Texas All-Payor Claims Database

Data Submission Guide

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1.0. Document Version History

VERSION HISTORY		
Version Number	**Date Published**	**Summary of Revisions**
01.05	01/10/2022	Initial draft for review along with the publication of the formal regulations review.
01.08	01/21/2022	Ongoing modifications prior to publication for public comment.
01.09	06/10/2022	Additional clarifications as per stakeholder comments and TDI final rulemaking. Added section headers and rule section cross reference; CARC code appendix.
2025.01	01/21/2025	Consolidation of Errata (1.0.9) and guidance for implementation of version 3.0.1 of the CDL.

2.0. Background

The 87th Texas Legislature enacted House Bill 2090, which became effective on September 1, 2021, and provides for the creation of a Texas All-Payor Claims Database (TX-APCD) to be developed and administered within The University of Texas Health Science Center at Houston (UTHealth Houston) and UTHealth School of Public Health (SPH) Center for Health Care Data (CHCD). The database is designed to increase transparency of health care information to the public and improve the quality of health care in the state of Texas. Consistent with this stated purpose the CHCD may produce statewide, regional, and geozip consumer reports available through a public access portal that addresses:

(a) health care costs, quality utilization, outcomes, and disparities;
(b) population health; or
(c) the availability of health care services.

Furthermore, the data may be used for research and other analysis conducted by the CHCD or a qualified research entity for non-commercial purposes that are consistent with the stated purposes of the TX-APCD.

The rule adopted by the Texas Department of Insurance (TDI) at 28 Texas Administrative Code §§21.5401–5406, concerning the TX-APCD, identifies compliance requirements for submitters. The regulations are directly related to the details within this Data Submission Guide.

2.1. The Center for Health Care Data at UTHealth Houston

The CHCD at UTHealth Houston is a Centers for Medicare and Medicaid Services (CMS) Certified Qualified Entity (QE) with proven expertise in the collection, management, and analysis of administrative claims data and adjacent health care data. The CHCD has been certified by CMS as meeting its rigorous requirements for data privacy and security. The CHCD is a non-profit entity, operating within UTHealth SPH. It is independent from all

provider organizations and health plans and maintains a mission of data informing policy and driving value in health care outcomes. For more information on the TX-APCD or the UTHealth Houston CHCD, visit the website at https://go.uth.edu/txapcd.

2.2. Data Submission Guide

This Data Submission Guide is provided as reference for payors submitting data to the TX-APCD. The Data Submission Guide addresses key operational issues and provides background and overall guidance to data submitters. Accompanying this Data Submission Guide is the TX-APCD Common Data Layout (CDL), which lists the specific data requirements, and is modeled after the APCD-CDL© established by the National Association of Health Data Organizations. Required data elements are included based on their usefulness to contribute to analysis and research relevant to health policy makers, employers, and consumers for purposes of improving health care quality and outcomes, improving population health, and controlling health care costs.

The goal of the TX-APCD is to have a standardized dataset across payors so that it can be integrated for the purpose of public reporting and research. The TX-APCD CDL sets forth the record specifications, data elements, definitions, code tables, and edit specifications for payor submission of member enrollment/eligibility data files, medical, dental, and pharmacy claims and encounters data files, and provider files to the database. The Data Submission Guide summarizes the required schedules, data file format, data collection procedures, and other details related to how data payors may submit data.

2.3. Technical Guide

The Technical Guide is intended to address the technical aspects of connecting data submitters and associated users to the Texas Advanced Computing Center's (TACC's) computing resources, thereby enabling the submission of data to the TX-APCD.

Topics covered in the Technical Guide include:

(a) how to register your organization with the TX-APCD

(b) how to obtain a submitter identity and encryption key

(c) how to obtain a TX-APCD user account

(d) how to create and prepare data file packages for submission

(e) how to submit data file packages using one of the three submission methods

(f) samples of what the data files should look like

(g) how to subscribe to system notifications

(h) if necessary, how to resubmit a file package to correct errors from a previous submission

2.4. Submitters

The rule adopted by TDI in Title 28 of the Texas Administrative Code identifies the required submitters. Two classes of submitters are identified below.

