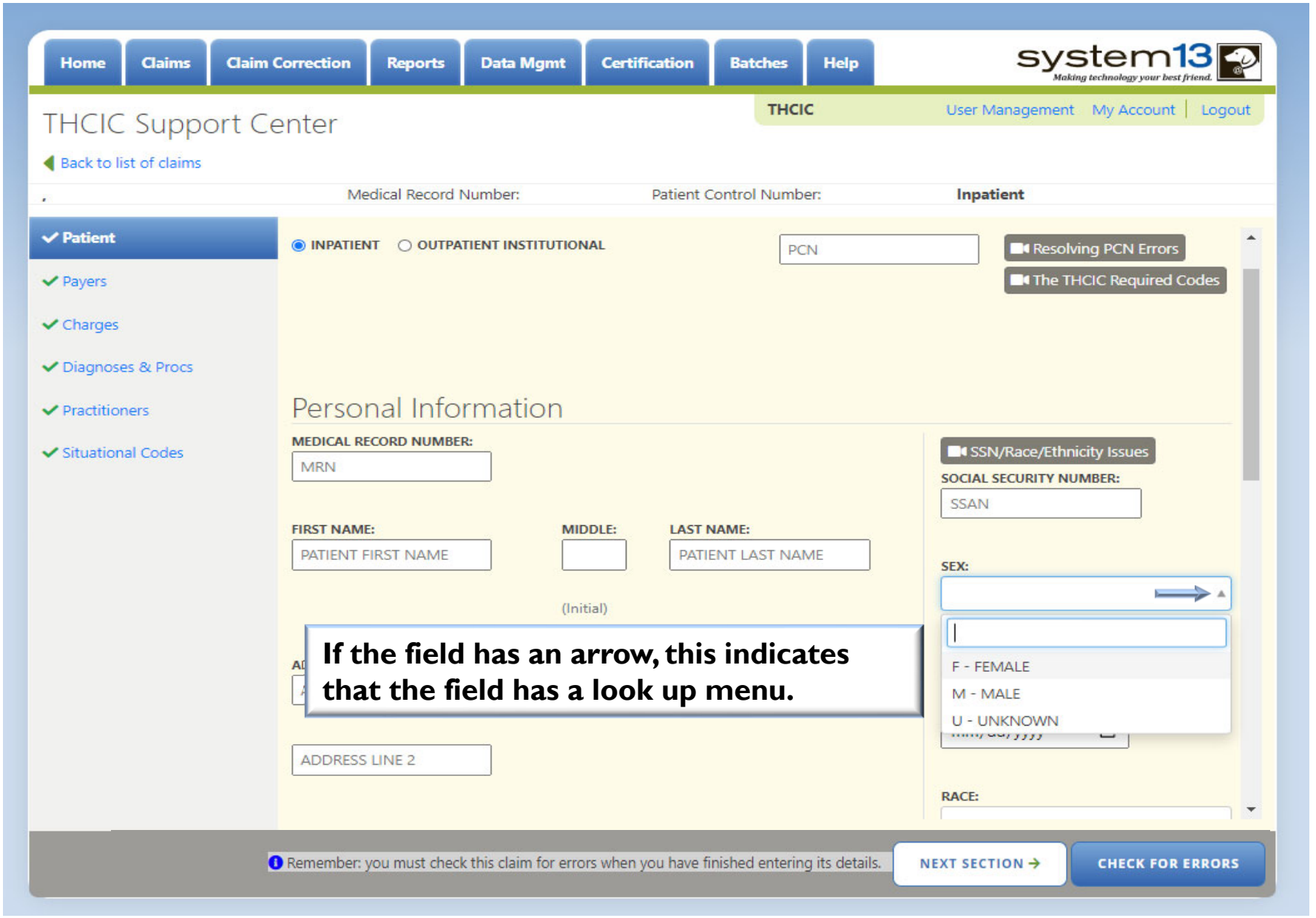
# Patient Tab


Home
Claims
Claim Correction
Reports
Data Mgmt
Certification
Batches
Help
system13
Making technology your best friend.
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:
INPATIENT
OUTPATIENT INSTITUTIONAL
PATIENT CONTROL NUMBER:
PCN
1st Choose Claim Type
Personal Information
MEDICAL RECORD NUMBER:
MRN
Then enter patient's personal Information
SOCIAL SECURITY NUMBER:
SSAN
FIRST NAME:
PATIENT FIRST NAME
MIDDLE:
LAST NAME:
PATIENT LAST NAME
SEX:
(Initial)
ETHNICITY:
ADDRESS:
ADDRESS LINE 1
BIRTH DATE:
mm/dd/yyyy
ADDRESS LINE 2
RACE:
All navigation of the application should be confined to the TAB
(not ENTER) key or via mouse selections.
Scroll down to complete the tab claim.
Remember: you must check this claim for errors when you have finished entering its details.
NEXT SECTION
CHECK FOR ERRORS

