

Status Reason (Pend) Codes

<u>Alpha-numeric Status Reason Codes:</u>	
01X: Incomplete claim information	
010	Date of Service
011	Type of Service
012	Patient's name
013	Line Service Charge
014	Provider ID
015	Place of Treatment
016	Total Charge
017	Procedure
018	Diagnosis
019	Admission Date or Billed from Date missing or invalid
01A	Discharge Date or Billed to Date missing or invalid
01B	Patient's Birthdate
01C	Patient's Address
01D	Operating Room Charge
01E	Delivery Room
01F	Anesthesia Charge
01G	Itemized Bill
01H	Contacting provider for license number
01J	Surgicenter Services - Investigation
01K	Provider inactive or license not renewed - Investigation
01M	Illinois Provider, no Provider Number
01P	Claim Type was either not provided or not valid
01Z	Other Incomplete Claim Information
02X: Additional Claim Information	
020	Operative Report
021	Anesthesia Units
022	Date of Accident
023	Provider Information
024	Time/Miles
026	Date of Onset
027	Late Checkout Reason
028	Private Room Reason
029	Late Charge Reason
02A	Verify Date Count
02B	MD Visits: Number of, Charge, Date
02C	Size, Number of Location (Cysts, etc.)
02D	RN/LPN License Number
02E	Medicare EOB
02F	Medicare Effective Date
02G	Need Medicare B Review
02H	No Pre-Certification Form attached claim returned to hospital
02I	Illinois Department of Public Aid (IDPA) Information
02J	Claim Reviewed by MRU/Medical Department, disposition maintained

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02K	Treatment Begin Date Research
02N	Medicare EDS System Information
02P	Claim previously pending for additional information from the provider by a PAR plan
02Z	Other claim information
	03X: Medical Necessity
030	Medical Records
031	Physician Certification
032	Operative Report
033	Long Stay Forms
034	Peer Review
035	Physician Certification - Pvt. Duty Nurse
036	Physician Certification - DME
037	Physician Certification - Ambulance
038	Transmittal Form (Psych Concurrent Review)
039	Private Room Certification
03A	Medical Group Approval
03B	Medical Necessity - Possible IPS
03C	Medical Necessity - Possible HCNR
03D	Medical Necessity - Partial IPS/HCNR
03E	Medical Necessity - Excessive Passes
03F	Medical Necessity - Length of Stay
03G	Medical Necessity - Dental Inpatient
03H	Nursing Notes requested
03P	Admit Date is not a valid date
	040X: Waiting Period
040	Pre-Existing Condition
041	Waiting Period not met
042	Pre-Existing reviewed, disposition maintained
043	Pre-Existing HIPAA Group
	050X: COB Investigation
050	COB Investigation
051	Secondary Payment
052	Secondary no payment
053	No Response CSQ
054	No Response DCI
055	OIC did not receive bill
056	OIC did not pay bill
057	Patient covered under spouse's policy with the same employer, no COB
058	Requesting other carrier EOB from our subscriber
05L	COB File Link problem
05P	Invalid To Date on Line No: XXX
05R	D & R Investigation
05S	Awaiting COB system update
	06X: Other TPL Investigation
060	Worker's Compensation
061	Medicare

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06P	From and To Date not provided on Shield claim
SUBRO	This code should be used exclusively on Subrogation and Reimbursement claims. It can be used until the Fund receives the correct information to process and finalize the claim. <i>Please note that this code should be reported in the second occurrence of the RFI Letter Code field (EDF2-RFI-Letter-Cd; position 100; 5 bytes). The first occurrence is reserved for the HIPAA Code.</i>
	07X - 120: In House Assistance
070	Medical Review Unit referral
071	Legal Department referral
072	Provider Affairs Departmental referral
073	Professional Relations Department referral
074	Training Department referral
075	Supervisor Assistance
076	Open Major Medical Claim under HCSC
077	Technical Assistance
078	Dental Department referral
079	Statistical Debit Awaiting FSS
07A	Advance Check Awaiting FSS
07B	Cost Containment file look-up/ referral
07C	Contract Assistance - Uncoded or incorrectly coded logic
07D	Provider hold flag investigation
07E	From Provider File area to Hospital Provider Affairs
07I	Contract Interface problem
07J	Internal Pend - Contract discrepancy
07K	Internal Pend - No paper work from Contract Processing
07M	MSA Department referral
07N	Operator has determined claim must be investigated for possible fraud (No Hold Flag exists)
07P	Provider File problem
07Q	Production & Quality Control referral
07T	SSD Technical Support referral
07U	GCPS archived file needed
080	Special Investigation Fraud - Used only when additional information has been requested from Corporate Quality Review (CQR). (NMIS errors will be charged for using 080 without prior authorization from CQR)
08P	Unexpected fatal error: Systems Error Code
090	Outside Assistance - Out-of-state Customary
091	Foreign claim handled by other than HCSC
092	Benefit handled by other than HCSC
093	Student Health Services verification
094	Group Required - Out-of-state pricing
095	HMOI/Medical Group responsibility investigation
096	All services for Mental and/or Drug or Alcohol Abuse are not covered
097	Group has not identified benefit requirements
09P	No data passed
100	Training
10P	Corporate Indicator was either not provided or not valid
110	Quality Review
11P	Claim Service Line: Overlaps cut-off date