2.4.1. Required Submitters

The regulation identifies required submitters at 28 Texas Administrative Code §21.504.

2.4.2. Voluntary Submitters

A payor that acts as an administrator on behalf of a health benefit plan or dental plan for which reporting is optional per Insurance Code §38.407, concerning Certain Entities Not Required to Submit Data, may voluntarily participate and may include data for such plans within the payor's data submission. Payors not currently subject to required submission by rule, including those with Employee Retirement Income Security Act (ERISA) self-insured health plans may voluntarily contribute their data to the TX-APCD by requesting that their administrative service organization (ASO) or their third-party administrator (TPA) include their data in their submission. By including claims information, employers can identify ways to save costs and improve the health of their employees, while enhancing health care transparency for the benefit of all Texans. Additionally, 28 TAC §21.5401(b)(9) permits, but does not require, payors to submit data with respect to Medicare Supplement plans.

3.0. Payor Registration

Payors as associated partner organizations must register as submitters with the TX-APCD before being able to submit any data or submit any requests (i.e., exceptions or extensions) to the TX-APCD. Any requests for submission, exceptions and/or extensions, can only be addressed for organizations which are registered. The registration process is outlined in detail in Section 3 of the Technical Guide. Both the online (preferred) and offline (legacy) methods of registration are covered.

The registration process collects information in the following categories:

(a) Company information, including National Association of Insurance Commissioners (NAIC) group and company code
(b) Location information
(c) Business contact information
(d) Lines of business and associated business entities operating in the state of Texas
(e) Files to be submitted (eligibility/enrollment, provider, medical, pharmacy, dental)
(f) Number of covered lives in most recent calendar year
(g) Contact persons for submissions

3.1. General Requirements

Each applicable payor, or it's designee (e.g., ASO/TPA), must register with the TX-APCD prior to submitting any data files as follows:

(a) Submit a completed/updated TX-APCD registration request or renewal request by January 1st of every calendar year.
(b) Notify the TX-APCD via the submitter portal (https://txapcd.org) or via email within 30 days of any changes to any of the annual TX-APCD registration information.
(c) Notify the TX-APCD by email or on the registration site of any changes to the individual contact information submitted on the TX-APCD registration form as soon as possible, but no later than 30 days after a reassignment occurs.

Keep in mind that it could take up to 14 days for a request (new, renewal, change) to be processed. Please plan accordingly.

4.0. Data Submission Schedules

Historical claims data must be submitted encompassing reporting periods beginning January 2019 (201901) through the most recent reporting period. For ongoing data submission, the regulation requires that the payor provides data to the CHCD not less frequently than monthly.

Regular data submissions started July 2023, at which time data adjudicated in March 2023 (202303) was due. Each reporting period submission should include all data with an adjudication date within that month.

4.1. Testing

Submitters are required to test before starting regular monthly data submission. In addition, submitters are required to test when updated data validation rulesets go into effect. The TX-APCD will provide notice in advance of such ruleset changes and the period when the test environment will be available to support testing activities. Submitters are encouraged to take full advantage of technical support so as to avoid disruption in the flow of regular submissions, and to avoid resubmissions that might be required to make submission corrections.

Testing guidelines are addressed in Section 5 of the Technical Guide.

4.2. Submission Time Lag

At the time the TX-APCD became operational, there was a 3-month lag built into the submission schedule. For example, data adjudicated in 202303 was due by July 7, 2023. Note that the monthly submission window runs from the 1st to the 7th of the month each month, hence the due date of July 7, 2023. An update to the regulation in 2024 has reduced the lag from 3 months to 1 month. This means that data adjudicated in 202503

would be due by May 7, 2023. This change in the number of lag periods takes effect in the March 2025 submission window, during which time submitters are expected to make the two submissions required for "catch-up". Note that these are in addition to the regularly scheduled submission for that month.

