

Individual Market Enrollment & Payment Disputes

Technical Reference Guide

Version 7.0

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1.0 Purpose

This Individual Market Enrollment and Payment Disputes Technical Reference Guide (TRG) provides issuers with a consolidated point of reference for technical guidance related to the Enrollment and Payment Dispute processes. This TRG includes:

- A detailed overview of the Enrollment and Payment Dispute processes
- Technical details and file specifications
- Guidance for completing the Enrollment and Payment Dispute Forms
- Guidance for submitting disputes through the Health Insurance Casework System (HICS)

This document also provides references to ancillary resources. See Related Documents for the complete list of related resources and website addresses.

2.0 Introduction

2.1 Individual Market Enrollment and Payment Disputes Overview

CMS regulations and guidance require that issuers who participate in the Federally-Facilitated Marketplace (FFM) reconcile enrollment records monthly. The objective of this monthly Reconciliation process is to ensure that issuer enrollment information aligns with Marketplace enrollment information. The dispute process provides a mechanism for issuers to correct an FFM enrollment record or related payment information that the monthly Reconciliation process cannot resolve.

As part of the Reconciliation process, issuers create FFM Inbound Enrollment Reconciliation (RCNI) files that reflect their current data for enrollments, then submit these files to CMS. The RCNI file includes information about the issuer's current enrollees, cancelled enrollment records, terminated enrollments, and financial data elements. The FFM Operations and Analytics Contractor compares the RCNI to the data in the FFM through an automated enrollment reconciliation process. The automated process matches records based on a unique collection of field information and determines any discrepancies between the issuer's records and the FFM. This process then uses the current enrollment policy rules to determine if the discrepancy needs to be resolved through a change to the FFM or a change to the issuer's records. If an issuer disagrees with any decisions made by the automated process, the issuer can submit a dispute.

Correcting enrollment data ensures that the issuer will receive payment for all policies. Issuers receive a separate FFM Outbound Enrollment Reconciliation (RCNO) file that integrates existing data with the newly reported RCNI data. Fields with identified discrepancies receive a flag indicator in the RCNO column directly following the data element. Issuers refer to the flag fields in the RCNO file to identify issues.

Separately, on a monthly basis, CMS uses FFM data to generate two reports: The Preliminary Payment Report (PPR) and the Health Insurance Exchange (HIX) 820 Remittance Advice File. The PPR details the policy-level payments issuers can expect from the Treasury Department for federal subsidies and the corresponding policy-level user fee offsets. The HIX 820 report details actual amounts paid by the Treasury to an issuer for the last cycle. Issuers should use these reports to identify payment discrepancies.

2.2 Individual Market Dispute Methods

Issuers submit disputes to the Enrollment Resolution and Reconciliation (ER&R) Contractor using one of the following:

- The CCIIO ER&R Dispute Resolution Template, which is referred to as the Enrollment Dispute Form. The Enrollment Dispute Form is for reporting enrollment discrepancies, though some financial discrepancies may be reported using this form.
- The HICS Direct Dispute option, which is the electronic submission of a dispute through HICS. The HICS Direct Dispute option is a method for submitting specific dispute types directly to the ER&R Contractor from HICS. The Direct Dispute option eliminates the need for submission of an Enrollment Dispute Form for the supported dispute types.
- The Financial Transfers (FT) PPR-820 Dispute Form, which is referred to as the Payment Dispute Form. The Payment Dispute Form is for reporting unexpected or missing payments that were identified in the PPR or HIX 820.

Exhibit 1 indicates which method(s) issuers can use when submitting specific dispute types.

Exhibit 1: Dispute Method Use by Dispute Type

Dispute Type	Enrollment Dispute Form	Payment Dispute Form	HICS Direct Dispute
Agent/Broker Name	Yes	No	No
Agent/Broker NPN	Yes	No	No
Applied APTC Amount	Yes	Yes	Yes
Benefit Start Date	Yes	Yes. Disputing coverage dates may affect financial dates.	No
Benefit End Date	Yes	Yes. Disputing coverage dates may affect financial dates.	No
Changing Subscriber	No	No	Yes
CSR Amount	Yes	Yes	No
Enrollment Blocker	Yes	No	Yes
Gender	Yes	No	No
Initial Premium Paid Status	Yes	Missing payment or unexpected payment disputes may affect the effectuation status.	No
Issuer Assigned Member ID	Yes	No	No
Issuer Assigned Policy ID	Yes	No	No
Issuer Assigned Subscriber ID	Yes	No	No
Mailing Address	Yes	No	No
QHP ID/Variant ID	Yes	No	Yes
Reinstatement	Yes	No	No
Rejected Enrollment	Yes	No	No
Removal of a Member	No	No	Yes
Term NLE Appeal	No	No	Yes
Tobacco Status	Yes	No	No

Dispute Type	Enrollment Dispute Form	Payment Dispute Form	HICS Direct Dispute
Total Premium Amount	Yes	Yes	Yes, except disputes that do not require a HICS case
User Fee	No	Yes	No

2.3 Individual Market Dispute Outcomes

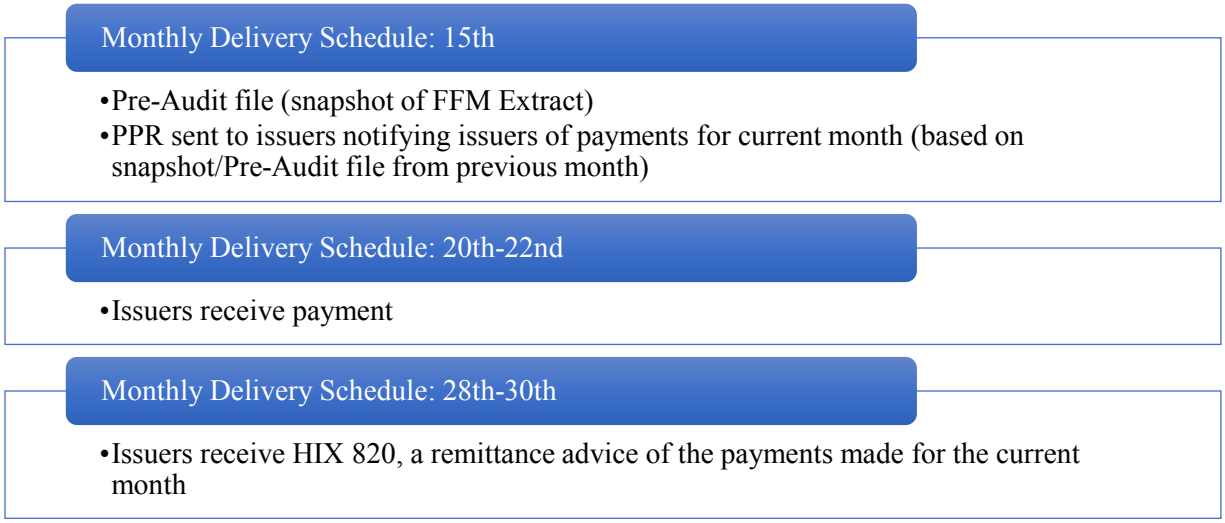
Many disputes result in an update to enrollment data within the FFM. The FFM receives monthly updates as part of the monthly corrections cycle. Due to the timing and frequency of updates, issuers should allow 1-2 cycles for the update to reflect in issuer files.

A cycle is the complete month of data exchange between the issuer and CMS. The monthly cycle includes the Reconciliation process and the Policy-Based Payment process. The Reconciliation process consists of the following:

- The issuer submitting an RCNI for each Trading Partner ID (TPID)
- CMS sending an RCNO file that matches issuer enrollment records to FFM records by comparing field-by-field on matched records

Exhibit 2 shows the timeline of items that the issuer receives as part of the Policy-Based Payment process.

Exhibit 2: Policy-Based Payment Process Timeline



NOTE: The PPR-820 Payment Dispute process does not apply to the Small Business Health Options Program (SHOP) Market, State-Based Marketplace (SBM) issuers, or FFM program-level amounts at this time. Refer to Section 7.2, Help Desk, for contact information related to these programs.

Issuers receive the following files with dispute outcomes:

- The Semi-Monthly Detailed Report provides Enrollment and Payment Dispute dispositions. The ER&R Contractor delivers the Semi-Monthly Detailed Report twice per month.
- The PPR-820 Dispute Response File, also referred to as the Response File, sent within 1-2 business days after the ER&R Contractor processes a dispute, provides information on payment dispositions.

3.0 Enrollment Disputes

3.1 Enrollment Dispute Process

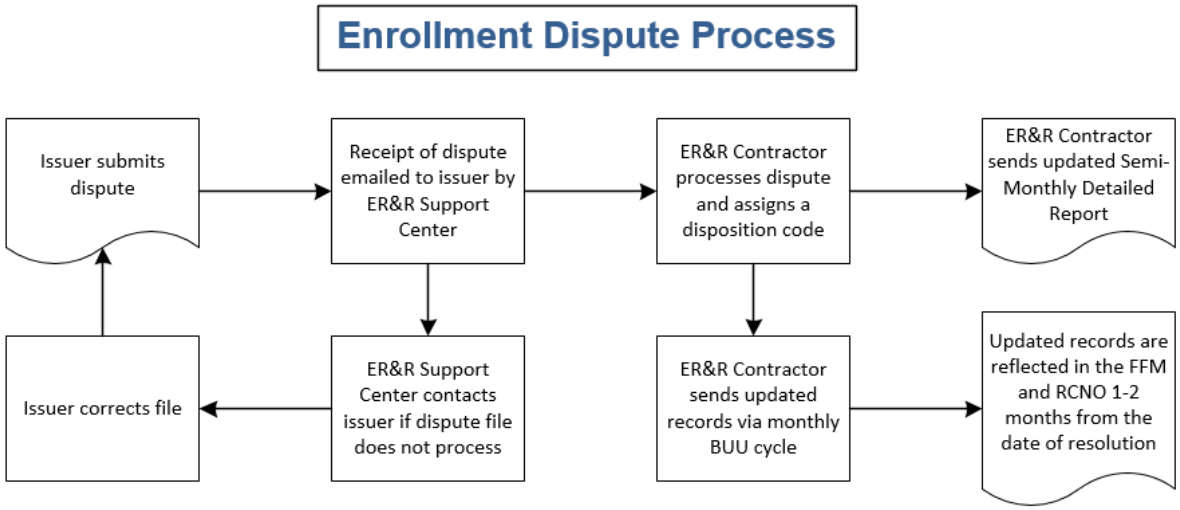
The ER&R Contractor investigates disputes by applying automated and manual rules to ensure disputes are resolved in accordance with CMS-approved enrollment and payment guidelines. The ER&R Contractor assigns each dispute a disposition code that informs the issuer of the outcome of the submitted dispute.

Actions needed for final dispute resolution fall into four categories:

1. The ER&R Contractor updates the FFM data through the data clean-up process known as the Batch Update Utility (BUU).
2. The issuer must take additional action to resolve data matching issues.
3. The consumer must take additional action to resolve data matching issues.
4. Upon review of the dispute, it was determined that there is no action needed for resolution. The issue is due to timing and will be resolved in the next cycle.

The following three exhibits explain the flow of a dispute through the dispute process, what forms and reports are involved in the process, and where to find the disposition codes and the associated descriptions.

Exhibit 3: CCIIO ER&R Enrollment Dispute Resolution Process Flow



1. The issuer submits the dispute file to the ER&R Contractor.
2. The ER&R Contractor notifies issuers via email of receipt and acceptance of the dispute file.
3. If the ER&R Contractor cannot process the file, the ER&R Support Center contacts the issuer by phone to resolve file errors.
4. If necessary, the issuer reviews, corrects, and resubmits the dispute file.
5. ER&R processes disputes and assigns corresponding disposition codes for each record.
6. ER&R sends a Semi-Monthly Detailed Report that informs issuers of the status of Enrollment Disputes. These reports are sent on the 1st and 16th of each month via Electronic File/Fund Transfer (EFT).
7. The ER&R Contractor sends updated records via monthly BUU cycle.

8. In 1-2 monthly Reconciliation cycles from the date of the ER&R resolution, the FFM and/or payment (if applicable) will update accordingly in the FFM and RCNO.

Exhibit 4 describes the transactions used in the Enrollment Dispute process.

Exhibit 4: CCIIO ER&R Dispute Resolution Template Transactions

Reference Name in Document	Transaction Description	File Direction
CCIIO ER&R Dispute Resolution Template Form	Used by issuers to submit disputes to ER&R.	Issuers to ER&R
Confirmation Email	Used by ER&R to notify issuers that a dispute form was received.	ER&R to issuers
Semi-Monthly Detailed Report	Used by ER&R to respond to issuers with updated dispute statuses at the beginning and middle of the month.	ER&R to issuers

Exhibit 5 provides a link for accessing the disposition codes and descriptions.

Exhibit 5: CCIIO Enrollment Dispositions List

Reference Name in Document	Description
CCIIO_Enrollment_Dispositions	The CCIIO Enrollment Dispositions list that provides the definition of the code describing the status of the dispute. Available on CMS zONE at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.

3.1.1 Correlated Cases

In some situations, ER&R must generate internal dispute cases, referred to as correlated cases, on behalf of issuers. ER&R creates these cases when the updates resulting from approved disputes impact additional coverage spans that are not being disputed by the issuer. Correlated cases ensure the success of the necessary updates by applying consistent updates at the policy level.

3.2 CCIIO ER&R Dispute Resolution Template Overview

The CCIIO ER&R Dispute Resolution Template, also known as the Enrollment Dispute Form, allows issuers to submit Enrollment Disputes. Enrollment Dispute Form version 11 was introduced to issuers in June 2018 and became active as of September 1, 2018. Issuers can access the CCIIO ER&R Dispute Resolution Template on CMS zONE at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.

Enrollment Dispute Form version 11 contains ten tabs:

- The **How to Guide** tab provides guidance on how to use the Enrollment Dispute Form, including answers to frequently asked questions and detailed information on Discrepancy Dispute types.
- The **Dispute Examples** tab provides examples of each dispute type that may be submitted using the Enrollment Dispute Form.
- The **PSV Format** tab explains step-by-step how issuers import add-ins into the dispute template and how to use add-ins to maintain proper form specifications.
- The remaining seven tabs, Discrepancy Disputes, Rejected Enrollments, Reinstatement End Date 12.31, Newborn Premium Updates, Enrollment Blocker, Mailing Address Change, and Agent Broker Information, each contain a formatted spreadsheet that the issuers use to submit Enrollment Disputes.

3.3 Completing the CCIIO ER&R Dispute Resolution Template

Issuers should not alter or make any changes to the Enrollment Dispute Form. Such changes include deletion of any rows or columns and any example fields. Altering an Enrollment Dispute Form will prevent it from being processed. The ER&R Contractor rejects files that do not follow the guidelines set forth in this document.

The following sections provide detailed instructions on completing the Enrollment Dispute Form.

3.3.1 CCIIO ER&R Dispute Resolution Template Add-Ins

Issuers may activate the automated add-ins when using the Enrollment Dispute Form. These add-ins prohibit form errors by rejecting entered data elements that do not meet form specifications. If data is in the wrong format or if a necessary field is missing, a pop-up window will appear to alert users to format an entry correctly or to complete a missing field. Instructions for installing the add-ins are detailed by the PSV (Pipe-Separated Value) Format tab of the Enrollment Dispute Form.

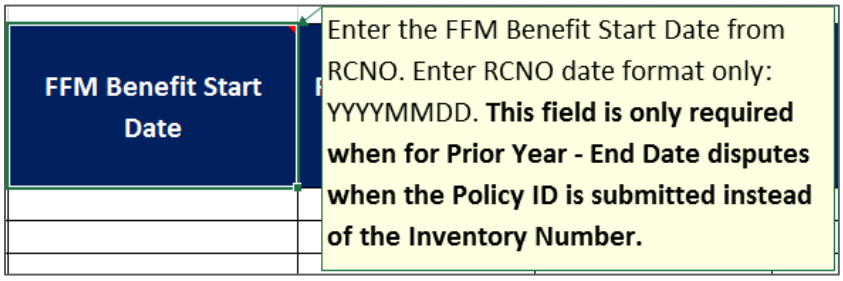
A hover feature aids issuers by presenting field specifications when the user hovers over any field. Exhibit 6 shows the red tip in the top right corner, which indicates that a field contains a hover feature. Exhibit 7 demonstrates what issuers can expect to see upon placing the computer cursor over any field that contains the red-tipped right corner.

NOTE: There is no need to click the cursor to reveal the instructions.

Exhibit 6: Red Tip Hover Features

FFM Internal Record Inventory Number	FFM Exchange Assigned Policy ID	FFM Exchange Assigned Subscriber Identifier	Description of Disputed Item	Issuer Value

Exhibit 7: Red Tip Hover Feature Pop-Up



3.3.2 CCIIO ER&R Dispute Resolution Template Header Record

The header record provides fields for issuer contact information. Issuers must complete all header items on the Enrollment Dispute Form. The header record consists of the following fields:

- Point of Contact Name
- Telephone Number
- Email Address

Issuers who submit incomplete forms will receive an email notification indicating that the form cannot be processed.

3.3.3 CCIIO ER&R Dispute Resolution Template Tabs

An issuer may dispute the value for a data element using one of the seven dispute tabs in the Enrollment Dispute Form. Issuers use the Discrepancy Dispute tab for the majority of disputes. Due to different processing requirements for different dispute types, issuers fill out separate tabs to submit Rejected Enrollment, Reinstatement End Date 12.31, Newborn Premium Update, Enrollment Blocker, Mailing Address, and Agent Broker Information disputes.

In-depth details for using each tab are provided in the following:

- Section 3.3.3.1, Discrepancy Dispute Tab
- Section 3.3.3.2, Rejected Enrollments Tab
- Section 3.3.3.3, Reinstatement End Date 12.31 Tab
- Section 3.3.3.4, Newborn Premium Updates Tab
- Section 3.3.3.5, Enrollment Blocker Tab
- Section 3.3.3.6, Mailing Address Change Tab
- Section 3.3.3.7, Agent Broker Information Tab

3.3.3.1 Discrepancy Dispute Tab

The Discrepancy Dispute tab (Exhibit 8 and Exhibit 9) allows issuers to dispute enrollment discrepancies identified in the RCNO. When the FFM values from the RCNO do not match the issuer's records, the issuer uses this tab to correct the records within the FFM.