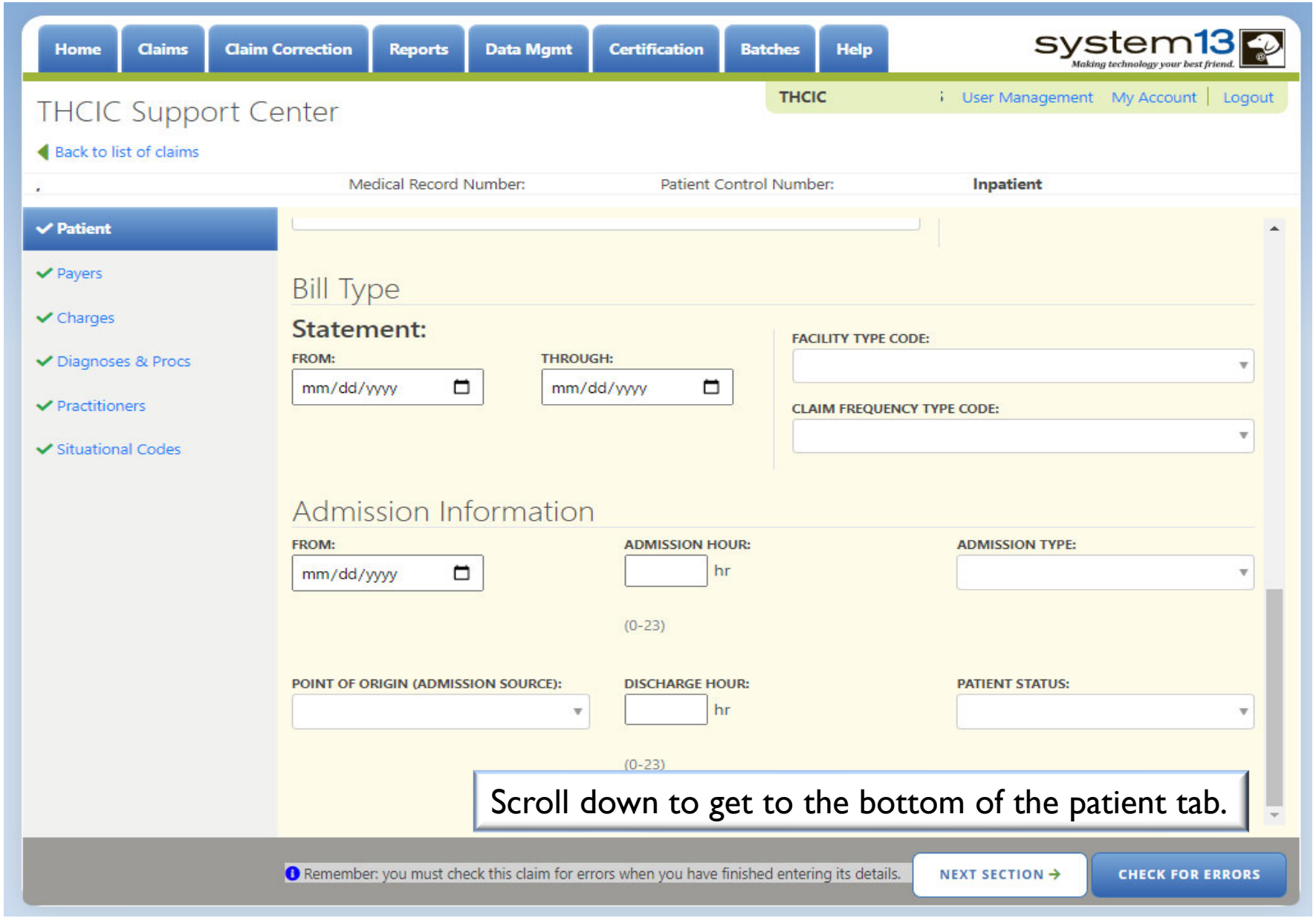
# Patient Tab


Home
Claims
Claim Correction
Reports
Data Mgmt
Certification
Batches
Help
system13
Making technology your best friend.
THCIC
User Management
My Account
Logout
THCIC Support Center
Back to list of claims
Medical Record Number:
Patient Control Number:
Outpatient Institutional
Patient
Payers
Charges
Diagnoses
Practitioners
Situational Codes
Claim Information
TYPE:
INPATIENT
OUTPATIENT INSTITUTIONAL
PATIENT CONTROL NUMBER:
PCN
Field with video will direct you to videos to aid with the entry of the field.
Personal Information
MEDICAL RECORD NUMBER:
MRN
SOCIAL SECURITY NUMBER:
SSAN
FIRST NAME:
PATIENT FIRST NAME
MIDDLE:
(Initial)
LAST NAME:
PATIENT LAST NAME
SEX:
ETHNICITY:
ADDRESS:
ADDRESS LINE 1
ADDRESS LINE 2
BIRTH DATE:
mm/dd/yyyy
RACE:
Remember: you must check this claim for errors when you have finished entering its details.
NEXT SECTION
CHECK FOR ERRORS