4.3. Submissions Ahead of Schedule

Submissions are expected by the 7th calendar day of each month. However, early submissions are allowed, except when validation ruleset changes take effect on a specific date. Typically, when an update is made to the validation ruleset, it takes effect as of a specific date for production submissions and will apply to the regular submission expected at that time, and to all subsequent submissions. For example, if a validation ruleset will be deployed in production to take effect April 1st, it will apply to the submission expected at that time (February adjudicated data), and all submissions following that one. This is to ensure that there are well-defined time spans to which different versions of the validation ruleset is applicable across all submissions, thereby, making possible the versioning of the TX-APCD dataset.

4.4. Submission Schedule Effective March 1, 2025

Submitters can reference the regulation adopted by TDI as of November 8, 2024, at this location on TDI's website. Specifically, section §21.5405 on "Timing and Frequency of Data Submissions". Effective March 1, 2025, payors must submit monthly data files according to the following schedule:

(1) January data must be submitted no later than March 7th of that year.
(2) February data must be submitted no later than April 7th of that year.
(3) March data must be submitted no later than May 7th of that year.
(4) April data must be submitted no later than June 7th of that year.
(5) May data must be submitted no later than July 7th of that year.
(6) June data must be submitted no later than August 7th of that year.
(7) July data must be submitted no later than September 7th of that year.

(8) August data must be submitted no later than October 7th of that year.

(9) September data must be submitted no later than November 7th of that year.

(10) October data must be submitted no later than December 7th of that year.

(11) November data must be submitted no later than January 7th of the following year.

(12) December data must be submitted no later than February 7th of the following year.

4.5. Extensions and Exceptions

A payor who is unable for any reason to meet the submission schedule may request a temporary extension to change expected submission date to a later date. A payor who is unable for any reason to meet any other requirement of the regulation may request a temporary exception. Requests for extensions and/or exceptions can be made on the TX-APCD portal (at https://txapcd.org) and should be made no less than 30 calendar days before the date the payor would have to comply with the requirement. The CHCD may grant an extension or exception for a maximum of one calendar year, if the payor demonstrates that compliance would impose an unreasonable cost relative to the public value that would be gained from full compliance. It is important to note that extensions and exceptions are temporary and are subject to (at minimum) annual renewal.

5.0. Data Requirements

The required data files and associated data formats are modeled after the APCD-CDL© adopted by the National Association of Health Data Organizations. Each data file is defined in the CDL document, including record specifications, data element definitions and descriptions, code tables, field compliance status, and threshold levels (a.k.a., fill rates). These details are provided for all data file types: eligibility/enrollment, provider, medical, pharmacy, and dental, along with the header and trailer records expected at the start and end of each data file.

5.1. Submission Definition

For the purposes of this guide, a submission is defined as a single month of adjudicated claims data, along with supporting member eligibility/enrollment and provider data. Each submission must include at least an eligibility/enrollment file, a provider file where applicable, and at least one claims data file (medical, pharmacy, and/or dental). Each data file must be UTF-8 encoded and pipe-delimited and named according to the scheme described in Section 6.1 of the Technical Guide. These files are then encrypted using procedures described in Sections 3.5 and 6.3.3 of the Technical Guide, then packaged in a ZIP archive (see Appendix B of the Technical Guide for an alternative) before submission. A single ZIP archive represents a single monthly submission. Section 6 of the Technical Guide describes the process of constructing a submission meeting this definition.

5.2. Consistent Cross-file Identifier

The eligibility/enrollment file, the provider file, and the claims file are intended to be components of a relational database. Consistent identifiers for members, providers and plans across all files are, therefore, critical. Payors and their delegates will ensure that member and subscriber identifiers for individuals are unique and consistent across all submitted files.