Issuers may submit a Discrepancy Dispute for a policy relating to the subscriber (the primary policy holder) or a dependent. If the requested change applies to the entire enrollment group (the subscriber and the dependents), the issuer may dispute the subscriber record, and the change will apply to the entire enrollment group. To change dates for the dependent record, the updated dates must fall within the correct dates for the subscriber record that are already on the RCNO file or consistent with the submitted updates. Issuers can include only one disputed element on each line of the Enrollment Dispute Form and must use a separate line to dispute additional data discrepancies.

Exhibit 8: Discrepancy Dispute Tab

HIOS	Coverage Year	Batch Number	FFM Internal Record Inventory Number	FFM Exchange Assigned Policy ID	FFM Exchange Assigned Subscriber Identifier	Description of Disputed Item

Exhibit 9: Discrepancy Dispute Tab (Continued)

Issuer Value	FFM Value	HICS Case ID	FFM Benefit Start Date	FFM Benefit End Date	Issuer Assigned Dispute Control Number	Comments

Each dispute must include certain data elements that uniquely identify the exact record the issuer is disputing. Exhibit 10 provides an example of a dispute of a Total Premium Amount.

Exhibit 10: Discrepancy Dispute Example

HIOS	Coverage Year	Batch Number	FFM Internal Record Inventory Number	FFM Exchange Assigned Policy ID	FFM Exchange Assigned Subscriber Identifier	Description of Disputed Item	Issuer Value	FFM Value	HICS Case ID
12345	2017	1701	1234567890		0000001234	Total Premium Amount	999.99	999.90	E00000000

Exhibit 11 provides a description of each data element in the Discrepancy Dispute tab, the data type of that element, field length requirements, and whether the fields of the form are required or situational.

Exhibit 11: Discrepancy Dispute Tab Data Elements

Data Element Description	Data Type	Field Length	Required or Situational
HIOS Identifier for the issuer as assigned via the Health Insurance Oversight System – corresponds to the first five characters of the Qualified Health Plan (QHP) ID	Numeric	5	This is a required field.
Coverage Year Coverage year for the disputed record	Numeric	4	This is a required field.
Batch Number RCNO Batch Number value associated to the record being reported, found in field 143 (FTI_INTERNAL_BATCH_ID) of the record	Numeric	1-4	This is a situational (optional) field.
FFM Internal Record Inventory Number The FFM's unique identifier for the specific record in the RCNO file, located in column 141	Numeric	1-12	This is a situational field. It is required for all Description of Disputed Items options except ***Prior Year – End Date***.
FFM Exchange Assigned Policy ID FFM Exchange Assigned Policy ID associated to the disputed record, located in column 44 of the RCNO file	Numeric	1-15	This is a situational field. It is required for ***Prior Year – End Date*** disputes when the primary identifier is the FFM Exchange Assigned Policy ID.
FFM Exchange Assigned Subscriber Identifier Exchange-assigned identifier for the subscriber of the enrollment group – if the member in the record is the subscriber, this will be the same as the Exchange Assigned Member ID	Numeric	10	This is a required field.

Data Element Description	Data Type	Field Length	Required or Situational
Description of Disputed Item Provides a drop-down menu that displays a set of values from which the issuer may select **NOTE**: Altering the Description of Disputed Item will prevent it from being processed and result in a rejection of the disputed record.	Drop-down menu	N/A Refer to Exhibit 12	This is a required field.
Issuer Value Represents what the issuer believes should be reflected in the FFM for the disputed item – in some cases, there are checks to ensure the Issuer Value on the Enrollment Dispute Form is the same as what is being reported in the RCNO/RCNI file	Alphanumeric	N/A	This is a required field. For current year disputes, this value must match the value submitted in RCNI.
FFM Value Represents what the FFM is currently reflecting in the RCNO for the disputed item	Alphanumeric	N/A	This is a required field.
HICS Case ID HICS case number, if a HICS case is required	Alphanumeric	11	This is a situational field.
FFM Benefit Start Date FFM Benefit Start Date associated to the disputed record within the RCNO data	Numeric	8-digit date (YYYMMDD) – dashes and spaces are not accepted	This is a situational field. It is required for ***Prior Year – End Date*** disputes when the primary identifier is the FFM Exchange Assigned Policy ID.
FFM Benefit End Date FFM Benefit End Date associated to the disputed record within the RCNO data	Numeric	8-digit date (YYYMMDD) – dashes and spaces are not accepted	This is a situational field. It is required for ***Prior Year – End Date*** disputes when the primary identifier is the FFM Exchange Assigned Policy ID.
Issuer Assigned Dispute Control Number Specific to the issuer – issuers may create and use this number to track disputes	Alphanumeric	1-64	This is a situational (optional) field.

Data Element Description	Data Type	Field Length	Required or Situational
Comments Used to enter information that could assist the ER&R Contractor with reconciling the discrepancy **NOTE:** The automated process does not apply comments.	Alphanumeric	1-3,000	This is a situational (optional) field.

In the Description of Disputed Item column, the issuer must select the type of Enrollment Dispute. Exhibit 12 provides a description of each dispute type. This table also identifies the issuer and FFM values from the RCNO file that must be included to complete the Enrollment Dispute Form, as well as the format to use for each Description of Disputed Item option.

Exhibit 12: Description of Disputed Items Column in Discrepancy Dispute Tab

Description of Disputed Items	Issuer Value from RCNO	FFM Value from RCNO	Format
Applied APTC Amount Amount of Advance Premium Tax Credit (APTC) applied to the premium monthly, based on the subscriber's election during enrollment **NOTE**: Issuer must include HICS case number reference in the HICS Case ID column of the Enrollment Dispute Form.	ISSUER_PLCY_APTC_AMT	FFM_PLCY_APTC_AMT	Financial value between 0.00 and 99,999.99 – do not include the dollar sign ($)
Benefit Start Date Effective date of benefit coverage associated with this enrollment record	ISSUER_PLAN_BNFT_STRT_DT	FFM_PLAN_BNFT_STRT_DT	8-digit date (YYYMMDD) – dashes and spaces are not accepted
CSR Amount Amount of Cost-Sharing Reduction (CSR) applied to the premium	ISSUER_PLCY_CSR_AMT	FFM_PLCY_CSR_AMT	Financial value between 0.00 and 99,999.99 – do not include the dollar sign ($)
End of Year Termination Indicator Indicates if the enrollment record will be terminated effective December 31st of the given plan year and should be ineligible for reenrollment through Batch Auto-Renewal (BAR)	ISSUER_END_YR_VLNTRY_TRM_IND	FFM_END_YR_VLNTRY_TRM_IND	Alpha character Y – Indicates terminated 12/31 N – Indicates not terminated 12/31 **NOTE:** This dispute type is not being accepted at this time.
Gender Indicates the gender of the member	ISSUER_PRSN_GNDR_CD	FFM_PRSN_GNDR_CD	Alpha character F – Female M – Male

Description of Disputed Items	Issuer Value from RCNO	FFM Value from RCNO	Format
Initial Premium Paid Status Indicates if the initial binder payment has been made for the enrollment, leading to effectuated coverage **NOTE**: This value is to be sent with the subscriber of the enrollment group and will apply to all members of the enrollment group.	ISSUER_PRM_PD_IND	FFM_PRM_PD_IND	Alpha character Y – Effectuated (active or terminated coverage) N – Un-effectuated (awaiting binder payment) C – Cancelled (no binder payment received, no period of coverage)
Issuer Assigned Member ID Issuer-assigned identifier for the member	ISSUER_BENE_ISSR_ASGNED_ID	FFM_BENE_ISSR_ASGNED_ID	Alphanumeric 1-50 characters
Issuer Assigned Policy ID Policy number for the benefit coverage as assigned by the issuer – must be unique to an enrollment group (within a HIOS ID) and consistent across all members of the enrollment group	ISSUER_PLAN_ISSR_ASG_PLCY_NUM	FFM_PLAN_ISSR_ASG_PLCY_NUM	Alphanumeric 1-50 characters
Issuer Assigned Subscriber ID Issuer-assigned identifier for the subscriber of the enrollment group – if the member in the record is the subscriber, this should be the same as the Issuer Assigned Member ID	ISSUER_BENE_SBS_ISSR_ASG_ID	FFM_BENE_SBS_ISSR_ASG_ID	Alphanumeric 1-50 characters
Issuer End Date Earlier Than FFM Issuer is disputing that the Issuer Benefit End Date is earlier than the FFM Benefit End Date – this category should be used for current coverage year disputes when the issuer is attempting to update the FFM to an earlier end date **NOTE**: Submit policy changes with a prior year end date with the Reinstatement dispute option.	ISSUER_PLAN_BNFT_END_DT	FFM_PLAN_BNFT_END_DT	8-digit date (YYYMMDD) – dashes and spaces are not accepted

Description of Disputed Items	Issuer Value from RCNO	FFM Value from RCNO	Format
Issuer End Date Later Than FFM Issuer is disputing that the Issuer Benefit End Date is later than the FFM Benefit End Date – this category should be used for current coverage year disputes when the issuer is attempting to update the FFM to a later end date that is not 12.31 **NOTE**: Submit policy changes with a prior year end date with the Reinstatement dispute option.	ISSUER_PLAN_BNFT_END_DT	FFM_PLAN_BNFT_END_DT	8-digit date (YYYMMDD) – dashes and spaces are not accepted
Paid Through Date Indicates the latest date through which the consumer paid premiums **NOTE**: This dispute type is not being accepted at this time. Submissions of Paid Through Date disputes will be rejected.	ISSUER_PD_THRU_DT	FFM_PD_THRU_DT	8-digit date (YYYMMDD) – dashes and spaces are not accepted **NOTE:** This dispute type is not being accepted at this time.
Prior Year – End Date Used to dispute all end dates for coverage years prior to the current year – Prior Year – End Date is the correction of an erroneous termination or cancellation action that results in the restoration of an enrollment with no break in coverage (45 CFR §155.430(e)(3)).	ISSUER_PLAN_BNFT_END_DT	FFM_PLAN_BNFT_END_DT	8-digit date (YYYMMDD) – dashes and spaces are not accepted
QHP ID Full 16-character QHP identifier, including CSR variant, that is required for all records	ISSUER_PLAN_PLCY_ID	FFM_PLAN_PLCY_ID	Alphanumeric 16 characters
Tobacco Status Specifies whether the member has indicated tobacco use in the past six months **NOTE**: For any individual under 18 years of age, this field should always be sent with a value of 2.	ISSUER_PRSN_SMKNG_USE_CD	FFM_PRSN_SMKNG_USE_CD	Numeric 1 – Tobacco Use 2 – No Tobacco Use

Description of Disputed Items	Issuer Value from RCNO	FFM Value from RCNO	Format
Total Premium Amount Total monthly premium amount for the enrollment group **NOTE**: Issuer must include HICS case number reference in the HICS case ID column of the Enrollment Dispute Form, when applicable.	ISSUER_PLCY_TOT_PRM_AMT	FFM_PLCY_TOT_PRM_AMT	Financial value between 0.00 and 99,999.99 – do not include the dollar sign ($).

3.3.3.2 Rejected Enrollments Tab

Exhibit 13: Rejected Enrollments Tab

HIOS	Coverage Year	Batch Number	FFM Internal Record Inventory Number	FFM Exchange Assigned Policy ID	FFM Exchange Assigned Subscriber Identifier	Issuer Assigned Dispute Control Number

Issuers should use the Rejected Enrollments tab to report member records that require cancellation in the FFM because the policy was never effectuated. Rejected Enrollments can be policies that should not have passively reenrolled, duplicate policies, "leftover" policies, or policies for which there was not coverage for that time period. Issuers may only submit Rejected Enrollment disputes for policies during the current RCNO year and should use the Initial Premium Paid Status dispute type, on the Discrepancy Dispute tab, for prior year cancellations.

Exhibit 14 provides a breakdown of the data element requirements for the Rejected Enrollments Dispute tab.

Exhibit 14: Rejected Enrollments Tab Data Elements

Data Element Description	Data Type	Field Length	Required or Situational
HIOS Identifier for the issuer as assigned via the Health Insurance Oversight System – corresponds to the first five characters of the QHP ID	Numeric	5	This is a required field.
Coverage Year Coverage year for the disputed record	Numeric	4	This is a required field.
Batch Number RCNO Batch Number value associated to the record being reported, found in field 143 (FTI_INTERNAL_BATCH_ID) of the record	Numeric	1-4	This is a situational (optional) field.
FFM Internal Record Inventory Number The FFM's unique identifier for the specific record in the RCNO file, located in column 141	Numeric	1-12	This is a situational field. It is required when it is the primary identifier.

Data Element Description	Data Type	Field Length	Required or Situational
FFM Exchange Assigned Policy ID FFM Exchange Assigned Policy ID associated to the disputed record, located in column 44 of the RCNO file	Numeric	1-15	This is a situational field. It is required when it is the primary identifier.
FFM Exchange Assigned Subscriber Identifier Exchange-assigned identifier for the subscriber of the enrollment group – if the member in the record is the subscriber, this will be the same as the Exchange Assigned Member ID	Numeric	10	This is a required field.
Issuer Assigned Dispute Control Number Specific to the issuer – issuers may create and use this number to track disputes.	Alphanumeric	1-64	This is a situational (optional) field.

3.3.3.3 Reinstatement End Date 12.31 Tab

Exhibit 15: Reinstatement End Date 12.31 Tab

HIOS	Coverage Year	Batch Number	FFM Internal Record Inventory Number	FFM Exchange Assigned Policy ID

Exhibit 16: Reinstatement End Date 12.31 Tab (Continued)

FFM Exchange Assigned Subscriber Identifier	FFM Benefit Start Date	FFM Benefit End Date	Issuer Assigned Dispute Control Number

Issuers use the Reinstatement End Date 12.31 tab to report member records that the issuer would like to reinstate to reflect the Benefit End Date as December 31. Issuers can submit disputes for any coverage year using this tab.

Exhibit 17 provides a breakdown of the data element requirements for the Reinstatement End Date 12.31 tab.

Exhibit 17: Reinstatement End Date 12.31 Tab Data Elements

Data Element Description	Data Type	Field Length	Required or Situational
HIOS Identifier for the issuer as assigned via the Health Insurance Oversight System – corresponds to the first five characters of the QHP ID	Numeric	5	This is a required field.
Coverage Year Coverage year for the disputed record	Numeric	4	This is a required field.
Batch Number RCNO Batch Number value associated to the record being reported – found in field 143 (FTI_INTERNAL_BATCH_ID) of the record	Numeric	1-4	This is a situational (optional) field.
FFM Internal Record Inventory Number The FFM's unique identifier for the specific record in the RCNO file, located in column 141	Numeric	1-12	This is a situational field. It is required when it is the primary identifier.
FFM Exchange Assigned Policy ID FFM Exchange Assigned Policy ID associated to the disputed record, located in column 44 of the RCNO file	Numeric	1-15	This is a situational field. It is required when it is the primary identifier.
FFM Exchange Assigned Subscriber Identifier Exchange-assigned identifier for the subscriber of the enrollment group – if the member in the record is the subscriber, this will be the same as the Exchange Assigned Member ID	Numeric	10	This is a required field.
FFM Benefit Start Date FFM Benefit Start Date associated to the disputed record within the RCNO data	Numeric	8-digit date (YYYMMDD) – dashes and spaces are not accepted	This is a situational field. It is required when the primary identifier is the FFM Exchange Assigned Policy ID.
FFM Benefit End Date FFM Benefit End Date associated to the disputed record within the RCNO data	Numeric	8-digit date (YYYMMDD) – dashes and spaces are not accepted	This is a situational field. It is required when the primary identifier is the FFM Exchange Assigned Policy ID.

Data Element Description	Data Type	Field Length	Required or Situational
Issuer Assigned Dispute Control Number Specific to the issuer – issuers may create and use this number to track disputes	Alphanumeric	1-64	This is a situational (optional) field.

3.3.3.4 Newborn Premium Updates Tab

Exhibit 18: Newborn Premium Updates Tab

HIOS	Coverage Year	Batch Number	FFM Internal Record Inventory Number	FFM Exchange Assigned Policy ID

Exhibit 19: Newborn Premium Updates Tab (Continued)

FFM Exchange Assigned Subscriber Identifier	Date to Begin Charging Newborn Premium	Subscriber Total Premium during Free Coverage Period	Subscriber APTC during Free Coverage Period	Issuer Assigned Dispute Control Number

Issuers use the Newborn Premium Updates tab to report newborn member records who qualify for a free premium coverage period in accordance with state laws. These Newborn Premium Updates are policies that currently reflect an individual premium amount for a period of time, when the state law indicates the newborn should not have a premium rate for the first month or more. Issuers may submit these disputes for any coverage year.

Exhibit 20 describes the specifications for each field on the Newborn Premium Updates tab.

Exhibit 20: Newborn Premium Updates Tab Data Elements

Data Element Description	Data Type	Field Length	Required or Situational
HIOS Identifier for the issuer as assigned via the Health Insurance Oversight System – corresponds to the first five characters of the QHP ID	Numeric	5	This is a required field.
Coverage Year Coverage year for the disputed record	Numeric	4	This is a required field.
Batch Number RCNO Batch Number value associated to the record being reported, found in field 143 (FTI_INTERNAL_BATCH_ID) of the record	Numeric	1-4	This is a situational (optional) field.
FFM Internal Record Inventory Number The FFM's unique identifier for the specific record in the RCNO file, located in column 141	Numeric	1-12	This is a required field.

