

Texas APCD Data Submission Guide

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The University of Texas
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School of Public Health

Center for Health Care Data

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1.0 Document Version History

VERSION HISTORY		
Version Number	Date Published	Summary of Revision
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.

1.1 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 (TXAPCD) to be developed and administered by the School of Public Health (SPH)-Center for Health Care Data (Center) at The University of Texas Health Science Center at Houston (UTHealth). The database is designed to increase public transparency of health care information and improve the quality of health care in this state. Consistent with this stated purpose the Center 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 Center or a qualified research entity for non-commercial purposes that are consistent with the stated purposes of the TXAPCD.

The rule adopted by the Texas Department of Insurance (TDI) at 28 Texas Administrative Code §§21.5401-5406, concerning the all-payor claims database, will identify compliance requirements for submitters. The regulations are directly related to the details within this Data Submission Guide.

1.2 The Center for Health Care Data at UTHealth

The Center at UTHealth is a Centers for Medicare and Medicaid Services (CMS) Certified Qualified Entity (QE) with proven expertise in the data collection, data management, and data analysis of health care claims data. The Center has been certified by CMS as meeting its rigorous requirements for data privacy and security. The Center is a non-profit entity, operating within the SPH at UTHealth. It is independent from all provider organizations and health plans and maintains a mission of data informing policy and driving value. For more information on the TXAPCD or the UTHealth Center for Health Care Data, visit the following website at <https://go.uth.edu/txapcd>.

1.3 Data Submission Guide

This Data Submission Guide is provided as reference for payors submitting data to the TXAPCD. The Data Submission Guide addresses key operational issues and provides technical guidance to submitters. Accompanying this Data Submission Guide is the TXAPCD-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 TXAPCD is to have a standardized data set across payors so that it can be integrated for the purpose of public reporting and research. The TXAPCD-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.

This Data Submission Guide, v01.09 dated 06/10/22, details the intended processes as originally conceived prior to any data submission to the TXAPCD. Processes and practices will likely change as a result of stakeholder input, development experience, and continued re-evaluations and reassessments. Therefore, this guide will be improved and updated as needed. Comments from payors and input from the TXAPCD Stakeholder Advisory Group will inform future revisions and improvements to ensure that the data are as complete and accurate as possible. All changes to the DSG will be communicated broadly via updates posted on the UTHealth Center for Health Care Data TXAPCD website as well as the emails to the registered contacts for each data submitter.

1.3.1 Technical Guide

After registration, a **Technical Guide** will be available that will provide technical guidance to one or more of the sections contained in the Data Submission Guide, such as:

- Samples of file-extracts for each submission file type.
- Examples of how to encrypt data file(s) before sending to TXAPCD.
- How to create, encrypt and split zip files.
- Examples of how to transmit data using the various transmission methods.

1.4 Required Submitters

The rule adopted by TDI in Title 28 of the Texas Administrative Code identifies the required submitters. The regulation identifies required submitters at 28 Texas Administrative Code §21.504.

1.4.1 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 TXAPCD 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.

1.5 Payor Registration

Payors must register as submitters before they are able to submit data to the TXAPCD. The registration process is outlined in this section.

Registration Form

Each submitter (and/or designated partner) will complete the TXAPCD registration form as the first step in the process of eventually submitting data to the TXAPCD. Initial 1st time open registration for TXAPCD go-live will be announced with 90 days' notice.

The registration form will include the following categories of information:

1. Company information (National Association of Insurance Commissioners [NAIC] group code)

2. Location information
3. General contact information
4. Company information (NAIC code)
5. Lines of business
6. Files that will be submitted (medical, pharmacy, dental, eligibility/enrollment, provider)
7. Number of covered lives in most recent calendar year
8. Contact information (for submissions)

General Requirements

Each applicable payor, or its designee (e.g., ASO or TPA), must register with the TXAPCD prior to submitting any data files as follows:

1. Submit a completed/updated TXAPCD registration form to the TXAPCD by January 1st of every calendar year;
2. Notify the TXAPCD by email or on the registration site within 30 days of changes to any of the annual TXAPCD registration information;
3. Notify the TXAPCD by email or on the registration site of any changes to the individual contact information submitted on the TXAPCD registration form as soon as possible, but no later than 30 days after a reassignment occurs.