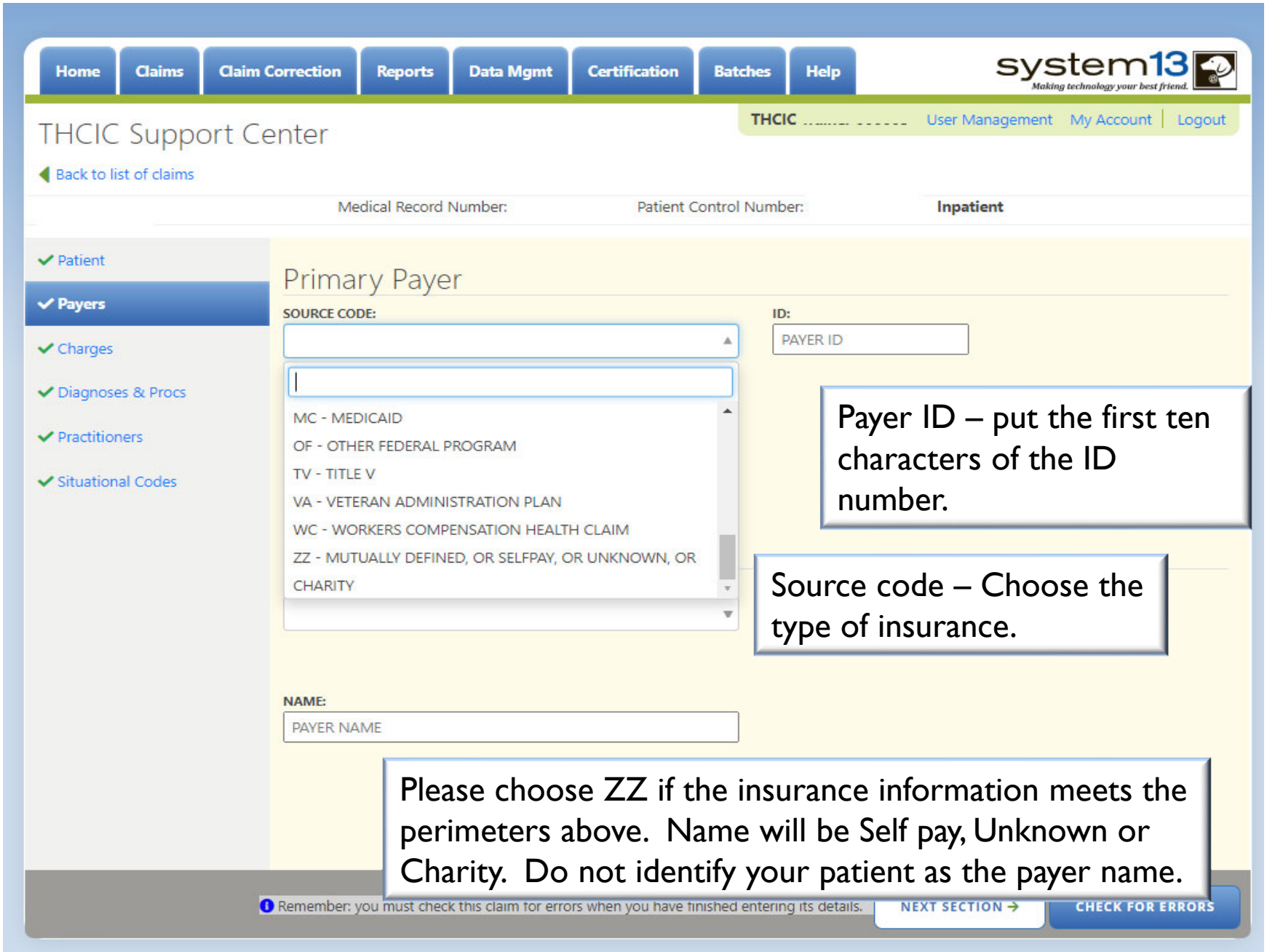
# Entering Claim Information



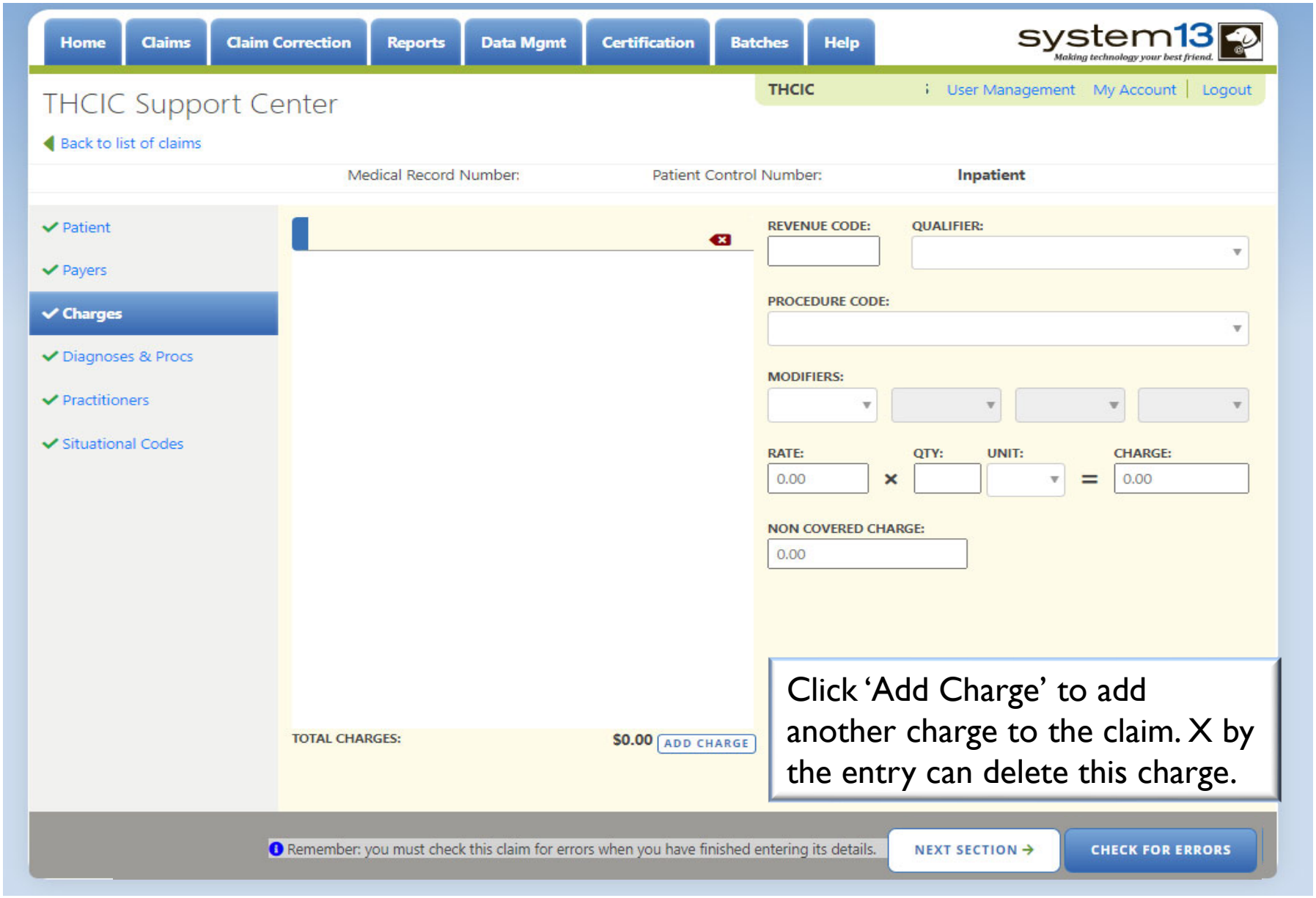
# Patient Tab


Home
Claims
Claim Correction
Reports
Data Mgmt
Certification
Batches
Help
system13
Making technology your best friend.
THCIC Support Center
THCIC
User Management
My Account
Logout
Back to list of claims
Medical Record Number:
Patient Control Number:
Inpatient
Patient
Payers
Charges
Diagnoses & Procs
Practitioners
Situational Codes
Bill Type
Statement:
FROM:
mm/dd/yyyy
THROUGH:
mm/dd/yyyy
FACILITY TYPE CODE:
CLAIM FREQUENCY TYPE CODE:
Admission Information
FROM:
mm/dd/yyyy
ADMISSION HOUR:
hr
(0-23)
ADMISSION TYPE:
POINT OF ORIGIN (ADMISSION SOURCE):
DISCHARGE HOUR:
hr
(0-23)
PATIENT STATUS:
Scroll down to get to the bottom of the patient tab.
Remember: you must check this claim for errors when you have finished entering its details.
NEXT SECTION →
CHECK FOR ERRORS

# Payer Tab


Home
Claims
Claim Correction
Reports
Data Mgmt
Certification
Batches
Help
system13
Making technology your best friend.
THCIC Support Center
THCIC
User Management
My Account
Logout
Back to list of claims
Medical Record Number:
Patient Control Number:
Inpatient
Patient
Payers
Charges
Diagnoses & Procs
Practitioners
Situational Codes
Primary Payer
SOURCE CODE:
ID:
PAYER ID
MC - MEDICAID
OF - OTHER FEDERAL PROGRAM
TV - TITLE V
VA - VETERAN ADMINISTRATION PLAN
WC - WORKERS COMPENSATION HEALTH CLAIM
ZZ - MUTUALLY DEFINED, OR SELFPAY, OR UNKNOWN, OR CHARITY
NAME:
PAYER NAME
Payer ID – put the first ten characters of the ID number.
Source code – Choose the type of insurance.
Please choose ZZ if the insurance information meets the perimeters above. Name will be Self pay, Unknown or Charity. Do not identify your patient as the payer name.
Remember: you must check this claim for errors when you have finished entering its details.
NEXT SECTION
CHECK FOR ERRORS