It is recognized that there is a time component to the consistency of identifiers across files. For example, it is possible that a member referenced in a claim reported in the 202303 submission is not present in the 202303 eligibility/enrollment file because the member is no longer eligible/enrolled, but a claim referencing that member is adjudicated in 202303. The same is true for providers who are referenced on claims but are no longer under contract or providing services to members at the time of adjudication of a claim referencing the provider.

5.3. Header and Trailer Records

Each member eligibility/enrollment, provider, medical, pharmacy, or dental file submitted should contain a control header record and a control trailer record as defined in the CDL. The header record is the first record of each distinct file, and the trailer record is the last record. Section 6.2 of the Technical Guide describes this structure in detail.

5.4. Member Eligibility Data

Payors will report health care service paid claims and encounters for all Texas resident members. A Texas resident is defined as any policyholder or certificate holder (subscriber) whose residence is within the state of Texas and all covered dependents, regardless of where the dependent resides.

A member eligibility file is composed of demographic information for each individual member eligible for medical, pharmacy, and/or dental benefits for one or more days of coverage at any time during the reporting period.

Submitters must provide a dataset that contains information on every covered plan member ***whether the member utilized services during the reporting period or not***. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, and other required fields as specified in the CDL. If dual coverage exists, the payor must identify if coverage of eligible members is primary or secondary. When a member's social security number is not available, a unique member ID should be used for the member's entire period of coverage under a particular plan. Additionally, it is acknowledged that the sequence number, representing the subscriber and dependents may change over time.

Dates of coverage are included in the member eligibility file. Submitters must provide a dataset that contains information on every covered plan member, regardless of whether the member utilized services during the reporting period. One record, per member, per

month, per plan, is required. For example, if a member is covered as both a subscriber and a dependent on two different policies during the same month, two records must be submitted. If a member has two contract numbers for two different coverage types, two member-eligibility records must be submitted.

5.5. Provider Data

Payors must provide a dataset that contains information:

(a) on every provider in the provider network, and
(b) every provider (in-network or out-of-network) for whom claims were adjudicated during the targeted reporting period or for those who were reported on the eligibility file during the reporting period.

A provider file is a data file composed of information including, but not limited to, provider IDs, provider names, National Provider Identifiers (NPI) when available, specialty codes, and practice location(s) for all providers as indicated by the payor on the eligibility and on the claim. One record must be provided for each unique physical location for a provider who may have several locations.

5.6. Claims and Encounter Data

Medical and dental claims and encounter data that were submitted to the payor for payment or processing and for which some action has been taken on that claim (i.e., payment, denial, adjustment, or other modification) must be included in the data submission. Claims and encounters are submitted with both master claim information and claim line detail information, thus referred to as service level information. A single claim may have many lines and, therefore, may result in many service level data. Each claim line submission for a single claim will, therefore, report data related to that claim line and will have master information repeated on each claim line submitted. Service level information includes, but is not limited to, member demographics, provider

information, charge/payment/allowed information, clinical diagnosis codes, and procedure codes from all non-denied adjudicated claims for each billed service.

Submitters must provide data for all pharmacy paid claims for prescriptions that were dispensed to members, processed, and paid. If the pharmacy benefit is outsourced to a vendor, the claims may be submitted directly from the vendor with proper identification (ID) of payor and plan.

5.7. Financial Data

Financial data reported on claims should assume the following:

- The sum of all claim lines for a given data element will equal the total charge, paid, prepaid, copay, coinsurance, or deductible amounts for the entire claim (variables may differ among the medical, pharmacy, and dental claims files).
- The paid amount provided for each non-charge financial amount data element is mutually exclusive.

5.8. Adjustment Records

Any claims that were rejected in the adjudication process, for such reasons as not related to an enrolled member or duplicate claim/encounter, may be excluded from the data submission. However, any legitimate, non-duplicate claims that have been denied (denied for incompleteness, being incorrect, or for other administrative reasons) must be submitted.