Registration Process

1. Submit completed registration form on registration site or send to txapcd@uth.tmc.edu.
2. Allow two weeks for processing of registration.
3. Review Data Submission Guide, CDL requirements and Technical Guide.
4. Attend submitter onboarding/training/Q&A session (in person, online, and/or self-paced).
5. Prepare test submissions.
6. Submit test files and obtain approval from the Center to submit production files.
7. Start submitting production files.

1.6 Data Submission Schedules

Historical claims data must be submitted that encompasses data for reporting periods beginning January 2019 through the most recent reporting period. For ongoing data submission, the rule requires that the payor provides data to the Center not less frequently than monthly.

It is anticipated that regular data submissions will begin no sooner than January 2023. The submission of the medical, pharmacy, and dental claims and encounters is based upon the adjudication date within a given monthly reporting period.

At that time, payors must submit monthly data according to the following schedule:

Reference 28 TAC §21.5405. Timing and Frequency of Data Submissions.

Payors must submit monthly data files according to the following schedule:

- January data must be submitted no later than May 7 of that year;
- February data must be submitted no later than June 7 of that year;
- March data must be submitted no later than July 7 of that year;
- April data must be submitted no later than August 7 of that year;
- May data must be submitted no later than September 7 of that year;
- June data must be submitted no later than October 7 of that year;
- July data must be submitted no later than November 7 of that year;
- August data must be submitted no later than December 7 of that year;
- September data must be submitted no later than January 7 of the following year;
- October data must be submitted no later than February 7 of the following year;
- November data must be submitted no later than March 7 of the following year;

- December data must be submitted no later than April 7 of the following year.

1.6.1 Schedule and Notification for Historical and Monthly Data Files

Payors must submit test, historical, and monthly data files according to the dates specified by the center, subject to the following requirements:

- Test data – 90 days’ notice, no sooner than October 1, 2022.
- Historical data – 120 days’ notice, no sooner than January 1, 2023.
- Monthly data – 180 days’ notice, no sooner than March 1, 2023.

This notification schedule only applies to the initial go-live of TXPACD. For new TXPACD submitters, who start business after January 1, 2023, or for annual reregistration, this notification schedule will not apply.

A payor may request a temporary exemption from one or more requirements of this subchapter by submitting a request to the Center no less than 30 calendar days before the date the payor would have to comply with the requirement. The Center may grant an exemption 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.

1.7 Data File Formats and Requirements

The required data file formats are modeled after the CDL accepted by the National Association of Health Data Organizations. Each data file format is defined in the TXPACD-CDL tables, which provide the record specifications, data elements, definitions, code tables, required status, and threshold levels for eligibility/enrollment data files, medical, dental, and pharmacy claims data files, and provider files.

Data submissions will include Member Eligibility and Enrollment, Medical Claims and Encounters, Pharmacy Claims, Dental Claims, and Provider data sets. Claims data will be provided by submitters in monthly files based on adjudication date. Member files will be organized by month of enrollment. The submission of the medical, pharmacy, and dental claims is based upon the adjudication date within a given monthly reporting period. The member eligibility file, medical claims file, pharmacy claims file, dental claims file, and provider file will be submitted as separate

American Standard Code for Information Interchange (ASCII) files with variable field lengths and pipe delimited.

1.7.1 Consistent Inter-file Identifier

The member file, claims files, and provider file are intended to be used as parts of a multi-relational database. Therefore, it is critical to provide a consistent person identifier across all files for any members, providers, and plans. A health care claims processor and any contracted entity acting on behalf of a carrier will ensure that member and subscriber identifiers for the same individuals are unique and consistent across medical claims, pharmacy claims, dental claims, and member eligibility files.