# Charges Tab


Home
Claims
Claim Correction
Reports
Data Mgmt
Certification
Batches
Help
system13
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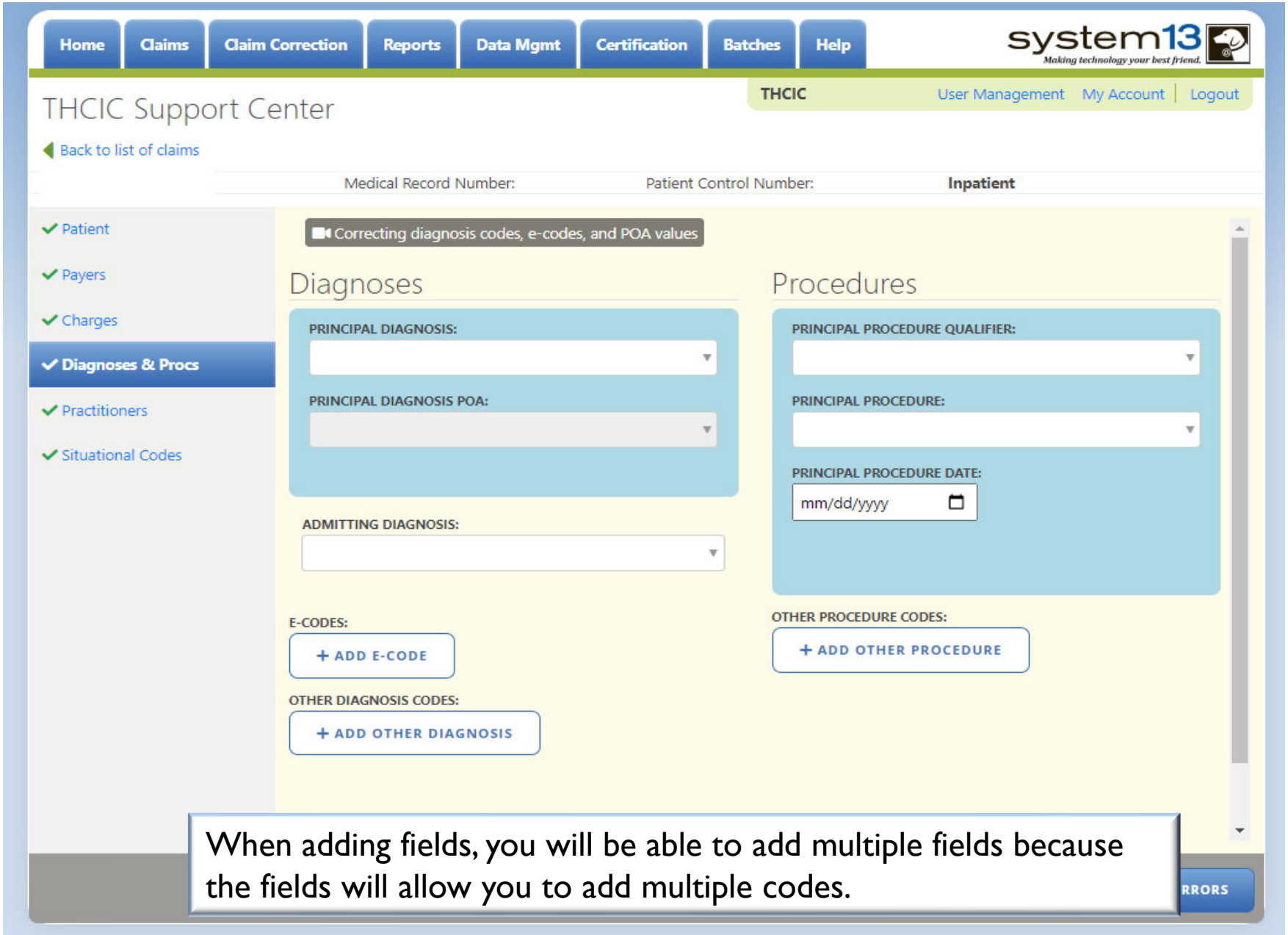
THCIC Support Center
THCIC
User Management
My Account
Logout
Back to list of claims
Medical Record Number:
Patient Control Number:
Inpatient
Patient
Payers
Charges
Diagnoses & Procs
Practitioners
Situational Codes
REVENUE CODE:
QUALIFIER:
PROCEDURE CODE:
MODIFIERS:
RATE:
QTY:
UNIT:
CHARGE:
0.00
0.00
NON COVERED CHARGE:
0.00
TOTAL CHARGES:
$0.00
ADD CHARGE
Click 'Add Charge' to add another charge to the claim. X by the entry can delete this charge.
Remember: you must check this claim for errors when you have finished entering its details.
NEXT SECTION
CHECK FOR ERRORS

# Diagnosis & Procedure Tab



# Present on Admission (POA)

POA data is required on inpatient data for acute care facilities as determined by the facility type. The list for Hospitals to verify POA status, either yes (required) or no (not required) can be found at https://www.dshs.state.tx.us/thcic/hospitals/FacilityList.xls

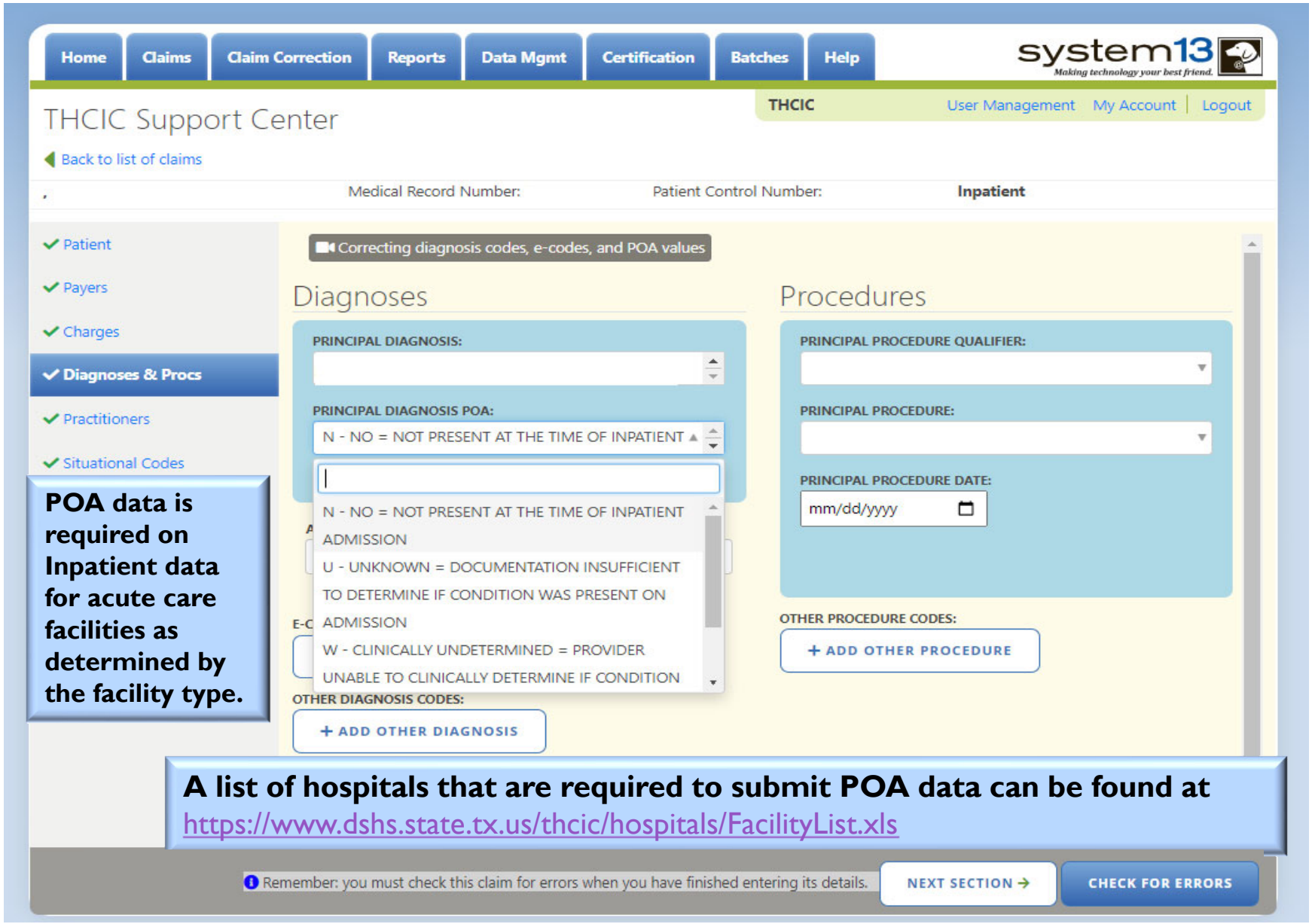
If a non-exempt hospital doesn't send POA indicators for the corresponding diagnosis fields, the claim will be marked as an error.

Exempt hospitals can also send POA data. Please be advised if an exempt facility sends POA data the POA data must be valid, otherwise, the claim(s) will show the corresponding field(s) in error.

