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What is FISS?
The Fiscal Intermediary Standard System (FISS) is the standard Medicare Part A claims processing system. It allows you to perform the following functions:

- Enter, correct, adjust, or cancel your Medicare home health and hospice billing transactions
- Inquire about beneficiary eligibility
- Inquire about the status of claims
- Inquire about the need to respond to an additional development request (ADR)
- Access various inquiry screens (e.g., revenue codes, diagnosis codes, reason codes, etc.)

**Note:** Throughout this chapter, the terms billing transaction and claims are used interchangeably to describe claims, notices of election (NOEs), and requests for anticipated payment (RAPs).

**FISS Availability**
FISS is available Monday through Friday typically between the hours of 5:00 a.m. and 8:00 p.m. CT (Central Time) and Saturday between the hours of 5:00 a.m. and 5:00 p.m. CT. **Note:** Depending on the time it takes the nightly system cycle to run, FISS may not always be available at 5:00 a.m. CT. In addition, FISS system releases may affect availability over weekends. FISS is not available on Sunday or on national holidays.

**Direct Access to FISS**
If you want direct electronic access to FISS in order to perform the above functions, contact the CGS EDI (Electronic Data Interchange) department between 7:00 a.m. – 4:00 p.m. CT at **1-877-299-4500 (select Option 2)** for assistance. You must also contract with a connectivity vendor to establish direct connection to the Enterprise Data Center (EDC) for FISS access through a connectivity product (e.g., IVANS). The CGS EDI department does not provide support for your connectivity product; therefore, you will need to contact your connectivity vendor for any issues related to your direct connection. For additional information, refer to the Electronic Data Interchange (EDI) Web page at [http://www.cgsmedicare.com/hhh/edi/index.html](http://www.cgsmedicare.com/hhh/edi/index.html) on the CGS website.

**Sign-on/Sign-off Procedures**
Once connection has been established, the CGS EDI department will provide the necessary logon-ID and password. If you experience any security issues with accessing FISS or need to have your password reset, please email the CGS Security Administration Team at cgs.medicare.opid@cgsadmin.com. Please
include the user ID that is experiencing problems and the first and last name of the user to which that ID is assigned in your email request.

**CMS DXC Virtual Data Center**

To access FISS, type 2 in the Enter Request field and press the *Enter* key. The DXC –Virtual Data Center screen will display.

| 1  | CDS-VDC Menu         |
| 2  | **DXC-VDC Menu**    |
| 3  | BDC-VDC Menu         |
| 4  | CMS Menu            |

T1SC0065 - DXC ENTER REQUEST ==> 2

**DXC-VDC Sign-on Menu**

FISS is accessed from the **DXC–VDC Menu** screen.

1. Type your logon-ID in the **Userid**: field.

2. Tab to the **Password**: field, and type your password.

3. Press the *ENTER* key.
The TPX MENU FOR <logon-id> screen will display. Your cursor will be positioned in the Command ===> field in the lower left corner.

4. Use your Tab key to move your cursor to the left of the MAC J15 FISS PROD – HHH application line. Type an S and press the Enter key.
The **Welcome to CMS** screen will appear as shown below. The cursor will be positioned in the upper left corner of the screen. Type `FSS0` (the 0 is the number zero; not the letter ‘O’) to access the FISS Main Menu.

```
fss0 WELCOME TO CMS CICSA552 - J15 MAC USER TEST

A C M F A 5 5 2 MVS/ESA VER 2R01 SP7.2.1 M2827 CICS TS 4.2.0

NETNAME: T22G1001 TERMINAL: $01A DATE: 01/08/18 TIME: 14:01:10

This warning banner provides privacy and security notices consistent with applicable federal laws, directives, and other federal guidance for accessing this Government system, which includes all devices/storage media attached to this system. This system is provided for Government-authorized use only. Unauthorized or improper use of this system is prohibited and may result in disciplinary action and/or civil and criminal penalties. At any time, and for any lawful Government purpose, the government may monitor, record, and audit your system usage and/or intercept, search and seize any communication or data transiting or stored on this system. Therefore, you have no reasonable expectation of privacy. Any communication or data transiting or stored on this system may be disclosed or used for any lawful Government purpose.

KEY IN TRANSACTION CODE AND PRESS ENTER

DFH3504I SIGN ON COMPLETE
```

Your connection also allows you to access the beneficiary eligibility information via the Common Working File (CWF) Part A Eligibility System screens, ELGA (Part A eligibility information) and ELGH (Home Health/Hospice eligibility information). To check beneficiary eligibility information via CWF records, instead of typing `FSS0`, type `ELGA` to access ELGA, or type `ELGH` to access ELGH. Press `Enter`.