1.7.2 Header and Trailer Records

Each member eligibility, medical claims, pharmacy claims, dental claims, and provider file submission must contain a control header record and a trailer record. The header record is the first record of each separate file submission, and the trailer record is the last.

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

Submitters must provide a data set that contains information on every covered plan member whether or not the member utilized services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, and other required fields as identified 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 data set 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.

1.7.4 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.

1.7.4 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, at a later date, any adjustments or corrections have been 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, provided that 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 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. 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 TXAPCD, see listing in Appendix B.

1.7.5 Financial Amounts

Financial amount data elements 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.

1.7.6 Provider Data

Health care payors must provide a data set that contains information on every provider in the provider network and 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.

1.8 Files

Data files must be zipped prior to submission as the TXAPCD will only accept zip files. Specifications for both data files and associated zip files are provided below.

1.8.1 Data Files

- Data files must conform to the following requirements:
 - Each data file must contain control totals and transmission control details as specified in the CDL.
 - Each data file must contain a header record and a trailer record with pipe-delimited data as specified in the CDL, including the total count of records in the file (note that the record count must NOT include the header and trailer records themselves). The date range for the data should be expressed in MMCCYY format (e.g., 012018 for January 2018).
 - All data files submitted to the TXAPCD must be formatted as standard UCS Transformation Format 8 (UTF-8) encoded text files, which comply with the following standards:
 - Use a single line per record, and do not include carriage returns or line feed characters within the record.
 - All records must be delimited by the carriage return and line feed character combination (a single time for each record).
 - All fields are variable length subject to the length constraints imposed by the CDL and should be delimited using the pipe character (ASCII 124). It is imperative that no pipes (|) appear in the data itself.
 - Text fields are never demarcated or enclosed in single or double quotes.
 - The first row of data will specify the header control record, the second row will contain column names as specified by the CDL.
 - Numerical fields (e.g., ID numbers, account numbers, etc.) do not contain spaces, hyphens or other punctuation marks, and are never padded with leading or trailing zeros.
 - Currency and unit fields should contain decimal points as appropriate.
 - If a field is not to be populated, a null value must be used. A null is represented as two consecutive pipe characters (||) with no content between them.

- The Member Eligibility file will supply information on every member enrolled with the health plan during the specified data period. The monthly member file must contain one record per member per month.
- Data files must be named according to the following convention: T/P_SubmitterCode_PayorCode_PeriodStartDate_PeriodEndDate_FileType_VersionNumber.txt (e.g., T_3409013_9032830_201901_201903_ME_01.txt)
 - T/P for Test or Production.
 - Submitter code assigned to submitter at time of registration.
 - Payor code assigned to payor at time of registration and could be the same as the submitter code.
 - Period start date as the date of the start of the period to which the submission applies expressed as CCYYMM (e.g., 201901 for January 2019).
 - Period end data as the date of the end of the period to which the submission applies expressed as CCYYMM (e.g., 201903 for March 2019).
 - File type is a two-letter code indicating the type of file.
 - DC for dental claims
 - MC for medical claims
 - ME for member eligibility
 - PC for pharmacy claims
 - MP for provider information
 - Version number – used to differentiate multiple submissions of the same file. This is important when a file must be resubmitted to resolve an issue, such as a validation failure. The letter v should be used, followed by two digits, starting with v01. Please include the leading zero. Original submissions of all files should be labeled v01. The portal will not accept files that have the same name as an existing file.

1.8.2 Zip Files

- Zip files must be named according to the following convention: T/P_SubmitterCode_PayorCode_PeriodStartDate_PeriodEndDate.zip.FilePartNumber.z (e.g., P_0123012392_B2393028_202101_202103.zip.010.z)
 - T/P for Test or Production.