Specifications for POA data can be found in the Technical Specifications for Inpatient Data in https://www.dshs.state.tx.us/thcic/hospitals/TechReqSpec5010_Inpatient_THCIC837.pdf

**POA data is NOT required for outpatient data.**

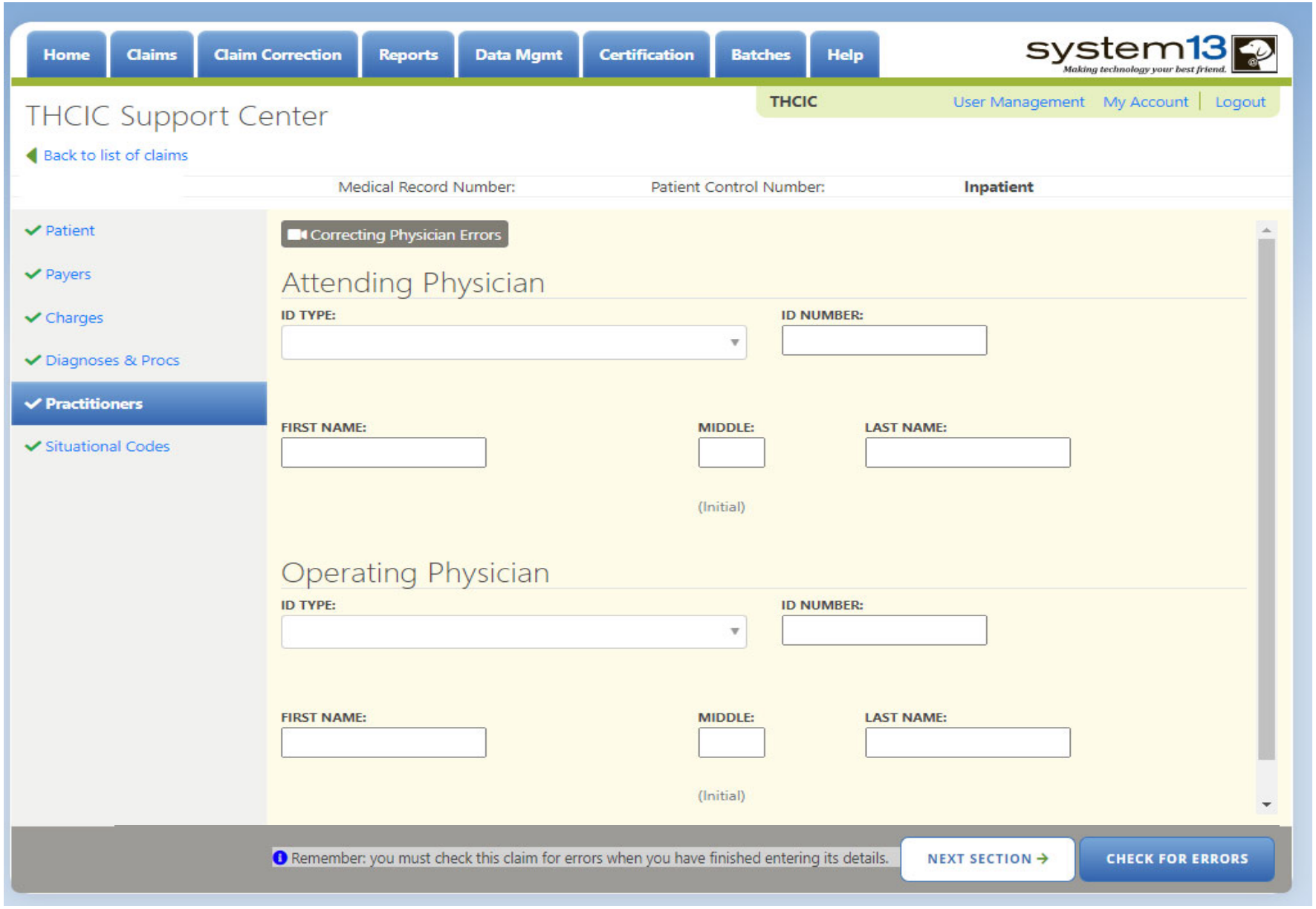
# Diagnosis & Procedure Tab



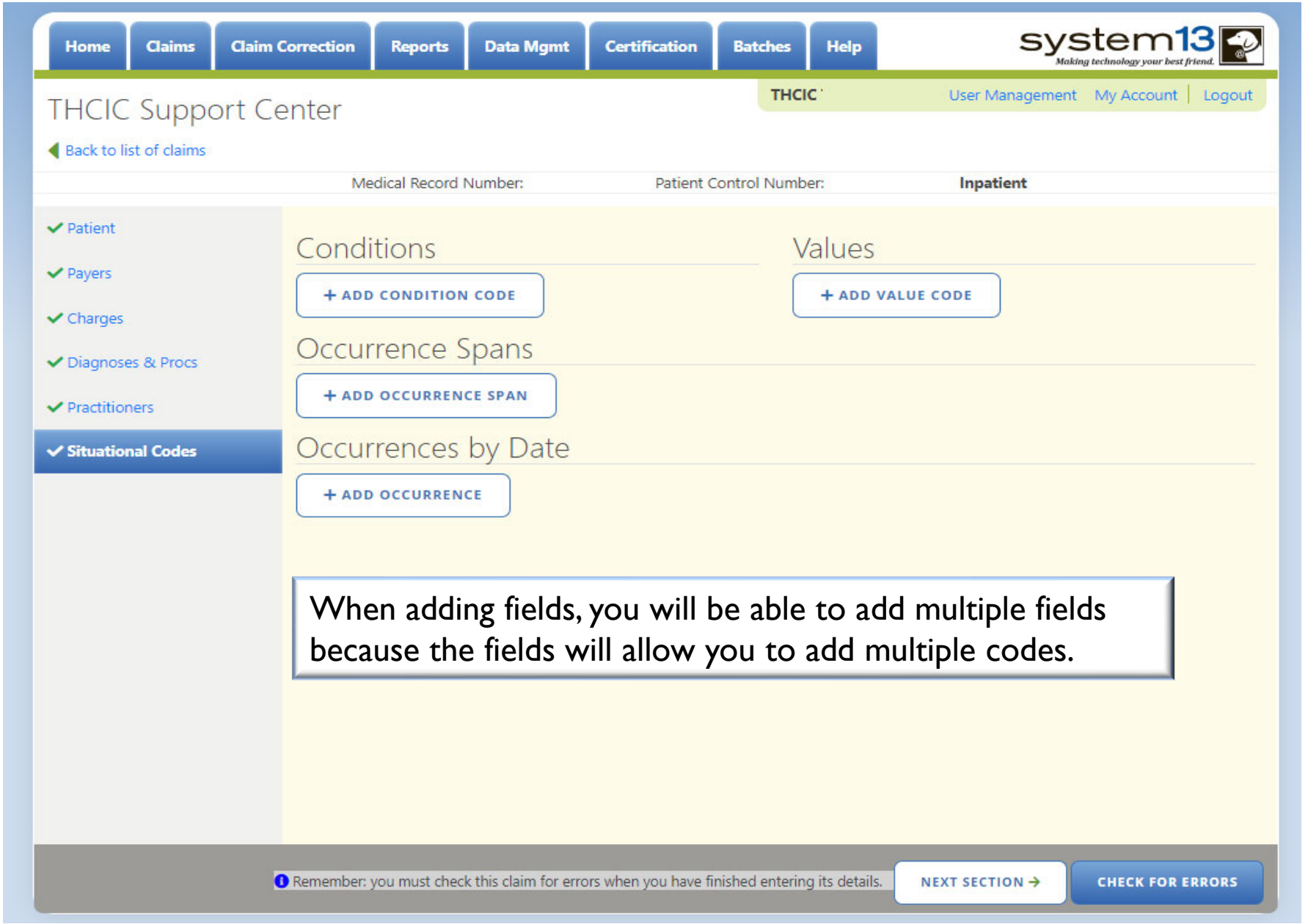

**POA data is required on Inpatient data for acute care facilities as determined by the facility type.**

**A list of hospitals that are required to submit POA data can be found at** https://www.dshs.state.tx.us/thcic/hospitals/FacilityList.xls

