Situation Codes on Provider Claim Summary

Situation Code	Message on EOB	Meaning	What should I do?
1	Child is not eligible on service dates.	This means the child's IFSP dates do not cover the service date(s) being billed or the child is now three years of age. IFSP's and authorizations end the day before the child's third birthday.	If the child has not reached the age of 3, contact your CFC to verify IFSP dates. If the service date is the day prior to the child's third birthday or after, the claim is not billable to the CBO
4	Program benefit is limited to one medical diagnostic evaluation per child, per year.	Only one diagnostic evaluation is approved for a child one time per year.	Verify the date of service the last diagnostic evaluation was billed for.
6	Services are not authorized.	There is no authorization in the CBO system for the services being billed.	You should contact the Call Center if you have a printed copy of the authorization. If not, contact your CFC. Do not bill the CBO until you verify the authorization is in the CBO system.
7	Claim exceeds the 9 month filing limit.	The CBO requires all provider billings related to a child's authorization be received no later than 9 months following the completion of the services.	If the claim was delayed due to primary insurance you should resumbmit the claim to the attention of the Claim Processing Supervisor for review.
13	Each line of service must be filled out completely. Ditto marks are not acceptable.	The CBO will not accept claims with ditto marks.	Fill out each line of service completely and resubmit the claim to the CBO.
16	Charges exceed the EI program allowable rate.	The CBO system cuts back any changes billed by the provider that is more than the EI rate or fee.	Verify you billed the CBO for the correct intensity and procedure code. Contact the Call Center if an error was made by the CBO. If you billed incorrectly, resubmit the claim with the correct information and write "corrected" on the claim. If there was no error, the balance should be written off and not billed to the family.
19	Insurance carrier's explanation of benefits was not received.	If an EOB is needed by the CBO a letter will be sent to the provider. The provider is given 90 days to send the EOB to the CBO or the claim will be denied.	Even after the initial denial the provider can still submit the claim to the CBO with the EOB attached.
21	Authorized procedure limit has been exceeded. Please check your authorization for frequency/ intensity of services.	This means there are no dollars/services left on the authorization.	Check your authorization for the intensity and frequency that DHS has agreed to pay.
24	Unable to pay the evaluation because the IFSP meeting has not been billed to the CBO or was not billed as authorized. If the meeting was not attended a letter from the CFC is required.	Per DHS policy, the provider must attend the initial IFSP meeting in order to be paid for the evaluation. If the IFSP meeting has not been billed and paid at the CBO the evaluation will not be paid.	Visit the DHS website regarding this procedure. If the provider was unable to attend the IFSP meeting contact the CFC for a letter. Attach the letter to the evaluation claim and submit to the CBO for payment.
27	Charges have been paid previoulsy.	The CBO system automatically denies any charges that have already been paid.	Review the EOB and check your files for payment. If payment cannot be located and you cannot find the EOB, contact the Call Center who will request a copy of the CBO Explanation of Benefits.
28	The amounts billed to insurance and the CBO don't match.	This means the provider has billed one amount to the insurance company and a different amount to the CBO.	Review the claims billed to insurance and the CBO. Resubmit the claim to the CBO with the same billed amount billed to insurance.
30	Child has secondary insurance which must be billed and requires EOB's from both insurance companies be submitted to the CBO.	This means the provider has to bill the primary and secondary insurance before billing the CBO.	The provider must bill the secondary insurance and resubmit the claim to the CBO with EOB's from both insurance companies attached.
31	CBO records indicate this child's insurance has	This means the family has a new insurance carrier.	The provider should contact the family or CFC to obtain

	changed. Resubmit the claim with an EOB from the current insurance carrier.		the latest insurance information.
33	This service was previously paid by insurance and therefore the denial submitted is not payable by the CBO.	This means the CBO has an EOB from the insurance showing payment had been made on other dates of service.	Check the denial reason on the insurance EOB. The provider may need to resubmit the claim to the insurance depending on the denial reason. May need to call for technical assistance.
34	This service is not billable to insurance per DHS policy. Refund the insurance payment and re-bill CBO with claim and proof of refund.	The service billed is not billable to insurance therefore should not be billed to insurance per DHS rule and policy.	The provider should refund the insurance company then re-submit the claim to the CBO along with the proof of the refund to the insurance attached to the claim.
35	The CBO cannot process payment on this claim until an explanation of the denial code is submitted.	This means there is no denial reason explanation listed on the insurance EOB. The CBO cannot pay without a denial reason.	The provider should resubmit the claim, with the entire EOB including the denial reason, to the CBO for consideration of payment.
39	The denial reason on the EOB is insufficient or not payable by the CBO.	This means the CBO cannot pay the claim based on the denial reason given on the EOB.	The provider should review the denial reason on the EOB. The insurance may be asking for more information from the provider which means the claim may need to be resubmitted to insurance again before submitting to the CBO.
40	The claim cannot be paid because the associate level provider was not credentialed on the date of service billed.	This means the latest information received by the CBO from Provider Connections indicates the associate level provider was not credentialed on the date of service.	You will need to contact Provider Connections to verify.
41	The procedure code/modifier combination submitted is not a valid service under the Early Intervention program. Please correct these codes and resubmit them for payment.	This means the CBO does not recognize the procedure code billed.	You should refer to the DHS Website for the procedure code list. Correct the code on your claim and resubmit.
42	The type of service/discipline interpreted is missing. Ex: PT, OT, ST written next to the procedure code.	This means the CBO needs to know what type of discipline was interpreted because many provider's interpret for more than one service type in a day. This may cause claims to deny as a duplicate.	You need to write the type of service you interpreted for in box 23 of the CMS-1500 form. See the Billing Information for Providers booklet at www.eicbo.info for more information.
45	There is a DHS insurance exemption in place for this service date. Refund the insurance and re-bill the CBO with proof of refund.	When there is an exemption in place the provider cannot bill the insurance for it.	The provider should refund insurance their payment and re-submit the claim to the CBO with the proof of refund.
46	The CBO is in receipt of an insurance EOB that is not an original copy. Resubmit the claim with an original copy of the EOB attached.	This means the original EOB appears to have been adjusted by hand or altered in some way from it's original form.	The provider should obtain a corrected EOB from the primary insurance or provide the CBO with a original unaltered copy along with the claim.
47	The insurance carriers EOB received is not legible.	This means the CBO cannot clearly read the EOB.	The provider should provide the CBO with a legible copy of the EOB along with the claim.
48	Claim exceeds the 90 day filing limit.	The CBO requires all provider billings related to a child's authorization be received no later than 90 days following the completion of the services or from the last communication from the insurance company.	If the claim was delayed due to primary insurance you should resumbmit the claim to the attention of the Claim Processing Supervisor for review.
49	The ICD-9 treatment diagnosis is missing or invalid.	The CBO requires a ICD-9 treatment diagnosis on the claim form.	The provider should correct the claim and resubmit the claim to the CBO.
99	Freeform message.	This is a freeform message entered by a EI Claims processor. This is information only pertinent to a certain claim or provider.	Read the message carefully. Contact the Call Center for further explanation of message.