If any adjustments or corrections are later made to a claim or encounter, the corrective actions must be submitted and must include a reference that links the original claim to all subsequent actions associated with that claim. Subsequent incremental claims submissions should include all reversal and adjustment/restated versions of previously submitted claim service lines. They should also include all new, fully-processed service lines associated with the claim, if they have paid dates in the reporting period. Claim status code should be used to indicate reversals of previously submitted claims.

Submitters that assign a completely new Payor Claim Control Number (PCCN) for adjusted claims must submit the original claim number on each record. The data supplier will use the designated field in the standard layout for inclusion of the original Claim Control Number.

Submitters must ensure that the entire chain of adjustments on a claim are accounted for in the reported data over the life of the claim. This requires use of one (and only one) of various claim versioning mechanisms that are available, either directly in the CDL or in the Claim Versioning Guide. This makes it possible for the TX-APCD to construct an overall view of each claim in its entirety. It is understood that there will be some cases where a claim's history is incomplete because there were adjudications outside the timeframe of the dataset (e.g., prior to 201901).

A claim or claim line may be omitted if it is denied using a Claim Adjustment Reason Code (CARC) *that has not been identified* as required within the Data Submission Guide. For a listing of CARCs that trigger a submission to the TX-APCD, see the listing in Appendix B of this guide.

6.0. Data Submission Process

The goal of the TX-APCD is to build a high-quality dataset that can support a wide range of research and reporting activities. The quality of submissions is checked at multiple levels in multiple stages as follows.

6.1. Test, Historical, and Partial Year Initial Submission

For payors required to begin submitting files to the TX-APCD, the CHCD will identify:

- the calendar month to be reported in test files,
- the specific full calendar years of data to be reported in the historical submission, and
- the calendar month in which to begin regular monthly submissions.

After successfully registering and obtaining the identifiers and encryption key required for the creation of requisite data files, those files can then be prepared for submission.

6.2. File Submission Methods

The TX-APCD will support the following file submission methods:

- Secure File Transfer Protocol (SFTP) – involves using an SFTP client (such as FileZilla) to log on to the appropriate File Transfer Protocol (FTP) site with credentials provided to the submitter at registration time and transmit the file to the TX-APCD Managed File Transfer (MFT) servers.
- Web upload – this method allows the submission of files via the Hypertext Transfer Protocol Secure (HTTPS) protocol. This can be done manually using any modern internet browser or programmatically using standard libraries. Credentials provided to the submitter at registration should be used to connect to the MFT servers before initiating the file transfer.

These methods are described in detail in Section 7 of the Technical Guide.

7.0. Data Quality

The goal of the TX-APCD is to build a high-quality dataset that can support a wide range of research and reporting activities. The quality of submissions is checked at multiple levels in multiple stages as follows.

7.1. Stage 1 Validation Checks

These checks are mostly focused on validating if a submission conforms with the guidelines and specifications provided in this Data Submission Guide, the Technical Guide, and the CDL. In other words, these are primarily conformance checks. These conformance checks are performed at three levels.

(a) Archive file validations – these include checking that files are named and encrypted in a manner consistent with the guidelines provided in Sections 6.1 and