# Practitioners Tab

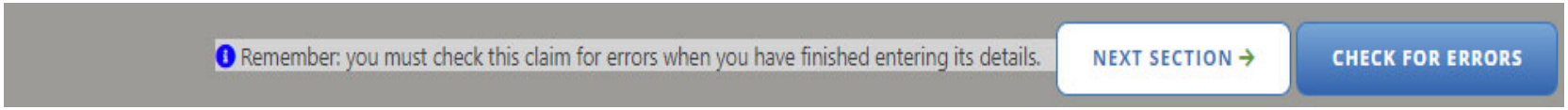


# Situational Codes Tab

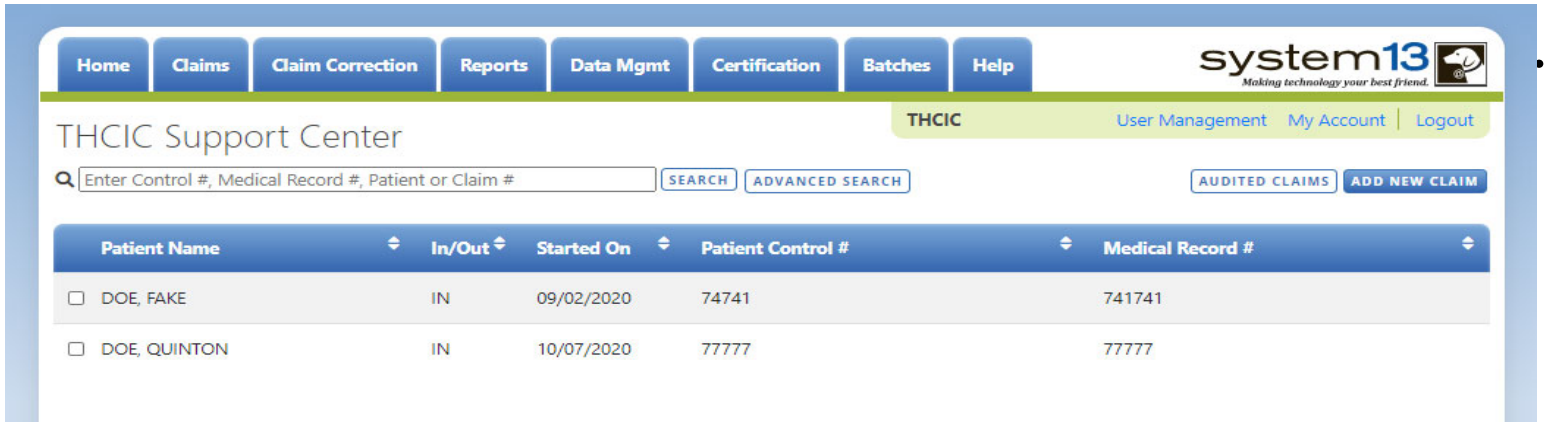


# Check for Errors/ Submitting Your Claim

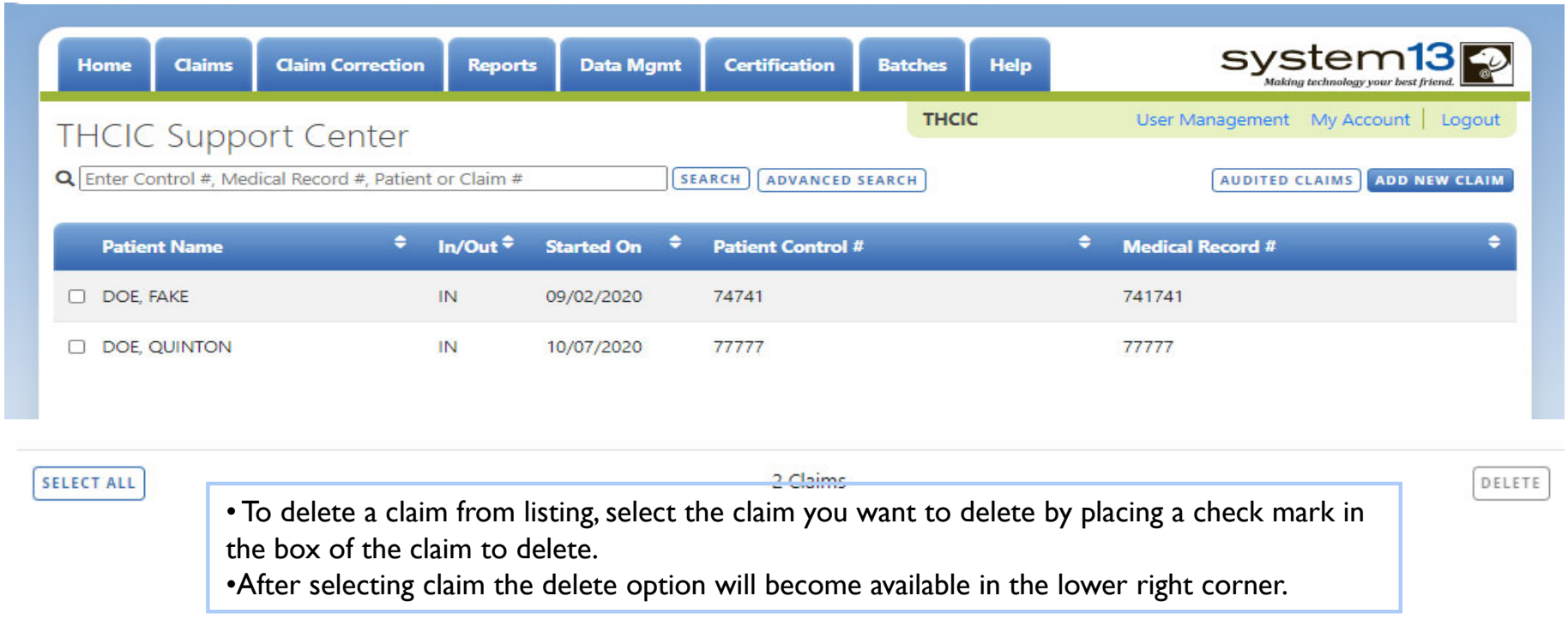
- The claims are automatically saved.
- You must click "check for errors" to submit claims entered in the system. The claims will be checked for errors and submitted.



