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1. myCGS—The Jurisdiction C Web Portal

The myCGS portal is a Web-based application developed by CGS that is available to DMEPOS suppliers who serve beneficiaries in Jurisdiction C. Using myCGS is a fast and easy way to get the Medicare claim and billing information that you need.

myCGS offers a wide range of functionality and support, such as:

- **Beneficiary Eligibility**
  Find beneficiary eligibility, Medicare Secondary Payer, Medicare Advantage Plan, home health episode, hospice, and inpatient stay information.
- **Claim Status**
  Check on the status of claims you've submitted to Jurisdiction C.
- **Same or Similar Information**
  Search beneficiary claim history for same or similar items.
- **Claim Correction**
  Make simple corrections to a claim.
- **ADR Viewing and Responding**
  View ADR cases and letters (i.e., TPE) and submit your response.
- **Redeterminations and Reopenings Submission and Status**
  Submit and check the status of your Redetermination and Reopening requests directly through myCGS.
- **ADMC and Prior Authorization Submission and Status**
  Submit and check the status of ADMC and Prior Authorization requests.
- **Automatic NPI/PTAN Combinations**

myCGS will automatically give you access to all of the NPI/PTAN combinations that are associated with your existing Tax ID and will automatically add all NPI/PTAN combinations for any newly added Tax IDs.

- **MBI Lookup Tool**
  Find a beneficiary's Medicare Beneficiary Identifier (MBI) when you have a patient who has been mailed a new Medicare Card with MBI, but you do not have a record of the MBI itself.

- **Overpayment Recovery Form Submission**
  Submit either an Offset Request form or an Overpayment Recovery Request form.

- **Overpayment Recovery Search**
  Search by AR/Invoice Number or Letter Number to receive financial, offset, and claim details for an overpayment.

For a complete listing of all that myCGS has to offer and information about how to register, visit our website at http://www.cgsmedicare.com/jc/mycgs.

2. Telephone Inquiries

Interactive Voice Response (IVR) Unit

CMS Manual System, Pub. 100-09, *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 6, §50.1

CGS offers a toll-free Interactive Voice Response (IVR) unit for the exclusive use of DMEPOS suppliers in Jurisdiction C. The IVR is available by calling 1.866.238.9650. The IVR system can respond to a variety of supplier inquiries and requests including:

- Claim status (line by line explanation of the payment/denial, expected payment amount and check date for claims on the payment floor, Claim Control Number (CCN), and appeal rights on denied claims)
- Pending claim information (payment floor information, pending claims at the Common Working File (CWF), and other pending claims)
- Redetermination status (pending, reversed, partially reversed, upheld, or dismissed)
- Ordering duplicate Remittance Advice
- Ordering/referring provider information
- CMN status (HCPCS code of same or similar equipment, initial, revised, and/or recertification date, length of need, previous supplier's phone number for rented items, and total months paid for rented items)
- Oxygen CMN status (most current stationary CMN information, most current portable CMN information, initial, revised, and/or recertification date, length of need, previous supplier's phone number, last paid date with modifier, total number of paid claims per modality, and other oxygen CMNs on file)
- Diabetic supplies and shoes
- Pricing information (fee schedules)
- Check information (outstanding check dates and amount and the last five checks issued)

- Offset information
- General information

For instructions on using the IVR, refer to the IVR User Guide on our website at https://www.cgsmedicare.com/jc/help/ivr.html. For an abbreviated version, refer to the IVR flow chart at https://www.cgsmedicare.com/jc/help/pdf/DME_IVR_checklist.pdf.

The IVR is available 24/7 with the exception of periodic system upgrades or routine maintenance. The IVR menu options which require system access are available Monday–Friday, 6 am–9 pm CT and Saturday, 6 am–4 pm CT.

Customer Support

CMS Manual System, Pub. 100-09, *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 6, §30

When the IVR system cannot answer your questions or provide the assistance you need, you may disconnect from the IVR and call 1.866.270.4909 to speak to a Customer Service Representative (CSR).

NOTE: *CSRs are not able to provide you with information that is readily available on the IVR. You must contact the IVR for the types of inquiries listed above.*

CSRs are trained to answer supplier questions and resolve problems. They should be your first contact with our office when you need assistance.

When calling, please have available your National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), the last five digits of your tax identification number (TIN) and, if appropriate, the beneficiary's name, Medicare ID, and date of service. So that we may assist as many callers as possible, you are limited to three separate inquiries per phone call. Lengthy requests should be submitted in writing.

CSRs are available to assist suppliers Monday–Friday, 7 am–5 pm CT. CSRs are not available on the following holidays: New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving holiday (Thursday and Friday), Christmas Eve, and Christmas Day. Please also note that the contact center is closed the 2nd and 4th Friday each month from 9:30 am to 12 noon CT for staff training (except for weeks in which there is a federal holiday closing). The contact center may also close to observe other Federal holidays. An electronic mailing list message will be sent out informing you of additional closings or changes in availability. To join our electronic mailing list, visit our website at https://www.cgsmedicare.com.