When accessing ELGA or ELGH, you will be prompted to enter beneficiary information. Refer to “Chapter Two: Checking Beneficiary Eligibility” ([http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_2-Checking_Beneficiary_Eligibility.pdf](http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_2-Checking_Beneficiary_Eligibility.pdf)) of the FISS Guide for additional information.

➤ Refer to the “Checking Beneficiary Eligibility” Web page at [http://www.cgsmedicare.com/hhh/claims/checking_bene_eligibility.html](http://www.cgsmedicare.com/hhh/claims/checking_bene_eligibility.html) for information about other systems that are available to check a beneficiary’s eligibility.
Terminating the Session
Follow the steps below when you are finished with FISS.

1. When you are finished in FISS, press F4 to terminate your session. When you are finished in ELGA or ELGH press F3 to exit.
2. Type logoff and press Enter. The TPX MENU FOR <logon-id> screen will display.
3. Your cursor will be positioned in the Command ==> field in the lower left corner. Type /K and press the ENTER key.

Accessing Multiple Sessions
With direct connection, you have the ability to access multiple sessions simultaneously. This means that you can be signed on to FISS and to ELGA or ELGH at the same time. To learn how to access more than one session, refer to the instructions provided by your connectivity vendor.

Proceed to the following page for information about FISS menu options.
FISS Menu Options

The FISS Main Menu contains four options (listed below). For instructions, screen illustrations and field descriptions of each option, refer to the appropriate chapters of this guide.

<table>
<thead>
<tr>
<th>01</th>
<th>INQUIRIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>CLAIMS/ATTACHMENTS</td>
</tr>
<tr>
<td>03</td>
<td>CLAIMS CORRECTION</td>
</tr>
<tr>
<td>04</td>
<td>ONLINE REPORTS</td>
</tr>
</tbody>
</table>

ENTER MENU SELECTION:

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

Note: Throughout this guide, the terms billing transaction and claims are used interchangeably to describe claims, notices of election (NOEs), and requests for anticipated payment (RAPs).

All of the FISS functionality that you will need for claims processing is available through FISS options 01, 02, and 03.

The CWF Part A Eligibility System screens, ELGA (Part A eligibility information) and ELGH (Home Health/Hospice eligibility information) are accessible through the FISS connection; however, they are not accessible within the FISS menu options. Refer to “Chapter Two: Checking Beneficiary Eligibility” (http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_2-Checking_Beneficiary_Eligibility.pdf) of the FISS Guide for information on accessing ELGA and ELGH.

The following pages provide screen prints of the menu options 01 (Inquiry), 02, (Claim/Attachments), and 03 (Claims Correction) and a summary of how providers can utilize these menu options.

⇒ All FISS direct data entry (DDE) screens display two lines of information in the top right corner that identifies the region (ACPFA052), the current date, release number (e.g., C20112VF) and the time of day. This information will assist CGS staff in researching issues when screen prints are provided.
FISS screens are referenced by Map numbers. Map numbers (e.g., MAP1701) are listed in the upper left corner of the screen. Each claim screen displays page numbers to the right of the Map number.

**Inquiry Menu**

The Inquiry Menu allows you to check the status of claims, including how to check for Additional Development Requests (ADRs), claims summary, Medicare check history, home health payment totals, and view inquiry screens to check the validity of diagnosis codes, revenue codes, and HCPCS codes, and review reason code narratives.

The menu options shown in bold text are those that you will use most often. For details about the Inquiry Menu, refer to the FISS Guide, “Chapter Three: Inquiry Menu” [here](http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf).

```plaintext
MAP1702    CGS J15 MAC - HHH REGION    ACPFA052 MM/DD/YY
XXXXXXXXX  INQUIRY MENU              C201314P HH:MM:SS

BENEFICIARY/CWF    10  ZIP CODE FILE     19
DRG (PRICER/GROUPER) 11  OSC REPOSITORY INQUIRY 1A
CLAIM SUMMARY       12  CLAIM COUNT SUMMARY 56
REVENUE CODES       13  HOME HEALTH PYMT TOTALS 67
HCPCS CODES         14  ANSI REASON CODES  68
DX/PROC CODES ICD-9 15  CHECK HISTORY     FI
ADJUSTMENT REASON CODES 16  DX/PROC CODES ICD-10 1B
REASON CODES        17  CMHC PAYMENT TOTALS 1C
INVOICE NO/DCN TRANS 88  PROV PRACTICE ADDR QUER 1D

ENTER MENU SELECTION:

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```
Claim and Attachments Entry Menu

The Claim and Attachments Entry Menu allows you to enter UB-04 claim information, including home health requests for anticipated payment (RAPs), hospices notices of election (NOEs), notices of election termination/revocation (NOTRs) and roster bill data entry for influenza vaccines provided by home health and hospice agencies and pneumococcal vaccines provided by home health agencies.

The menu options shown in bold text are those that you will use most often. For details about the Claim and Attachments Entry Menu, refer to the FISS Guide “Chapter 4: Claims and Attachments Menu” (http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter_4-Claims_and_Attachments_Menu.pdf).

The “Attachment Entry” options are not accepted electronically via FISS DDE.
**Claims and Attachments Correction Menu**

The Claims and Attachments Correction Menu allows you to correct billing transactions that are in the Return to Provider (RTP) file, adjust and cancel billing transactions.

The menu options shown in bold text are those that you will use most often. For details about the Claim and Attachments Correction Menu, refer to the FISS Guide “Chapter 5: Claims Correction” ([http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_5-claims_correction_menu.pdf](http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_5-claims_correction_menu.pdf)).

The “Attachments” options are not accepted electronically via FISS DDE.