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120	Non-Retention Membership
12P	Claims Service Line: XXX Overlaps cut-off date
	13X -140: Miscellaneous
130	Miscellaneous
131	Illinois hospital claim must be hospital submitted
132	Prior to HCMS conversion (process on prior system)
133	Charges considered on prior/different claim system
134	Item is not a claim
135	Non-approved state Medical Assistance Program
136	Foreign claim review
137	Substance Abuse history investigation
138	Fake claim for systems testing
139	Batch mode hospital
13P	BCBS code was either not provided or not valid
140	Multiple reasons
14P	Corp entity CCD was either not provided or not valid
	15X: Membership
150	No record of coverage
151	Coverage cancelled
152	Service prior to effective date
153	Dependent not covered
154	Name differs
155	Age differs
156	Student Certification
157	Disabled Certification
158	Insufficient membership information
159	Dental coverage only HCMS research
15A	Service after expiration date research
15B	Direct Membership not handled through HCMS
15C	Blue Cross coverage only
15D	Diagnosis file problem
15E	Eligibility of member/spouse
15F	Membership file problem
15G	Grace period exceeded - research
15H	Inpatient Blue Cross coverage only
15I	More than 5 key changes in membership
15J	Terminal Obstetrics benefit research
15K	Away from Home Care membership being investigated by Host Plan
15L	Away from Home Care membership being investigated by Home Plan
15M	Claim dates greater than members package code/effective dates
15N	Membership is rescinded
15P	Programming problem
15Q	Insufficient Qualified Medical Child Support payee information
15S	Member/group stop
15T	Not timely filed
15U	FEP, non-Illinois provider cannot be paid by FEP

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15Z	PAR plan shows no membership on file - zero priced line involved
	16X: Patient
160	Overage dependent
161	Services rendered after patient expired
162	No spouse coverage
163	No dependent trailer on membership - required
164	Group recertification for benefit eligibility
165	TOB date calculation required
166	Start-up date calculation required
167	Group determined patient ineligible
168	Investigate possible duplicate patient
169	Termination of Benefits research
16A	HMOI clinic number investigation
16P	Error reading criteria file
	17X: Document Control
170	Not an HCMS group
171	No Transrouting for group
173	Changed the Mailroom Received Date
	18X - 2XX: Service
180	Benefit code can not be derived
181	Provider billing error
182	Services for future dates
183	Procedure file problem
184	Derivation problem
185	Provider Type invalid for procedure
186	OB/normal newborn eligibility
187	Procedure Code invalid for diagnosis
188	Separate baby's charges from mother's claim
189	Baby's charges not billed on mother's claim
18P	Non-Plan facility claim pended for pricing
190	Prior history check
191	Programming problem
192	Pricing-internal general
193	Accumulator table occurrences exceeded
194	Diagnosis file problem
195	Maximum reinstatement data being researched
196	Internal use only; possible duplicate, awaiting microfilm
197	Duplicate charge
198	Overlapping admission/OP within IP
199	Continuous stay problem
200	Follow-up for surgery research
201	TPL calculation problem
202	PAR denial
203	Year not on Medicare table
204	Billing more than 30 Medicare coinsurance days
205	Medicare deductible exceeded

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206	Dental, Cosmetic, Congenital (DCC) investigation
207	Partial Payment for future Obstetrics/delivery charge
208	Maximum Met - research and possible manual calculation required
209	Medicare Crossover adjustment investigation
210	Non-covered charges
211	FRAK occurrence exceeded
212	All CMIC Cross claims must be pended at this time
213	Unable to release split payments for CMIC
214	Pricing-drug and related services and "J" codes (Internal)
215	Pricing-CPT Modifiers (Internal)
216	Pricing-Ambulance and related services (Internal)
	30X: Claim Release
300	Draft limit exceeded
301	Draft limit exceeded for member payee
	4XX: Cost Containment Outside Investigation
4AS	Mandatory Additional Surgical Opinion (MASOP)
4AT	Additional Transplant Coverage Program (ATCP)
4MH	Mental Health Care
4MN	Medical necessity
4MO	Mandatory Outpatient Surgery Program (MOPS)
4MS	Medical Services Advisory Program (MSA)
4MU	Multiple Cost Containment Programs
4PP	Preferred Provider Option (PPO)
4PR	Pre-Admission Review Program(PAR)
4PT	Pre-Admission Testing Program(PAT)
4SU	Sunderbruch Investigation
4UR	Utilization Review
4WE	Weekend admission
	60X: Manual Check Release
610	House Bill
611	Claim processed in accordance with Texas Legislation; further investigation possibly required
612	BCBSTX has reviewed the claim and maintains original payment
613	BCBSTX has deemed these services ineligible for benefits, a refund is being requested.
	90X: FSS
900	Inconsistent FSS file information
901	Held for prior advance check
902	Stat Debit - no additional payment
903	Stat Debit - additional payment