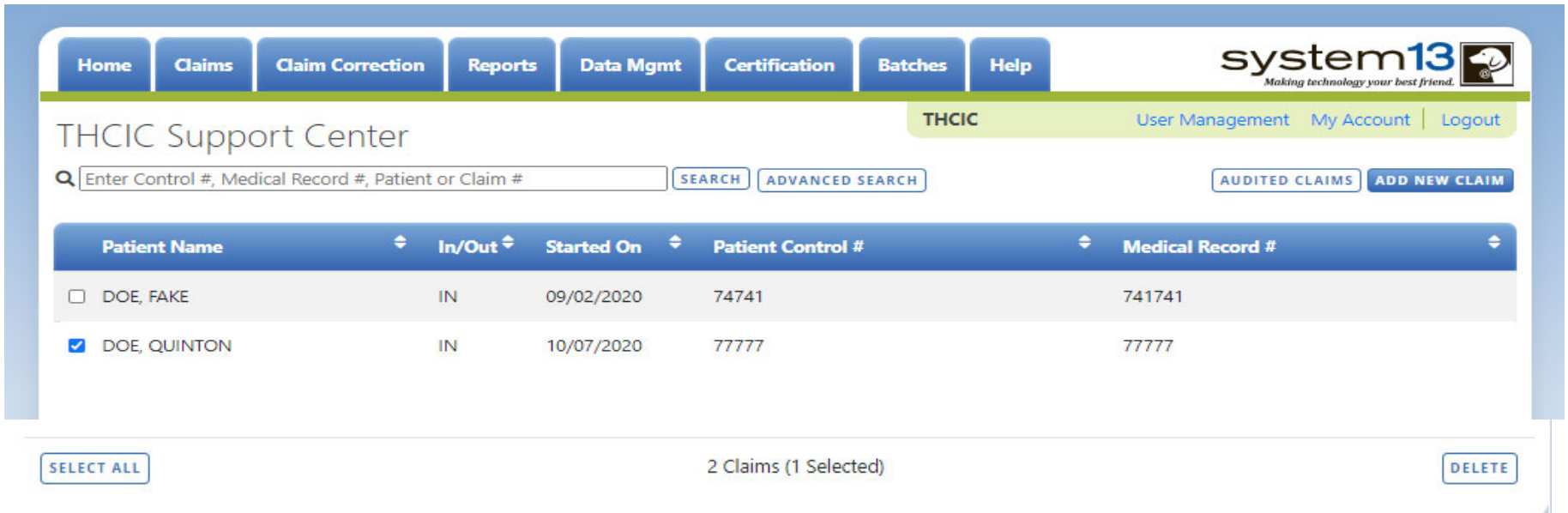

- If you do not "check for errors" the claim, it will go to new claims in progress through the claims tab, NEW CLAIMS IN PROGRESS .



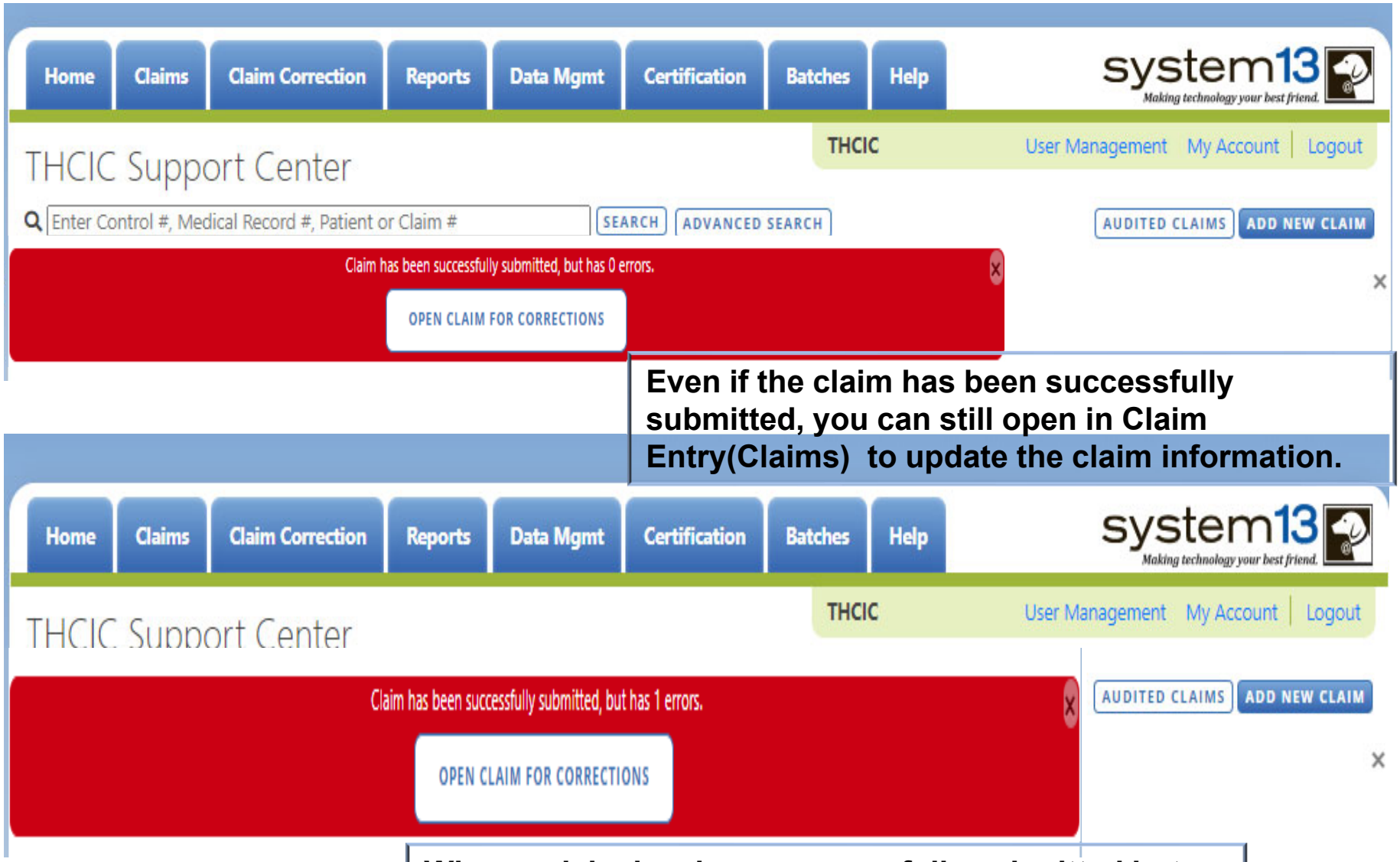
# Options…Delete Claim(s)



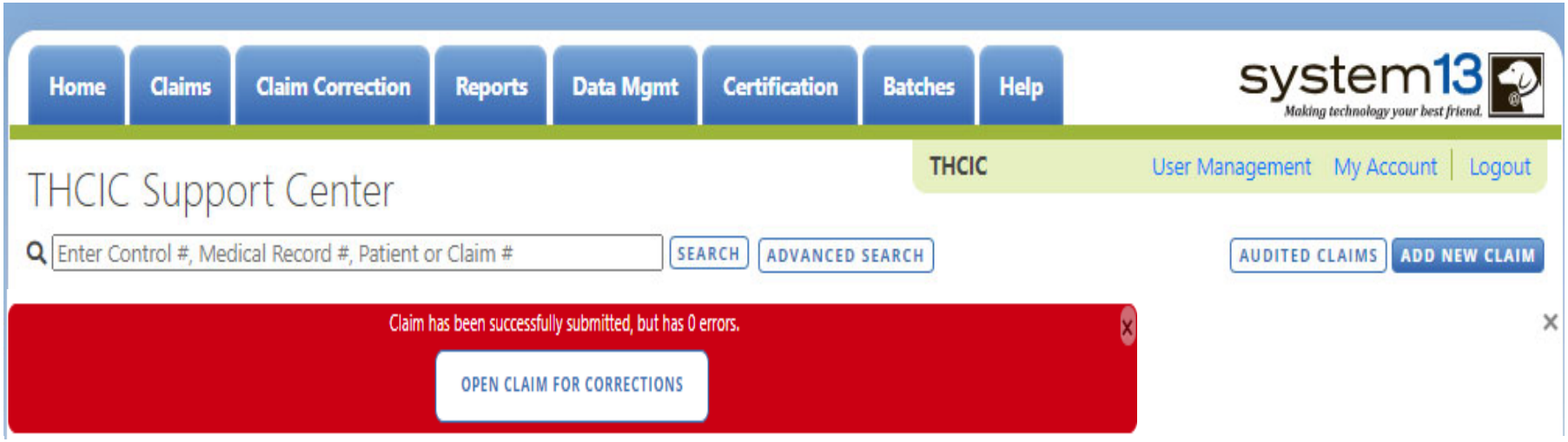

- To delete a claim from listing, select the claim you want to delete by placing a check mark in the box of the claim to delete.
- After selecting claim the delete option will become available in the lower right corner.