Data Element Description	Data Type	Field Length	Required or Situational
FFM Exchange Assigned Policy ID FFM Exchange Assigned Policy ID associated to the disputed record, located in column 44 of the RCNO file	Numeric	1-15	This is a required field.
FFM Exchange Assigned Subscriber Identifier Exchange-assigned identifier for the subscriber of the enrollment group – if the member in the record is the subscriber, this will be the same as the Exchange Assigned Member ID	Numeric	10	This is a required field.
Date to Begin Charging Newborn Premium Date the Newborn Premium should be applied – this is the first day after the free coverage period ends and the date the FFM will begin to reimburse the issuer	Numeric	8-digit date (YYYMMDD) – dashes and spaces are not accepted	This is a required field.
Subscriber Total Premium During Free Coverage Period Total Premium Amount for the primary subscriber, the individual who is the primary policy holder – generally the same as the Total Premium Amount prior to the Newborn dependent being added to the policy, as the Total Premium Amount does not increase until after the free coverage period ends	Numeric	Financial value between 0.00 and 99,999.99 – do not include the dollar sign ($)	This is a required field.
Subscriber APTC During Free Coverage Period APTC amount for the primary subscriber, the individual who is the primary policy holder – generally the same as the APTC amount after the Newborn dependent was added to the policy	Numeric	Financial value between 0.00 and 99,999.99 – do not include the dollar sign ($)	This is a required field.
Issuer Assigned Dispute Control Number Specific to the issuer – issuers may create and use this number to track disputes	Numeric	1-64	This is a situational (optional) field.

3.3.3.5 Enrollment Blocker Tab

Exhibit 21: Enrollment Blocker Tab

HIOS	Coverage Year	Batch Number	FFM Exchange Assigned Policy ID	FFM Exchange Assigned Subscriber Identifier	Total Premium to be Applied	APTC Amount	QHP Variant ID

Exhibit 22: Enrollment Blocker Tab (Continued)

CSR	Issuer Start Date as a result of Add or Removal of Member(s)	HICS Case ID	FFM Benefit Start Date	FFM Benefit End Date	Issuer Assigned Dispute Control Number	Comments

Issuers use the Enrollment Blocker tab to update financial information associated to an enrollment group when the addition of a new member is blocked. An Enrollment Blocker prevents the enrollee from completing the enrollment, which results in the FFM not generating the 834 transaction with the updated information.

To correct Enrollment Blockers, the consumer must contact the FFM call center to open a HICS case. The HICS case ID is required for the dispute to be processed. The ER&R Contractor cannot add the consumer information into the Federal Marketplace or update demographic information, such as name, DOB, or SSN; rather, the dispute aligns dates and financial amounts of a policy that already exists in the FFM database.

Exhibit 23 provides a breakdown of the data element requirements for the Enrollment Blocker tab.

Exhibit 23: Enrollment Blocker Tab Data Elements

Data Element Description	Data Type	Field Length	Required or Situational
HIOS Identifier for the issuer as assigned via the Health Insurance Oversight System – corresponds to the first five characters of the QHP ID	Numeric	5	This is a required field.
Coverage Year Coverage year for the disputed record	Numeric	4	This is a required field.
Batch Number RCNO Batch Number value associated to the record being reported, found in field 143 (FTI_INTERNAL_BATCH_ID) of the record.	Numeric	1-4	This is a situational (optional) field.
FFM Exchange Assigned Policy ID FFM Exchange Assigned Policy ID associated to the disputed record, located in column 44 of the RCNO file	Numeric	1-15	This is a required field.
FFM Exchange Assigned Subscriber Identifier Exchange-assigned identifier for the subscriber of the enrollment group – if the member in the record is the subscriber, this will be the same as the Exchange Assigned Member ID	Numeric	10	This is a required field.
Total Premium to Be Applied Total Premium Amount to be applied for the entire enrollment group, including the primary subscriber, with all dependents and the member that was blocked	Numeric	Financial value between 0.00 and 99,999.99 – do not include the dollar sign ($)	This is a situational (optional) field.
APTC Amount APTC amount to be applied for the entire enrollment group, including the primary subscriber, with all dependents and the member that was blocked	Numeric	Financial value between 0.00 and 99,999.99 – do not include the dollar sign ($)	This is a situational (optional) field.

Data Element Description	Data Type	Field Length	Required or Situational
QHP Variant ID Last two digits of the QHP identifier	Numeric	2	This is a situational (optional) field.
CSR CSR Amount calculated by CMS based on the premium amount and the Variant ID the consumer is enrolled in **NOTE**: This information is no longer required as of 8/15/17. This field should be left blank.	Numeric	Financial value between 0.00 and 99,999.99 – do not include the dollar sign ($)	This is a situational (optional) field.
Issuer's Start Date as a Result of the New Member(s) A Change in Circumstance (CIC), such as adding a new member to an enrollment group, initiates a new start date for the affected policy; this date is the date the change in financial amounts will be applied to the issuer's account	Numeric	8-digit date (YYYMMDD) – dashes and spaces are not accepted	This is a situational (optional) field.
HICS Case ID HICS number assigned to a consumer dispute when the dispute is reported to the Marketplace	Numeric	11	This is a required field.
FFM Benefit Start Date FFM Benefit Start Date associated to the disputed record within the RCNO data	Numeric	8-digit date (YYYMMDD) – dashes and spaces are not accepted	This is a situational (optional) field.
FFM Benefit End Date FFM Benefit End Date associated to the disputed record within the RCNO data	Numeric	8-digit date (YYYMMDD) – dashes and spaces are not accepted	This is a situational (optional) field.
Issuer Assigned Dispute Control Number Specific to the issuer – issuers may create and use this number to track disputes	Alphanumeric	1-64	This is a situational (optional) field.
Comments Used to enter information that could assist the ER&R Contractor with reconciling the discrepancy	Alphanumeric	1-3,000	This is a situational (optional) field.

3.3.3.6 Mailing Address Change Tab

Exhibit 24: Mailing Address Change Tab

HIOS	Coverage Year	Batch Number	FFM Internal Record Inventory Number	FFM Exchange Assigned Policy ID	FFM Exchange Assigned Subscriber Identifier	Issuer Mailing Address Line 1

Exhibit 25: Mailing Address Change Tab (Continued)

Issuer Mailing Address Line 2	Issuer Mailing Address City	Issuer Mailing Address State	Issuer Mailing Address ZIP Code	Issuer Assigned Dispute Control Number	Comments

Issuers use the Mailing Address Change tab to submit mailing address changes for any coverage year. For current year updates, issuers must submit the same address in RCNI that is being requested on the Enrollment Dispute Form.

Exhibit 26 provides a breakdown of the data element requirements for the Mailing Address Change tab.

Exhibit 26: Mailing Address Change Tab Data Elements

Data Element Description	Data Type	Field Length	Required or Situational
HIOS Identifier for the issuer as assigned via the Health Insurance Oversight System – corresponds to the first five characters of the QHP ID	Numeric	5	This is a required field.
Coverage Year Coverage year for the disputed record	Numeric	4	This is a required field.
Batch Number RCNO Batch Number value associated to the record being reported, found in field 143 (FTI_INTERNAL_BATCH_ID) of the record	Numeric	1-4	This is a situational (optional) field.
FFM Internal Record Inventory Number The FFM's unique identifier for the specific record in the RCNO file, located in column 141	Numeric	1-12	This is a required field.
FFM Exchange Assigned Policy ID FFM Exchange Assigned Policy ID associated to the disputed record, located in column 44 of the RCNO file	Numeric	1-15	This is a required field.
FFM Exchange Assigned Subscriber Identifier Exchange-assigned identifier for the subscriber of the enrollment group – if the member in the record is the subscriber, this will be the same as the Exchange Assigned Member ID	Numeric	10	This is a required field.
Issuer Mailing Address Line 1 Mailing street address of the member (Line 1)	Numbers, letters, periods, spaces, and hyphens are accepted	1-55	This is a required field.

Data Element Description	Data Type	Field Length	Required or Situational
Issuer Mailing Address Line 2 Mailing street address of the member (Line 2)	Numbers, letters, periods, spaces, hyphens, and the pound symbol (#) are accepted	1-55	This is a situational (optional) field.
Issuer Mailing Address City Mailing city of the member	Numbers, letters, periods, spaces, and hyphens are accepted	2-30	This is a required field.
Issuer Mailing Address State State abbreviation for the mailing state of the member	Alpha characters	2-digit state code	This is a required field.
Issuer Mailing Address ZIP Code Mailing ZIP Code of the member	Numeric	5- or 9-digit ZIP Code – may include a hyphen between the fifth and sixth digits	This is a required field.
Issuer Assigned Dispute Control Number Specific to the issuer – issuers may create and use this number to track disputes	Alphanumeric	1-64	This is a situational (optional) field.
Comments Used to enter information that could assist the ER&R Contractor with reconciling the discrepancy	Alphanumeric	1-3,000	This is a situational (optional) field.

3.3.3.7 Agent Broker Information Tab

Exhibit 27: Agent Broker Information Tab

HIOS	Coverage Year	Action	FFM Internal Record Inventory Number	FFM Exchange Assigned Policy ID	FFM Exchange Assigned Subscriber Identifier	Issuer Agent Broker First Name

Exhibit 28: Agent Broker Information Tab (Continued)

Issuer Agent Broker Middle Name	Issuer Agent Broker Last Name	Issuer Agent Broker Suffix	Issuer Agent Broker NPN	Issuer Assigned Dispute Control Number	Comments

Issuers use the Agent Broker Information to remove or update the Agent/Broker name or National Producer Number (NPN) associated to a policy. These disputes can be submitted for any coverage year

and are applied at the policy level to all active coverage spans. For current year updates, issuers must submit the same information in RCNI that is being requested on the Enrollment Dispute Form.

Exhibit 29 provides a breakdown of the data element requirements for the Agent Broker Information tab.

Exhibit 29: Agent Broker Information Tab Data Elements

Data Element Description	Data Type	Field Length	Required or Situational
HIOS Identifier for the issuer as assigned via the Health Insurance Oversight System – corresponds to the first five characters of the QHP ID	Numeric	5	This is a required field.
Coverage Year Coverage year for the disputed record	Numeric	4	This is a required field.
Action Provides a drop-down menu that displays the values from which the issuer may select – select ***Agent/Broker Name/NPN - Remove*** to remove the Agent/Broker information from the policy; select ***Agent/Broker Name/NPN - Update*** to change the Agent/Broker information for the policy	Drop-down menu	N/A	This is a required field.
FFM Internal Record Inventory Number The FFM's unique identifier for the specific record in the RCNO file, located in column 141	Numeric	1-12	This is a required field.
FFM Exchange Assigned Policy ID FFM Exchange Assigned Policy ID associated to the disputed record, located in column 44 of the RCNO file	Numeric	1-15	This is a required field.
FFM Exchange Assigned Subscriber Identifier Exchange-assigned identifier for the subscriber of the enrollment group – if the member in the record is the subscriber, this will be the same as the Exchange Assigned Member ID	Numeric	10	This is a required field.
Issuer Agent Broker First Name First name or first part of the company name of the agent/broker associated with the enrollment	Letters, apostrophes, spaces, and hyphens are accepted	1-25 or blank (0)	This is a situational field. It is required when the Action is Agent/Broker Name/NPN – Update but must be left blank when the Action is Agent/Broker Name/NPN – Remove.

Data Element Description	Data Type	Field Length	Required or Situational
Issuer Agent Broker Middle Name Middle name or initial of the agent/broker associated with the enrollment, if applicable	Letters, apostrophes, spaces, and hyphens are accepted	1-25 or blank (0)	This is a situational field. It is optional when the Action is Agent/Broker Name/NPN – Update but must be left blank when the Action is Agent/Broker Name/NPN – Remove.
Issuer Agent Broker Last Name Last name or second part of the company name of the agent/broker associated with the enrollment	Letters, apostrophes, spaces, and hyphens are accepted	1-25 or blank (0)	This is a situational field. It is required when the Action is Agent/Broker Name/NPN – Update but must be left blank when the Action is Agent/Broker Name/NPN – Remove.
Issuer Agent Broker Suffix Suffix of the agent/broker associated with the enrollment, if applicable	The following values are accepted: II, III, IV, V, Jr., and Sr.	1-3 or blank (0)	This is a situational field. It is optional when the Action is Agent/Broker Name/NPN – Update but must be left blank when the Action is Agent/Broker Name/NPN – Remove.
Issuer Agent Broker NPN NPN of the Agent/Broker associated with the enrollment	Numeric	1-10 or blank (0)	This is a situational field. It is required when the Action is Agent/Broker Name/NPN – Update but must be left blank when the Action is Agent/Broker Name/NPN – Remove.

Data Element Description	Data Type	Field Length	Required or Situational
Issuer Assigned Dispute Control Number Specific to the issuer – issuers may create and use this number to track disputes	Alphanumeric	1-64	This is a situational (optional) field.
Comments Used to enter information that could assist the ER&R Contractor with reconciling the discrepancy	Alphanumeric	1-3,000	This is a situational (optional) field.

3.4 Enrollment Dispute Submission Guidelines

ER&R accepts and resolves current year disputes from issuers on a continual basis. Issuers should submit disputes as soon as possible upon identification of a discrepancy to allow the FFM to issue an accurate Form 1095-A to consumers in advance of the tax filing deadline.

In July 2018, ER&R introduced the ER&R Dispute Submissions Due date indicator on the Pre-Audit and Reconciliation Calendar. This is the target date by which issuers should submit disputes in order to have the corrections reflected in the following month's Pre-Audit file. Please note that a small percentage of disputes submitted prior to the due date may need additional cycles to update. Issuers can access the Pre-Audit and Reconciliation Calendar on CMS zONE at https://zone.cms.gov/document/pre-audit-and-recon-calendar-and-file-specification.

To permit past year updates due to retroactive appeals determinations, the ER&R Contractor accepts prior year disputes. In 2016, there were quarterly windows to submit prior year disputes. Starting in 2017, issuers may submit prior year disputes anytime; however, as of May 1, 2019, issuers must obtain approval from their Account Manager (AM) prior to submitting these disputes to ER&R for resolution. Each coverage year going forward, prior year disputes will require AM approval as of May 1st of the following year. This does not apply to HICS Direct Disputes or disputes that contain supporting HICS cases. To request approval, the issuer must email the completed Issuer Prior Year Approval Request Form to the AM to provide the following information:

- Volume of disputes/polices involved
- HIOS ID(s) impacted
- Point of contact for ER&R during dispute resolution
- Planned dispute submission date
- Reason for delay
- Actions the issuer is taking to prevent delayed disputes in the future
- Status of Form 1095-A impact notifications (if applicable)

The AM will notify ER&R of the prior year dispute approval and provide the pertinent details, including the dispute submission deadline for the issuer. ER&R will notify the AM and the issuer once the approval has been processed, and the issuer must submit the disputes in the allotted timeframe.

3.4.1 File Format

Submit the Enrollment Dispute Form in Excel or PSV formats.

3.4.2 EFT Submission and File Naming Convention

Submit all CCIIO ER&R Dispute Resolution Templates via EFT. Issuers with questions related to the Electronic Data Interchange (EDI) Onboarding or EFT setup process should refer to Section 7.2, Help Desk, for contact information.

Issuers should submit the Enrollment Dispute Forms to the Inbound30 inbound folder/directory, which issuers currently use for either 834 or 820 transactions, using the following the file naming convention:

TPID.*COG*.*ERRS*.*D*YYMMDD.*T*HHMMSSmmm.*P*.*IN*

Following is an explanation of the file name structure.

- TPID – Issuer's TPID, also known as the Source ID
- COG – Application ID, defaulted to "COG"
- ERRS – Function code for the Enrollment Dispute process, defaulted to "ERRS"
- DYYMMDD – Date, first character, D, is static; YY is year, MM is month, DD is day
- THHMMSSmmm – Timestamp, first character, T, is static; HH is hours, MM is minutes, SS is seconds, and mmm is milliseconds
- P/T – Environment, "P" for Production or "T" for Test
- IN – Direction (Inbound to CMS), defaulted to "IN"

Example: 12345.COG.ERRS.D160215.T162055453.P.IN

3.5 Avoiding Common Issuer Enrollment Dispute Errors

Following is a list of common disposition codes applied to unsuccessful Enrollment Disputes:

- FR6 – Not enough or conflicting information provided
- FR1/FR7 – Total Premium/APTC Amount was not updated due to a missing or inapplicable HICS case
- FR9 – RCNI end date does not match the value reported on the Enrollment Dispute Form
- FR10 – HIOS and primary identifier (FFM Internal Inventory Number or FFM Exchange Assigned Policy ID) cannot be found
- FR33 – Prior year dispute submitted using current year dispute type
- RJ31 – Overlapping date span within the same HIOS
- RJ32 – Overlapping date span within a different HIOS

This section provides guidance for issuers that will help prevent submitting these Enrollment Dispute errors.

3.5.1 Tips to Avoid Enrollment Dispute Error – FR6 Disposition

Disposition code FR6 (Exhibit 30) posts when ER&R does not have enough information to proceed with the dispute for resolution.

Exhibit 30: FR6 Disposition Code

Disposition Code and Rule Description	Verbiage Returned to Issuer
FR6 – Not Enough or Conflicting Information Provided	The information provided by the issuer does not match the description, there is not enough information regarding the disputed record, or the RCNI does not match the issuer values on the form. Please review the dispute form submitted. If it is a date dispute, please ensure that a date is provided on the dispute form. If it is a financial dispute, please ensure an amount is provided on the dispute form. If it is an issuer-assigned value (i.e., Issuer Assigned Subscriber ID, Issuer Assigned Policy ID, Issuer Assigned Member ID, Initial Premium Paid Indicator, or Tobacco Status), please ensure the RCNI is reporting the same value as the issuer value on the form. Please review and resubmit this dispute with the correct value and necessary information for ER&R to resolve the dispute. If you have questions or need technical assistance with updating the RCNI to ensure it is correct, please contact the FMCC help desk at fmcc@cms.hhs.gov.

To avoid the FR6 disposition:

- Select the appropriate Description of the Disputed Item option from the Discrepancy Dispute tab of the Enrollment Dispute Form.
- Confirm date validity for all dates on the form. The date must follow the YYYYMMDD format.
- Ensure that amount disputes include an Issuer Value that is an amount.
- Ensure that amounts are numeric.
- Confirm that the RCNI is reporting the same value provided on the Enrollment Dispute Form.

3.5.2 Tips to Avoid Enrollment Dispute Error – FR1 and FR7 Dispositions

Disposition codes FR1 and FR7 (Exhibit 31) post when ER&R receives an APTC amount dispute (FR1) or a Total Premium Amount dispute (FR7) that does not contain a valid HICS case.

