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FACT SHEET
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Checking Medicare Claim Status

What's Changed?

We added information about the Fiscal Intermediary Standard System (FISS) claim status functionality (page 3).

Substantive content changes are in dark red.

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Health Insurance Portability and Accountability Act (HIPAA)-covered entities, like health plans, clearinghouses, and certain health care providers, must check claims' status according to federal operating rules. These rules streamline how you get claim status information electronically.

What Happens After I Submit a Claim?

After you submit a claim to your Medicare Administrative Contractor (MAC), it goes through an editing process:

1. Your MAC conducts initial edits, also called front-end edits or 277CA Health Care Claims Acknowledgements, to determine if your claim meets basic HIPAA requirements. If the system detects errors at this stage, your MAC will reject the entire batch of claims for correction and resubmission.
2. Once your claims pass the initial edits, your MAC edits them against HIPAA implementation guide requirements. If the system detects errors at this stage, your MAC rejects only individual claims with errors for correction and resubmission.

These 2 editing steps can take up to 3 days. Don't resubmit your claim while it's in the editing process because that creates a duplicate claim.

Once your claim passes the first 2 levels of edits, the MAC accepts the claim and assigns a unique tracking number, called a:

- Document Control Number (DCN) for Medicare Part A or Home Health and Hospice (HHH) claims
- Internal Control Number (ICN) for Medicare Part B claims

How Do I Know My Accepted Claim's Status?

Your MAC uses Status/Location (S/LOC) codes to define the status of your **accepted** claim as it moves through the processing system.

Once the MAC accepts your claim, its initial S/LOC code is:

- S (Suspense) code (Part A/HHH claims)
- B code (Part B claims)

If you see either of these codes, it means your MAC is currently processing the claim. You can't make changes or additions to a claim while it's in S (Part A/HHH) or B (Part B) status.

If the MAC **rejected** or returned your claim, your electronic or hard copy remittance will explain why. You may see these S/LOC codes for rejected claims:

- R code (Part A/HHH claims)
- W code (Part B claims)

For Part A/HHH claims, you may see a Returned to Provider (RTP) code. If you encounter an RTP code on a claim, review the specific code and the accompanying explanation to understand the reason for the return. You can then take appropriate steps to correct the issue and resubmit the claim if necessary.

What's a Clean Claim?

A clean claim is a claim that MACs don't need to investigate or develop outside the MAC's Medicare operation on a prepayment basis. This means the MAC can process the claim without getting more information from another source, like the provider or a third party.

When Should I Check My Claim's Payment Status?

All clean claims go through a waiting period, or payment floor, before we make a payment determination. We can't finalize, or pay for, the initial determination on a clean claim during this period.

To check the payment status of a clean claim, wait at least:

- 14 days for electronic claims
- 29 days for paper claims

Processing time can vary. For example, a claim may take longer to process if the MAC needs more information. Once the waiting period is over, your MAC will update the S/LOC code to show the new status.

How Do I Check My Claim Status?

After the waiting period, you can:

- Check your claim status in your MAC's secure internet portal. This is the fastest way to check an individual claim status.
- Send an electronic Health Care Claim Status Request (276 transaction). You'll get a Health Care Claim Status Response (277 transaction).
  - You can use this system to check the status of a batch of claims.
  - It may take up to 24 hours to get the 277 response.
  - Contact your software vendor or billing service to see if they provide this service and whether they charge a fee for it.
  - When you submit a 276 request for your Part B claims' status, use the billing provider's NPI so you can see the status for all claims the billing provider submitted for the date of service. Include the DCN or ICN.
- Enter the claim data in your MAC's interactive voice response (IVR) phone system.

The Fiscal Intermediary Standard System (FISS) is the standard Part A claims processing system. Through its direct data entry system, you can:

- Enter, correct, adjust, or cancel your Medicare billing transactions
- Inquire about patient eligibility, the status of Part A/HHH claims, and the need to respond to an additional development request
- Access various inquiry screens (for example, revenue codes, diagnosis codes, and reason codes)

If your claim didn't pass the initial editing process, it won't have a DCN or ICN, and you won't get claims information using these methods. Check your 277CA report for information about rejected claims.

While HIPAA rules don't include requirements about business associates protecting electronic health information processed or stored outside the U.S., your risk may vary depending on geographic location.

If the third-party entity outsources work overseas, you may have greater risks and vulnerabilities to the information. As a HIPAA-covered entity, consider these risks when conducting your risk analysis and management as required by the Security Rule at 45 CFR 164.308(a)(1)(ii)(A) and (a)(1)(ii)(B).

If a billing agency, clearinghouse, software vendor, or other third-party entity does your Medicare billing, ask them:

- If they use sub-contractors
- How they protect your data
- If the data goes outside the U.S.

Resources

- Claim Status Basics
- Claim Status Request and Response
- Medicare Claims Processing Manual, Chapter 1
- Operating Rules for Eligibility and Claims Status