

## X12 ADJUSTMENT CODES

X12 ADJUSTMENT CODE	X12 ADJUSTMENT TEXT
2	Coinsurance Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.
7	The procedure/revenue code is inconsistent with the patient's gender.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender.
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
18	Duplicate claim/service.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
29	The time limit for filing has expired.
31	Claim denied as patient cannot be identified as our insured.
35	Lifetime benefit maximum has been reached.
38	Services not provided or authorized by designated (network/primary care) providers.
39	Services denied at the time authorization/pre-certification was requested.
40	Charges do not meet qualifications for emergent/urgent care.
42	Charges exceed our fee schedule or maximum allowable amount.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. Note: Split into codes 150, 151, 152, 153 and 154.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
78	Non-Covered days/Room charge adjustment.
92	Claim Paid in full.
96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
104	Managed care withholding.
107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim.
108	Payment adjusted because rent/purchase guidelines were not met.
110	Billing date predates service date.
118	Charges reduced for ESRD network support.
119	Benefit maximum for this time period or occurrence has been reached.
120	Patient is covered by a managed care plan. Note: Use code 24.

## X12 ADJUSTMENT CODES

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125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
129	Payment denied - Prior processing information appears incorrect.
133	The disposition of this claim/service is pending further review.
140	Patient/Insured health identification number and name do not match.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.
150	Payment adjusted because the payer deems the information submitted does not support this level of service.
153	Payment adjusted because the payer deems the information submitted does not support this dosage.
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.
163	Claim/Service adjusted because the attachment referenced on the claim was not received.
164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.
166	These services were submitted after this payers responsibility for processing claims under this plan ended.
167	This (these) diagnosis(es) is (are) not covered.
170	Payment is denied when performed/billed by this type of provider.
171	Payment is denied when performed/billed by this type of provider in this type of facility.
172	Payment is adjusted when performed/billed by a provider of this specialty.
177	Payment denied because the patient has not met the required eligibility requirements.
181	Payment adjusted because this procedure code was invalid on the date of service.
183	The referring provider is not eligible to refer the service billed.
A1	Claim/Service denied. This change to be effective 6/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
B1	Non-covered visits.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.
D21	This (these) diagnosis(es) is (are) missing or are invalid.

## X12 REMARK CODES

X12 REMARK CODE	X12 REMARK TEXT
M29	Missing operative report. (Modified 2/28/03) Related to N233
M46	Missing/incomplete/invalid occurrence span code(s). (Modified 12/2/04) Related to N300
M51	Missing/incomplete/invalid procedure code(s).
M52	Missing/incomplete/invalid 'from' date(s) of service.
M53	Missing/incomplete/invalid days or units of service.
M57	Missing/incomplete/invalid provider identifier.
M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
M62	Missing/incomplete/invalid treatment authorization code.
M67	Missing/incomplete/invalid other procedure code(s). (Modified 12/2/04) Related to N302
M68	Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.
M77	Missing/incomplete/invalid place of service.
M78	Missing/incomplete/invalid HCPCS modifier. (Modified 2/28/03, Deactivated eff. 5/18/06) Consider using Reason Code 4
M86	Service denied because payment already made for same/similar procedure within set time frame.
M90	Not covered more than once in a 12 month period.
M139	Denied services exceed the coverage limit for the demonstration.
M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
MA32	Missing/incomplete/invalid number of covered days during the billing period.
MA33	Missing/incomplete/invalid noncovered days during the billing period.
MA36	Missing/incomplete/invalid patient name.
MA63	Missing/incomplete/invalid principal diagnosis.
MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
MA66	Missing/incomplete/invalid principal procedure code. (Modified 12/2/04) Related to N303
MA92	Missing plan information for other insurance. (Modified 2/1/04) Related to N245
MA119	Provider level adjustment for late claim filing applies to this claim.
N19	Procedure code incidental to primary procedure.
N20	Service not payable with other service rendered on the same date.
N29	Missing documentation/orders/notes/summary/report/chart.
N29	Missing documentation/orders/notes/summary/report/chart. (Modified 2/28/03, 8/1/05) Related to N225
N30	Patient ineligible for this service.
N31	Missing/incomplete/invalid prescribing provider identifier.
N39	Procedure code is not compatible with tooth number/letter.
N43	Bed hold or leave days exceeded.
N55	Procedures for billing with group/referring/performing providers were not followed.
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
N59	Please refer to your provider manual for additional program and provider information.
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
N192	Patient is a Medicaid/Qualified Medicare Beneficiary.

**X12 ADJUSTMENT CODE/ X12 REMARK CODE/ MMIS EOB CODE CROSSWALK**

<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
2	N59	2230	NO CROSSOVER COINSURANCE OR DEDUCTIBLE DUE
4	M78	2317	PROCEDURE CODE/MODIFIER CONFLICT
4	N59	0400	INVALID MODIFIER FOR ARNP. REGISTERED NURSE ANESTHETISTS CAN PROVIDE ONLY ANESTHESIA SERVICES - MODIFIER 48 NOT VALID.
4	N59	3043	PRIOR AUTHORIZATION/PROCEDURE CODE MODIFIER CONFLICT
4	N59	4070	INVALID PROCEDURE CODE MODIFIER
4	N59	4257	INVALID PROCEDURE CODE MODIFIER
4	N59	5038	INVALID PROCEDURE/MODIFIER COMBINATION
5	N59	4036	PROVIDER TYPE/PLACE OF SERVICE CONFLICT
5	N59	4821	PROV TYPE/PLACE OF SERVICE CONFLICT
5	N59	4822	PROC CANNOT BE PERFORMED AT PLACE OF SERVICE INDICATED ON CLAIM OR IF 99160 OR 99162 BILLED. SERV PAYABLE ONLY IF EMERGENCY BLOCK CHECKED.
6	N59	2001	SURGICAL PROCEDURE CONFLICTS WITH AGE LIMITATIONS
6	N59	4034	PROCEDURE CODE/AGE CONFLICT
6	N59	4044	PROCEDURE CODE/AGE CONFLICT
6	N59	4714	PROCEDURE CODE/AGE CONFLICT
6	N59	0964	CLAIM DENIED. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES ARE NOT PAYABLE TO MEMBERS OVER AGE 21.
6	N59	4715	PROCEDURE CODE/AGE CONFLICT
7	N59	1062	FIRST SURGICAL PROCEDURE INVALID FOR RECIPIENT SEX
7	N59	1063	SECOND SURGICAL PROCEDURE INVALID FOR RECIPIENT SEX
7	N59	1064	THIRD SURGICAL PROCEDURE INVALID FOR RECIPIENT SEX
7	N59	1065	4TH SURGICAL PROCEDURES/SEX CONFLICT
7	N59	1066	5TH SURGICAL PROCEDURES/SEX CONFLICT
7	N59	1067	6TH SURGICAL PROCEDURES/SEX CONFLICT
7	N59	1062	FIRST SURGICAL PROCEDURE INVALID FOR RECIPIENT SEX
7	N59	1063	SECOND SURGICAL PROCEDURE INVALID FOR RECIPIENT SEX
7	N59	1064	THIRD SURGICAL PROCEDURE INVALID FOR RECIPIENT SEX
7	N59	1065	4TH SURGICAL PROCEDURES/SEX CONFLICT
7	N59	1066	5TH SURGICAL PROCEDURES/SEX CONFLICT
7	N59	1067	6TH SURGICAL PROCEDURES/SEX CONFLICT
7	N59	4035	PROCEDURE CODE OR DRUG / SEX CONFLICT
8	N59	0563	INVALID LEVEL OF CARE PROV TYPE
8	N59	2094	PROVIDER SPECIALTY REQUIRES THE BENEFICIARY BE ELIGIBLE FOR WAIVER RELATED PROC
8	N59	4140	PAY-TO PROVIDER TYPE INVALID FOR PROCEDURE CODE
8	N59	4149	ENROLLED FOR NECESSARY SPECIALTY. (OR TREATING PROV NOT IDENTIFIED ON CLAIM).
8	N59	4150	PROCEDURE/PROVIDER CONFLICT
9	N59	1136	INVOLVED, MAKE SURE YOU DID NOT USE BABY DIAG FOR MOTHER OR VICE VERSA
9	N59	1137	RECIPIENT AGE ON FILE INCOMPATIBLE W/2ND DIAG - IF BABY AND MOTHER INVOLVED, MAKE SURE YOU DID NOT USE BABY DIAG FOR MOTHER OR VICE VERSA
9	N59	1138	THIRD DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS
9	N59	1139	FOURTH DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS
9	N59	1140	FIFTH DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS
9	N59	1136	INVOLVED, MAKE SURE YOU DID NOT USE BABY DIAG FOR MOTHER OR VICE VERSA
9	N59	1138	THIRD DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS
9	N59	1139	FOURTH DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS
9	N59	1140	FIFTH DIAGNOSIS CODE CONFLICTS WITH AGE LIMITATIONS
9	N59	4030	MOTHER, CHECK TO SEE IF YOU USED A NEWBORN-ONLY DIAG CODE OR VICE