Exhibit 31: FR1 and FR7 Disposition Codes

Disposition Code and Rule Description	Verbiage Returned to Issuer
FR1 – APTC Amount: No HICS Case is Provided or the HICS Case Provided Does Not Apply to the Disputed Record	ER&R is unable to process this request. Either the subscriber information provided by the issuer is not associated with the HICS case, the HICS case provided is invalid, or the HICS case does not support the change requested. ER&R must use the APTC amount in the HICS case. Therefore, the APTC amount was not changed in the FFM. The issuer needs to provide a valid HICS case and ensure the subscriber ID provided is associated to the application/HICS case on the dispute form or update their records to match the APTC amount in the FFM, provided on the RCNO file. If you have any questions, please contact the ER&R Support Center at errsupportcenter@cognosante.com.

Disposition Code and Rule Description	Verbiage Returned to Issuer
FR7 – Total Premium Amount: No HICS Case Provided or the HICS Case Provided Does Not Apply to the Disputed Record	ER&R is unable to process this request. Either the subscriber information provided by the issuer is not associated with the HICS case, the HICS case provided is invalid, or the HICS case does not support the change requested. ER&R must use the Total Premium Amount in the HICS case. Therefore, the Total Premium Amount was not changed in the FFM. The issuer needs to provide a valid HICS case and ensure the subscriber ID provided is associated to the application/HICS case on the dispute form or update their records to match the Total Premium Amount in the FFM, provided on the RCNO file. If you have any questions, please contact the ER&R Support Center at errsupportcenter@cognosante.com.

To avoid the FR1 and FR7 dispositions:

- Include a HICS case on the form in the HICS Case ID field on the Discrepancy Dispute tab of the Enrollment Dispute Form.
- Confirm the HICS case is valid and relevant to the dispute.
- Confirm the HICS Case Narrative specifies the changed financial amount (Total Premium and/or APTC).

3.5.3 Tips to Avoid Enrollment Dispute Error – FR9 Disposition

Disposition code FR9 (Exhibit 32) posts when the Benefit End Date in the RCNI is different from what the issuer is reporting in the Enrollment Dispute Form.

Exhibit 32: FR9 Disposition Code

Disposition Code and Rule Description	Verbiage Returned to Issuer
FR9 – End Date: Different in the RCNO File than on the Dispute Form	The RCNI file submitted reflects a Benefit End Date of [RCNO Issuer Benefit End Date]. If you believe that the Benefit End Date should be [dispute form Benefit End Date value], the issuer must apply the appropriate Benefit End Date on the RCNI before it can be reviewed and updated via the ER&R dispute process. If you have questions or need technical assistance with updating the RCNI to ensure it is correct, please contact the FMCC help desk at fmcc@cms.hhs.gov.

To avoid the FR9 disposition:

- Ensure the RCNI reflects the desired Benefit End Date.
- Ensure the Benefit End Date in the Issuer Value field on the Enrollment Dispute Form matches the RCNI value.

3.5.4 Tips to Avoid Enrollment Dispute Error – FR10 Disposition

Disposition code FR10 (Exhibit 33) posts when ER&R is unable to locate the disputed record with the HIOS and the primary identifier provided by the issuer.

Exhibit 33: FR10 Disposition Code

Disposition Code and Rule Description	Verbiage Returned to Issuer
FR10 – FFM Inventory Number or Policy ID Not Found	ER&R is unable to process this request. When attempting to find the record using the information the issuer provided, the record was not found for HIOS [HIOS ID]. If the FFM Internal Inventory Number was the primary identifier provided on the dispute form, it was not found for the HIOS provided. If the FFM Exchange Assigned Policy ID was the primary identifier provided on the dispute form, it was not found for the FFM Benefit Start Date, FFM Benefit End Date, and HIOS provided. When using the FFM Exchange Assigned Policy ID as the primary identifier, please ensure the FFM Benefit End Date and FFM Benefit Start Date supplied on the dispute form correspond to the most recent RCNO data for the record in dispute.

To avoid the FR10 disposition:

- Ensure the HIOS ID is complete and correct.
- When using the FFM Internal Inventory Numbers as the primary identifier:
  - Ensure the FFM Internal Inventory Number is valid with 10 characters, all numeric.
  - Ensure the FFM Internal Inventory Number matches the value from column EK of the disputed record on the RCNO file, as shown in Exhibit 34.

Exhibit 34: FFM Internal Inventory Record RCNO Example

FFM_PRM_PD_IND	ISSUER_PRM_PD_IND	FTI_PRM_PD_IND_FLAG	FTI_ISSUER_OVERALL_RECORD_FLAG	FFM_INTERNAL_INVENTORY_RECORD	FTI_ISSUER_LINK_KEY	FTI_INTERNAL_BATCH_ID
Y	Y	M	P	1234567890		15

- When using the FFM Exchange Assigned Policy ID as the primary identifier, ensure the value provided is valid, with 15 characters, all numeric.

3.5.5 Tips to Avoid Enrollment Dispute Error – FR33 Disposition

Disposition code FR33 (Exhibit 35) posts when an issuer has submitted a prior year Benefit End Date dispute using a current year dispute type.

Exhibit 35: FR33 Disposition Code

Disposition Code and Rule Description	Verbiage Returned to Issuer
Prior Year Dispute Submitted Using Current Year Dispute Type	ER&R is unable to process this request. The dispute was submitted as a dispute type of "Issuer End Date Later than FFM" or "Issuer End Date Earlier than FFM" and the dispute year is prior to the current coverage year. These dispute types can only be used for disputes in the current coverage year. If you have any questions, please contact the ER&R Support Center at errsupportcenter@cognosante.com.

To avoid the FR33 disposition:

- Submit prior year Benefit End Date disputes using the Prior Year – End Date option on the Enrollment Dispute Form.

3.5.6 Tips to Avoid Enrollment Dispute Error – RJ31 Disposition

Disposition code RJ31 (Exhibit 36) posts when the issuer has requested coverage date changes that would result in overlapping coverage with another policy under the same HIOS.

Exhibit 36: RJ31 Disposition Code

Disposition Code and Rule Description	Verbiage Returned to Issuer
Overlapping Date Span (Subscriber Level) – Same HIOS	The dispute was not able to be processed for an update. The update failed to process because the dates provided are now overlapping the dates for another policy for the same HIOS. Please review all policies associated to the covered individuals and ensure each policy is reporting the correct coverage period and financial amounts. If you have questions or need technical assistance with updating the RCNI to ensure it is correct, please contact the FMCC help desk at fmcc@cms.hhs.gov.

To avoid the RJ31 disposition:

- Be sure to review all effectuated coverage spans for all members within an enrollment group to confirm that no overlapping coverage exists for any of the members.

3.5.7 Tips to Avoid Enrollment Dispute Error – RJ32 Disposition

Disposition code RJ32 (Exhibit 37) posts when the issuer has requested coverage date changes that would result in overlapping coverage with another policy under a different HIOS.

Exhibit 37: RJ32 Disposition Code

Disposition Code and Rule Description	Verbiage Returned to Issuer
Overlapping Date Span (Subscriber Level) – Cross HIOS	The dispute was not able to be processed for an update. The update failed to process because the dates provided are now overlapping the dates for a policy for another HIOS. Please review all policies associated to the covered individuals and ensure each policy is reporting the correct coverage period and financial amounts. If you have questions or need technical assistance with updating the RCNI to ensure it is correct, please contact the FMCC help desk at fmcc@cms.hhs.gov.

To avoid the RJ32 disposition:

- Refer to the guidance returned in the Semi-Monthly Detailed Report.

3.6 Enrollment Dispute Responses

ER&R assigns a disposition code to all disputes to describe the current condition. This disposition code informs the issuer of the outcome of the dispute and any next steps.

Issuers receive Enrollment Dispute outcomes on the Semi-Monthly Detailed Report. The report identifies issuer-submitted disputes and correlated cases created by ER&R since the previous report, as well as disputes that have received a new disposition since the previous report. See Section 6.1, Semi-Monthly Detailed Report, for more information.

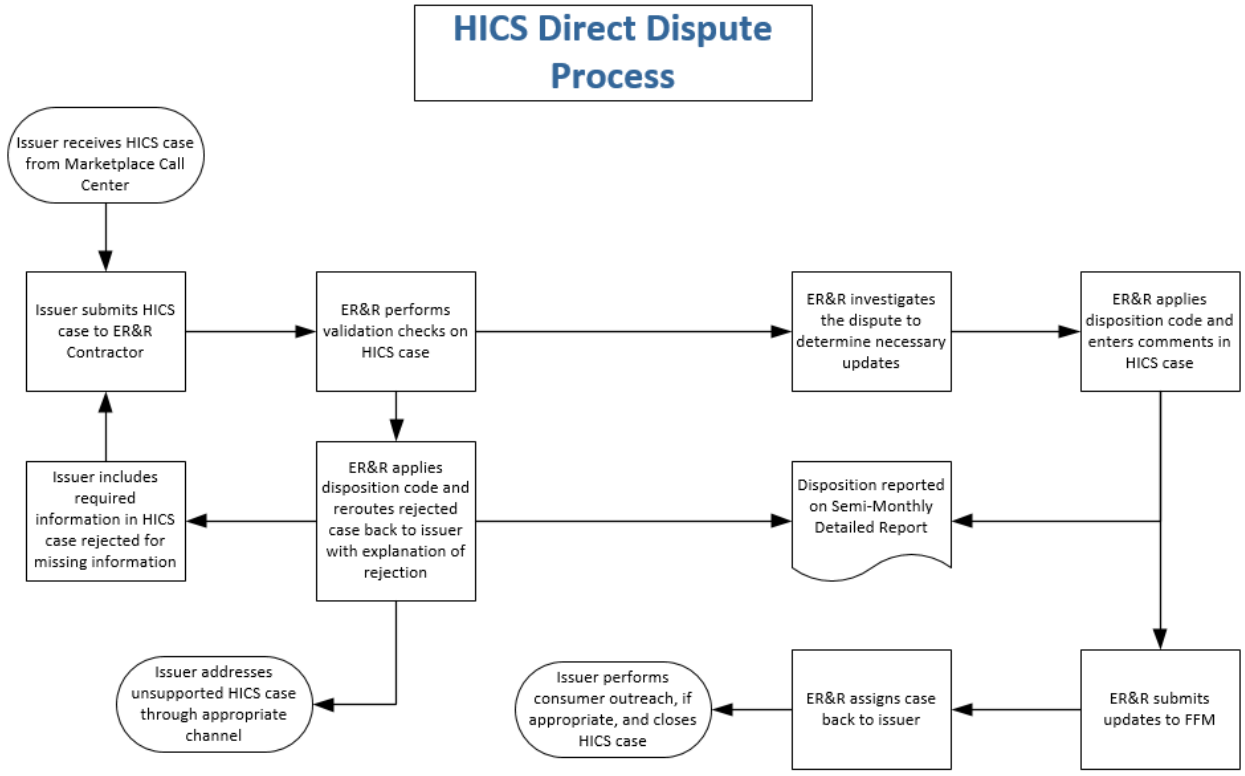
4.0 HICS Direct Disputes

4.1 HICS Direct Dispute Process

CMS implemented the HICS Direct Dispute feature to streamline the dispute process for issuers. Previously, when issuers were notified of a financial change through HICS, it was resolved by updating data elements on the RCNI and submitting an Enrollment Dispute to the ER&R Contractor. Starting in June 2017, the updated HICS system allows issuers to directly route specific HICS case types to the ER&R Contractor for dispute processing.

Issuers can select a radio button within a HICS case to initiate a HICS Direct Dispute. Selection of this Direct Dispute option populates the ER&R Review Requested column with "Yes" in the HICS Extract. Upon receipt of a HICS Direct Dispute case, the ER&R Contractor performs validation checks to ensure that the issuer has submitted a supported dispute type and included the necessary information. ER&R applies a disposition code to each case prior to reassigning the case back to the issuer in HICS. Issuers can track HICS Direct Dispute outcomes from the HICS case and the Semi-Monthly Detailed Report.

Exhibit 38: HICS Direct Dispute Process



1. The issuer receives a HICS case from the Marketplace Call Center.
2. The issuer selects the ***Yes*** ER&R Review Requested option within the HICS case to submit the case to ER&R.
3. If ER&R cannot validate the case, ER&R applies the appropriate disposition code and rejects the case to the issuer.
4. The issuer updates and resubmits the case or addresses the case through the appropriate channel.
5. ER&R investigates successfully validated cases to determine necessary updates.

6. After a determination is made, ER&R applies a disposition code and enters comments into the case regarding the processing of the dispute.
7. ER&R submits updates to the FFM.
8. ER&R assigns the completed case back to the issuer in HICS.
9. The issuer performs consumer outreach, if appropriate, and closes the case in HICS.
10. The Semi-Monthly Detailed Report provides the outcome of each HICS Direct Dispute case.

4.2 HICS Direct Dispute Overview

When an issuer receives a HICS case that requires an update to enrollment data, they may route the applicable HICS case to the ER&R Contractor in lieu of submitting an Enrollment Dispute Form for supported dispute types. Issuers may submit eligible HICS cases from any coverage year using the Direct Dispute method.

The following HICS cases are eligible for Direct Dispute processing:

- Enrollment Blocker
- Applied APTC Amount
- Total Premium Amount*
- Term NLE Appeals
- QHP ID/Variant ID
- Removal of a Member
- Changing Subscriber

***NOTE:** Total Premium Amount disputes not requiring a HICS case are not eligible for Direct Dispute processing. See Section 4.4.3, Total Premium Amount, for further details.

The ER&R Contractor assigns a unique case ID to each Direct Dispute. This case ID includes a "D" identifier.

ER&R uses initial validation checks to ensure that each case is acceptable for dispute processing. When cases do not pass the validation, ER&R rejects the cases back to the issuer. ER&R performs analysis on accepted cases using normal dispute handling processes. Both rejected and accepted cases receive a disposition code prior to being reassigned to the originating issuer. Direct Dispute cases also receive a disposition code if an issuer removes the ***Yes*** ER&R Review Requested selection while the ER&R Contractor is investigating the case.

HICS Direct Dispute cases remain open to issuers during ER&R research; however, issuers are not responsible for adhering to standard resolution timelines while the ER&R Contractor is processing the cases. When the issuer submits the HICS Direct Dispute case to the ER&R Contractor, the timer related to the 72-hour or 15-calendar day resolution timeline is on hold. The timer resumes when ER&R returns the processed case to the issuer. This allows the issuer time to take the necessary action after receiving the dispute response from ER&R. Issuers should pull a HICS Extract to view current information on Direct Dispute cases. When the ER&R Review Requested field is set to ***Yes***, the case is still being worked by ER&R. This field will change to ***No*** once the case is assigned back to the issuer.

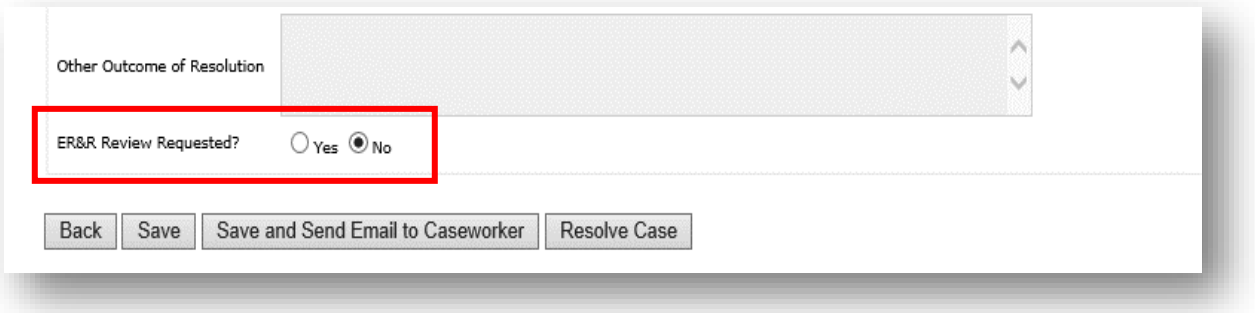
4.3 Completing a HICS Direct Dispute

Issuers must manually update each applicable HICS case to initiate a Direct Dispute. In situations where an issuer receives a HICS case with instructions to update policy information, the issuer must update the information prior to submitting the HICS case to ER&R for processing.

To complete the HICS Direct Dispute process for eligible HICS cases:

1. Log in to the secure HICS website at https://hics.cms.gov with a four-character CMS ID and the corresponding password.
   NOTE: For HICS support, including access requests, technical assistance, and password reset assistance, refer to Section 7.0, CMS Guidance and Support. Issuers may refer to the CMS Quick Reference Guide for Issuers: Managing Casework in the Health Insurance Casework System (HICS) for additional guidance on using HICS.
2. Select ***Enter Casework Tracking*** to access the Casework Tracking Start Page.
3. Select the ***Search Case*** option from the Cases menu.
4. Locate the appropriate HICS case using the HICS Search function.
5. Enter details regarding the requested change and any required or pertinent information into the Comments (External) section on the Resolution page. Refer to Section 4.4, HICS Direct Dispute Submission Guidelines, to verify that the necessary information has been included based on the dispute type.
   NOTE: Adding "ER&R" to the beginning of the case details will help separate the HICS Direct Dispute case notes from any notes added at a later time.
6. Select ***Yes*** from the ER&R Review Requested options (Exhibit 39).

Exhibit 39: ER&R Review Requested Options



7. Select ***Save*** to submit the updated HICS case to the ER&R Contractor.

4.4 HICS Direct Dispute Submission Guidelines

In addition to providing details regarding the requested change, issuers must provide the applicable required information within each HICS Direct Dispute case. This required information varies based on the dispute type the issuer is submitting and should be supported by the HICS Case Narrative. If an issuer finds that certain required information is missing from the HICS Case Narrative, the issuer must enter the missing values in the HICS case comments.

Reference the sections below to find the information needed for successful processing of each HICS Direct Dispute type.

4.4.1 Enrollment Blocker

As with Enrollment Blockers submitted via the Enrollment Dispute Form, issuers may only use the HICS Direct Dispute process to align dates and financial amounts of a policy that already exists in the FFM database. ER&R cannot update demographic information, such as name, DOB, and SSN. In situations where there is no existing plan enrollment, ER&R cannot add consumers into the FFM database.

