Situation Codes on Provider Claim Summary

Situation Code	Message on PCS	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	No matching authorization found.	There is no authorization in the CBO system for the services being billed.	The provider should contact the Help Desk 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.
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 charges 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 Help Desk if an error was made by the CBO. If you billed incorrectly, resubmit the claim with the correct information and write "correction" 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.	This means that an EOB is needed for the date(s) of service billed on the claim form. The insurance carrier's EOB is required for payment consideration by the CBO.	Bill the insurance carrier and resubmit the claim to the CBO with the EOB attached. If you have billed the insurance carrier, resubmit the claim with the EOB attached. If a waiver is in place or the insurance coverage has been terminated contact the Help Desk for assistance.
21	Authorized procedure limit has been exceeded. Please check your authorization for frequency/ intensity of service.	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 policy. If the provider was unable to attend the IFSP meeting, contact the CFC for a letter. Attach the letter to the evolution claim and submit to the CBO for payment.
26	Intensity billed over authorized amount.	The intensity billed on this claim exceeds the authorized amount.	Check your authorization for the intensity DHS has agreed to pay.
27	Charges have been paid previously.	The CBO system automatically denies any charges that have already been paid.	Review the PCS and check your files for payment. If payment cannot be located, contact the Help Desk who can provide the claim number and date of the PCS the claims data displays on.

28	The amounts billed to insurance and the CBO don't match.	This means that provider has billed one amount to the insurance company and a different amount to the CBO.	Review the claims billed to the insurance and the CBO. Resubmit the claim to the CBO with the same billed amount billed to insurance carrier.
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 must 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 carriers attached.
31	CBO records indicate this child's insurance has changed. Resubmit the claim with an EOB from the current insurance carrier.	This means the family has a new insurance carrier.	The provider should contact the family or CFC to obtain the latest insurance information.
33	This service was previously paid by insurance and therefore, the denial submitted is not payable.	This means the CBO has an insurance EOB on file from the insurance carrier showing they previously made payment on another dates of service.	Check the denial reason on the insurance EOB. The provider or biller should contact the insurance carrier for more information regarding the recent service denial. The provider may need to resubmit the claim to the insurance depending on the denial reason.
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 resubmit 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 and 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 give 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 the 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 or translated is missing. Ex: PT,OT ,ST,SR written in box 23 of CMS -1500 claim form.	This means the CBO needs to know what type of discipline was interpreted because many providers interpret for more than one service type in a day. This may cause claims to deny as a duplicate.	The provider should write the type of service they 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 services.	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 its original form.	The provider should obtain a corrected EOB from the primary insurance or provide the CBO with an original unaltered copy along with the claim.
47	The insurance carrier's EOB received in 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 resubmit the claim along with an informational letter to the attention of the Claim Processing Supervisor for review.
49	The ICD-10 treatment diagnosis is missing or invalid.	The CBO requires an ICD-10 treatment diagnosis on the claim form.	The provider should correct the claim and resubmit the claim to the CBO.
53	Private insurance declined. Refund	Parent declined use of private insurance. Please refund insurance and resubmit to CBO with proof or refund.	The provider should refund the insurance company and resubmit proof of the refund to the CBO. Proof of refund includes, a copy of the processed check issued to the insurance carrier and a copy of the adjusted EOB from the insurance carrier. See' How to Send Resubmitted or Corrected Claims to the Central Billing Office' at www.eicbo.info for additional information.
54	Private insurance declined. Resubmit	Parent declined use of private insurance. Resubmit to insurance as billed in error then resubmit correction to CBO.	The provider should notify the insurance carrier that the claim was billed in error. Resubmit the adjusted insurance EOB along with a claim form to the CBO. See 'How to Send Resubmitted or Corrected Claims to the Central Billing Office' at www.eicbo.info for additional information.
99	Freeform message.	This is freeform message entered by an EI Claims Processor. This information is only pertinent to a certain claim or provider.	Read the message carefully. Contact the Call Center for further explanation of message.