**X12 ADJUSTMENT CODE/ X12 REMARK CODE/ MMIS EOB CODE CROSSWALK**

<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
10	N59	1080	INVOLVED, MAKE SURE YOU DID NOT USE BABY DIAG FOR MOTHER OR VICE VERSA
10	N59	1081	INVOLVED, MAKE SURE YOU DID NOT USE BABY DIAG FOR MOTHER OR VICE VERSA
10	N59	1082	THIRD DIAGNOSIS CODE INVALID FOR RECIPIENT SEX
10	N59	1083	FOURTH DIAGNOSIS CODE INVALID FOR RECIPIENT SEX
10	N59	1084	FIFTH DIAGNOSIS CODE INVALID FOR RECIPIENT SEX
10	N59	1080	INVOLVED, MAKE SURE YOU DID NOT USE BABY DIAG FOR MOTHER OR VICE
10	N59	1081	INVOLVED, MAKE SURE YOU DID NOT USE BABY DIAG FOR MOTHER OR VICE VERSA
10	N59	1082	THIRD DIAGNOSIS CODE INVALID FOR RECIPIENT SEX
10	N59	1083	FOURTH DIAGNOSIS CODE INVALID FOR RECIPIENT SEX
10	N59	1084	FIFTH DIAGNOSIS CODE INVALID FOR RECIPIENT SEX
10	N59	0324	DIAGNOSIS INCOMPATIBLE WITH RECIPIENTS SEX
11	N59	4016	PROCEDURE CODE INCOMPATIBLE WITH DIAG
11	N59	4312	PROCEDURE CODE INCOMPATIBLE WITH DIAGNOSIS CODE
11	N59	4315	PROCEDURE CODE INCOMPATIBLE WITH DIAGNOSIS CODE
11	N59	4316	PROCEDURE CODE INCOMPATIBLE WITH DIAGNOSIS CODE
12	N59	0779	INVALID PROCEDURE CODE MODIFIER
13	M62	0274	SERVICE DATE IS AFTER THE RECIPIENTS DATE OF DEATH.
14	N59	5578	ASAP BILLING - DENY
16	N59	0407	PLACE OF SERVICE IS MISSING
16	N59	0338	FINANCIAL CLASS/PATIENT RESPONSIBILITY MISMATCH
16	MA64	0259	DATE BILLED INVALID
16	M58	0184	TOTAL/SUBMITTED CHARGE MISSING
16	M67	1090	1ST SURGICAL PROCEDURE DATE IS MISSING OR ZEROS
16	N59	1033	SPAN (FIELD 6)
16	N59	1091	2ND SURGICAL PROCEDURE DATE IS MISSING OR ZEROS
16	N59	1034	DATE SPAN (FIELD 6)
16	N59	1092	3RD SURGICAL PROCEDURE DATE IS MISSING OR ZEROS
16	N59	1038	5TH SURGERY DATE/STAY CONFLICT
16	N59	1039	6TH SURGERY DATE/STAY CONFLICT
16	M68	2345	ATTENDING PROVIDER NOT FOUND
16	N59	1052	DEPT OF HEALTH LICENSE NUMBER IS MISSING
16	M29	0308	INVALID DATE OF SERVICE
16	N59	0406	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO
16	M53	0030	MILEAGE RATE MISSING OR ZEROS
16	N59	1097	OCCURRENCE SPAN FROM DATE MISSING
16	N59	1096	OCCUR SPAN TO DATE MISSING
16	N55	0450	MOUTH QUADRANT REQUIRED
16	N59	0495	REVENUE
16	N20	0506	BILLED DATE GREATER THAN BATCH DATE
16	M52	2126	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV
16	N59	0133	SUBMITTED CHARGES/TOTAL CLAIM CHARGE CONFLICT
16	N59	0408	SINGLE DATE OF SERVICE
16	N59	0314	ASSISTIVE CARE SERVICE CLAIMS CANNOT SPAN MORE THAN ONE MONTH. PLEASE CHECK THE DATES OF SERVICE AND RESUBMIT THE CORRECTED CLAIM.
16	N59	0565	ITEM(S) OF YOUR CLAIM IS NOT EQUAL TO THE AMOUNT ENTERED IN THE TPL TOTAL FIELD
16	N59	0175	FIRST SURGERY PROCEDURE CODE IS MISSING
16	N59	0315	TPL ON CLAIM, NOT ON RECIPIENT FILE
16	M46	2463	SPAN THRU DATE LESS THAN SPAN FROM DATE
16	N20	0524	MOTHER DISCHARGE DATE IS ZERO