Issuers should include the following information for Enrollment Blocker Direct Dispute submissions:

- Reference to Enrollment Blocker, Enrollment Blocker code number, or confirmation blocker in the HICS Case Narrative*
- Total Premium Amount to be applied (required if being updated)
- APTC amount
- CSR variant (required if being updated)
- FFM Exchange Assigned Policy ID*
- Benefit Start Date as a result of the new member, if applicable

*__NOTE:__ This information is required for the dispute type. The case will be rejected if this information is not provided within the HICS Case Narrative or comments.

4.4.2 Applied APTC Amount

Issuers should include the following information for Applied APTC Amount Direct Dispute submissions:

- APTC amount
- FFM Exchange Assigned Policy ID*

*__NOTE:__ This information is required for the dispute type. The case will be rejected if this information is not provided within the HICS Case Narrative or comments.

4.4.3 Total Premium Amount

For some Total Premium Amount cases, a correlated HICS case is not required to update the Total Premium Amount. Issuers correct these discrepancies either through automated Reconciliation or the Enrollment Dispute Form.

A HICS case is not needed when one or more of the following conditions is met:

- The update is required for a Stand Alone Dental Plan (SADP).
- The Benefit Start Date was updated.
- The Tobacco Status changed on an adult within acceptable ranges.
- A non-subscriber on a previous policy became the subscriber on a new policy linked by a CIC
- The enrollment group is in the same QHP, but there was a gap in coverage or a cancelled record prior to the new initial/effectuated coverage span and no change to the FFM Total Premium Amount between the prior record and the new record.
- The enrollment group is in the same QHP, but there was a new enrollment without a gap in coverage and no change to the enrollment group size, the FFM Total Premium Amount is higher in the new initial/effectuated coverage span than in the prior record, and the issuer's value is less than the new premium amount.

In situations where a HICS case exists, issuers may resolve the discrepancy using the HICS Direct Dispute option.

Issuers should include the following information for Total Premium Amount Direct Dispute submissions:

- Total Premium Amount*
- FFM Exchange Assigned Policy ID*

*__NOTE:__ This information is required for the dispute type. The case will be rejected if this information is not provided within the HICS Case Narrative or comments.

4.4.4 Term NLE Appeal

Term NLE Appeal HICS cases instruct an issuer to reinstate or extend an end date on a policy that was previously terminated as no longer eligible.

Issuers should include the following information for Term NLE Appeal Direct Dispute submissions:

- Benefit Start Date*
- Benefit End Date
- FFM Exchange Assigned Policy ID*
  ***NOTE:** This information is required for the dispute type. The case will be rejected if this information is not provided within the HICS Case Narrative or comments.

4.4.5 QHP ID/Variant ID

Issuers should include the following information for QHP ID/Variant ID Direct Dispute submissions:

- QHP ID/Variant ID*
- FFM Exchange Assigned Policy ID*
- Effective date
- APTC amount
  ***NOTE:** This information is required for the dispute type. The case will be rejected if this information is not provided within the HICS Case Narrative or comments.

4.4.6 Removal of a Member

Issuers can use the Removal of a Member dispute type when a HICS case indicates that a member should be removed from an enrollment group for a coverage period. Most commonly, this is necessary in cases of death or when a member becomes eligible for Medicare.

Issuers should include the following information for Removal of a Member Direct Dispute submissions:

- Name of the member being removed*
- Date of removal*
- Subscriber that will remain on the policy (if member removed was the subscriber)
- Total Premium Amount after the removal of the member
- APTC amount after the removal of the member
- FFM Exchange Assigned Policy ID*
  ***NOTE:** This information is required for the dispute type. The case will be rejected if this information is not provided within the HICS Case Narrative or comments.

4.4.7 Changing Subscriber

Issuers can use the Changing Subscriber dispute type when there is a change in subscriber, but a member is not being removed.

Issuers should include the following information for Changing Subscriber Direct Dispute submissions:

- FFM Exchange Assigned Policy ID*
- Name of existing subscriber*
- Name of new subscriber*
- Date of subscriber change*
  ***NOTE:** This information is required for the dispute type. The case will be rejected if this information is not provided within the HICS Case Narrative or comments.

4.5 Avoiding Common HICS Direct Dispute Errors

Following is a list of common disposition codes applied to unsuccessful HICS Direct Disputes:

- HU1 – HICS case requests a retroactive Benefit Start/End Date
- HU22 – HICS case requests a demographic change

This section provides guidance for issuers that will help prevent submitting these HICS Direct Dispute errors.

4.5.1 Tips to Avoid HICS Direct Dispute Error – HU1 Disposition

Disposition code HU1 (Exhibit 40) posts when an issuer has submitted a HICS case requesting a retroactive start date.

Exhibit 40: HU1 Disposition Code

Disposition Code and Rule Description	Verbiage Returned to Issuer
HDD Ineligible – Current Year: Retroactive Start and/or End Date (Non-Enrollment Blocker)	ER&R is unable to accept the requested change through the HICS Direct Dispute process. The FFM is already reporting a coverage span with the requested financial amounts supported by the HICS case. In order to resolve the HICS case, a retroactive start/end date or reinstatement should be updated through the RCNI process. The HICS Direct Dispute process is reserved for disputes that cannot be resolved through the Reconciliation or Issuer Dispute process because a HICS case is required to verify the request. If you have questions or need technical assistance with updating the RCNI to ensure it is correct, please contact the FMCC help desk at fmcc@cms.hhs.gov.

To avoid the HU1 disposition:

- Submit retroactive adjustments via the monthly Reconciliation process.
- If a Benefit Start or End Date update is not processing through the monthly Reconciliation process, submit an Enrollment Dispute to ER&R.

4.5.2 Tips to Avoid HICS Direct Dispute Error – HU22 Disposition

Disposition code HU22 (Exhibit 41) posts when an issuer has submitted a HICS case that requests a demographic change.

Exhibit 41: HU22 Disposition Code

Disposition Code and Rule Description	Verbiage Returned to Issuer
HDD Ineligible – Demographic	ER&R is unable to accept the requested change through the HICS Direct Dispute process. Issuers cannot update the member demographic field (name, DOB, SSN and mailing address, as applicable) through the Enrollment Dispute process. If the demographic change is the result of a non-Special Enrollment Period (non-SEP) Change in Circumstances Enrollment Confirmation Blocker error, the issuer should contact their Lead CMS Caseworker for assistance. Otherwise, consumers must update the fields (if applicable) by updating their application in the FFM.

To avoid the HU22 disposition:

- Advise the consumer to change the necessary demographic information by updating their application.

4.6 HICS Direct Dispute Responses

ER&R includes detailed comments regarding the processing of the dispute in the case notes of each HICS Direct Dispute case. The ER&R Contractor also applies a disposition code to each HICS dispute case prior to reassigning the case to the issuer. Issuers can find the applied disposition code in the HICS case notes. As with disputes submitted through other methods, the disposition code indicates the outcome of the Direct Dispute case. Issuers should reference the CCIIO Enrollment Dispositions list on CMS zONE for definitions of each disposition code.

Issuers can also monitor the outcomes of HICS Direct Dispute cases on the Semi-Monthly Detailed Report. ER&R identifies these disputes as "HICS Case Only" in the Dispute Category field on the Enrollment Disputes tab of the report. Issuers should note that these disputes will only appear on the Semi-Monthly Detailed Report transmitted through ERRD. HICS Direct Disputes will not appear on the Response Files sent through ERRP. See Section 6.1, Semi-Monthly Detailed Report, for more information.

4.6.1 Accepted HICS Direct Dispute Cases

The ER&R Contractor performs dispute analysis on accepted HICS Direct Dispute cases and submits any necessary updates to the FFM. When the investigation of the dispute is complete, the ER&R Contractor enters comments into the HICS case notes to convey the outcome of the dispute. If ER&R has submitted an update as a result of the dispute, the FFM update typically occurs within 1-2 Reconciliation cycles. ER&R selects the ***No*** ER&R Review Requested radio button to assign the case back to the issuer in HICS.

Issuers can close a case prior to seeing the update on the Pre-Audit file; however, issuers should not complete closeout activities, including customer outreach, prior to receiving notification of resolution from the ER&R Contractor.

Upon receipt of a completed case, the issuer should take the following actions:

1. Notify the consumer of the outcome, if appropriate.
2. Enter a resolution note and close the case in HICS.
   NOTE: Refer to the CMS Quick Reference Guide for Issuers: Managing Casework in the Health Insurance Casework System (HICS) for additional guidance on resolving HICS cases.
3. Monitor the Semi-Monthly Detailed Report.
   a. If an update to the FFM fails, the case will have an RJ disposition on the report. Reference the CCIIO Enrollment Dispositions list for further information regarding any RJ disposition.

4.6.2 Rejected HICS Direct Dispute Cases

The ER&R Contractor rejects unsupported dispute types that are incorrectly assigned to ER&R or cases missing required information. For each rejected case, the ER&R Contractor enters comments into the HICS case to inform the issuer of the reason for the rejection. ER&R selects the ***No*** ER&R Review Requested radio button to reroute the case back to the issuer.

In instances of rejection, the issuer should take the following action(s) based on the scenario:

- Invalid dispute type:
  - Address the HICS case through the appropriate channel.
- Incomplete information:
  - Provide all required information in the HICS case in accordance with the submission guidelines. See Section 4.4 HICS Direct Dispute Submission Guidelines.

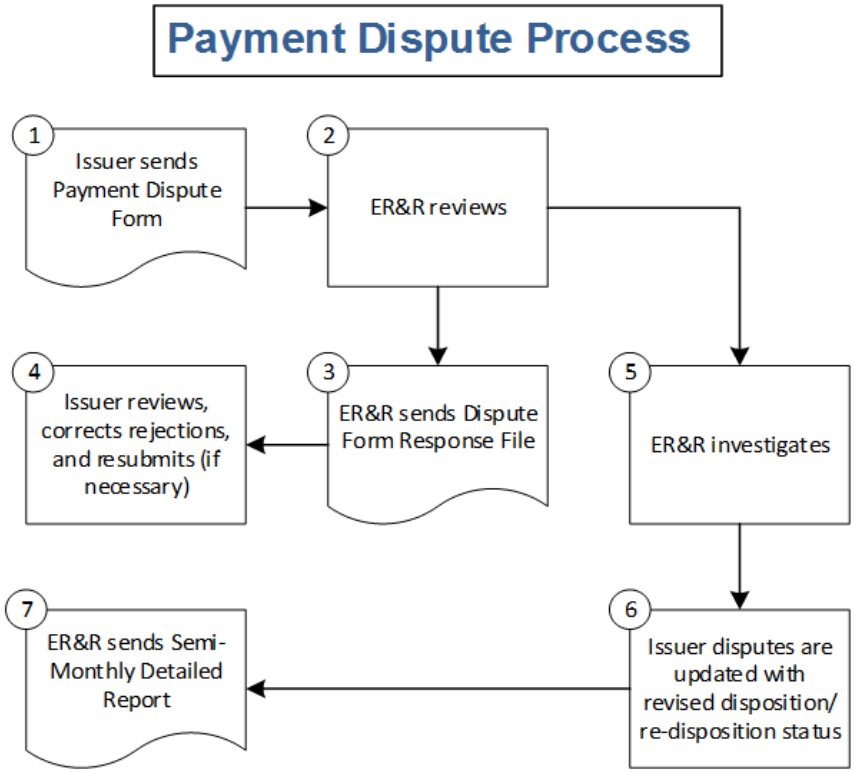
- Reselect the ***Yes*** ER&R Review Requested radio button in HICS.
- Save the updated HICS case to reassign to ER&R.

5.0 Payment Disputes

5.1 Payment Dispute Process

The Payment Dispute process is the process by which FFM issuers submit disputes of Policy-Based Payments to CMS. Monthly, issuers receive the PPR and HIX 820. Issuers use these files to identify discrepancies between the FFM and issuer databases. If an issuer finds a discrepancy that requires resolution, the issuer submits the PPR-820 Dispute Form (Payment Dispute Form) to ER&R to initiate the dispute process outlined in Exhibit 42. The ER&R Contractor evaluates and investigates each dispute and provides a response to the issuer via EFT using the transactions outlined in Exhibit 43 and the Payment Dispute FFE Disposition and Detail Codes list outlined in Exhibit 44.

Exhibit 42: PPR-820 Dispute Process



1. The issuer submits the Payment Dispute Form to ER&R via EFT.
2. The ER&R Contractor immediately reviews the Payment Dispute Form for syntax and semantic errors.
3. ER&R replies to issuers with the PPR-820 Dispute Response File via EFT. The Response File provides a CMS Dispute Control Number (tracking number for the dispute), a disposition code, and up to five applicable detail codes for each reported dispute that passes validation and is ingestible. Response Files identify dispositions with one of three statuses: Rejected/Returned, Completed/Closed, or In Process/In Analysis.

4. The issuer reviews the PPR-820 Dispute Response File. In situations where the report indicates rejected disputes exist, the issuer investigates and resubmits the dispute after correcting the original submission error(s).
5. ER&R investigates disputes with the status In Process/In Analysis that failed for any reason that was not a submission error.
6. After ER&R completes the investigation and makes a determination, ER&R changes the disposition code to signify the resolution of the dispute.
7. ER&R informs issuers of any dispute change in status on the 1st and 16th of each month using the Semi-Monthly Detailed Report. Issuers will only receive this report if any disputes have had a change in status since the previous Semi-Monthly Detailed Report.

Exhibit 43: PPR-820 Dispute Transactions

Reference Name in Document	Transaction Description	File Direction	File Type	EFT Function Code
PPR-820 Dispute Form	Used by issuers to submit disputes to ER&R	Issuers to ER&R	Excel or PSV	ERRP
PPR-820 Dispute Response File	Used by ER&R to respond to issuers with initial dispute status including tracking number	ER&R to issuers	PSV	ERRP
Semi-Monthly Detailed Report	Used by ER&R to respond to issuers with updated dispute status on 1st and 16th of month	ER&R to issuers	Excel	ERRD
Semi-Monthly Payment Report **NOTE:** This report consists of excerpted data from the Semi-Monthly Detailed Report and was established to offer the data in PSV format.	Used by ER&R to respond to issuers with Payment Dispute statuses on 1st and 16th of month	ER&R to issuers	PSV	ERRZ

Exhibit 44: Payment Dispute FFE Disposition and Detail Codes List

Reference Name in Document	Description
FFEDispositionandDetailCodes	The FFE Disposition and Detail Codes list provides a complete list of disposition codes and detail codes. Each detail code includes an explanation of why the Payment Dispute received the code and may suggest issuer actions for remediation. Available on CMS zONE at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation and on the Registration for Technical Assistance Portal (REGTAP) at https://www.regtap.info/reg_librarye.php?i=1442

5.2 PPR-820 Dispute Form Overview

The PPR-820 Dispute Form, referred to as the Payment Dispute Form, allows issuers to submit disputes to policy-level payments and charges related to Individual Marketplace coverage. The form allows disputes to policy Benefit Start and End Dates, Total Premium Amount, APTC, CSR, and User Fee (UF).

The Payment Dispute Form includes an Instructions tab that provides a description of each field; the expected format; location of data on the PPR or HIX 820; an example of the data; minimum and maximum field lengths; and whether the fields are required, not required, or situational. Issuers can access the PPR-820 Dispute Form using the following links:

- CMS zONE: https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.
- REGTAP: https://www.regtap.info/reg_librarye.php?i=1442.

5.3 Completing the PPR-820 Dispute Form

Each month, issuers receive two files from CMS in support of Policy-Based Payments. The PPR posts via EFT between the 11th-15th of the month and the HIX 820 posts via EFT between the 28th-30th of the month. The PPR provides each issuer with a list of the policies for which CMS will send payments later that month. Later in the month, following the EFT payment to issuers from the U.S. Treasury, the HIX 820 Remittance Advice File arrives and includes the same policy details supplied in the PPR (except for individual policy Total Premium Amounts). Each month's payment includes prospective payment for policies active in the current month, plus retroactive adjustments to previous months' payments.

Issuers should use either of these files to identify discrepancies between the latest FFM data and the data in their own systems. If an issuer believes that the payment is wrong (for example, the amount is incorrect, a payment is missing for a policy, or an unexpected payment is received for a policy), then the issuer should complete and submit the Payment Dispute Form to resolve the discrepancy.

The following sections offer supplemental guidance to assist issuers with completing the Payment Dispute Form.

5.3.1 General Submission Tips

The Policy-Based Payment process became active in 2016. Issuers should not submit disputes based on PPR or HIX 820 data for any HIOS not offering coverage during or after 2016 on the federal platform, HealthCare.gov. The Payment Dispute Form asks issuers to complete the submission by supplying data as reported on one of the two FFM sources files (either the PPR or the HIX 820) and as it appears in the issuers' own systems.

ER&R's dispute processing verifies consistency between issuer values on the Payment Dispute Form and the issuer's RCNI file. If the value(s) on the Payment Dispute Form is not consistent with the RCNI, that record will receive a disposition indicating that the issuer should review their RCNI submission to address the dispute. When checking for consistency with the RCNI, ER&R confirms that:

- The issuer date fields fall within the range of the benefit coverage dates reported on the most recent RCNI submission.
- The issuer Total Premium, APTC, and CSR Amounts match the dollar amount values reported, and the issuer User Fee is -3.5% of the Total Premium Amount on the most recent RCNI submission.

For partial coverage months, the dispute record should show pro-rated APTC, CSR, and User Fee amounts based on the number of days of coverage.

Issuers should submit date fields for the coverage month in dispute, not the benefit coverage dates for the whole coverage period (e.g., if disputing March payment for a policy active January through May, submit dates 03/01-03/31, not 01/01-05/31).

Issuers should allow for a two cent ($0.02) variation at the policy-level between issuer records and the PPR and HIX 820 to allow for rounding differences until further notice.

For APTC and Total Premium Amount disputes, issuers must include the applicable HICS Case ID in the HICS Case Number field (F20).

CMS encourages issuers to submit any apparent data discrepancies without validating for timing issues or RCNI consistency. Automated processing rules will examine the data elements supplied to screen for these issues and produce dispositions for each dispute accordingly.

