FISS OVERVIEW

DIRECT DATA ENTRY (DDE) MANUAL

CHAPTER 1

CGS®
A CELERIAN GROUP COMPANY

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 Part A 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.)

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

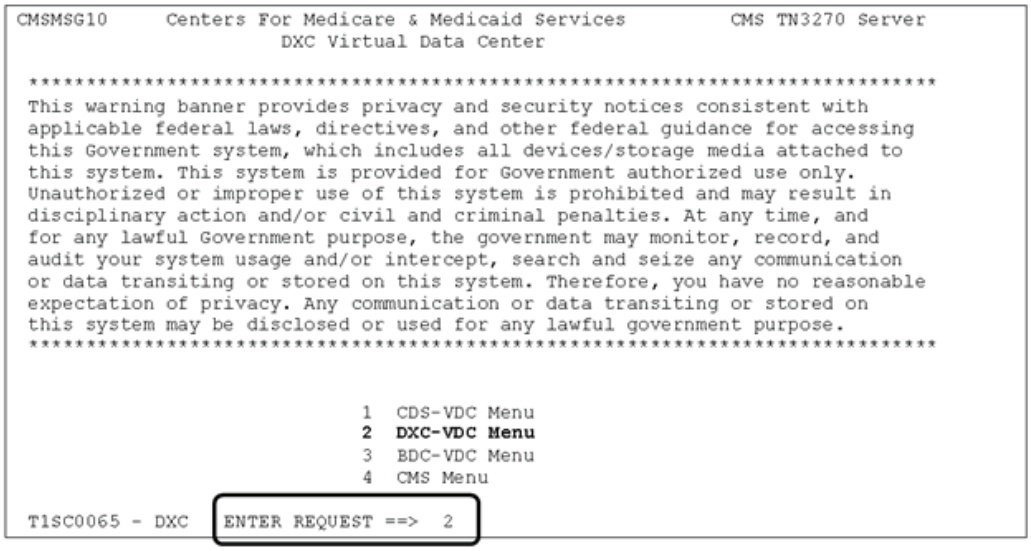
If you want direct electronic access to FISS in order to perform the above functions, contact the CGS EDI (Electronic Data Interchange) department between 8:00 p.m. and 5:00 p.m. ET at 1.866.590.6703 (select Option 2) for assistance. You must also contract with a connectivity vendor to establish direct connection to the Enterprise Data Center (EDC) for FISS access through a connectivity product (e.g., IVANS or VisionShare). 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.

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 or you may call them at 1.615.660.5444. 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.

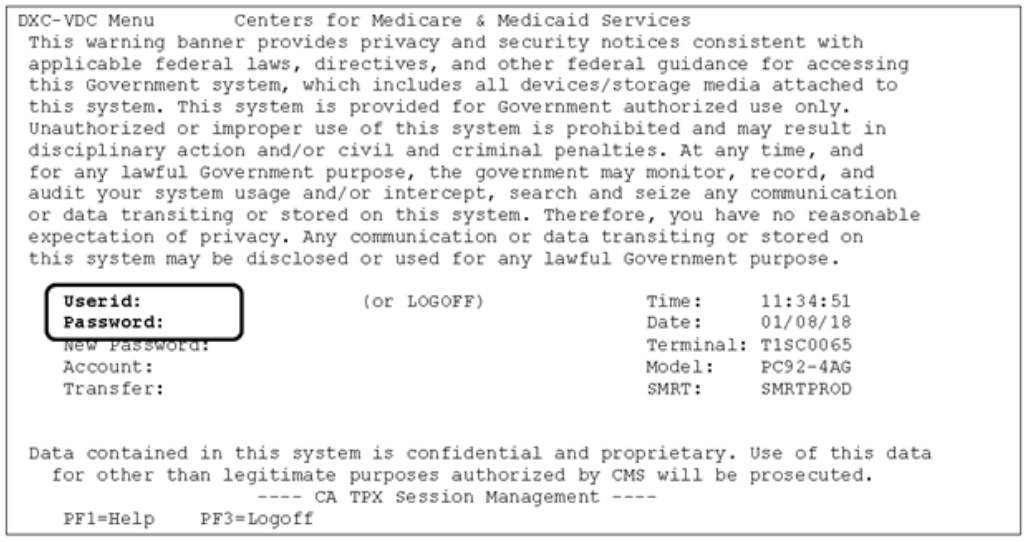
CMS DXC Virtual Data Center

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



DXC-VDC Sign-on Menu

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.

```
                        TPX MENU FOR      XXXXXX            Panelid - TEN0041
                                                            Terminal  - SG153799
 Cmdkey=PF15        Jump=PF13       Menu=PF14               Model     - 3292-4A
 Print=NONE         Cmdchar=/                               System    - A1TPXP2

    Sessid       Sesskey       Session Description            Status

  S FISP15-1     PF            MAC J15 FISS PROD - Part A


Command ===>
PF1=Help  PF7/19=Up  PF8/20=Down  PF10/22=Left  PF11/23=Right  H =Cmd Help
```