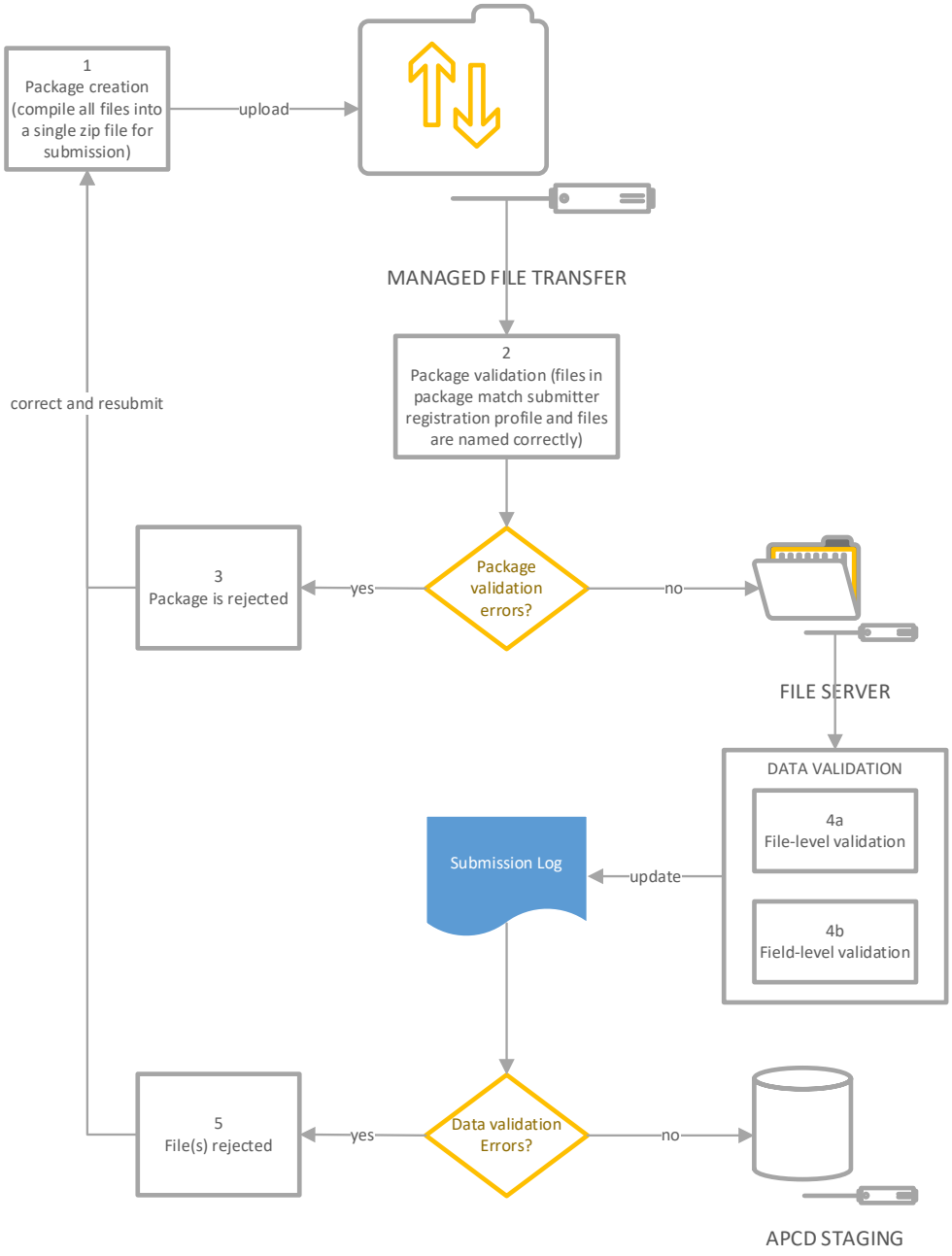
6.3.3 of the Technical Guide, and that the data files contained in the archive are the data files expected based on the submitter's registration (eligibility/enrollment, provider, medical, pharmacy, dental).

(b) Data file validations – these include file naming based on the guidelines provided in Section 6.1 of the Technical Guide, the presence of header and trailer records in each data file, and consistency between header/trailer data and the contents of each file (e.g., number of data records in the file should match the number of records indicated in the trailer record).

(c) Data element (field) validations – these include if data provided in each field is of the correct data type as specified in the CDL, that each field is of the correct length where applicable, that the values provided match values in the code set associated with the field where applicable, that the "fill rate" for the field matches or exceeds the threshold level specified for the field in the CDL, and that field values satisfy any relevant condition specified in the CDL for the field (e.g., if a field is "Institutional only" it should only be populated for institutional claims).