```
MAP1704 CGS J15 MAC - HHH REGION ACPFA052 MM/DD/YY
XXXXXXXX CLAIM AND ATTACHMENTS CORRECTION MENU C201314P HH:MM:SS

CLAIMS CORRECTION
INPATIENT  21
OUTPATIENT  23
SNF  25
HOME HEALTH  27
HOSPICE  29

CLAIM ADJUSTMENTS CANCELS
INPATIENT  30  50
OUTPATIENT  31  51
SNF  32  52
HOME HEALTH  33  53
HOSPICE  35  55

ATTACHMENTS
PACEMAKER  42
AMBULANCE  43
THERAPY  44
HOME HEALTH  45

ENTER MENU SELECTION:

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```
### FISS Function Keys

The use of the function keys described below allows you to move within the FISS screens. FISS displays what function keys are available for use on the bottom of each screen. Function keys are most often found across the top of your keyboard.

<table>
<thead>
<tr>
<th>Function Key</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>Help</td>
</tr>
<tr>
<td>F2</td>
<td>Line Item Detail Info</td>
</tr>
<tr>
<td>F3</td>
<td>Screen Exit</td>
</tr>
<tr>
<td>F4</td>
<td>System Exit</td>
</tr>
<tr>
<td>F5</td>
<td>Scroll Back</td>
</tr>
<tr>
<td>F6</td>
<td>Scroll Forward</td>
</tr>
<tr>
<td>F7</td>
<td>Page Back</td>
</tr>
<tr>
<td>F8</td>
<td>Page Forward</td>
</tr>
<tr>
<td>F9</td>
<td>Save</td>
</tr>
</tbody>
</table>
| F10          | Scroll Left | Scrolls one page to the left. Only available on the following screens:  
  - MAP171A, MAP171E, MAP171D, MAP 1719, MAP1772  
  Also retrieves claim data for an archived claim. |
| F11          | Scroll Right | Scrolls one page to the right. Only available on the following screens:  
  - MAP1712, MAP1713, MAP171A, MAP171E and MAP1771 |
Use caution before pressing F3 because it will take you back to the previous screen and could cause you to lose your work. For example, if you are entering a billing transaction into FISS and accidentally press F3, you will be returned to the Claim and Attachments Entry Menu and the information you were entering on the billing transaction will be lost.

➡ You may need to contact your connectivity vendor for assistance in mapping your keyboard if your function keys do not achieve the same results as described above.

FISS Shortcuts

✔ Use your arrow keys and/or Tab key to move between fields. Do not use your ENTER key or the space bar. Using the Tab key is preferred, as your arrow keys may not place your cursor in the correct field position.

✔ If you attempt to type in an invalid field position, your keyboard will lock, and you will see this icon in the lower left hand corner of your screen. To “unlock” your keyboard, try to press the ESC key or the left Ctrl key. The method used to unlock your keyboard depends on your keyboard set up. Once you have unlocked your keyboard, you must press the Tab key to move your cursor into a valid field position.

✔ To move back one data field at a time, press and hold the SHIFT key and then press Tab.

✔ To quickly move between claim pages, press your HOME key on your keyboard, which takes your cursor to the ‘Page’ field. Type the number of the page to which you want to move, and then press Enter. In FISS, the claim consists of six pages. However, two additional pages, page 7 and page 8, are available for claims in Additional Development Request (ADR) status/location SB6001.