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<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
16	N59	0647	PROVIDER NUMBER NOT ON FILE
16	N65	2615	INCORRECT PROVIDER NUMBER)
16	N31	2302	DPR NUMBER IS NOT ON FILE
16	N59	0302	DPR NUMBER IS NOT FOUND ON FILE
16	N59	0302	DPR NUMBER IS NOT FOUND ON FILE
16	N59	1052	DEPT OF HEALTH LICENSE NUMBER IS MISSING
16	N59	1054	DPR NUMBER IS NOT ON FILE
16	N59	0564	INVALID LOC FOR SNU PROVIDER
16	N59	1100	REFERRING PROVIDER NUMBER REQUIRED
16	N59	2010	EQUAL AND THE NEWBORNS LENGTH OF STAY EXCEEDS THE MOTHERS - USE
16	N59	0471	RECIPIENT IS NOT ELIGIBLE FOR MEDICAID SERVICES, BUT MAY BE ELIGIBLE FOR MEDICARE. MEDICAID PRESCRIPTION SERVICES NOT COVERED.
16	N59	2268	INVALID PER DIEM AMOUNT
16	N59	2517	TPL ON RECIPIENT FILE, NOT ON CLAIM (PAY CLAIM)
16	N59	2521	TPL ON RECIPIENT FILE, NOT ON CLAIM (PAY AND LIST)
16	N56	7261	INVALID CHCUP REFERRAL CODE
16	N59	1152	CREDIT/ADJUSTMENT REQUIRES TCN
16	N59	1154	NO MATCH ON PROVIDER NUMBER
16	N59	0332	PHOTOCOPIED FORM 2902 MUST CONTAIN DENIAL TCN IN TOP RIGHT WHEN
16	N59	3053	DS WAIVER NOT APPROVED
16	N59	3054	UNIT RATE NOT ALLOWED
16	N59	3055	DS WAIVER ERROR, DATA REJECTED BY GATEKEEPER MATRIX
16	N59	3058	SCREENING REQUIRED, NONE INDICATED
16	N59	3322	INVALID UNITS OF SERVICE FOR REVENUE CODE 652, 652, 655-657 AND 659
16	N59	3340	PROCEDURE CODE REQUIRES MANUAL PRICING
16	M77	0136	REVENUE CENTER CODE IS MISSING/INVALID
16	N59	3348	DIAGNOSIS CODE NOT COVERED FOR BIRTH CENTER PROCEDURE CODE
16	N59	4121	MOUTH QUADRANT REQUIRED
16	N59	4311	279 NOT PAYABLE UNLESS DIAGNOSIS IS INCLUDED IN RANGE 940.0-949.5.
16	N59	4311	279 NOT PAYABLE UNLESS DIAGNOSIS IS INCLUDED IN RANGE 940.0-949.5.
16	N59	4393	INVALID REVENUE CODE/PROCEDURE CODE COMBINATION
16	N59	4798	SUBMITTED CHARGE IS NOT EVENLY DIVISIBLE BY UNITS OF SERVICE
16	M90	0609	9TH DIAG CODE REQUIRES MED REVIEW
16	N59	5017	MOUTH QUADRANT/ TOOTH SURFACE DUPLICATE
16	N59	4216	MODIFIERS 24, 78 AND 79 REQUIRE AHCA REVIEW
16	N59	5831	PROCEDURE CANNOT BE BILLED INDEPENDENTLY
16	N59	0318	MANUAL PRICE-REQUIRES REPORT
18	N59	1001	THERAPY NOT COVERED FOR RECIPIENTS UNDER 21 YEARS OF AGE
18	N59	5000	THIS IS A DUPLICATE OF ANOTHER CLAIM
18	N59	5007	ADJUSTMENT, PLEASE SUBMIT THE APPROPRIATE ADJUSTMENT REQUEST FORM.
18	N59	5008	SUSPECT DUPE - HEADER
18	N59	5009	SUSPECT DUPE - DIFFERENT PROV/ALLOWED
18	N59	5011	POSSIBLE DUPLICATE - TOOTH SURFACE
18	N59	0482	CLAIM/DETAIL DENIED. DUPLICATE SERVICE BILLED.
18	N59	5010	EXACT DUPLICATE - TOOTH SURFACE
18	N59	5501	SERV NOT PAYABLE FOR DAY BEFORE OR SAME DAY OF AN INPATIENT
18	N20	0220	CPHU ENCOUNTER LIMIT - CANNOT BILL MULTIPLE CPHU ENCOUNTERS FOR THE SAME SERVICE DATE
18	N20	5512	RURAL HEALTH ENCOUNTER LIMIT. CANNOT BILL MULTIPLE RURAL HEALTH ENCOUNTERS FOR THE SAME SERVICE DATE.
18	N59	5514	FQHC ENCOUNTER LIMIT - CANNOT BILL MULTIPLE FQHC ENCOUNTERS FOR THE SAME SERVICE DATE.

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18	N59	6062	MORE THAN TWO SURGEONS BILLED MODIFIER 62 FOR SAME RECIPIENT, DOS, PROCEDURE
18	N59	6658	DUPLICATE DENTAL RESIN WITHIN THREE YEARS
22	N59	0720	MEDICARE COVERAGE IS PRESENT
23	N59	2369	MEDICARE COINSURANCE GREATER THAN MEDICARE PAID
24	N59	4181	ENCOUNTER BLANKET DENIAL
29	N59	0405	EXCEPTION CRITERIA
29	N59	0142	CLAIM EXCEEDS 12 MONTH FILING LIMIT
29	M58	0555	EOMB DATE OR 36 MOS. FROM DATE OF SERVICE, WHICHEVER IS LATER.
29	N59	0557	MEDICARE EOMB DATE OR 36 MOS FROM DATE OF SERVICE, WHICHEVER IS LATER.
31	N59	0439	INVALID RECIPIENT ID NUMBER
31	N59	4486	UPDATE IF NUMBER IS INCORRECT, RESUB. IF CORRECT, CONTACT YOUR AHCA
31	N59	0251	INCORRECT MEMBER IDENTIFICATION NUMBER
31	N56	0285	UPDATE. RECIPIENT ELIGIBLE RECHECKED WEEKLY FOR ARRIVAL OF AHCA
31	N59	0253	RECIPIENT INELIGIBLE FOR DOS WILL PEND FOR UP TO 14 DAYS AWAITING AHCA UPDATE RECIPIENT ELIG RECHECKED WEEKLY FOR ARRIVAL OF AHCA UPDATE
31	MA36	0252	RECIPIENT IS NOT ACTIVE
31	N56	0285	UPDATE. RECIPIENT ELIGIBLE RECHECKED WEEKLY FOR ARRIVAL OF AHCA
35	N59	6035	THIS PROCEDURE IS LIMITED TO FOUR TIMES IN A LIFETIME. RESUBMIT CLAIM AND ATTACH DOCUMENTATION WHICH JUSTIFIES EXCEEDING THE LIMIT.
35	N59	6037	LIMIT FIVE TIMES PER LIFETIME
35	N59	6039	LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
35	N59	6042	MALOCCLUSION ADJUSTMENT LIMIT 24 PER LIFETIME
35	N59	6043	INITIAL CONSULTATIONS ARE LIMITED TO ONE PER RECIPIENT PER PROVIDER
35	N59	6052	VISIT LIMITATION EXCEEDED
35	N59	6071	PROCEDURE LIMITED TO FOUR TIMES IN A LIFETIME
35	N59	6072	HAS BEEN PREVIOUSLY MET.
35	N59	6073	NEW PATIENT NURSING HOME VISITS ARE LIMITED TO ONE PER LIFETIME PER RECIPIENT
35	N59	6079	PROCEDURE LIMITED TO FOUR TIMES IN A LIFETIME
35	N59	6082	PREVIOUSLY MET.
35	N59	6083	ORCHIECTOMY IS LIMITED TO TWO IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
35	N59	6084	SALPINGECTOMY/OOPHORECTOMY IS LIMITED TO TWO IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
35	N59	6085	APPENDECTOMY IS LIMITED TO ONE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
35	N59	6087	VISIT LIMITATION EXCEEDED
35	N59	6090	PREVIOUSLY MET.
35	N59	6091	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
35	N59	6092	LARYNGECTOMY IS LIMITED TO ONE PER LIFETIME
35	N59	6093	HAS BEEN PREVIOUSLY MET.
35	N59	6095	SPLENECTOMY IS LIMITED TO ONE TIME IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
35	N59	6097	COMPLETE GASTRECTOMY IS LIMITED TO ONE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
35	N59	6100	HEPATECTOMY IS LIMITED TO ONE TIME IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
35	N59	6101	CHOLECYSTECTOMY IS LIMITED TO ONE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
35	N59	6102	CYSTECTOMY IS LIMITED TO ONE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
35	N59	6103	NORMAL NEWBORN CARE. LIMIT 1 IN LIFETIME.
35	N59	6104	PREVIOUSLY MET.