# Claim Successfully Submitted …Claim Submitted with Errors



# 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.

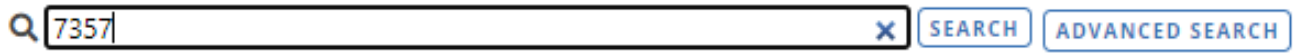
The user can click AUDITED CLAIMS and will be taken to the Claim Correction listing.

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

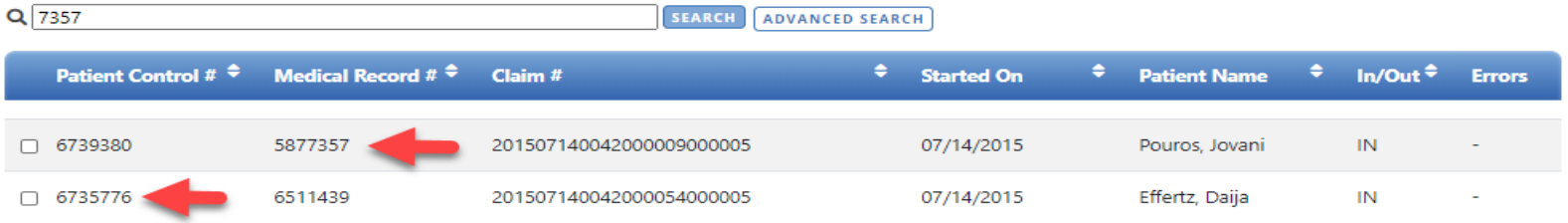
# Options…Search for Claims

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

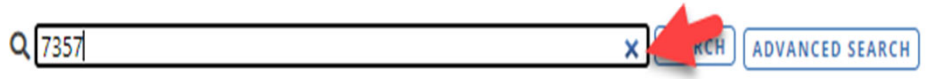
- Type in your search request.



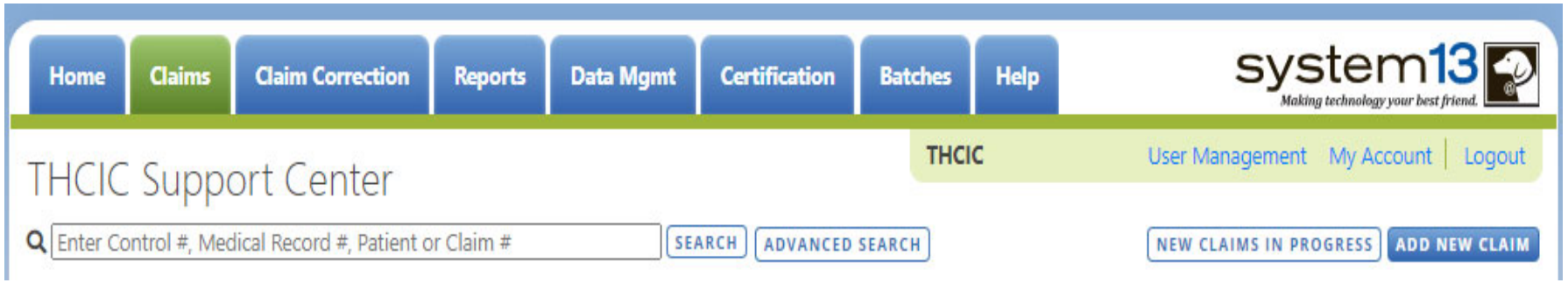

- Click search to sort your listing by search criteria requested.



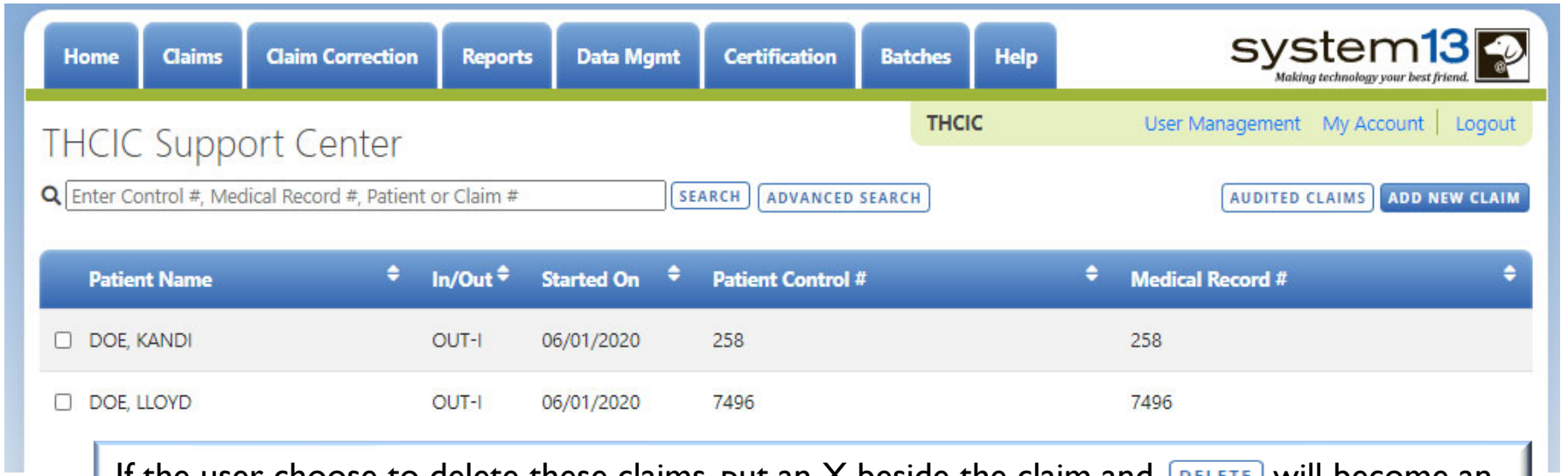

- Click clear to return to the unfiltered list of claims click the X.



# Incomplete (Saved) Claims
# New Claims in Progress




If the user does not click "check for errors" the claim is still 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 or if the user chooses 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.

# Inpatient Claim Entry

## Questions/ Comments

Questions, comments or need clarification please e-mail
thcichelp@dshs.state.tx.us
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.state.tx.us**

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

# THCIC Contact

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

- Contact Dee Roes at email Dee.Roes@dshs.state.tx.us if submitter test/production files reject due to a submission address or EIN/NPI number.

- For general questions or to request information about THCIC please e-mail to thcichelp@dshs.state.tx.us.

system13
Formerly Commonwealth Clinical Systems and Computer Services

# 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