✔ While in a claim, use the SC (Screen Control) field located in the upper left corner (under the Page field) of the FISS screen as a shortcut to information within the Inquiry Menu. To access this field, press the HOME key and then the Tab key. To quickly move to one of the following options, type the option number (e.g., 13) in the ‘SC’ field and press Enter. Press F3 to return to the claim page. Refer to the following example.

- 10 (Beneficiary/CWF)
- 13 (Revenue Codes)
- 14 (HCPC Codes)
- 15 (Diagnosis/Procedure Codes)
- 16 (Adjustment Reason Codes)
- 17 (Reason Codes)
- 56 (Claim Count Summary)
- 68 (ANSI Reason Codes)
Example: To move from the Claim Entry screen to the revenue code screen, type 13 in the SC field and press Enter. The Revenue Code Table Inquiry screen appears.

You may need to contact your connectivity vendor for assistance in mapping your keyboard if you are unable to perform the shortcuts listed above.

FISS Screen Prints

To print a copy of an FISS screen, try one of the following options:

☑ Select File from the Toolbar and click on Print from the dropdown box
☑ Press ALT+PRINT SCREEN
☑ Press SHIFT+PRINT SCREEN
☑ Press ALT+L

If you are unable to print using the options above, try pressing the PRINT SCREEN key on your keyboard, which will make a copy of the screen; then open a word processing software document and paste the copied image into it. You should then be able to print the word processing document. If none of these options work, and you have consulted with your technical support department with no resolution, please contact your connectivity vendor.

Monitoring your Billing Transactions

CGS recommends that you use FISS to check your billing transactions at least once a week. Checking more often is encouraged. For some billing transactions, you may need to take additional action after you have submitted them. There are often provider deadlines associated with these additional actions. For example, when responding to a medical review additional development request (MR ADR) (status/location S B6001), documentation must be received by CGS within 45 calendar days.
Some claims may be returned to the provider (RTPd) due to missing, incorrect, or incomplete information. You will need to access your billing transactions in the Return to Provider (RTP) to make the necessary corrections. When a claim is corrected from the RTP file, it will receive a new receipt date.

To assist you with monitoring your billing transactions, CGS has developed the following checklist. When you sign on to FISS, you should:

- Check option 56 (Claim Count Summary) within the “Inquiry Menu” to see a quick summary of billing transactions that are currently processing in FISS. Refer to “Chapter 3: Inquiry Menu” (http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf) of the FISS Guide for information about the Claim Count Summary screen.

- Correct any billing transactions that are in your RTP file. Refer to “Chapter 5: Claims Correction” (http://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_5-claims_correction_menu.pdf) of the FISS Guide for additional information.


### About Status/Location Codes

As billing transactions process in FISS, they move through various stages of the system. These stages are identified by status/location codes and provide information about what’s happening to the claim. Sometimes the status/location indicates that you need to take action on the billing transaction in order for it to continue processing. There are six status codes that are represented in FISS by one letter (e.g., P for Paid). By looking at the status, you can quickly find what’s happening to your billing transaction. Review the table below to familiarize yourself with these codes. This table will be a valuable resource when reviewing the Claim Count Summary (56) screen.
## Claim Status

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>Which Means?</th>
</tr>
</thead>
</table>
| **P** (Processed/Paid) | Claim is approved for payment and is on the payment floor, NOE** is processed or RAP*/claim is paid (full or partial).  
* The acronym RAP (Request for Anticipated Payment) applies only to home health providers.  
** The acronym NOE (Notice of Election) applies only to hospice providers. |
| **R** (Rejected)  | Billing transaction is rejected for reasons such as:  
  - Medicare eligibility issue  
  - Billing issues  
  - Duplicate to a previously submitted claim |
| **D** (Denied)    | Claim was denied. Denials may be for various reasons, such as medical review denial, demand billing, or eligibility.                                                                                           |
| **S** (Suspended) | Billing transaction is temporarily paused in FISS for processing and/or Medicare staff intervention may be required. No action is required by you unless the claim is in status/location S B6001 (Additional Development Request (ADR)). Billing transactions may be suspended for about 30 days. Claims that have been selected for an ADR or for medical review may be suspended for more than 30 days. Claims with Medicare Secondary Payer (MSP) information often require Medicare staff intervention and may be suspended for more than 60 days. |
| **T** (Return to Provider [RTP]) | Billing transaction is waiting for correction by you in the RTP file.                                                                                                                                       |
| **I** (Inactivated) | Billing transaction was inactivated or suppressed from RTP. Awaiting final system purge.                                                                                                                    |