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<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
35	N59	6105	C SECTION WITH HYSTERECTOMY IS LIMITED TO ONE IN A LIFETIME. THIS LIMIT HAS BEEN PREVIOUSLY MET.
35	N59	6108	WHEEL CHAIR RENTAL LIMITED TO 10 PAYMENTS IN TEN MONTHS, ONCE PER LIFETIME
35	N59	6111	PROCEDURE APPLICABLE TO THIS EDIT ARE LIMITED TO 10 IN A LIFETIME
35	N59	6112	LIFETIME
35	N59	6115	THIS PROCEDURE IS LIMITED TO TWO TIMES IN A LIFETIME
35	N59	6122	THIS PROCEDURE IS LIMITED TO ONE TIME IN A LIFETIME
35	N59	6123	THIS PROCEDURE IS LIMITED TO TWO TIMES IN A LIFETIME
35	N59	6322	PREVIOUSLY MET.
35	N59	6361	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
35	N59	6362	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
35	N59	6364	HOSPICE CAP LIMIT REACHED
38	N59	1085	CLAIM MUST BE PROCESSED THROUGH THE PSN
38	N59	1085	CLAIM MUST BE PROCESSED THROUGH THE PSN
38	N59	0475	ENCOUNTER PAY TO NOT WITHIN SUBMITTER PROVIDER NETWORK
38	N59	6326	PHYSICIAN NOT MEDIPASS PRIMARY CARE PHYSICIAN.
39	N59	3041	PRIOR AUTH LINE NOT APPROVED
40	N59	1061	CLAIM WAS REVIEWED. SRVS DEEMED NON-EMERGENCY AND NON-COVERED.
40	N59	3024	ELECTIVE SURGERY: NO EMERGENCY REPORT
40	N59	3036	ELECTIVE SURGERY EMERGENCY INDICATED
42	MA33	0351	ALLOW TO SUB PERCENT DIFF EX
42	MA33	0351	ALLOW TO SUB PERCENT DIFF EX
42	N59	0470	ALLOWED
42	N43	0660	ALLOWABLE.
42	N59	0470	ALLOWED
42	N43	0660	ALLOWABLE.
42	N59	0362	MEDICARE DEDUCTIBLE GREATER THAN ALLOWED DEDUCTIBLE
42	N59	6299	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
42	N59	6300	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
42	N59	6301	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
42	N59	6302	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
42	N59	6303	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
47	M139	0874	SECOND DIAGNOSIS CODE INVALID
47	M139	0878	FOURTH DIAGNOSIS CODE NOT ON FILE
47	M67	0886	FIFTH DIAGNOSIS CODE NOT ON FILE
47	N59	0887	6TH THRU 11TH DIAG CODE IS NOT FOUND
47	N56	0891	6TH THRU 11TH DIAG CODE IS NOT FOUND
47	M57	0897	6TH THRU 11TH DIAG CODE IS NOT FOUND
47	N59	0899	6TH THRU 11TH DIAG CODE NOT FOUND
47	N59	2453	INVALID DIAGNOSIS TREATMENT INDICATOR
47	N59	0872	FIRST DIAGNOSIS CODE NOT ON FILE
47	M139	0873	SECOND DIAGNOSIS CODE NOT ON FILE
47	M139	0878	FOURTH DIAGNOSIS CODE NOT ON FILE
47	N65	0885	FIFTH DIAGNOSIS CODE NOT ON FILE
47	M144	0888	6TH THRU 11TH DIAG CODE IS NOT FOUND
47	N59	0892	6TH THRU 11TH DIAG CODE IS NOT FOUND
47	N59	0898	6TH THRU 11TH DIAG CODE IS NOT FOUND
47	N56	0891	6TH THRU 11TH DIAG CODE IS NOT FOUND
57	N59	5031	PROCEDURE NOT ALLOWED SAME DATE OF SERVICE
57	N59	5116	NOT ALLOWED WITH EP STUDIES
57	N59	5152	MANAGEMENT

**X12 ADJUSTMENT CODE/ X12 REMARK CODE/ MMIS EOB CODE CROSSWALK**

<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
62	N59	0312	PHYSICIANS-REFER PROV REQD FOR THIS PROC IN FIELD 17A/19. THERAPISTS, HOME HEALTH AND DME SUPPLIERS: SVC REQUIRES A SVC AUTH IN FIELD 17A/19.
62	N29	4012	ABORTION PROCEDURE INDICATED.
62	N29	4022	ABORTION DIAGNOSIS INDICATED.
62	N59	0488	ABORTION CERTIFICATION MISSING
62	N59	0633	DIAGNOSIS REQUIRES PRIOR AUTHORIZATION
62	N59	3000	PRIOR AUTH LINE ITEM IS USED
62	N59	3001	PA NOT ON FILE OR NOT IN DATE
62	N59	2289	PROCEDURE REQUIRES PRIOR AUTHORIZATION
62	N59	3010	PRIOR AUTHORIZATION NUMBER IS MISSING
62	N59	3023	NON-PRIOR AUTHORIZED HYSTERECTOMIES PERMISSIBLE IN DOCUMENTED
62	N59	3035	PROCEDURE PERFORMED ON DOS AFTER PRIOR AUTHORIZATION EXPIRATION DATE
62	N59	3037	ELECTIVE SURGERY - NO PRIOR AUTHORIZATION NUMBER ON CLAIM
62	N59	3044	PROVIDER NUMBER DOES NOT MATCH PRIOR AUTHORIZATION
62	N59	3045	DENTAL CLAIM FILED BEFORE PRIOR AUTHORIZATION BEGINNING VALID DATE
62	N59	3047	SERVICE DATE 912 DAYS AFTER PA ISSUE
62	N59	3048	7/1/98 OR 3333 FOR ADMIT ON OR AFTER 7/1/98, OR XXXX 895 XXX (AFTER 1/1/01)
62	N59	3050	PROCEDURE BILLED NOT IN PRIOR AUTHORIZATION RECORD
62	N59	3059	PERFORMED AS A RESULT OF CHCUP SCREEN. SEE MEDICAID PRO REIM HANDBK
62	N59	6329	EXCEPT SIGNATURE AND DATE OF: PATIENT, PERSON OBTAINING CONSENT AND INTERPRETER.
78	N59	2857	HOSPICE TOTAL UNITS GREATER THAN TOTAL DAYS
92	N59	9999	PROCESSED PER MEDICAID POLICY
96	N59	1071	SECOND SURGICAL PROCEDURE NOT ON FILE
96	N59	1072	THIRD SURGICAL PROCEDURE NOT ON FILE
96	N59	1073	4TH SURGICAL PROCEDURE NOT FOUND
96	N59	1074	5TH SURGICAL PROCEDURE NOT FOUND
96	N59	1075	6th SURGICAL PROCEDURE NOT FOUND
96	N59	0712	AND CASE MANAGEMENT)
96	N59	1050	SERVICE NOT REFERRED BY PRIMARY CARE CASE MANAGER
96	N59	2005	NO CASH PAYMENT FOR HCBS
96	N59	2241	XOVER DATA MISSING AT DETAIL LEVEL
96	N59	2091	RECIPIENT SERVICES COVERED BY HMO PLAN
96	M86	0321	PROCEDURE CODE NOT ALLOWED FOR DATE OF SERVICE
96	N192	0260	SERVICE NOT ALLOWED
96	N59	1027	FIRST SURGICAL PROCEDURE CODE NOT ON FILE
96	N59	1028	SECOND SURGICAL PROCEDURE NOT ON FILE
96	N59	1029	THIRD SURGICAL PROCEDURE NOT ON FILE
96	N59	1030	4TH SURGICAL PROCEDURE NOT FOUND
96	N59	1031	5TH SURGICAL PROCEDURE NOT FOUND
96	N59	1032	6TH SURGICAL PROCEDURE NOT FOUND
96	N59	4108	PROVIDER CHARGE RECORD/ HMO PHP RECORD NOT FOUND
96	N59	1908	PROCEDURE REQUIRES REVIEW REPORT
96	N59	1171	SECOND SURGICAL PROCEDURE NOT COVERED
96	N59	1172	THIRD SURGICAL PROCEDURE NOT COVERED
96	N59	1173	4TH SURGICAL PROCEDURE NOT COVERED
96	N59	1174	5TH SURGICAL PROCEDURE NOT COVERED
96	N59	1175	6TH SURGICAL PROCEDURE NOT COVERED
96	N59	1177	SECOND SURGICAL PROCEDURE NOT BILLED
96	N59	1178	THIRD SURGICAL PROCEDURE NOT BILLED
96	N59	1179	4TH SURGICAL PROCEDURE NOT BILLED
96	N59	1180	5TH SURGICAL PROCEDURE NOT BILLED