- Submitter code – a code assigned by the TXAPCD to the submitter at the time of registration. It may or may not be the same as payor code.
- Payor code – a code assigned to a carrier in the case of premium-based coverage or of the administrator in the case of self-funded coverage.
- Period start date – the date for the start of the time period covered by the submission expressed as CCYYMM (e.g., 202101 for January 2021).

Period end date – the date for the end of the time period covered by the submission expressed as CCYYMM (e.g., 202112 for December 2021). File part number – is a sequential number generated and added to the end of the file name when the zip file is split into multiple parts. If only a single zip file is being submitted, do NOT assign a file part number. When submitting multiple parts, the files will be numbered in sequence. The final file part should be assigned ".z" at the end of the filename to indicate the end of the data. Please refer to the technical guide for more information about creating zip files and zip file parts.

Single file example:

P_01230123_B2393028_202101_202103.zip

Multiple file part example (with 4 parts):

P_01230123_B2393028_202101_202103.zip.001

P_01230123_B2393028_202101_202103.zip.002

P_01230123_B2393028_202101_202103.zip.003

P_01230123_B2393028_202101_202103.zip.004.z

1.9 Data Submission Process

1.9.1 Test, Historical, and Partial Year Initial Submission

For payors required to begin submitting files to the TXAPCD, the Center 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.

1.9.2 File Submission Methods

The TXAPCD 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 TXAPCD 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.
- USB Flash Drive – in the case of very large files to be submitted, a submitter can opt to store the encrypted zip file on a Universal Storage Bus (USB) disk and send the USB disk via secure courier to the TXAPCD data center in Austin.

2.0 Data Quality

As illustrated in the flow diagram below, submitters will package all files being submitted into a single zip file with encryption. The zip file will then be uploaded to the TXAPCD MFT servers.

Upon completion of the receipt of the file, the zip package will undergo some basic validation. First, the file contents will be checked to make sure that the file names are consistent with the naming scheme described in this guide. Secondly, the files submitted will be validated against the submitter's registration to ensure that they are consistent with the files expected based on the submitter's registration record. If any of these validations fail, the entire package will be rejected, and the submitter will need to resubmit the entire package.

Packages which pass the validation step will be saved to the Center's secure file server where processing will begin. Two levels of data validation will be done on each file in the package.