Locations further define what is happening to a billing transaction in a particular status. Locations are 5-character positions that follow the status code (e.g., PB9997; where P is the status and B9997 is the location). There are thousands of combinations of status/locations and not all are represented in this guide. Because of the quantity, CGS does not provide a printed handout of all the possible status/location code combinations. However, we do provide you with the most common status/location codes listed below.
## Common Status/Location Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P B9996</td>
<td>Payment floor</td>
</tr>
<tr>
<td>P B9997</td>
<td>Processed or paid (full or partial) billing transaction</td>
</tr>
<tr>
<td>P B7501</td>
<td>Post-pay MSP review</td>
</tr>
<tr>
<td>P B7505</td>
<td>Post-pay MSP review</td>
</tr>
<tr>
<td>P O9998</td>
<td>Archived claim</td>
</tr>
<tr>
<td>R B9997</td>
<td>Rejected billing transaction (finalized)</td>
</tr>
<tr>
<td>R B75XX</td>
<td>Rejected billing transaction (suspended). It may take at least 75 days for</td>
</tr>
<tr>
<td></td>
<td>the claim to move to R B9997 finalized status/location.</td>
</tr>
<tr>
<td>D B9997</td>
<td>Denied claim (all services denied). Claims with partial denials will appear</td>
</tr>
<tr>
<td></td>
<td>in the P status.</td>
</tr>
<tr>
<td>T B9900</td>
<td>Billing transaction will need correction when it moves into T B9997 in next</td>
</tr>
<tr>
<td></td>
<td>cycle.</td>
</tr>
<tr>
<td>T B9997</td>
<td>Billing transaction needing correction by provider (referred to as the</td>
</tr>
<tr>
<td></td>
<td>Return to Provider (RTP) status/location).</td>
</tr>
<tr>
<td>S B0100</td>
<td>System processing (billing transaction is suspended).</td>
</tr>
<tr>
<td>S B6000</td>
<td>Claim will need additional information when it moves to S B6001.</td>
</tr>
<tr>
<td>S B6001</td>
<td>Claim needs additional information from provider (referred to as the</td>
</tr>
<tr>
<td></td>
<td>medical review Additional Development Request (MR ADR or a non-MR ADR).</td>
</tr>
<tr>
<td></td>
<td>Refer to the “Additional Development Request (ADR) Overview” Web page at</td>
</tr>
<tr>
<td>S M50MR</td>
<td>Medical review of documentation (claims move to this location once ADR</td>
</tr>
<tr>
<td></td>
<td>information has been received). This review process may take up to 60 days</td>
</tr>
<tr>
<td></td>
<td>to complete.</td>
</tr>
<tr>
<td>S B90XX</td>
<td>Claim data is being compared with beneficiary eligibility information</td>
</tr>
<tr>
<td></td>
<td>posted at the Common Working File (CWF).</td>
</tr>
<tr>
<td>S MXXXX</td>
<td>Suspended claim/adjustment requires Medicare staff intervention and may be</td>
</tr>
<tr>
<td></td>
<td>suspended for about 30 days. Claims with Medicare Secondary Payer (MSP)</td>
</tr>
<tr>
<td></td>
<td>information may be suspended for more than 60 days. Providers may call the</td>
</tr>
<tr>
<td></td>
<td>Provider Contact Center if their claims have been in the same “S MXXXX”</td>
</tr>
<tr>
<td></td>
<td>status/location for longer than 30 days, or 60 days for MSP claims.</td>
</tr>
<tr>
<td>S M87DR</td>
<td><strong>Hospice Only</strong> – acknowledgement that CGS has received the documentation</td>
</tr>
<tr>
<td></td>
<td>for an exception request for an untimely notice of election. Refer to the</td>
</tr>
</tbody>
</table>
### Common Status/Location Codes, continued…

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S M87RE</td>
<td><strong>Hospice Only</strong> – the documentation provided in the Remarks field for an exception request for an untimely notice of election is being reviewed.</td>
</tr>
<tr>
<td>S M8877</td>
<td><strong>Hospice Only</strong> – if documentation for an exception request for an untimely notice of election is not received within 30 days of the initial request, the claim will move to this status/location until day 45, or until your documentation is received. If documentation is not received by day 46, the claim will be released to process as billed. Refer to the “Requesting an Exception for an Untimely NOE” Web page at <a href="http://www.cgsmedicare.com/hhh/education/materials/requesting_exception_untimely_noes.html">http://www.cgsmedicare.com/hhh/education/materials/requesting_exception_untimely_noes.html</a> for additional information.</td>
</tr>
<tr>
<td>S MRADJ</td>
<td>MSP adjustment – created after MSP adjustment received; awaiting completion.</td>
</tr>
<tr>
<td>I B9900</td>
<td>Billing transaction inactivated from RTP file; waiting to purge from FISS.</td>
</tr>
</tbody>
</table>