**X12 ADJUSTMENT CODE/ X12 REMARK CODE/ MMIS EOB CODE CROSSWALK**

<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
96	N59	1181	6TH SURGICAL PROCEDURE NOT BILLED
96	N59	4874	RANGE 960-981 (PROFESSIONAL SERVICES), IT MUST BE BILLED ON THE CMS-1500
96	N59	5057	SERVICE NOT ALLOWED WITH ANESTHESIA
96	N59	5128	SERVICE NOT ALLOWED WITH CRITICAL CARE
96	N59	6861	PROCEDURE INVALID IN NURSING HOME
97	N59	5032	NOT ALLOWED WITH COMPONENT
97	N59	5036	NOT ALLOWED WITH C-SECTION
97	N59	5042	NOT ALLOWED WITH OBSTETRIC PANEL
97	N59	5043	NOT ALLOWED WITH OBSTETRIC PANEL-LABORATORY
97	N59	5048	NOT ALLOWED WITH LIPID PANEL
97	N59	5049	NOT ALLOWED WITH LIPID PANEL - LABORATORY
97	N59	5052	NOT ALLOWED WITH ARTHRITIS PANEL ? TORCH ANTIBODY PANEL
97	N59	5053	NOT ALLOWED WITH ARTHRITIS PANEL ? TORCH ANTIBODY PANEL LAB
97	N59	5118	NOT ALLOWED WITH COMPONENT
97	N59	5119	NOT ALLOWED WITH COMPONENT
97	N59	5124	NOT ALLOWED WITH C-SECTION
97	N59	5474	PROCEDURE NOT ALLOWED WITH HEPATITIS PANEL BILLING 80059 OR 80074
97	N59	5475	PROCEDURE NOT ALLOWED WITH HEPATITIS PANEL BILLING 80059 OR 80074
97	N59	5476	PROCEDURE NOT ALLOWED WITH HEPATITIS PANEL BILLING 80059 OR 80074
97	N59	5477	PROCEDURE NOT ALLOWED WITH HEPATITIS PANEL BILLING 80059 OR 80074
104	N59	5473	PROCEDURE CODE COMBINATION NOT ALLOWED
107	N59	0401	ELECTRONIC ADJUSTMENT/VOID CLAIM TYPES DO NOT MATCH
107	N59	0566	ELECTRONIC ADJUSTMENT/VOID SET TO DENY
107	N59	1156	ELECTRONIC ADJUSTMENT/VOID ADJUSTING A DENIED CLAIM
107	N59	1157	CLAIM NOT ON HISTORY
108	N59	5114	BED RAILS PURCHASED WITH BED
110	MA119	0102	LAST DATE OF SERVICE AFTER BILLING DATE
110	N59	2128	DATE OF ACCIDENT IS GREATER THAN LAST DATE OF SERV
110	N59	1020	SURGERY DATE AFTER BILLING DATE
110	N59	1021	SURGERY DATE AFTER BILLING DATE
110	N59	1022	SURGERY DATE AFTER BILLING DATE
110	N59	1023	SURGERY DATE AFTER BILLING DATE
110	N59	1024	SURGERY DATE AFTER BILLING DATE
110	N59	1025	SURGERY DATE AFTER BILLING DATE
110	N59	1026	SURGERY DATE AFTER BILLING DATE
118	N59	4183	INVALID COMBINATION OF RPICC SERVICES. THERE IS TPL FOR THIS CLAIM
118	MA64	5626	INVALID COMBINATION OF RPICC SERVICES. THERE IS TPL FOR THIS CLAIM
118	MA64	5627	INVALID COMBINATION OF RPICC SERVICES. THERE IS TPL FOR THIS CLAIM.
119	N59	6505	1 TARGET CASE MANAGEMENT.
119	N59	5121	CMH SERVICES NOT ALLOWED SAME DAY
119	N59	5122	NOT ALLOWED SAME DAY WITH CMH SERVICES
119	M90	6030	MORE THAN ONE UNIT ON THIS CLAIM, REBILL FOR ONE UNIT ONLY.
119	M90	6031	PROCEDURE IS LIMITED TO ONE TIME IN A ONE YEAR PERIOD. IF YOU BILLED FOR MORE THAN ONE UNIT ON THIS CLAIM, REBILL FOR ONE UNIT ONLY.
119	M90	6032	PROCEDURE IS LIMITED TO THREE TIMES IN ONE YEAR PERIOD PER RECIPIENT
119	N59	6033	PROCEDURE LIMITED TO TWO TIMES IN A ONE YEAR PERIOD
119	N59	6034	PROCEDURE LIMITED TO TWO TIMES IN A ONE YEAR PERIOD
119	N59	6038	HAS BEEN PREVIOUSLY MET.
119	N59	6040	SERVICE LIMITED TO ONE IN 280 DAYS. THIS LIMIT HAS BEEN EXCEEDED
119	N59	6044	CRUTCHES ARE LIMITED TO ONE PER YEAR
119	N59	6046	THIS PROCEDURE CODE IS LIMITED TO TWO UNITS PER CLIENT PER MONTH
119	N59	6047	IN A NURSING HOME. SERVICE LIMIT EXCEEDED.
119	N59	6054	TREATMENT PLAN CANNOT NOT EXCEED ONE PER STATE FISCAL YEAR

**X12 ADJUSTMENT CODE/ X12 REMARK CODE/ MMIS EOB CODE CROSSWALK**

<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
119	N59	6055	HEARING AID DISPENSING FEES ARE LIMITED TO ONE IN THREE YEARS
119	N59	6056	MAX ALLOWED 20 UNITS PER CALENDAR MONTH
119	M58	6057	56 MAX UNITS OF SERVICE PER CALENDAR MONTH
119	N31	6058	DAY TREATMENT NOT TO EXCEED 192 UNITS/FISCAL YEAR
119	N59	6061	W1074 LIMITED TO 26 PER FISCAL YEAR FOR CMH
119	N59	6063	CMH LIMIT TO ONE PER FISCAL YEAR
119	N59	6064	BILLABLE LIMIT ONCE MONTHLY
119	N59	6065	COMPREHENSIVE ASSESSMENT LIMITED TO ONE PER FISCAL YEAR
119	N59	6066	PROCEDURE LIMITED TO ONE TIME IN SIX MONTHS
119	N59	6067	NEBULIZER RENTAL LIMIT EXCEEDED.
119	N59	6068	TREATMENT PLAN REVIEW LIMITED TO SIX TIMES PER FISCAL YEARS
119	N59	6069	MORE THAN TWO UNITS ON THIS CLAIM, REBILL FOR TWO UNITS ONLY.
119	N59	6074	PROCEDURE IS LIMITED TO TWO TIMES IN THREE YEARS. IF YOU BILLED FOR MORE THAN TWO UNITS ON THIS CLAIM, REBILL FOR TWO UNITS ONLY.
119	N59	6075	SERVICE LIMITED TO ONE/THREE YEARS
119	N59	6076	C-SECTIONS OR TOTAL OB CARE IS LIMITED TO ONE IN 300 DAYS
119	N59	6081	THIS PROCEDURE IS LIMITED TO TWO IN 280 DAYS
119	N59	6089	THIS PROCEDURE LIMITED TO 6 UNITS PER YEAR PER CLIENT
119	N59	6096	LIMIT OF ONE PRENATAL PAYMENT A YEAR
119	N59	6098	ONE PER MONTH
119	N59	6099	MONTH. PLEASE CHECK THE SUBMITTED CLAIM FOR THE CORRECT UNITS.
119	N59	6106	VAGINAL DELIVERIES OR TOTAL OB CARE IS LIMITED TO ONE PER RECIPIENT IN 280 DAYS. THIS LIMIT HAS BEEN PREVIOUSLY MET.
119	N59	6107	SERVICES APPLICABLE TO THIS EDIT ARE LIMITED TO ONE IN 280 DAYS. THIS LIMIT HAS BEEN PREVIOUSLY MET.
119	N59	6109	PROCEDURES APPLICABLE TO THIS EDIT ARE LIMITED TO ONE IN THREE YEARS
119	N59	6110	WALKERS ARE LIMITED TO ONE PER YEAR
119	N59	6113	THIS PROCEDURE IS LIMITED TO FOUR IN ONE WEEK. LIMIT HAS BEEN MET
119	N59	6116	LIMITED TO 52 PER FISCAL YEAR CMH
119	N59	6118	2PROCEDURE LIMITED TO ONE TIME IN A ONE YEAR PERIOD
119	N59	6119	99203/99214 LIMITED TO ONE PER FISCAL YEAR FOR CMH
119	N59	6125	SERVICE LIMIT 224 UNITS IN 7 DAYS PER RECIPIENT
119	N59	6126	THIS PROCEDURE IS LIMITED TO 10 IN 280 DAYS
119	N59	6127	THIS PROCEDURE IS LIMITED TO 14 IN 280 DAYS
119	N59	6128	ONE VISIT PER RECIPIENT PER PROVIDER PER MONTH
119	N59	6131	CHIROPRACTIC SERVICES ARE LIMITED TO TWENTY-FOUR PER CALENDAR YEAR
119	N59	6132	MORE THAN TWO UNITS ON THIS CLAIM, REBILL FOR TWO UNITS ONLY.
119	N59	6133	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6134	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6135	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6136	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6137	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6138	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6139	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6140	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6141	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6142	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6143	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6144	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6145	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6146	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6147	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6148	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT







