

**WASHINGTON STATE DEPARTMENT OF HEALTH
EARLY INTERVENTION PROGRAM (EIP)
MESSAGE CODE DESCRIPTION AND INSTRUCTIONS**

DOH 410-052 October 2016

This guide supersedes all previous message code descriptions and/or instructions published by the Early Intervention Program (EIP), Washington State Department of Health. The following descriptions and instructions must be followed to remain compliant with your Early Intervention program (EIP) contract. All paid services are reimbursed at our maximum allowed amount unless otherwise stated. The difference between the billed amount and EIP's allowed amount and/or the amount paid by EIP is not billable to the client.

CPT Code 90000- Represents multiple services and/or services non-covered by EIP that is being denied for the same reason (EOB code).

Code	Instruction/Description	
P00	Split payment	Payment has been split between deductible, coinsurance and/or co-pay.
P01	Pay full payment	Client is uninsured and accessing services with EIP as the only payer so services are paid up to full EIP allowed amount.
P02	Payment applied toward deductible	Client is insured; payment may be up to the full EIP allowed amount and is applied to the deductible. Remaining balance may NOT be billed to the patient.
P03	Pay during Pre-Exist Condition period	Client is insured and service is paid up to the full EIP allowed amount since it's denied by the primary insurance due to a pre-exist condition. Provider can NOT bill client for the balance.
P12	Pay Co-insurance	Client is insured; payment may be up to the full EIP allowed amount and payment was applied to coinsurance. Remaining balance may NOT be billed to the patient.
P39	Pay Co-pay	Client is insured; payment may be up to the full EIP allowed amount and payment was applied to co-pay. Remaining balance may NOT be billed to the patient.
D00	Deny Client is not eligible on Date of Service	Coverage not in effect at the time the service was provided.
D02	Deny Medicaid Coverage	The client may be eligible for Medicaid coverage on DOS. The provider may bill the client or Medicaid/HCA for these services.
D05	Deny exception request	The provider may bill the client for these services.
D11	Deny missing EOB info from primary insurance.	The provider must submit a copy of the primary EOB with the claim to be reprocessed. You may NOT bill the client during this time.
D13	Deny primary insurance paid in full	The submitted EOB indicates no client financial responsibility since the primary insurance paid their full contracted amount. The provider may NOT bill the client for these services.
D17	Dental Max Paid	\$3000 EIP dental Max has been Paid. The provider may only bill the client the EIP allowed amount for the service.
D30	Deny procedure not covered on DOS	Procedure is not an EIP covered service. The provider may bill the client for these services.
D31	Claim over 9 months old	Claim not submitted within required time limits. You may appeal this denial if you have documented proof that the client NEVER provided Early Intervention Program coverage information. You may NOT bill the Client.
D32	Duplicate Claim	The claim was previously submitted and paid. Contact the Early Intervention Program if you cannot locate a payment for the service date.
D33	Deny Provider not contracted on DOS	Providers must have an active contract with the Early Intervention Program (EIP) to be reimbursed. The provider may bill the client for these services.
D34	Deny no Preauthorization	The billed service is not an allowed service or was not preauthorized.
D35	Insufficient Information received with claim	You must provide a copy of a detailed explanation of benefits from the primary insurance that has amount paid for deductible, Co-payment and Co-insurance listed for each service. You may NOT bill the client during this time.

Code	Instruction/Description	
D37	Deny service considered included in other service	This service is considered complimentary to another service performed on the same day. You may NOT bill the client.
D38	Deny Incomplete Client Application	Client has not provided all needed information to complete the application process. Please check client's ID card for coverage dates.
D40	Deny service ineligible for coordination of benefits on DOS	<input type="checkbox"/> The service was performed after December 31, 2010, and not allowed by the primary insurance. <input type="checkbox"/> The provider may bill the client for these services.
D41	Deny procedure not allowed in Group 2	This service is not allowed in Group 2 coverage. The provider may only bill the client the EIP allowed amount for the service.
D42	Deny procedure not allowed in Group 3	This service is not allowed in Group 3 coverage. The provider may only bill the client the EIP allowed amount for the service.
D43	Emergency room and related services are not covered.	The Early Intervention Program (EIP) does not cover emergency, in-patient or most radiology services.
D45	Incorrect back up sent with claim	We received a claim but the EOB submitted does not include either the patient name, date of service or corresponding procedures listed on the claim.
E01	Partial payment – dental max exceeded	\$2500.00 EIP dental Max has been Paid. The provider may only bill the client the EIP allowed amount for the service.
E02	Partial payment – deductible max exceeded	Deductible Max Paid for Client. The provider may only bill the client the EIP allowed amount for the service.
E04	Exception authorized	The exception request has been approved and is paid at full EIP allowed amount. Provider can NOT bill client for balance.
E05	Claim reprocessed to correct error	The provider may NOT bill the client for these services while correction is being processed.
E11	Resubmit with primary insurance EOB	The provider must submit a detailed copy primary EOB with the claim to be reprocessed. You may NOT bill the client during this time.
E12	Resubmit with Regence EOB	The provider must submit a detailed copy primary EOB with the claim to be reprocessed. You may NOT bill the client during this time.
E13	Resubmit with Premiera EOB	The provider must submit a detailed copy primary EOB with the claim to be reprocessed. You may NOT bill the client during this time.
E14	Resubmit with Medicare EOB	The provider must submit a detailed copy primary EOB with the claim to be reprocessed. You may NOT bill the client during this time.
E15	Resubmit with PCIP-WA EOB	The provider must submit a detailed copy primary EOB with the claim to be reprocessed. You may NOT bill the client during this time.
E16	Resubmit with WSHIP EOB	The provider must submit a detailed copy primary EOB with the claim to be reprocessed. You may NOT bill the client during this time.
E17	Less than \$500 Dental allowance remaining	Please verify coverage before the next visit.
E18	Resubmit with Aetna EOB	The provider must submit a detailed copy primary EOB with the claim to be reprocessed. You may NOT bill the client during this time
E19	Resubmit with Cigna EOB	The provider must submit a detailed copy primary EOB with the claim to be reprocessed. You may NOT bill the client during this time
E20	Resubmit with United EOB	The provider must submit a detailed copy primary EOB with the claim to be reprocessed. You may NOT bill the client during this time
E22	Client did not reapply for assistance	The patient is not eligible because he/she did not reapply for assistance
E23	Client is eligible for Medicaid	Our records show that the patient is eligible for Medicaid. Bill future services to Medicaid.
E24	Service exceeds coverage maximum	Coverage limits for this procedure have been exhausted for the coverage period.