5.3.2 PPR-820 Dispute Form Specifications

The PSV submission of the Payment Dispute Form is comprised of two elements: a header record and one or more detail records. The header record is composed of nine fields separated by eight pipes. The detail record is composed of 23 fields separated by 22 pipes. Neither record should include leading pipes or trailing pipes.

Exhibit 45 describes the contents of the header record.

Exhibit 45: Header Record

Field Number and Description	Format	PPR/HIX 820 Mapping	Example	Field Length	Comments
H1: File Control Number (Issuer) File Control Number the issuer assigned to the file	Any American Standard Code for Information Interchange (ASCII) characters, except a vertical pipe (i.e., |)	N/A	C12345678	1-50	This is a required field.
H2: Point of Contact Name The first and last name of contact that CMS may reach out, to discuss the dispute form	Any ASCII characters, except a vertical pipe (i.e., |)	N/A	John Smith	1-50	This is a required field.
H3: Point of Contact Telephone Number Telephone number and extension of point of contact	Must contain groups of three digits, three and four digits, and may contain extension details; issuers may use any delimiters around these digits	N/A	Without Extension: 8001111234 With Extension: 8001111234 EXT849204	10-50	This is a required field.
H4: Point of Contact Email Address Email address of point of contact	Any ASCII characters, except a vertical pipe (i.e., |)	N/A	johnsmith@company.com	1-256	This is a required field.

Field Number and Description	Format	PPR/HIX 820 Mapping	Example	Field Length	Comments
H5: Date Submitted Date issuer submitted the form to ER&R	YYYYMMDD	N/A	20160101	8	This is not a required field. Must be a valid date
H6: Time Submitted Time issuer submitted the form to ER&R	HHMMSS	N/A	162055	6	This is not a required field. Must be a valid time; HH is the hour for a 24-hour clock (00 to 23)
H7: PPR Transaction Set Control Number PPR Transaction Set Control Number used to uniquely identify the PPR	Numeric	Element B1 on PPR Schema	000004930	2-20	This is a situational field. Must include one of the following: ► PPR Transaction Set Control Number ► HIX 820 EFT Trace Number
H8: HIX 820 EFT Trace Number HIX 820 EFT Number used to uniquely identify the HIX 820	Alphanumeric	Element TRN02 on HIX 820	7439245	2-20	This is a situational field. Must include one of the following: ► PPR Transaction Set Control Number ► HIX 820 EFT Trace Number
H9: Payee ID Payee identifier setup during Vendor Management registration process	Alphanumeric – The letter "A" followed by six or seven digits	Element B3 on PPR Schema Element GS03 in header on HIX 820	A000009	7-8	This is not a required field.

Exhibit 46 describes the contents of the detail record.

Exhibit 46: Detail Record

Field Number and Description	Format	PPR/HIX 820 Mapping	Example	Field Length	Comments
F1: Issuer HIOS ID HIOS ID, assigned by the FFM that uniquely identifies the issuer	Numeric	Column A in record detail of PPR Schema (labelled "Issuer ID") Element REF02 in 2100 Loop on HIX 820 (first five digits of QHP ID), when REF01=38	12345	5	This is a required field.
F2: Issuer Assigned Dispute Control Number Unique identifying Control Number assigned to each dispute by the issuer to track it over time **NOTE:** CMS will provide this Control Number on the Semi-Monthly Detailed Report provided back to the issuers.	Any ASCII characters, except a vertical pipe (i.e., |)	N/A	ABC123456789	1-50	This is not a required field.
F3: Exchange Assigned Subscriber ID Exchange Assigned Subscriber ID assigned by the FFM	Numeric	Column J on PPR Schema Element NM109 in 2100 Loop on HIX 820	0001503934	10	This is a required field.
F4: Exchange Assigned Policy ID Exchange Assigned Policy ID assigned by the FFM	Numeric	Column L on PPR Schema Element REF02 in 2100 Loop on HIX 820, when REF01=POL	56291448	1-15	This is a required field.

Field Number and Description	Format	PPR/HIX 820 Mapping	Example	Field Length	Comments
F5: Payment Cycle Month One of the following, depending on which type of file the issuer used to report the discrepancy: ► PPR: Policy-Based Transition Month used to identify the Payment Month and Year the PPR corresponds to ► HIX 820: EFT Effective Date used to identify the corresponding HIX 820 Payment Month and Year	YYYYMM	Element B5 on PPR Schema Element BPR16 on HIX 820	201601	6	This is a required field.
F6: Issuer Assigned Subscriber ID Issuer Assigned Subscriber ID assigned by the issuer	Any ASCII characters, except a vertical pipe (i.e., |)	Column N on PPR Schema Element REF02 in 2100 Loop on HIX 820, when REF01=0F	492616725	1-50	This is not a required field.
F7: Issuer Assigned Policy ID Issuer Assigned Policy ID assigned by the issuer	Any ASCII characters, except a vertical pipe (i.e., |)	Column M on PPR Schema Element REF02 in 2100 Loop on HIX 820, when REF01=AZ	693816725	1-50	This is not a required field.

Field Number and Description	Format	PPR/HIX 820 Mapping	Example	Field Length	Comments
F8: Coverage Period Start Date (FFM) Coverage Period Start Date from the specific file (PPR or HIX 820) sent from CMS, used to report the discrepancy	YYYYMMDD	Column T on PPR Schema Element DTM06 on HIX 820 (1st eight characters)	20160101	8	This is a situational field. This is required for any record that has an FFM dollar amount value populated.
F9: Coverage Period Start Date (Issuer) Coverage Period Start Date from the issuers records for the specific period	YYYYMMDD	N/A	20160110	8	This is a situational field. This is required for any record that has an issuer dollar amount value populated.
F10: Coverage Period End Date (FFM) Coverage Period End Date from the specific file (PPR or HIX 820) sent from CMS, used to report the discrepancy	YYYYMMDD	Column U on PPR Schema Element DTM06 on HIX 820 (last eight characters)	20160131	8	This is a situational field. This is required for any record that has an FFM dollar amount value populated.
F11: Coverage Period End Date (Issuer) Coverage Period End Date from the issuers records for the specific period	YYYYMMDD	N/A	20160128	8	This is a situational field. This is required for any record that has an issuer dollar amount value populated.
F12: Policy Total Premium Amount (FFM) Policy Total Premium Amount from the PPR sent from CMS (does not appear on the HIX 820)	Numeric, with optional decimal point **NOTE**: Do not include $ symbol. Do not include commas to separate digit groupings.	Element O11 on PPR Schema Element Not Provided on HIX 820	4022.35	1-15	This is not a required field.

Field Number and Description	Format	PPR/HIX 820 Mapping	Example	Field Length	Comments
F13: Policy Total Premium Amount (Issuer) Policy Total Premium Amount from the issuers records for the specific coverage period	Numeric, with optional decimal point **NOTE**: Do not include $ symbol. Do not include commas to separate digit groupings.	N/A	2534.50	1-15	This is not a required field.
F14: APTC Amount (FFM) APTC amount from the specific file (PPR or HIX 820) sent from CMS to report the discrepancy	Numeric, with optional decimal point **NOTE**: Do not include $ symbol. Do not include commas to separate digit groupings.	Reference Column P on PPR Schema for Payment Type of APTC, Column Q on PPR for Payment Amount. Reference Element RMR02 in 2300 Loop on HIX 820 for Payment Type of APTC and RMR04 in 2300 Loop on HIX 820 for Payment Amount.	513.48	1-15	This is not a required field.
F15: APTC Amount (Issuer) APTC amount from the issuers records for the specific period	Numeric, with optional decimal point **NOTE**: Do not include $ symbol. Do not include commas to separate digit groupings.	N/A	234.06	1-15	This is not a required field.

Field Number and Description	Format	PPR/HIX 820 Mapping	Example	Field Length	Comments
F16: CSR Amount (FFM) CSR Amount from the specific file (PPR or HIX 820) sent from CMS to report the discrepancy	Numeric, with optional decimal point **NOTE**: Do not include $ symbol. Do not include commas to separate digit groupings.	Reference Column P on PPR Schema for Payment Type of CSR and Column Q on PPR for Payment Amount Reference Element RMR02 in 2300 Loop on HIX 820 for Payment Type of CSR and RMR04 in 2300 Loop on HIX 820 for Payment Amount.	174.59	1-15	This is not a required field.
F17: CSR Amount (Issuer) CSR Amount from the issuers records for the specific period	Numeric, with optional decimal point **NOTE**: Do not include $ symbol. Do not include commas to separate digit groupings.	N/A	90.48	1-15	This is not a required field.

Field Number and Description	Format	PPR/HIX 820 Mapping	Example	Field Length	Comments
F18: UF Amount (FFM) User Fee from the specific file (PPR or HIX 820) sent from CMS to report the discrepancy	Numeric, with optional decimal point **NOTE**: Do not include $ symbol. Do not include commas to separate digit groupings. Indicate negative dollar amounts with a leading minus sign (-) rather than within parentheses.	Reference Column P on PPR Schema for Payment Type of UF and Column Q on PPR for Payment Amount. Reference Element RMR02 in 2300 Loop on HIX 820 for Payment Type of UF and RMR04 in 2300 Loop on HIX 820 for Payment Amount.	-12.36	1-15	This is not a required field.
F19: UF Amount (Issuer) User Fee from the issuers records for the specific period	Numeric, with optional decimal point **NOTE**: Do not include $ symbol. Do not include commas to separate digit groupings. Indicate negative dollar amounts with a leading minus sign (-) rather than within parentheses	N/A	-8.43	1-15	This is not a required field.
F20: HICS Case Number HICS case number requesting a change to any amounts or dates	Alphanumeric – The letter "E" followed by 10 digits	N/A	E0000000000	11	This is a situational field. It is required if it exists and for Total Premium Amount and APTC amount disputes.

Field Number and Description	Format	PPR/HIX 820 Mapping	Example	Field Length	Comments
F21: Recurring Indicator to be set to Y if the exact dispute (all field values are identical except Payment Cycle Month) was reported in prior month(s)	Y or N	N/A	N	1	This is not a required field.
F22: Existing CMS Dispute Control Number The number of another CMS case for the same FFM Subscriber ID, if known	Alphanumeric – The letter "P" followed by 1-9 digits	N/A	P999999	1-10	This is a situational field. This is required if applicable and known.
F23: Comments Used to enter any supporting comments that may assist in resolving the dispute	Any ASCII characters, except a vertical pipe (i.e., |)	N/A	E0000000001	1-255	This is a situational field. Issuers should list additional HICS case numbers here, if they exist.

5.3.3 Non-Disputable Fields

Many fields found within the Payment Dispute Form identify the disputed data element and confirm the validity of the dispute.

Issuers must maintain the (F4) Exchange Assigned Policy ID for each subscriber enrolled to be able to accurately identify the latest Policy-Based Payment details supplied by the FFM in the payment file formats.

Issuers supply certain fields for their own reference and traceability. These fields have minimal formatting requirements aside from a maximum length, as noted in the Payment Dispute Form Specifications, and may consist of any ASCII characters except a vertical pipe. These include:

- (F2) Issuer Assigned Dispute Control Number
- (F6) Issuer Assigned Subscriber ID
- (F7) Issuer Assigned Policy ID
- (F23) Comments

5.3.4 Disputable Fields

The Payment Dispute Form allows for FFM and issuer values. The form includes six pairs of disputable fields, as outlined in Exhibit 47: one set of six for FFM values and one set of six for the corresponding issuer values.

Exhibit 47: Disputable Fields

Field Type	Disputable Fields	Fields with FFM Value	Fields with Issuer Value
Date	Date Coverage Period Start Date	F8	F9
Date	Coverage Period End Date	F10	F11
Dollar Amount	Total Premium Amount*	F12	F13
Dollar Amount	APTC Amount	F14	F15
Dollar Amount	CSR Amount	F16	F17
Dollar Amount	UF Amount	F18	F19

*Not provided on the HIX 820

5.3.5 Disputing Multiple Values on the Same Policy Using a Single Dispute Record

The issuer may provide a single dispute record for all disputable fields for a policy and coverage period. For example, one dispute record could dispute APTC, CSR, and User Fee amounts for a March policy. See Payment Dispute Form examples in Exhibit 48, Exhibit 49, and Exhibit 50.

Exhibit 48: Payment Dispute Form Example – Missing Payment Single Dispute Record

Exchange_ Assigned_ Subscriber_ ID	Exchange_ Assigned_ Policy_ID	Payment_ Cycle_ Month	Coverage_ Period_ Start_Date_ (FFM)	Coverage_ Period_ Start_Date_ (Issuer)	Coverage_ Period_ End_Date_ (FFM)	Coverage_ Period_ End_Date_ (Issuer)	Policy_ Total_ Premium_ Amount_ (FFM)	Policy_ Total_ Premium_ Amount_ (Issuer)	APTC_ Amount_ (FFM)	APTC_ Amount_ (Issuer)	CSR_ Amount_ (FFM)	CSR_ Amount_ (Issuer)	UF_ Amount_ (FFM)	UF_ Amount_ (Issuer)
0000999999	12345678	201903		20190301		20190331	0.00	311.59	0.00	206.00	0.00	68.55	0.00	-10.91

Exhibit 49: Payment Dispute Form Example – Unexpected Payment Single Dispute Record

Exchange_ Assigned_ Subscriber_ ID	Exchange_ Assigned_ Policy_ID	Payment_ Cycle_ Month	Coverage_ Period_ Start_Date_ (FFM)	Coverage_ Period_ Start_Date_ (Issuer)	Coverage_ Period_ End_Date_ (FFM)	Coverage_ Period_ End_Date_ (Issuer)	Policy_ Total_ Premium_ Amount_ (FFM)	Policy_ Total_ Premium_ Amount_ (Issuer)	APTC_ Amount_ (FFM)	APTC_ Amount_ (Issuer)	CSR_ Amount_ (FFM)	CSR_ Amount_ (Issuer)	UF_ Amount_ (FFM)	UF_ Amount_ (Issuer)
0000999999	12345678	201903	20190301		20190331		311.59	0.00	206.00	0.00	68.55	0.00	-10.91	0.00

Exhibit 50: Payment Dispute Form Example – Incorrect Payment Amount Single Dispute Record

Exchange_ Assigned_ Subscriber_ ID	Exchange_ Assigned_ Policy_ID	Payment_ Cycle_ Month	Coverage_ Period_ Start_Date_ (FFM)	Coverage_ Period_ Start_Date_ (Issuer)	Coverage_ Period_ End_Date_ (FFM)	Coverage_ Period_ End_Date_ (Issuer)	Policy_ Total_ Premium_ Amount_ (FFM)	Policy_ Total_ Premium_ Amount_ (Issuer)	APTC_ Amount_ (FFM)	APTC_ Amount_ (Issuer)	CSR_ Amount_ (FFM)	CSR_ Amount_ (Issuer)	UF_ Amount_ (FFM)	UF_ Amount_ (Issuer)
0000999999	12345678	201903	20190301	20190301	20190331	20190331	311.59	311.59	206.00	225.00	68.55	65.88	-10.91	-10.91

5.3.6 Disputing Multiple Values on the Same Policy Using Multiple Dispute Records

It is also possible to provide multiple dispute records for the same policy and coverage period. For example, one dispute record could dispute APTC amount, and different dispute records could dispute CSR and User Fee amounts. See Payment Dispute Form examples in Exhibit 51, Exhibit 52, and Exhibit 53.

Exhibit 51: Payment Dispute Form Example – Missing Payment Multiple Dispute Records

Exchange_ Assigned_ Subscriber_ ID	Exchange_ Assigned_ Policy_ID	Payment_ Cycle_ Month	Coverage_ Period_ Start_Date_ (FFM)	Coverage_ Period_ Start_Date_ (Issuer)	Coverage_ Period_ End_Date_ (FFM)	Coverage_ Period_ End_Date_ (Issuer)	Policy_ Total_ Premium_ Amount_ (FFM)	Policy_ Total_ Premium_ Amount_ (Issuer)	APTC_ Amount_ (FFM)	APTC_ Amount_ (Issuer)	CSR_ Amount_ (FFM)	CSR_ Amount_ (Issuer)	UF_ Amount_ (FFM)	UF_ Amount_ (Issuer)
0000999999	12345678	201903		20190301		20190331	0.00	311.59						
0000999999	12345678	201903		20190301		20190331			0.00	206.00				
0000999999	12345678	201903		20190301		20190331					0.00	68.55		
0000999999	12345678	201903		20190301		20190331							0.00	-10.91

Exhibit 52: Payment Dispute Form Example – Unexpected Payment Multiple Dispute Records

Exchange_ Assigned_ Subscriber_ ID	Exchange_ Assigned_ Policy_ID	Payment_ Cycle_ Month	Coverage_ Period_ Start_Date_ (FFM)	Coverage_ Period_ Start_Date_ (Issuer)	Coverage_ Period_ End_Date_ (FFM)	Coverage_ Period_ End_Date_ (Issuer)	Policy_ Total_ Premium_ Amount_ (FFM)	Policy_ Total_ Premium_ Amount_ (Issuer)	APTC_ Amount_ (FFM)	APTC_ Amount_ (Issuer)	CSR_ Amount_ (FFM)	CSR_ Amount_ (Issuer)	UF_ Amount_ (FFM)	UF_ Amount_ (Issuer)
0000999999	12345678	201903	20190301		20190331		311.59	0.00						
0000999999	12345678	201903	20190301		20190331				206.00	0.00				
0000999999	12345678	201903	20190301		20190331						68.55	0.00		
0000999999	12345678	201903	20190301		20190331								-10.91	0.00

Exhibit 53: Payment Dispute Form Example – Incorrect Payment Amount Multiple Dispute Records

Exchange_ Assigned_ Subscriber_ ID	Exchange_ Assigned_ Policy_ID	Payment_ Cycle_ Month	Coverage_ Period_ Start_Date_ (FFM)	Coverage_ Period_ Start_Date_ (Issuer)	Coverage_ Period_ End_Date_ (FFM)	Coverage_ Period_ End_Date_ (Issuer)	Policy_ Total_ Premium_ Amount_ (FFM)	Policy_ Total_ Premium_ Amount_ (Issuer)	APTC_ Amount_ (FFM)	APTC_ Amount_ (Issuer)	CSR_ Amount_ (FFM)	CSR_ Amount_ (Issuer)	UF_ Amount_ (FFM)	UF_ Amount_ (Issuer)
0000999999	12345678	201903	20190301	20190301	20190331	20190331			206.00	225.00				
0000999999	12345678	201903	20190301	20190301	20190331	20190331					68.55	65.88		

All completed disputable fields (not blank or zero) must be consistent across these multiple records. If the automated system detects multiple dispute records with identical values for a single policy, it is possible that an issuer will receive a duplicate/merge disposition (R4/R5, respectively) for subsequent disputes encountered after the first one. If there are multiple disputes for a single policy with conflicting information, it is possible that an issuer will receive and R8 disposition.