**X12 ADJUSTMENT CODE/ X12 REMARK CODE/ MMIS EOB CODE CROSSWALK**

<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
119	N59	6317	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6318	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6319	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6320	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6321	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6323	CHIROPRACTIC SERVICES ARE LIMITED TO TWELVE IN TWELVE MONTHS
119	N59	6324	THIS PROCEDURE LIMITED TO \$500.00 PER MONTH PER CLIENT
119	N59	6325	THIS PROCEDURE LIMITED TO \$500.00 PER MONTH PER CLIENT
119	N59	6330	TREATMENT PLAN CANNOT NOT EXCEED ONE PER STATE FISCAL YEAR
119	N59	6331	SERVICE LIMITED TO ONE IN 280 DAYS. THIS LIMIT HAS BEEN EXCEEDED
119	N59	6332	MONTH. PLEASE CHECK THE SUBMITTED CLAIM FOR THE CORRECT UNITS.
119	N59	6333	THIS PROCEDURE IS LIMITED TO ONE IN SEVEN DAYS
119	N59	6334	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6335	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6336	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6337	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6338	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6339	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6340	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6341	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6342	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6343	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6344	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6345	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6346	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6347	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6348	HMO REFORM SERVICE LIMIT OF 280 DAYS FOR OB SERVICES
119	N59	6350	TREATMENT PLAN CANNOT NOT EXCEED ONE PER STATE FISCAL YEAR
119	N59	6351	TREATMENT PLAN REVIEW LIMITED TO SIX TIMES PER FISCAL YEARS
119	N59	6354	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
119	N59	6355	WITH MEDICAL REPORT ATTACHED.
119	N59	6356	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
119	N59	6357	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
119	N59	6358	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
119	N59	6359	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
119	N59	6360	SNU MAX DAYS EXCEEDED
119	N59	6363	BENEFIT CAP LIMIT HAS BEEN EXCEEDED
119	N59	6365	PROCEDURE LIMITED TO TWO TIMES IN A ONE YEAR PERIOD
119	N59	6368	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT
119	N59	6369	CLAIM/DETAIL DENIED. T1028 UA LIMITED TO 2 UNITS PER 366 DAYS.
119	N59	6370	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 1 UNIT PER MONTH.
119	N59	6371	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO \$7500 PER 366 DAYS.
119	N59	6372	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO \$10,000 PER 366 DAYS.
119	N59	6373	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO \$300 PER 366 DAYS.
119	N59	6374	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO \$5000 PER 366 DAYS.
119	N59	6375	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 14 UNITS PER MONTH.
119	N59	6376	CLAIM/DETAIL DENIED. THIS PROCEDURE CODE LIMITED TO 1 UNIT PER 8 YEARS.
119	N59	6377	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 1 PER MONTH.
119	N59	6378	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 1 UNIT PER 8 YEARS.
119	N59	6379	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 52 PER 365 DAYS.
119	N59	6380	CLAIM/DETAIL DENIED. PROCEDURE LIMITED TO 1 PER MONTH.
120	N59	7834	RECIPIENT SERVICES COVERED BY PMHP PLAN
125	N59	1093	4TH SURGICAL PROCEDURE DATE INVALID

**X12 ADJUSTMENT CODE/ X12 REMARK CODE/ MMIS EOB CODE CROSSWALK**

<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
125	N59	1094	5TH SURGICAL PROCEDURE DATE INVALID
125	N59	1095	6TH SURGICAL PROCEDURE DATE INVALID
125	N59	1098	MISSING OCCURRENCE SPAN CODE AND DATES
125	N59	0317	SPANS
125	N59	1011	SYSTEM ERROR
125	N59	4142	REVENUE CODE NOT ALLOWED FOR DIALYSIS PROVIDER
129	N59	0529	SERVICES HAVE BEEN PAID FOR THE SAME TOOTH SAME DOS
133	M90	6050	1 UPPER TRANSITIONAL APPLIANCE ALWD/12 MON/MEMBER
133	N39	0273	RECIPIENT IS UNDER REVIEW. POSSIBLE PA FOR TRANSPLANT SERVICE
133	MA92	0279	ALIEN - CLAIM REQUIRES MEDICAL REVIEW. IF YOU DID NOT ATTACH MEDICAL TO THIS SUBMISSION, PLEASE DO SO AND RESUBMIT.
133	N59	1077	RECIPIENT IS UNDER REVIEW. POSSIBLE PA FOR TRANSPLANT SERVICE
133	N59	3034	EMERGENCY TREATMENT UNDER REVIEW-DENTAL
133	N59	3358	CLAIM REQUIRES AHCA MANUAL REVIEW
133	N59	4223	PROCEDURE REQUIRES MEDICAL REVIEW
133	N59	4229	DIAGNOSIS REQUIRES MEDICAL REVIEW
133	M139	0612	12TH - 24TH DIAG CODE REQUIRES MED REVIEW
133	N59	4350	DIAGNOSIS REQUIRES MEDICAL REVIEW
133	N59	4802	NO CONTRACT FOR BILLED DIAGNOSIS
133	N59	4812	DIAGNOSIS REQUIRES MEDICAL REVIEW
133	N59	4813	PROCEDURE REQUIRES MEDICAL REVIEW
133	N56	0606	6TH DIAG CODE REQUIRES MED REVIEW
133	M139	0607	7TH DIAG CODE REQUIRES MED REVIEW
133	M139	0608	8TH DIAG CODE REQUIRES MED REVIEW
133	M90	0610	10TH DIAG CODE REQUIRES MED REVIEW
133	M139	0611	11TH DIAG CODE REQUIRES MED REVIEW
133	M139	0612	12TH - 24TH DIAG CODE REQUIRES MED REVIEW
133	N30	0276	SOBRA - CLAIM REQUIRES MEDICAL REVIEW
133	N59	0309	BILLING PROVIDER IS UNDER REVIEW
140	N59	1153	NO MATCH ON RECIPIENT ID
141	N59	0463	DATE
141	N59	0463	DATE
141	N59	0463	DATE
141	N29	0661	SNU LEAVE DAYS PRESENT
146	M139	0875	THIRD DIAGNOSIS CODE NOT ON FILE
146	M139	0875	THIRD DIAGNOSIS CODE NOT ON FILE
147	N59	2601	PART A CROSSOVER SPANS 20020501
147	N59	2599	STOP LOSS THRESHOLD REACHED
148	N59	0358	TREATING PROVIDER/REFERRING PROVIDER NUMBER ARE EQUAL
150	N59	0562	INVALID NURSING HOME LEVEL OF CARE
153	MA63	0831	CLAIM DENIED. DRG CANNOT USE DIAGNOSIS CODE.
160	N59	2581	MEMBER IS LOCKED-IN TO ANOTHER PHYSICIAN
163	N59	0651	WAITING FOR PAPER ATTACHMENT FROM PROVIDER
163	N59	0651	WAITING FOR PAPER ATTACHMENT FROM PROVIDER
164	N59	0485	PAPER ATTACHMENT NOT RECEIVED WITHIN 21 DAYS
166	N59	6502	1 ULTRASOUND PER DAY
167	N59	1145	FIRST DIAGNOSIS CODE NOT COVERED
167	N59	1146	SECOND DIAGNOSIS NOT COVERED
167	N59	1147	THIRD DIAGNOSIS CODE NOT COVERED
167	N59	1148	FOURTH DIAGNOSIS CODE NOT COVERED
167	N59	1149	FIFTH DIAGNOSIS CODE NOT COVERED
167	N59	1169	SIXTH DIAGNOSIS CODE NOT COVERED
167	N59	1182	FIRST DIAGNOSIS CODE NOT BILLED