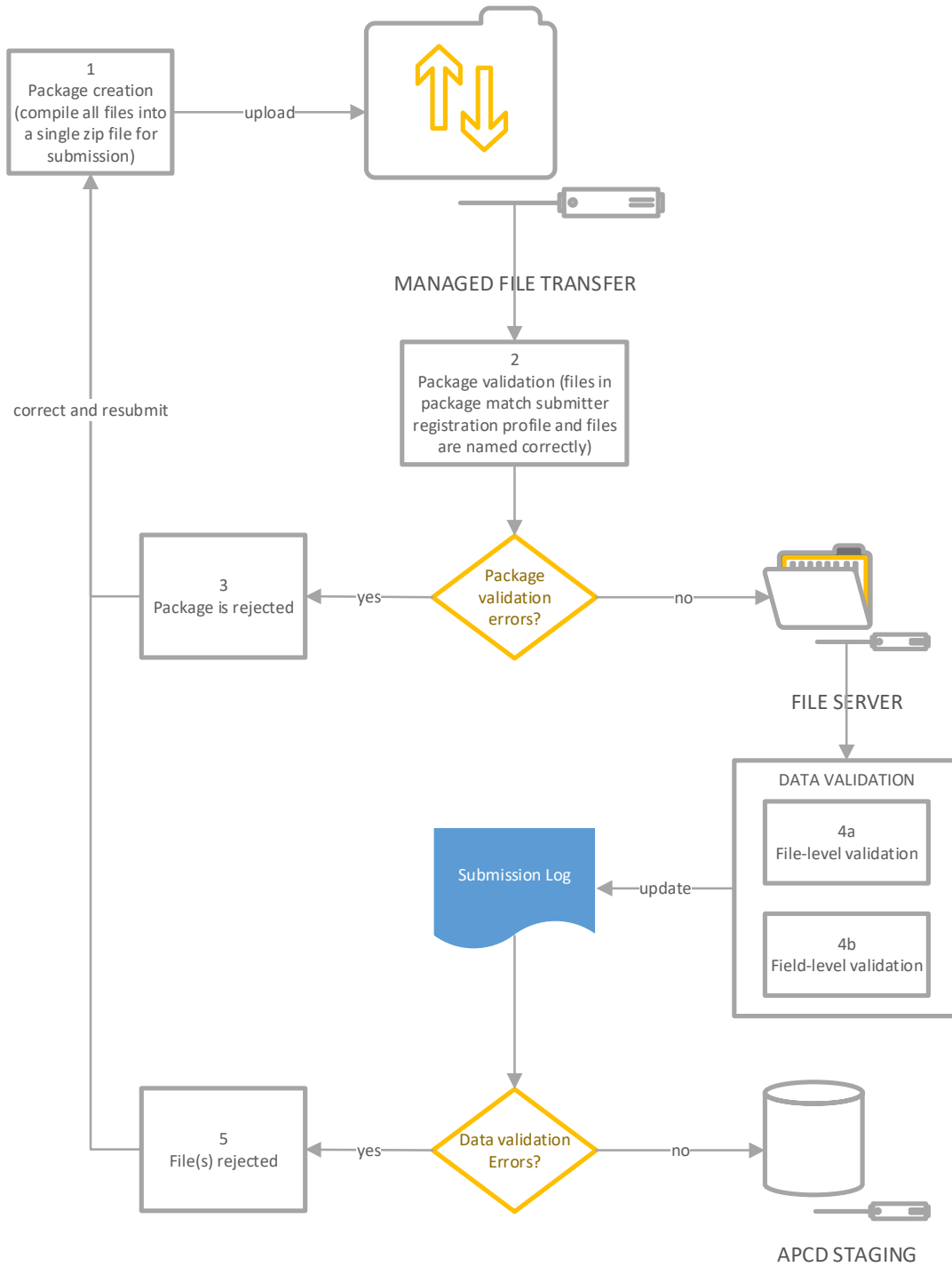
1. File-level checks – these include correct file naming, presence of header and footer, and consistency between header/footer information and the overall contents of each file (e.g., number of records).

2. Field-level checks – these include checking that each field’s data is of the data type that is expected and length that is expected. Please refer to the requirements detailed in the CDL for more information about the expectations for each field in each file.

While the file-level and field-level validations are being done, a detailed submission log will be updated reflecting the outcome of each validation check. Upon completion of the validations, the submission log will be scanned for errors. The presence of errors could result in the rejection of the submitted package. Files will be validated individually, and any failure would require a resubmission of the entire package.

After all validations are completed, and any resubmissions have been received and processed, the data will be staged for loading into the TXAPCD data warehouse.

Figure 1 Submission package upload and validation



2.1 TXAPCD and Data Submitter Communications

The Center will work with submitters to ensure ease of submission and to resolve any technical or quality issues. The Service Desk may be contacted via the designated support mailbox (txpacd@uth.tmc.edu) or through the administrative portal, when available, and a Client Service Representative will be available during business hours in Central Time (CT) to work directly with the submitters.

2.2 Enforcement

It is the operational philosophy of the TXAPCD 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 Center 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 Center will notify TDI of the failure to report. TDI may pursue compliance via any appropriate corrective action, sanction, or penalty.

2.3 Data Protection and Privacy

The Center maintains CMS certified data privacy controls and data security measures. Additionally, the Texas Advanced Computing Center (TACC), which serves as the data storage center for the TXAPCD, similarly maintains the highest levels of data security and privacy as required by state and federal law.

The Center 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	Center
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	TXAPCD
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 TXAPCD.

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.