5.3.7 Scenario Types

The following three scenario types represent the three ways issuers may complete the disputable fields:

- To report a **missing payment** that was not in the PPR or HIX 820 but should have been, according to the issuer's records, fill in the issuer coverage period dates and issuer amounts. In this case, the FFM coverage period dates must be blank, and the FFM amounts must all be blank or zero (e.g. 0 or 0.00), as shown in Exhibit 54.

Exhibit 54: Payment Dispute Form Examples – Missing Payment

Exchange_ Assigned_ Subscriber_ ID	Exchange_ Assigned_ Policy_ID	Payment_ Cycle_ Month	Coverage_ Period_ Start_Date_ (FFM)	Coverage_ Period_ Start_Date_ (Issuer)	Coverage_ Period_ End_Date_ (FFM)	Coverage_ Period_ End_Date_ (Issuer)	Policy_ Total_ Premium_ Amount_ (FFM)	Policy_ Total_ Premium_ Amount_ (Issuer)	APTC_ Amount_ (FFM)	APTC_ Amount_ (Issuer)	CSR_ Amount_ (FFM)	CSR_ Amount_ (Issuer)	UF_ Amount_ (FFM)	UF_ Amount_ (Issuer)
0000999999	12345678	201903		20190301		20190331	0.00	311.59	0.00	206.00	0.00	68.55	0.00	-10.91
0000999999	12345678	201903		20190301		20190331		311.59		206.00		68.55		-10.91

- To report an **unexpected payment** that was in the PPR or HIX 820 but should not have been, according to the issuer's records, fill in the FFM coverage period dates and FFM amount. In this case, the issuer coverage period dates must be blank, and the issuer amounts must all be blank or zero, as shown in Exhibit 55.

Exhibit 55: Payment Dispute Form Examples – Unexpected Payment

Exchange_ Assigned_ Subscriber_ ID	Exchange_ Assigned_ Policy_ID	Payment_ Cycle_ Month	Coverage_ Period_ Start_Date_ (FFM)	Coverage_ Period_ Start_Date_ (Issuer)	Coverage_ Period_ End_Date_ (FFM)	Coverage_ Period_ End_Date_ (Issuer)	Policy_ Total_ Premium_ Amount_ (FFM)	Policy_ Total_ Premium_ Amount_ (Issuer)	APTC_ Amount_ (FFM)	APTC_ Amount_ (Issuer)	CSR_ Amount_ (FFM)	CSR_ Amount_ (Issuer)	UF_ Amount_ (FFM)	UF_ Amount_ (Issuer)
0000999999	12345678	201903	20190301		20190331		311.59	0.00	206.00	0.00	68.55	0.00	-10.91	0.00
0000999999	12345678	201903	20190301		20190331		311.59		206.00		68.55		-10.91	

- To report an **incorrect payment** amount, fill in the issuer and FFM coverage period dates and any relevant amounts, as shown in Exhibit 56.

Exhibit 56: Payment Dispute Form Examples – Incorrect Payment Amount

Exchange_ Assigned_ Subscriber_ ID	Exchange_ Assigned_ Policy_ID	Payment_ Cycle_ Month	Coverage_ Period_ Start_Date_ (FFM)	Coverage_ Period_ Start_Date_ (Issuer)	Coverage_ Period_ End_Date_ (FFM)	Coverage_ Period_ End_Date_ (Issuer)	Policy_ Total_ Premium_ Amount_ (FFM)	Policy_ Total_ Premium_ Amount_ (Issuer)	APTC_ Amount_ (FFM)	APTC_ Amount_ (Issuer)	CSR_ Amount_ (FFM)	CSR_ Amount_ (Issuer)	UF_ Amount_ (FFM)	UF_ Amount_ (Issuer)
0000999999	12345678	201903	20190301	20190301	20190331	20190331	311.59	311.59	**206.00**	**225.00**	68.55	65.88	-10.91	-10.91
0000999999	12345678	201903	20190301	20190301	20190331	20190331	0	0	**206.00**	**225.00**	68.55	65.88	0	0

For any dollar amount that is in dispute, the FFM and issuer values should differ by more than two cents. For any dollar amount not in dispute, the FFM and issuer values should be equal; the cells should either both be blank, both contain a zero, or both contain an equal integer. If a value is not available in its data source (e.g., Total Premium Amount on the HIX 820), leave it blank or zero (i.e., 0 or 0.00) on both the FFM and issuer fields.

Issuers should complete the remaining header and detail fields in accordance with the guidance provided in Section 5.3.2, PPR-820 Dispute Form Specifications.

5.4 Payment Dispute Submission Guidelines

As of May 1, 2019, issuers must obtain approval from their AM prior to submitting prior year disputes to ER&R for resolution. See Section 3.4, Enrollment Dispute Submission Guidelines, for additional information.

5.4.1 File Format

Issuers must submit the Payment Dispute Form template in an Excel or PSV format.

5.4.2 EFT Submission and File Naming Convention

Issuers must submit the Payment Dispute Forms via EFT. The dispute submission process utilizes the same EFT setup used for the 834/820 file transfer process.

Issuers with questions related to the EDI Onboarding or EFT setup process should refer to Section 7.2, Help Desk, for contact information.

Submit Payment Dispute Forms to the Inbound30 inbound folder/directory, which issuers use for 834 and 820 transactions, using the following file naming convention:

TPID.*COG.ERRP.D*YYMMDD.*T*HHMMSSmmm.*P.IN*

Following is an explanation of the file name structure.

- TPID – Issuer's TPID, also known as the Source ID
- COG – Application ID, defaulted to "COG"
- ERRP – Function code for the Payment Dispute process, defaulted to "ERRP"
- DYYMMDD – Date, first character, D, is static; YY is year, MM is month, DD is day

- THHMMSSmmm – Time Stamp, first character, T, is static; HH is hours, MM is minutes, SS is seconds, and mmm is milliseconds
- P/T – Environment, "P" for Production or "T" for Test
- IN – Direction (Inbound to CMS), defaulted to "IN"

Example: 12345.COG.ERRP.D160215.T162055453.P.IN

5.5 Avoiding Common Issuer Payment Dispute Errors

The following list contains the most common disposition and detail codes for unsuccessful Payment Disputes:

- R10 and R11 – Dispute not supported by RCNI – prior year
- FV202 – Coverage period does not fall within the disputed payment month
- FV803 – Multiple disputes received with conflicting information based on the combination of HIOS ID, Exchange Assigned Policy ID, and issuer Coverage Start Date month
- FV9 – No matching record found on the PPR or HIX 820
- FV900 – Issuer disputed a missing payment, but a PPR record was found
- PD5 – No matching RCNI record was found using the identifying information the issuer provided
- PD552 – Issuer disputed an unexpected payment, but a matching RCNI record with the Issuer Initial Premium Paid Status of "Y" was found

This section provides guidance for issuers that will help prevent submitting Payment Disputes that result in a rejected disposition.

5.5.1 Tips to Avoid Payment Dispute Error – Disposition Codes R10 and R11

Disposition codes R10 and R11 post when issuers have submitted prior year disputes against outdated RCNO data. In these situations, the expected dispute resolution cannot be reached through the Payment Dispute process because Reconciliation for the prior coverage year has ended. Issuers should not resubmit these as Payment Disputes, as the disputes will continue to receive R10/R11 dispositions. To resolve a prior year discrepancy, issuers must refer to the most recent Pre-Audit file for the policy and submit an Enrollment Dispute. These disposition codes can be associated to many detail codes.

To avoid an R10 or R11 disposition code:

- Evaluate the policy status in the Pre-Audit file.
- Submit an Enrollment Dispute to resolve any discrepancy.
  NOTE: Issuers should ensure that there are procedures in place to address cases that are returned with R10 and R11 disposition codes through the Enrollment Dispute process.

5.5.2 Tips to Avoid Payment Dispute Error – Detail Code FV202

Detail code FV202 (Exhibit 57) posts when an issuer disputes a coverage period that does not fall within the disputed payment month. The Payment Dispute receives an R2 disposition code.

Exhibit 57: FV202 Detail Code

Detail Code and Associated Disposition Code	Verbiage Returned to Issuer
FV202/R2 (Record Does Not Meet Dispute Requirements)	Coverage Period Start Date value and Coverage Period End Date value are not in the same calendar month.

To avoid the FV202 detail code:

- Complete the date fields with the coverage month in dispute, not the benefit coverage dates for the whole coverage period.

5.5.3 Tips to Avoid Payment Dispute Error – Detail Code FV803

Detail code FV803 (Exhibit 58) posts when an issuer has submitted two or more disputes on the same Payment Dispute Form for the same HIOS, policy, and coverage month with conflicting issuer values. The Payment Dispute receives an R8 disposition code.

Exhibit 58: FV803 Detail Code

Detail Code and Associated Disposition Code	Verbiage Returned to Issuer
FV803/R8 (Multiple Conflicting Disputes for Same Policy)	The Payment Dispute record submitted was matched to another dispute submitted on the same file for the same field, but the data in the disputed fields do not match. The ER&R Contractor is not able to resolve this dispute. Please review the information and resubmit the corrected dispute to the ER&R Contractor. For assistance with resolving this Payment Dispute record, please contact the FMCC help desk at fmcc@cms.hhs.gov.

To avoid the FV803 detail code:

- Ensure that each dispute on a Payment Dispute Form for a HIOS, Exchange Assigned Policy ID, Coverage Period Start Date (Issuer), and Coverage Period End Date (Issuer):
  - Has a single dollar amount for any APTC Amount (Issuer), CSR Amount (Issuer), UF Amount (Issuer), or Total Premium Amount (Issuer) that is in dispute.
  - Does not have overlapping coverage dates with an associated record.

5.5.4 Tips to Avoid Payment Dispute Error – Detail Code FV9

Detail code FV9 (Exhibit 59) posts when an issuer has submitted a dispute for an incorrect or unexpected payment that could not be found in the PPR or HIX 820. The Payment Dispute receives an R3 disposition code.

Exhibit 59: FV9 Detail Code

Detail Code and Associated Disposition Code	Verbiage Returned to Issuer
FV9/R3 (Dispute Form Fields Do Not Match PPR/820)	The ER&R Contractor was not able to match this dispute to a record on the PPR or HIX 820. Please verify the Exchange Assigned Policy ID and coverage period for this dispute, correct the dispute, and resubmit. For technical assistance with submitting a Payment Dispute, please contact the FMCC help desk at fmcc@cms.hhs.gov.

To avoid the FV9 detail code:

- Ensure that the following required fields are present and accurate in the dispute:
  - HIOS ID
  - Exchange Assigned Policy ID
  - Payment Cycle Month as reported on the PPR
  - Coverage Period Start Date (FFM)
  - Coverage Period End Date (FFM)

5.5.5 Tips to Avoid Payment Dispute Error – Detail Code FV900

Detail code FV900 (Exhibit 60) posts when an issuer has submitted a dispute for a missing payment, but a payment was found in the PPR or HIX 820. The Payment Dispute receives an R3 disposition code.

Exhibit 60: FV900 Detail Code

Detail Code and Associated Disposition Code	Verbiage Returned to Issuer
FV900/R3 (Dispute Form Fields Do Not Match PPR/820)	The issuer is disputing a missing payment, but a potential PPR record match was found for this policy and payment month. Please review the coverage period on the dispute form and resubmit the dispute form with the corrected information identifying the value the issuer is disputing.

To avoid the FV900 detail code:

- If any record can be found in the PPR or HIX 820 that matches on all of the following elements, then the issuer should not submit a dispute indicating a missing payment for that policy:
  - HIOS
  - Exchange Assigned Policy ID
  - Payment Cycle Month
  - Coverage Period Start Date (Issuer)
  - Coverage Period End Date (Issuer)
- If disputing an APTC, CSR, or UF amount, then be sure that the issuer APTC, CSR, or UF amount is a value other than zero, with the following exception:
  - If the cumulative payment amount (the sum of all payments and adjustments for the policy/coverage month) the issuer received is zero, then a zero amount may appear in the applicable issuer APTC, CSR, or UF amount field(s).

5.5.6 Tips to Avoid Payment Dispute Error – Detail Code PD5

Detail code PD5 (Exhibit 61) posts when an issuer has submitted a dispute but there was no matching RCNO record found using the identifying information the issuer provided. The Payment Dispute receives an R6 disposition code.

Exhibit 61: PD5 Detail Code

Detail Code and Associated Disposition Code	Verbiage Returned to Issuer
PD5/R6 (Dispute Not Supported by RCNI)	The ER&R Contractor was unable to locate this policy on the current RCNO using the issuer identifying information on the Payment Dispute. Please verify the information on the Payment Dispute Form and/or RCNI and make any necessary corrections. For assistance with resolving this Payment Dispute record, please contact the FMCC help desk at fmcc@cms.hhs.gov.

Tips to avoid the PD5 detail code:

- Verify that the HIOS and FFM Exchange Policy ID for the subscriber on the dispute match the values in the most recent RCNO file.

5.5.7 Tips to Avoid Payment Dispute Error – Detail Code PD552

Detail code PD552 (Exhibit 62) posts when an issuer has submitted a dispute of an unexpected payment, but a matching RCNI record was found with the Issuer Initial Premium Paid Status of "Y" was found.

Exhibit 62: PD552 Detail Code

Detail Code and Associated Disposition Code	Verbiage Returned to Issuer
PD552/R6 (Dispute Not Supported by RCNI)	The issuer is disputing an unexpected payment; however, an RCNI record was found with issuer values that reflected member coverage for the disputed coverage dates and the Issuer Premium Paid Indicator value of "Y". If this policy needs to be cancelled, the issuer will need to input "C" in the Issuer Premium Paid Indicator field in their next RCNI file. For assistance with resolving this Payment Dispute record, please contact the FMCC help desk at fmcc@cms.hhs.gov.

To avoid the PD552 detail code:

- Input "C" in the Issuer Initial Premium Paid Status field in the next RCNI submission to cancel the policy.

5.5.8 Tips for Passing File-Level Validation

When submitting the form in a PSV format, be sure that:

- The file name follows the correct EFT file naming convention as described in Section 5.4.2, EFT Submission and File Naming Convention.
- The header record has only nine fields separated by eight vertical pipes (i.e., |).
- There is a reference to only one of the FFM source files – either the PPR Transaction Set Control Number in header record field H7 or the HIX 820 EFT Trace Number in header record field H8.
- All header fields (H1-H9) conform to the usage and length requirements described in Section 5.3.2, PPR-820 Dispute Form Specifications.
  NOTE: Any errors at the header level prohibit the entire file from ingesting into the automated system and impact all the detail records associated with the submission.
- All detail records consist of 23 fields separated by 22 vertical pipes.
- Empty fields, where needed, are completely empty; pipe-to-pipe field separations may occur. Do not populate fields with artificial contents such as NULL or spaces.
- No leading or trailing pipes are used.

5.6 Payment Dispute Responses

5.6.1 PPR-820 Dispute Response File

In response to an issuer's Payment Dispute Form submission, issuers should expect to receive a PPR-820 Dispute Response File within 1-2 business days from the time the form is processed. For each dispute submitted, the Response File reports the results of the dispute process. This process ensures that the disputes conform to the prescribed syntax and semantic guidelines detailed in the Instructions tab of the Payment Dispute Form, are logical and complete, and correctly reflect PPR/HIX 820 and issuer data (consistent with the most recent RCNI file).

For each dispute submitted on the Payment Dispute Form, the Response File provides a CMS Dispute Control Number (tracking number for the dispute), a disposition code (a code describing the status of the

dispute), and up to five applicable detail codes (codes that convey additional information based on business rules). Issuers can typically expect to receive a response within one business day.

5.6.2 File Format

The ER&R Contractor sends the PPR-820 Dispute Response File to issuers in a PSV format. The Response File layout is the same as the Payment Dispute Form submitted by the issuer, with eight additional fields appended to the end.

5.6.3 EFT Response File Naming Convention

The ER&R Contractor sends the PPR-820 Dispute Response File to the issuer via EFT to the same trading partner ID from which the Payment Dispute Form was submitted (except in instances in which an issuer, during EDI registration, designated a Clearinghouse Submitter ID as the receiver), using the following file naming convention:

TPID.*ERRP*.*D*YYMMDD.*T*HHMMSSmmm.*P*.*OUT*

Following is an explanation of the file name structure.

- TPID – Issuer's TPID, also known as the Source ID
- ERRP – Function code for the Payment Dispute process, defaulted to "ERRP"
- DYYMMDD – Date, first character, D, is static; YY is year, MM is month, DD is day.
- THHMMSSmmm – Timestamp, first character, T, is static; HH is hours, MM is minutes, SS is seconds, and mmm is milliseconds
- P/T – Environment, "P" for Production or "T" for Test
- OUT – Direction (outbound from CMS), defaulted to "OUT"

Example: 12345.ERRP.D160215.T162055453.P.OUT

5.6.4 Interpreting the PPR-820 Dispute Response File

Issuers can expect to receive a response for all Payment Dispute Forms that pass validation and process through the automated system. If the automated system rejects the Payment Dispute Form due to an invalid number of pipes in the file, the ER&R Support Center will contact the issuer. If the file's header record fails syntactical validation, the system will automatically generate a Response File to notify the issuer that the error occurred, and the ER&R Support Center will contact the issuer.

The PPR-820 Dispute Response File returns all the data submitted by the issuer and appends each detail record with up to eight fields of data that provide information on how ER&R dispositioned each dispute. Issuers should associate the details of the response with the details of the disputes sent on their submission. Issuer-supplied values from the submission such as File Control Number (H1) and Issuer Assigned Dispute Control Number (F2), with CMS-supplied values such as CMS Dispute Control Number (F24) and Disposition (F25), can help provide traceability for any dispute submitted.