**X12 ADJUSTMENT CODE/ X12 REMARK CODE/ MMIS EOB CODE CROSSWALK**

<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
167	N59	1183	SECOND DIAGNOSIS NOT BILLED
167	N59	1184	THIRD DIAGNOSIS CODE NOT BILLED
167	N59	1185	FOURTH DIAGNOSIS CODE NOT BILLED
167	N59	1186	FIFTH DIAGNOSIS CODE NOT BILLED
167	N59	1187	SIXTH DIAGNOSIS CODE NOT BILLED
167	N59	4776	DIAGNOSIS NOT COVERED
170	N59	1202	X-OVER CLAIM TYPE NOT ALLOWED FOR PROVIDER TYPE
170	N59	1144	BILLED ON THE CLAIM FORM USED OR NEW ANESTH CODE CONFLICTS WITH
170	N59	1069	PROVIDER NOT AUTHORIZED TO TAPE BILL
170	N59	1603	PROVIDER NOT AUTHORIZED TO TAPE BILL
170	N59	1603	PROVIDER NOT AUTHORIZED TO TAPE BILL
171	N59	1150	OR 74
172	N59	0313	SPECIAL PROGRAM INDICATOR FIELD - ONLY VALID ENTRY IS (04) FOR FAMILY. LEAVE THIS FIELD BLANK UNLESS FAMILY PLANNING APPLICABLE.
177	N59	0721	RECIP INELIG FOR DATE OF SRV - DENIED AFTER BEING PENDED FOR 14 DAYS AWAITING DCF UPDATE. IF YOU HAVE ELIG PROOF CONTACT DCF DISTRICT OFFICE.
177	N59	2100	RECIPIENT INELIGIBLE FOR MEDICAID ONLY SERVICES
181	N59	3601	PROCEDURE/DIAGNOSIS/DRUG NOT COVERED FOR FAMILY PLANNING
181	N20	0361	PROCEDURE CODE NOT ON FILE
181	N59	4046	PROCEDURE CODE NOT ALLOWED FOR DATE OF SERVICE
181	N59	4201	NO RATE ON PROCEDURE FILE FOR DATE OF SERVICE
181	N59	5056	SERVICES NOT ALLOWED ON THE SAME DAY
181	N59	5104	SERVICES NOT ALLOWED ON THE SAME DAY
181	N59	5111	SERVICES NOT ALLOWED ON THE SAME DAY (STANDBY)
181	N59	5112	SERVICES NOT ALLOWED ON THE SAME DAY (NEWBORN)
181	N59	5113	SERVICES NOT ALLOWED ON THE SAME DAY (EPSDT)
181	N59	4415	PROCEDURE NOT ALLOWED WITH NOT ALLOWED WITH S5102
181	N59	5415	PROCEDURE NOT ALLOWED WITH NOT ALLOWED WITH S5101
181	N59	5150	SERVICES NOT ALLOWED ON THE SAME DAY
181	N59	5151	SERVICES NOT ALLOWED ON THE SAME DAY (90749)
183	M68	2346	REFERRING PROVIDER NUMBER NOT ON FILE
A1	M51	1070	FIRST SURGICAL PROCEDURE CODE NOT ON FILE
A1	N59	2623	THE CLAIM WAS CREATED BY A MASS ADJUSTMENT OR A MASS CREDIT
A1	N59	0630	BILLED, A DATE SPAN MAY BE REQUIRED FOR NUMBER OF UNITS BILLED.
A1	N19	0604	INVALID FINANCIAL CLASS CODE
A1	N59	0639	CANNOT AUTO DENY ADJUSTMENT
A1	N59	0643	CANNOT AUTO DENY ADJUSTMENT
A1	N59	0419	INDEPENDENT LABORATORY - INVALID PLACE OF SERVICE
A1	N59	0300	TREATING PROVIDER NUMBER NOT ON FILE
A1	N59	0300	TREATING PROVIDER NUMBER NOT ON FILE
A1	N59	1103	MID-MONTH RATE CHANGE
A1	N59	1158	CANNOT ADJUST A CREDIT
A1	N59	3038	ELECTIVE SURGERY: NO SCREENING ON CLAIM
A1	N59	3039	AUTHORIZED AND NON EMERGENCY AND ARE THEREFORE NOT COVERED.
A1	N59	3042	RECIPIENT NUMBER ON PA DIFF VS CLAIM
A1	N59	3049	MEDICAL I/P PA NOT ON FILE OR DATE ON CLAIM IS NOT IN PA DATE SPAN
A1	N59	4014	SEGMENT
A1	M86	0479	NO CLIA REGISTRATION ON FILE FOR THIS PROVIDER
A1	N59	4208	NO CLIA REGISTRATION ON FILE FOR THIS PROVIDER
A1	N56	0307	NO CLIA REGISTRATION ON FILE FOR THIS PROVIDER
A1	M67	0425	SERV ON A SEPARATE CLAIM LINE.