In this stage, two system notifications are triggered and sent via email to the submitter and subscribing contacts. The first notification is called the "Submission Receipt Notification" and serves to inform the submitter that the submission has been received, and whether it has been accepted for processing. Acceptance for processing depends on successful validation of the archive (ZIP) file as described in item (a) above. The second notification is called the "Submission Validation Notification" and serves to provide feedback to the submitter on pass/fail status of the submission along with the detailed results of the checks that were conducted at the data file and data field levels covered in items (b) and (c) above.

Figure 1 – Submission Package Upload and Validation



7.2. Stage 2 Quality Checks

The checks at this stage are less about conformance and more about semantic consistency, i.e., that the data represents what it is intended to represent. In other

words, the checks go beyond the bits and bytes to explore the meaning of the data and its appropriateness to the intended use of the data in research and reporting.

A major difference from Stage 1 is that the checks in this stage are not meant to identify pass/fail but rather provide signals of potential issues in the data which could compromise its utility. When issues are identified, the relevant submitters are engaged with the following possible outcomes:

(a) No issue – the submitter can explain the reason for the occurrence. No action expected from any party.
(b) Issue with TX-APCD fix – the submitter can explain how the submitted data can be used to make a correction that addresses the issue detected. The TX-APCD undertakes to make the correction and no further action is required from the submitter.
(c) Issue with submitter fix – the submitter can explain the reason for the occurrence and knows how to fix the issue. The fix should be applied to all future submissions. A joint determination is made on whether the fix should be applied to previous submissions, taking into consideration the burden to the submitter and the criticality of the issue to the utility of the data.

While the CDL in a way provides a basis for these quality checks, the process of developing a master list of checks has been organic, focusing squarely on actual data submissions, and relying in large part on the expertise of the CHCD staff. The master list of checks continues to evolve, with the first version of core checks published to submitters in November 2024. The document can be found on the TX-APCD website and lays out in detail the core checks in place as of this writing.

8.0. TX-APCD and Data Submitter Communications

The CHCD will work with submitters to ensure ease of submission and to resolve any operational, technical, or quality issues. There are multiple mechanisms available to contact the CHCD.

(a) The main tool for submitters to interact with the TX-APCD is the submitter portal (https://txapcd.org). Most actions can be done in the portal in self-service mode.

(b) For operational questions related to the regulations governing the TX-APCD, the registration renewal and update process, extension and exception requests, and general questions, the general mailbox should be used (txapcd@uth.tmc.edu).

(c) For technical questions or issues, please use the submitter portal to open a support ticket. This is the preferred option for getting questions answered and issues resolved. Tickets are followed to completion and are unlikely to "fall through the cracks".

(d) Tickets can also be created by sending an email to support@tickets.txapcd.org (which is not an attended mailbox). Emails sent to this address are converted to tickets in the ticketing system.

(e) If you have opened a ticket, or sent a request to the general mailbox, and your situation is urgent requiring escalation, you can use the TX-APCD phone number. You will be prompted to leave a voicemail for Operations Support (option 1) or Technical Support (option 2).

TX-APCD Phone Number: 713-500-9455

The CHCD's staff will respond in a timely fashion to all requests during business hours in US Central Time (CT). It is important to note that using more than one of the mechanisms listed above at the same time for the same issue to expedite the issue will more than likely result in your request taking more time and effort to address.

For submitters using emails to communicate with the CHCD, it is important to whitelist the uth.tmc.edu and tacc.utexas.edu domains to avoid the interruption of the flow of email messages.

9.0. Enforcement

It is the operational philosophy of the TX-APCD to seek successful submission of data over potential enforcement activity. However, TDI is responsible for establishing oversight and enforcement mechanisms to ensure that payors submit data to the database. If a payor fails to submit required data or fails to correct submissions rejected due to errors or omissions, the CHCD will provide written notice to the payor. If the payor fails to provide the required information within 30 calendar days following receipt of said written notice, the CHCD will notify TDI of the failure to report. TDI may pursue compliance via any appropriate corrective action, sanction, or penalty.

