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FACT SHEET
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Checking Medicare Claim Status

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

Health Insurance Portability and Accountability Act (HIPAA)-covered entities, like health plans, clearinghouses, and certain health care providers, must comply with federal operating rules for checking claims status. 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, 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 only rejects 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 Part A or Home Health and Hospice (HHH) claims
- Internal Control Number (ICN) for 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 and HHH claims)
- B code (Part B claims)

If you see 1 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.

When Should I Check My Accepted Claim's Payment Status?

After the MAC accepts your claim, your claim goes through a waiting period. Your MAC can't make a final payment decision until the waiting period, as required by law, ends.

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.

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.

What's the Waiting Period?

All clean claims go through a waiting period, or payment floor, before we can make a payment determination. We can't finalize or issue payment for the initial determination on a clean claim during this period. Under Sections 1816 and 1842 of the Social Security Act, we can't issue payment for 13 (electronic) or 28 (paper) days after the date we get the claim.

Which NPI Number Should I Use to Submit My Part B Claim?

Large organizations with many providers may need to report an NPI for both the rendering and billing providers:

- The **rendering provider** is the provider who performs the service. Report the rendering provider's NPI in Loop 2310B (electronic claim) or Box 24J (paper claim).
- The **billing provider** is the person or entity who we should pay for the service. Report the billing provider's NPI in Loop 2010AA (electronic claim) or Box 33 (paper claim).

How Do I Check My Claim Status?

After the waiting period, you can:

- Submit a claim status inquiry through your MAC's secure internet portal. This is the fastest way to check the status of individual claims.
- 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 the status of your Part B claims, use the billing provider's NPI so you can see the status for all claims submitted by the billing provider for the date of service. We also recommend you include the DCN or ICN number.
- Enter the claim data in your MAC's interactive voice response (IVR) phone system.

If your claim didn't pass the initial editing process, it won't have a DCN or ICN number, and you won't be able to get claims information using these methods. Check your electronic or hard copy remittance for information about rejected or returned claims.

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.

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).

Resources

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