**X12 ADJUSTMENT CODE/ X12 REMARK CODE/ MMIS EOB CODE CROSSWALK**

<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
A1	N59	1043	CLAIM HAS BEEN REVIEWED. REFER TO EOB CODES 1901 - 1940 FOR DENIAL REASON.
A1	MA32	0914	PAPER CLAIM REQUIRED. SUBMIT WITH REPORT/ATTACHMENT IF INDICATED.
A1	MA32	0914	PAPER CLAIM REQUIRED. SUBMIT WITH REPORT/ATTACHMENT IF INDICATED.
A1	M51	1170	FIRST SURGICAL PROCEDURE NOT COVERED
A1	M51	1176	FIRST SURGICAL PROCEDURE NOT BILLED
A1	N59	1043	REASON.
A1	MA32	0914	PAPER CLAIM REQUIRED. SUBMIT WITH REPORT/ATTACHMENT IF INDICATED.
A1	N59	4371	PROCEDURE CODE NOT COVERED FOR CLAIM TYPE
A1	N59	4801	TYPE LISTED FOR THIS PROVIDER NUMBER CANNOT FILE THIS TYPE OF CLAIM
A1	MA32	0914	PAPER CLAIM REQUIRED. SUBMIT WITH REPORT/ATTACHMENT IF INDICATED.
A1	N59	1043	REASON.
A1	MA32	0914	PAPER CLAIM REQUIRED. SUBMIT WITH REPORT/ATTACHMENT IF INDICATED.
A1	MA32	0914	PAPER CLAIM REQUIRED. SUBMIT WITH REPORT/ATTACHMENT IF INDICATED.
A1	MA32	0914	PAPER CLAIM REQUIRED. SUBMIT WITH REPORT/ATTACHMENT IF INDICATED.
A1	MA32	0914	PAPER CLAIM REQUIRED. SUBMIT WITH REPORT/ATTACHMENT IF INDICATED.
A1	N59	1043	REASON.
A1	N59	1043	REASON.
A1	N59	1043	REASON.
A1	N59	1043	REASON.
A1	N59	1043	REASON.
A1	N59	4282	REASON.
A1	N59	4871	PROCEDURE CODE NOT COVERED FOR CLAIM TYPE
A1	N59	0492	REASON.
A1	N59	1043	REASON.
A1	N59	5033	NOT ALLOWED SAME DAY WITH CMH SERVICES
A1	N59	5035	PAID RELATED CLAIM
A1	N59	5058	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5060	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5061	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5062	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5063	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5065	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5066	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5067	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5068	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5069	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5070	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5071	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5072	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5073	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5074	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5076	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5077	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5078	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5079	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5080	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5081	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5082	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5083	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5084	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5085	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5086	PROCEDURE CODE COMBINATION NOT ALLOWED

**X12 ADJUSTMENT CODE/ X12 REMARK CODE/ MMIS EOB CODE CROSSWALK**

<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
A1	N59	5087	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5088	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5089	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5090	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5091	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5092	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5093	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5094	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5095	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5096	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5097	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5098	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5099	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5100	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5101	PROCEDURE CODE COMBINATION NOT ALLOWED
A1	N59	5117	SERVICE NOT ALLOWED WITH NICU (VARIED)
A1	N59	5120	SPEECH THERAPIES NOT ALLOWED SAME DAY
A1	N59	5130	SERVICE NOT ALLOWED WITH NICU
A1	N59	5140	NOT ALLOWED WITH STFC CRISIS (S5145 HK)
A1	N59	5149	PPEC SERVICES NOT ALLOWED SAME DAY
A1	N59	6041	PAID RELATED CLAIM
A1	M139	0583	PROVIDER AND DATES OF SERVICE ARE NOT ALLOWED
A1	N56	0305	TREATING PROVIDERS CLAIM DENIED AFTER DEPT OF HEALTH AND REHAB SRVS REVIEW
B1	N59	5129	SERVICE NOT ALLOWED SAME DATE OF SERVICE/PROVIDER (VARIED
B1	N59	5132	SERVICE NOT ALLOWED SAME DATE OF SERVICE/PROVIDER (MEDICINE, PSYCH)
B1	N59	5133	SCREENING)
B1	N59	5134	SERVICE NOT ALLOWED SAME DATE OF SERVICE/PROVIDER (CPAP)
B1	N59	5135	CARE/FOLLOW-UP)
B1	N59	5136	SERVICE NOT ALLOWED SAME DATE OF SERVICE/PROVIDER (CIRCUMCISION)
B1	N59	5139	NOT ALLOWED WITH ER SCREENING
B1	N59	6283	UNIT/VISIT LIMIT EXCEEDED
B1	N59	6284	UNIT/VISIT LIMIT EXCEEDED
B1	N59	6286	UNIT/VISIT LIMIT EXCEEDED
B5	N59	6059	UNITS OF SERVICE EXCEED ALLOWED FOR THIS REVENUE CODE
B5	N59	6060	UNITS OF SERVICE EXCEED ALLOWED FOR THIS REVENUE CODE
B7	MA66	0296	PAY TO PROVIDER INELIGIBLE FOR DATE(S) OF SERVICE
B7	N30	0297	PAY TO PROVIDERS GROUP IS NOT VALID FOR THE TREATING PROVIDER
B7	N59	1143	KICK PAY-TO-PROVIDER AND SERV PROV ERR
B7	N59	1200	PAY TO PROVIDER NUMBER IS NOT A GROUP
B7	N59	1602	TREATING PROVIDER IS A GROUP PROV
B7	N59	0480	ENROLLMENT FOR INSTRUCTIONS.
B7	M139	0681	PAY TO PROVIDER NONPARTICIPATING
B7	N59	1002	PRESCRIBER NOT ACTIVE
B7	N59	1201	INSTRUCTIONS
B7	N59	0664	PAY TO PROVIDERS MAIL IS UNDELIVERABLE. CONTACT PROVIDER ENROLLMENT FOR INSTRUCTIONS.
B7	N59	1990	OUT-STATE PROV NON-PARTICIPATING
B7	N59	2516	PROVIDER TYPE NOT ON TPL MATRIX
B7	N59	4086	INDEPENDENT LAB NOT CERTIFIED
B7	N59	4161	INDEPENDENT LAB NOT CERTIFIED
B7	N59	4804	PROVIDER INELIGIBLE FOR CATEGORY OF SERVICE FOR THIS DATE OF SERVICE
B7	N59	4806	PROVIDER INELIGIBLE FOR CATEGORY OF SERVICE FOR THIS DATE OF SERVICE

**X12 ADJUSTMENT CODE/ X12 REMARK CODE/ MMIS EOB CODE CROSSWALK**

<b>X12 ADJUSTMENT CODE</b>	<b>X12 REMARK CODE</b>	<b>MMIS EOB Code</b>	<b>MMIS EOB Text</b>
B13	N59	2097	COVERED IN PER DIEM
B13	N59	1155	CLAIM HAS ALREADY BEEN CREDITED/ADJUSTED
B13	N59	6086	NEW PATIENT VISIT HAS BEEN PREVIOUSLY PAID
B14	N59	5030	NOT ALLOWED SAME DATE OF SERVICE
B14	N59	5059	MULTIPLE VISITS SAME DAY
B14	N59	5115	NOT ALLOWED SAME DAY, SAME RECIPIENT, SAME PROVIDER
B14	N59	5137	NOT ALLOWED SAME DATE OF SERVICE - OB
B14	N59	5138	NOT ALLOWED SAME DATE OF SERVICE ? HOME HEALTH
B14	N59	5146	MANAGEMENT)
B14	N59	5147	MANAGEMENT)
B14	N59	5148	MANAGEMENT)
B18	M139	0737	INVALID PROCEDURE CODE AND MODIFIER
B18	N59	5142	NOT ALLOWED WITH ROOT CANALS
B18	N59	5143	NOT ALLOWED WITH PULP DEBRIDE
B18	N59	0110	EDI EDIT DO NOT RESUBMIT.
B20	N59	6863	POSSIBLE DUPLICATE CONFLICT. MAY BE A CONFLICT WITH ANOTHER PROVIDERS CLAIM
D21	N59	1079	DIAGNOSIS NOT SPECIFIC
D21	N59	1162	FOURTH DIAGNOSIS IS SUB-CLASSIFIED
D21	N59	1163	FIFTH DIAGNOSIS IS SUB-CLASSIFIED
D21	N59	1164	SIXTH DIAGNOSIS IS SUB-CLASSIFIED
D21	N59	1165	SEVENTH DIAGNOSIS IS SUB-CLASSIFIED
D21	N59	1166	EIGHTH DIAGNOSIS IS SUB-CLASSIFIED
D21	N59	1167	NINTH DIAGNOSIS IS SUB-CLASSIFIED
D21	N59	1168	10TH - 24TH DIAGNOSIS IS SUB-CLASSIFIED
D21	N59	1159	FIRST DIAGNOSIS IS SUB-CLASSIFIED
D21	N59	1160	SECOND DIAGNOSIS IS SUB-CLASSIFIED
D21	N59	1161	THIRD DIAGNOSIS IS SUB-CLASSIFIED