10.0.Data Protection and Privacy

The CHCD maintains CMS certified data privacy controls and data security measures. Additionally, TACC and UTHealth Houston, which together manage and store the data for the TX-APCD, similarly maintain the highest levels of data security and privacy as required by state and federal law.

The CHCD removes many personal identifiers from the data warehouse, replacing them with a unique member ID created within the master patient index (MPI). The MPI is created to avoid duplication of individuals within the database across time and across insurers, thus allowing for longitudinal analysis.

Public reporting of health care costs, utilization, and quality through the portal will not contain any information that may identify a patient, health care provider, health benefit plan, health benefit plan issuer, or other payor.

APPENDIX A – Abbreviations/Acronyms Used

Description	Abbreviation/Acronym
Administrative service organization	ASO
Advanced Encryption Standard	AES
American Standard Code for Information Interchange	ASCII
Center for Health Care Data (the Center)	CHCD
Center for Medicare and Medicaid Services	CMS
Central Time	CT
Century	CC
Certified Qualified Entity	QE
Common Data Layout	CDL
Dental claims	DC
Employee Retirement Income Security Act	ERISA
File Transfer Protocol	FTP
Gnu Privacy Guard	GnuPG
Hypertext Transfer Protocol Secure	HTTPS
Identification	ID
Managed File Transfer	MFT
Master patient index	MPI
Medical claims	MC
Member eligibility	ME
Month	MM
National Association of Insurance Commissioners	NAIC
National Provider Identifiers	NPI
Pharmacy claims	PC
Pretty good privacy	PGP
Provider information	MP
School of Public Health	SPH
Secure File Transfer Protocol	SFTP
Texas Advanced Computing Center	TACC
Texas All-Payor Claims Database	TX-APCD
Texas Department of Insurance	TDI
Third-party administrator	TPA
UCS Transformation Format 8	UTF-8
Universal Storage Bus	USB
University of Texas Health Science Center at Houston	UTHealth
Year	YY

APPENDIX B – Claim Adjustment Reason Code(s) (CARC)

If one or more claims lines contains a CARC from the following table, it should be submitted to the TX-APCD.

Claim Adjustment Reason Codes	Code Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
24	Charges are covered under a capitation agreement/managed care plan.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
35	Lifetime benefit maximum has been reached.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
54	Multiple physicians/assistants are not covered in this case. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
59	Processed based on multiple or concurrent procedure rules. (For example, multiple surgery or diagnostic imaging, concurrent anesthesia.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
78	Non-Covered days/Room charge adjustment.
90	Ingredient cost adjustment. Usage: To be used for pharmaceuticals only.
91	Dispensing fee adjustment.
104	Managed care withholding.
111	Not covered unless the provider accepts assignment.
119	Benefit maximum for this time period or occurrence has been reached.
128	Newborn's services are covered in the mother's Allowance.
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
149	Lifetime benefit maximum has been reached for this service/benefit category.
161	Provider performance bonus
181	Procedure code was invalid on the date of service.
182	Procedure modifier was invalid on the date of service.
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)
200	Expenses incurred during lapse in coverage
210	Payment adjusted because pre-certification/authorization not received in a timely fashion
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
242	Services not provided by network/primary care providers.
245	Provider performance program withhold.
249	This claim has been identified as a readmission. (Use only with Group Code CO)

256	Service not payable per managed care contract.
279	Services not provided by Preferred network providers. Usage: Use this code when there are member network limitations. For example, using contracted providers not in the member's 'narrow' network.
A8	Ungroupable DRG.
B14	Only one visit or consultation per physician per day is covered.
B16	'New Patient' qualifications were not met.
B22	This payment is adjusted based on the diagnosis.