For all files that are accepted, each dispute receives a disposition code that falls into one of three categories:

1. A Rejected/Returned disposition code (e.g., R1, R2, R3, R6, R7, R8, R9) indicates that CMS is not processing the dispute because it failed one of the validation checks or it duplicated another dispute already in process. For any dispute that returns a Rejected/Returned disposition code, the issuer should consult the associated detail codes (F27-F31) for additional information that describes how the dispute reached that disposition conclusion. The detail codes provide guidance on what the issuer can do to remediate problems that rejected the dispute.

a. Disputes that return disposition codes of R4 and R5 are duplicates of other disputes presently in process (in the case of R4) or are records merged with another case for the same policy-month on the submission (in the case of R5).

2. A Completed/Closed disposition code (e.g., C2, C3, or C5) indicates the issuer should consider those disputes completed and closed. C2s are timing issues that will resolve with the next payment cycle. C3s are timing issues that will resolve within an upcoming payment cycle but not the next payment cycle. C5s are disputes resolved by adjustments reported on either the PPR or HIX 820.
3. An In Process/In Analysis disposition code (i.e., I1, I2, I3, I4, I6) indicates that CMS is researching the dispute. Issuers should monitor their Semi-Monthly Detailed Reports for updates on any cases that received such dispositions on the Response File.

5.6.5 Dispute Response File Specifications

Exhibit 63 identifies the eight fields (F24-F31) appended at the end of each detail record on the PPR-820 Dispute Response File.

Exhibit 63: PPR-820 Dispute Response File

Field Number	Field Description	Format	Example	Field Length
F24	**CMS Dispute Control Number** Unique case number – ER&R Contractor use only	Alphanumeric – The letter "P" followed by 1-9 digits	P999999	1-10
F25	**Disposition** Code representing the status of the dispute	Alphanumeric	R1	1-50
F26	**Feedback to Issuer** Comments or feedback from ER&R	Alphanumeric	Rejected, syntax errors, see response	1-1000
F27	**Detail Code 1** The first dispute detail code	Alphanumeric – If applicable, this field includes a value detailing the field in which the error was encountered (e.g., F5 [Field 5] =Payment Cycle Month) and the specific rules that caused the dispute to fail (e.g., SR1 [Situational Rule 1] =Field did not meet expected format).	F5SR1	1-10
F28	**Detail Code 2** The second dispute detail code	Alphanumeric – See Detail Code 1.	F5SR1	1-10
F29	**Detail Code 3** The third dispute detail code	Alphanumeric – See Detail Code 1.	F5SR1	1-10

Field Number	Field Description	Format	Example	Field Length
F30	**Detail Code 4** The fourth dispute detail code	Alphanumeric – See Detail Code 1.	F5SR1	1-10
F31	**Detail Code 5** The fifth dispute detail code	Alphanumeric – See Detail Code 1.	F5SR1	1-10

6.0 Semi-Monthly Reporting

6.1 Semi-Monthly Detailed Report

Issuers receive dispute outcomes on the Semi-Monthly Detailed Report, which is delivered on the 1st and 16th (or the first business day thereafter) via EFT. The report is unique to a single HIOS and includes the outcome of all disputes submitted since the previous report, along with disputes that are either in process or have received a new disposition since the previous report. In addition, the report provides the outcomes of correlated cases, which will align with the outcomes of the associated issuer-submitted disputes.

This report includes four tabs:

- Enrollment Summary
- Enrollment Disputes
- Payment Summary
- Payment Disputes

6.1.1 Enrollment Tabs

The first two tabs of the Semi-Monthly Detailed Report pertain to Enrollment and HICS Direct Disputes.

- The Enrollment Summary tab includes the number of dispute outcomes reported on the file.
- The Enrollment Disputes tab provides an individual outcome for each submitted dispute, with data to reference the disposition back to the original dispute.

Exhibit 64 provides descriptions and examples of the fields of the Enrollment Disputes tab.

Exhibit 64: Enrollment Disputes Tab

Field Description	Format	Example	Field Length
ERR Case ID The ER&R-assigned case ID	Alphanumeric – The letter "D" or "A" followed by 10 digits **NOTE:** Only case IDs for correlated cases contain the "A" identifier.	D0012043606	11
Date Received The date ER&R received the dispute. **NOTE:** For correlated cases, this will display the date the correlated case was created in the ER&R system.	DD/MM/YYYY	3/8/2016	6-8

Field Description	Format	Example	Field Length
File Name The name of the dispute form file **NOTE:** For correlated cases, this field will be blank.	Alphanumeric	Sample.xlsx	N/A
Batch Number The RCNO Batch Number value associated to the record being reported	Numeric	9	1-4
Internal Inventory Number The value found within the specific record being reported	Numeric	123456789	1-12
FFM Exchange Assigned Policy ID FFM Exchange Assigned Policy ID associated to the record being reported	Numeric	12345678	1-15
Dispute Category The dispute type as submitted by the issuer	Alphanumeric	Initial Premium Paid Status	N/A
Disposition The ER&R-assigned disposition code	Alphanumeric	BU14	N/A
Description Verbiage returned to the issuer to describe the outcome of the dispute	Alphanumeric	ER&R accepted the Issuer Initial Premium Paid Status. Please allow 1-2 monthly Reconciliation cycles from the date of ER&R resolution for the FFM and payments (if applicable) to be updated accordingly.	N/A
Coverage Year The coverage year for the disputed record	Numeric	2016	4
Updated Since Last Report Identifies whether the record has received an update since the previous report	Alpha character	N	1
Issuer Assigned Dispute Control Number Specific to the issuer – issuers may create and use this number to track disputes **NOTE:** For correlated cases, this field will be blank.	Alphanumeric	123456789	1-64

Field Description	Format	Example	Field Length
HICS Issuer Assigned Dispute Control Number Specific to the issuer – issuers may create and use this number to track HICS Direct Disputes	Alphanumeric	123456789	1-64
HICS Case Number The HICS case ID associated with the record	Alphanumeric – The letter "E" followed by 10 digits	E1234567890	11
Initial Dispute Case ID The ER&R-assigned case ID of the original dispute that resulted in a correlated case.	Alphanumeric – The letter "D" followed by 10 digits	D0123456789	11

6.1.2 Payment Tabs

The latter two tabs of the Semi-Monthly Detailed Report include data related to Payment Disputes.

- The Payment Summary tab supplies a few statistics for the issuer's HIOS ID that are cumulative year-to-date (YTD) figures.
- The Payment Disputes tab is identical to the Response File except for the presence of an additional field, the Disposition Date field. Each row of this tab provides the original fields from the issuer's dispute submission detail record (F1-F23) and all the fields from the Response File (F24-F31).

Exhibit 65 provides descriptions for the values that may appear in the Payment Summary tab.

Exhibit 65: Semi-Monthly Detailed Report – Payment Summary Tab

Payment Summary Tab Row Label	Description
Total Number of Files Processed	Cumulative YTD count of all Payment Dispute Form files received and ingested
Loaded – With Some Errors	Cumulative YTD count of Payment Dispute Form files received, ingested, and having certain detail codes applied to some of the detail records
Total Number of Records Received	Cumulative YTD count of Payment Dispute Form records processed (a sum of all disputes that received an Rx, Cx, or Ix disposition)
Total Number of Records In Process	Cumulative YTD count of Payment Dispute Form records presently in an In Process disposition status (Ix disposition)
Total Number of Records Completed	Cumulative YTD count of Payment Dispute Form records presently in a Rejected or Completed disposition status (Rx or Cx, respectively)

Exhibit 66 provides descriptions and examples of the fields on the Payment Disputes tab.

Exhibit 66: Payment Disputes Tab

Field Description	Format	Example	Field Length
CMS Dispute Control Number A unique case number – ER&R Contractor use only	Alphanumeric – The letter "P" followed by 1-9 digits	P999999	1-10
Disposition Display Value A code representing the newest status of the dispute	Alphanumeric	R1	1-50
Disposition Date The date and time the disposition code was assigned	M/D/YYYY H: MM	5/15/2016 6:52:34 PM	1-22
Feedback to Issuer Comments or feedback from ER&R	Alphanumeric	Rejected, syntax errors, see response	1-1000
Detail Code 1 The first dispute detail code	Alphanumeric – If applicable, this field includes the value detailing the field in which the error was encountered (e.g., F5 [Field 5] = Payment Cycle Month) and the specific rules that caused the dispute to fail (e.g., SR1 [Situational Rule 1] = Field did not meet expected format).	F5SR1	1-10
Detail Code 2 The second dispute detail code	Alphanumeric – See Detail Code 1.	F5SR1	1-10
Detail Code 3 The third dispute detail code	Alphanumeric – See Detail Code 1.	F5SR1	1-10
Detail Code 4 The fourth dispute detail code	Alphanumeric – See Detail Code 1.	F5SR1	1-10
Detail Code 5 The fifth dispute detail code	Alphanumeric – See Detail Code 1.	F5SR1	1-10

6.1.3 Using the Semi-Monthly Detailed Report

The first tab of the Semi-Monthly Detailed Report, the Enrollment Summary tab, lists the count of Enrollment and HICS Direct Disputes reported.

The second tab of the report includes the processed Enrollment Disputes and correlated cases. Each row of this tab provides information pertaining to the issuer's original dispute or correlated case as well as the disposition code and description of the disposition. Issuers should use this data to reference updates submitted on their behalf for the disputed coverage period or at the policy level. Outcomes of HICS Direct Dispute cases also appear on this tab. These cases are marked as "HICS Case Only" in the Dispute Category field.

The third tab of the report provides cumulative YTD figures for the issuer.

The fourth tab, if populated, contains disputes based on a payment file (PPR/HIX820) that had a change in the disposition code since the last Semi-Monthly Detailed Report. Similar to the Response File, issuers should associate the details found here with the details of the disputes sent on their original dispute submission. Using a combination of issuer-supplied values from the submission and CMS-supplied values can help provide traceability for any dispute. An additional field present on this tab, Disposition Date, supplies the date and time on which the dispute's disposition code changed. The adjacent field includes the new disposition code. If the tab is empty, then none of the disputes for that HIOS have had a change in their disposition status since the last Semi-Monthly Detailed Report.

6.1.4 File Format

The Semi-Monthly Detailed Report is an Excel file.

6.1.5 EFT File Naming Convention

Issuers receive the Semi-Monthly Detailed Report via EFT to the same trading partner ID from which the dispute form was submitted, using the following file naming convention:

TPID.*ERRD.D*YYMMDD.*T*HHMMSSmmm.*P.OUT*

Following is an explanation of the file name structure.

- TPID – Issuer's TPID, also known as the Source ID
- ERRD – Function code for Semi-Monthly Detailed Report
- DYYMMDD – Date, first character, D, is static
- THHMMSSmmm – Timestamp, first character, T, is static
- P/T – Environment, "P" for Production or "T" for Test
- OUT – Direction (Outbound from CMS), defaulted to "OUT"

Example: 12345.ERRD.D160216.T162055453.P.OUT

6.2 Semi-Monthly Payment Report

In addition to the Semi-Monthly Detailed Report, issuers receive a separate Semi-Monthly Payment Report containing only the Payment Disputes data. This report is transmitted via EFT on the same schedule as the Semi-Monthly Detailed Report. The Semi-Monthly Payment Report was established to offer Payment Dispute updates in the same format as the Response Files. Section 5.6.5, Dispute Response File Specifications, identifies the fields issuers can expect to see on the Semi-Monthly Payment Report.

NOTE: The first row, which would contain Payment Dispute header information in the Response File, will contain pipes only in the Semi-Monthly Payment Report.

6.2.1 File Format

The Semi-Monthly Payment Report is a PSV file.

6.2.2 EFT File Naming Convention

Issuers receive the Semi-Monthly Payment Report via EFT to the same trading partner ID from which the dispute form was submitted, using the following file naming convention:

TPID.*ERRZ.D*YYMMDD.*T*HHMMSSmmm.*P.OUT*

Following is an explanation of the file name structure.

- TPID – Issuer's TPID, also known as the Source ID
- ERRZ – Function code for Semi-Monthly Payment Report

- DYYMMDD – Date, first character, D, is static
- THHMMSSmmm – Timestamp, first character, T, is static
- P/T – Environment, "P" for Production or "T" for Test
- OUT – Direction (Outbound from CMS), defaulted to "OUT"

Example: 12345.ERRZ.D180216.T163155453.P.OUT

7.0 CMS Guidance and Support

7.1 Issuer Guidance

The CMS zONE website contains issuer guidance regarding the Affordable Care Act (ACA). For detailed guidance on how to access CMS zONE, issuers should refer to the CMS Enterprise Identity Management (EIDM) User Guide. Issuers should use the guidance to register in the CMS EIDM system and request access to CMS zONE. Within CMS zONE, issuers must join the Private Issuer Community to access issuer resources.

- Issuers may access CMS zONE to review posted documents at https://zone.cms.gov.
- Issuers may access the most recent version of this Individual Market Enrollment and Payment Disputes TRG on CMS zONE at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.

CMS facilitates a series of Reconciliation webinars to share information and technical guidance. Register at https://www.regtap.info to receive notice of these webinars and access to updated materials.

- For more information on gaining access to or using HICS features, refer to the HICS Casework presentation on REGTAP at https://www.regtap.info/reg_librarye.php?i=2487.

Issuers may access the CMS Quick Reference Guide for Issuers: Managing Casework in the Health Insurance Casework System (HICS) at https://hics.cms.gov/app/Casework/Documentation/HICSGuide-Issuer_Manual.pdf.

7.2 Help Desk

Issuers who have questions related to the discrepancy reporting process, dispute form submissions, or Response Files:

- Please contact the ER&R Contractor's Enrollment Reconciliation and Resolution team at ERRSupportCenter@cognosante.com or call **(855) 591-7113**.
- The ER&R Support Center hours of operation are Monday through Friday, 8 AM-8 PM ET. **NOTE**: Please supply File Control Number (Issuer) (H1) from the submission when initiating inquiries about Response Files.

Issuers who have questions related to manual payments or program-level payments on their PPR or HIX 820:

- Please send an email to MarketplacePayments@cms.hhs.gov and include your Issuer ID(s) and Payee ID(s), along with your question.

Issuers who have questions related to the Policy-Based Payments process or who require technical assistance with updating the RCNI to ensure it is correct:

- Please send an email to the Financial Management Coordination Center (FMCC) at FMCC@cms.hhs.gov and include your HIOS ID and Payee ID(s), along with your question.

Issuers who have technical issues or questions related to EDI Onboarding and EFT:

- Please send an email to the Federal Exchange Program System (FEPS) Helpdesk at CMS_FEPS@cms.hhs.gov.

Issuers who have questions related to the SHOP issuer discrepancy reporting process:

- Please send an email to: ShopRecon@cms.hhs.gov.

Issuers requiring HICS password reset assistance:

- Please contact the CMS IT Service Desk at **(410) 786-2580**.

Issuers requiring technical assistance with HICS:

- Please contact the HICS Help Desk at HICS@cms.hhs.gov.

Appendix A. Acronyms

The table provides a list of acronyms used in this document.

Acronym	Definition
ACH	Automated Clearing House
AM	Account Manager
APTC	Advanced Premium Tax Credit
ASCII	American Standard Code for Information Interchange
BUU	Batch Update Utility
CFR	Code of Federal Regulations
CCIIO	Center for Consumer Information and Insurance Oversight
CIC	Change in Circumstance
CMS	Centers for Medicare and Medicaid Services
CSR	Cost-Sharing Reduction
EDI	Electronic Data Interchange
EFT	Electronic File Transfer
EPS	Enrollment Payment System
ER&R	Enrollment Resolution and Reconciliation
FEPS	Federal Exchange Program System
FFE/FFM	Federally-Facilitated Exchange/Federally-Facilitated Marketplace
FM	Financial Management
FMCC	Financial Management Coordination Center
FT	Financial Transactions
HICS	Health Insurance Casework System
HIOS	Health Insurance Oversight System
HIX	Health Insurance Exchange
ITMS	Inquiry Tracking Management System
LOB	Line of Business – type of coverage by an issuer under a particular HIOS ID; may be QHP (Health), SADP (Dental), or Dual (both Health and Dental)
PBP	Policy-Based Payment
PPR	Preliminary Payment Report
QHP	Qualified Health Plan
RCNI	FFM Inbound Enrollment Reconciliation (File)
RCNO	FFM Outbound Enrollment Reconciliation (File)
REGTAP	Registration for Technical Assistance Portal
SBE/SBM	State-Based Exchange/Marketplace
SHOP	Small Business Health Options Program
TRG	Technical Reference Guide
TPID	Trading Partner ID

Acronym	Definition
YTD	Year-To-Date

Appendix B. Related Documents

The following documents pertaining to the dispute process are available on CMS zONE at https://zone.cms.gov/document/enrollment-resolution-and-reconciliation.

- Disputes 101: Provides guidance regarding the Enrollment, Payment, and HICS Direct Dispute processes
- CCIIO ER&R Dispute Resolution Template Version 11: Provides the dispute template as well as business rules and instructions, including:
  - Dispute Examples: Examples of the dispute types that can be submitted on the form
  - Add-Ins Instructions: Detailed instructions for using the add-ins to validate data entered into the form
- CCIIO Enrollment Dispositions: A list providing the definition of each Enrollment Dispute disposition code
- HICS Direct Disputes – Master Guidance: Provides guidance regarding the HICS Direct Dispute process
- HICS Direct Dispute Cheat Sheet: Outlines the required and requested elements for each accepted HICS Direct Dispute type and offers sample comments that issuers may reference when initiating a HICS Direct Dispute
- Enrollment Blocker Cheat Sheet: Provides additional guidance and answers to common issuer questions regarding Enrollment Blockers
- PPR-820 Payment Dispute Form: Provides the schema, business rules, and instructions
  - This document is also available on REGTAP at https://www.regtap.info/reg_librarye.php?i=1442.
- FFE Disposition and Detail Codes: Provides a complete list of valid disposition codes for Payment Disputes
  - This document is also available on REGTAP at https://www.regtap.info/reg_librarye.php?i=1442.