4. Use your Tab key to move your cursor to the left of the **MAC J15 FISS PROD – Part A** 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.

```
FSS0ME 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  5.2.0
        NETNAME: T32G1001 TERMINAL: $021   DATE: 04/06/18   TIME: 09:16:17

        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 through the Enterprise Data Center (EDC) may also allow you to access the beneficiary eligibility information via the Common Working File (CWF) Part A Eligibility System screen (ELGA). To check beneficiary eligibility information via CWF records, instead of typing FSS0, type ELGA to access ELGA. Press ***ENTER*** .

When accessing ELGA, you will be prompted to enter beneficiary information. Refer to "Chapter Two: Checking Beneficiary Eligibility" (https://www.cgsmedicare.com/parta/edi/pdf/DDE_Chapter2.pdf) of the *DDE Manual* for additional information.

Beginning fall of 2019, CMS discontinued clearinghouse and vendor access to the CWF beneficiary eligibility data when they already access this same data through the HIPAA Eligibility Transaction System (HETS). Providers can continue to submit individual provider queries using the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) Beneficiary/CWF (Option 10). Refer to the *CGS DDE User Manual/FISS Reference Guide, Chapter Three: Inquiry Menu* at https://www.cgsmedicare.com/parta/edi/pdf/dde_chapter3.pdf for additional information.

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 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 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.

```
MAP1701            CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
AB01CD                    MAIN MENU                   C20112VF HH:MM:SS


                    01    INQUIRIES

                    02    CLAIMS/ATTACHMENTS

                    03    CLAIMS CORRECTION

                    04    ONLINE REPORTS

   ENTER MENU SELECTION:


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

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 screen, ELGA (Part A eligibility information) is accessible through the FISS connection; however, it is not accessible within the FISS menu options.

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, Part A payment totals, view inquiry screens to check the validity of diagnosis codes, revenue codes, 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 *DDE Manual*, "Chapter Three: Inquiry Menu" (https://www.cgsmedicare.com/parta/edi/pdf/DDE_Chapter3.pdf).

```
MAP1702              CGS J15 MAC - Part A REGION        ACPFA052 MM/DD/YY
  XXXXXXX                  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

    HCPC 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

                                     NEW HCPC SCREEN          1E
  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 roster bill data entry for influenza and pneumococcal vaccines provided by approved facilities.

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 *DDE Manual* "Chapter 4: Claims and Attachments Menu" (https://www.cgsmedicare.com/parta/edi/pdf/DDE_Chapter4.pdf).

The "Attachment Entry" options are not accepted electronically via FISS DDE.

```
MAP1703              CGS J15 MAC - Part A REGION        ACPFA052 MM/DD/YY
 XXXXXXX        CLAIM AND ATTACHMENTS ENTRY MENU       C201314P HH:MM:SS

                       CLAIMS ENTRY

                INPATIENT                  20
                OUTPATIENT                 22
                SNF                        24
                HOME HEALTH                26
                HOSPICE                    28
                NOE/NOA                    49
                ROSTER BILL ENTRY          87

                      ATTACHMENT ENTRY

                HOME HEALTH                41
                DME HISTORY                54
                ESRD CMS-382 FORM          57

    ENTER MENU SELECTION:


     PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

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 *DDE Manual*, “Chapter 5: Claims Correction” (https://www.cgsmedicare.com/parta/edi/pdf/DDE_Chapter5.pdf).

```
  MAP1704              CGS J15 MAC - Part A REGION        ACPFA052 MM/DD/YY
  XXXXXXX      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
                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.

F1	Help	From a claims entry, inquiry, or correction screen, F1 provides a narrative description of a reason code that appears on a billing transaction (used most often in the return to provider (RTP) file).
F2	Line Item Detail Info	Enables user to access line item detail information for a particular revenue code line in FISS from page 02 of the claim.
F3	Screen Exit	Exits user to previous screens.
F4	System Exit	Terminates FISS session and returns user to blank screen where 'FSS0' 'ELGA' information can be entered.
F5	Scroll Back	Scrolls up (backward) through a list of revenue code page.
F6	Scroll Forward	Scrolls down (forward) through a list or revenue code page.
F7	Page Back	Moves user one FISS claim page back.
F8	Page Forward	Moves user one FISS claim page forward.
F9	Save	Saves/stores claim information. (Note: FISS will only save information when the information is complete and correct.)
F10	Scroll Left	Scrolls one page to the left. Only available on the following screens: • MAP171A, MAP171E, MAP171D, 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, 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. 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 S B6001).

- 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)	**16**	(Adjustment Reason Codes)
13	(Revenue Codes)	**17**	(Reason Codes)
14	(HCPC Codes)	**56**	(Claim Count Summary)
15	(Diagnosis/Procedure Codes)	**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.

```
MAP1711    PAGE 01    CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
 AB01CD   SC 13     INST CLAIM ENTRY                  C20112VF HH:MM:SS
 HIC         TOB 322   S/LOC S B0100 OSCAR              SV:     UB-FORM
NPI      TRANS HOSP PROV                  PROCESS NEW HIC
PAT.CNTL#:              TAX#/SUB:                 TAXO.CD:
```

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, you need to mail medical documentation to CGS no later than 30 days after the request date of an Additional Development Request (ADR) (status/location S B6001).

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 of the DDE Manual for information about the Claim Count Summary screen.
- Correct any billing transactions that are in your RTP file. Refer to "Chapter 5: Claims Correction of the DDE Manual for additional information.
- Respond to any Additional Development Requests (ADRs). Refer to "Chapter 3: Inquiry Menu" of the DDE Manual for information about accessing ADRs.

NOTE: Section 6404 of the Patient Protection and Affordable Care Act (PPACA) amended the timely filing requirements for submission of claims and adjustments) **to one calendar year after the date of service (i.e. "TO" date of the claim)**. Additional information about timely filing requirements is available on the CGS Web page at: http://www.cgsmedicare.com/Articles/COPE18411.html

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	Which Means?
P (Processed/Paid)	Claim is approved for payment and is on the payment floor.
R (Rejected)	Billing transaction is rejected for reasons such as: • Medicare eligibility issue • Billing issues • Duplicate to a previously submitted claim
D (Denied)	Claim is denied by medical review or claim was submitted as a demand denial.
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.

Claim Status	Which Means?
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., P B9997; 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

P B9996	Payment floor
P B9997	Processed or paid (full or partial) billing transaction
P B7501	Post-pay MSP review
P B7505	Post-pay MSP review
P O9998	Archived claim
R B9997	Rejected billing transaction (finalized)
R B75XX	Rejected billing transaction (suspended). It may take at least 75 days for the claim to move to R B9997 finalized status/location.
D B9997	Denied claim (all services denied). Claims with partial denials will appear in the P status.
T B9900	Billing transaction will need correction when it moves into T B9997 in next cycle.
T B9997	Billing transaction needing correction by provider (referred to as the Return to Provider (RTP) status/location).
S B0100	System processing (billing transaction is suspended).
S B6000	Claim will need additional information when it moves to S B6001.
S B6001	Claim needs additional information from provider (referred to as Additional Development Request or ADR). Requested information should be sent by the 30th day. If requested information is not received, the claim will be automatically denied on day 46. If the claim has reason code 5ADR2, additional signature documentation is being requested. The documentation must be returned within 15 days. If documentation is not received by day 20, the claim will be denied.
S M5CLM	After Additional Development Request (ADR) documentation has been reviewed by the Medical Review department, the claim is moved to S M5CLM for additional processing
S M50MR	Medical review of documentation (claims move to this location once ADR information has been received). This review process may take up to 60 days to complete.
S B90XX	Claim data is being compared with beneficiary eligibility information posted at the Common Working File (CWF).

S MXXXX	Suspended claim/adjustment requires Medicare staff intervention and may be suspended for about 30 days. Claims with Medicare Secondary Payer (MSP) information may be suspended for more than 60 days. Providers may call the Provider Contact Center if their claims have been in the same "**S M**XXXX" status/ location for longer than 30 days, or 60 days for MSP claims.
S MRADJ	MSP adjustment – created after MSP adjustment received; awaiting completion.
I B9900	Billing transaction inactivated from RTP file; waiting to purge from FISS.