Customer Support is able to:

- Clarify the denial reason associated with a claim
- Provide general information regarding Medicare coverage
- Explain terminology and information published in issues of the *DME MAC Jurisdiction C Insider* and this *Supplier Manual*
- Assist with other complex issues

Customer Support is *not* able to:

- Provide claim status, beneficiary eligibility, or other information which is available through the IVR
- Give preauthorization of beneficiary entitlement for specific DMEPOS

- Adjust a claim, unless the claim was processed incorrectly by the DME MAC (please call Telephone Reopenings at 1.866.813.7878)
- Answer questions about supplier enrollment (please call the NPEAST at 1.866.520.5193 or NPWEST at 1.866.238.9652)
- Answer questions about electronic billing software or claims that have not been received in our claim processing system (please call CEDI at 1.866.311.9184)
- Answer inquiries from beneficiaries or their representatives (please call 1.800.MEDICARE – 1.800.633.4227)
- Review documentation related to redetermination cases or Automated Development Letter responses

Before You Call…

Before calling a Customer Support, you should take the following steps:

- Consult your Remittance Advice (RA)
- Consult the Claim Denial Resolution Tool (https://www.cgsmedicare.com/medicare_dynamic/jc/claim_denial_resolution_tool/search.aspx) on the CGS website
- For medical necessity and coverage issues, consult the appropriate Local Coverage Determination (LCD)
- For general questions about DME MAC, consult this *Supplier Manual*

When calling Customer Service, please be sure to have the following information ready to give to the CSR:

- Your NPI number
- Your Provider Transaction Access Number (PTAN)
- The last five digits of your tax identification number (TIN)
- Beneficiary's Medicare ID, name, date of service, and/or date of birth (if appropriate)

Three Levels of Customer Support

When calling Customer Support, you will initially speak to a Tier 1 CSR. Tier 1 CSRs are capable of handling most supplier inquiries. In some cases, Tier 1 CSRs may need to transfer the call to a Tier 2 CSR (also known as the Help Desk). If a callback is required, a Tier 2 CSR will return your call within 10 business days.

If you have a complex inquiry that goes above and beyond the normal scope of a Tier 1 or Tier 2 CSR, the inquiry will be forwarded to the third level of Customer Support, the Provider Relations Research Specialist (PRRS) team. The PRRS will research the inquiry and respond either by phone or by mail within 45 business days.

3. Written Inquiries

CMS Manual System, Pub. 100-09, *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 6, §30.3

CGS is committed to providing the highest level of service to our Medicare suppliers. It is our goal to handle all written inquiries in a timely and efficient manner. When writing, please state your question or concern as clearly as possible including all pertinent information, i.e., NPI, PTAN, the last 5-digits of your TIN, and, if appropriate, the beneficiary's name, Medicare ID, and date of service (note that email inquiries must not contain sensitive personal information). Please send letters and faxes on official letterhead and attach your official letterhead to email inquiries. The supplier's name and address should be included on the letterhead, RA, or preformatted inquiry form. If there is more than one location listed, make sure at least one matches the practice location address on file. You must also include your name and phone number. Including this information will allow us to respond more specifically to the inquiry. After the correspondence is received by the DME MAC, a Written Correspondent will respond to the inquiry within 45 business days.

Please send all general written inquiries to:

CGS
DME MAC Jurisdiction C
PO Box 20010
Nashville, TN 37202
ATTN: Correspondence Department

Fax: 615-782-4490

Email inquiries may be submitted through our website at https://www.cgsmedicare.com/jc/help/contact/onlinehelp.html. Information that is personal/private (e.g., Medicare ID, Social Security numbers, Tax ID numbers, financial information, etc.) must not be included in the inquiry. A response will be returned via email. Responses that require personal/private information will be returned by phone or in writing.

4. Provider Outreach and Education (POE) Department

CMS Manual System, Pub. 100-09, *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 6, §20

CGS offers several different methods of educational training that offer the latest and most up-to-date Medicare information. Visit https://www.cgsmedicare.com/jc/education/index.html for a complete listing of webinars, online training, workshops, and more.

You can find our calendar of scheduled educational events at https://www.cgsmedicare.com/medicare_dynamic/wrkshp/DME_COE/dme_coe_c/jc_Report.aspx.

5. Reopenings for Minor Errors and Omissions

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 34, §10

There is no need to request an appeal/redetermination if you have made a minor error or omission during filing of the claim. In the case where a minor error or omission is involved, you can request Medicare to reopen the claim so the error or omission can be corrected, rather than having to go through the appeal process. You have one year to request a reopening from the date on your Remittance Advice (RA). No action can be taken until a final claim determination is issued. See Chapter 17 of this manual for more information about RAs.

The easiest and fastest way to correct or reopen a claim is to utilize the myCGS Web Portal. To do so, use the Claim Correction or Reopening Form Submission option in the Reprocessing menu. Refer to the myCGS User Manual (https://cgsmedicare.com/mycgs/manual/dme/index.html) for instructions.

You may also request a reopening by telephone or by mail.

If you need to submit a written reopening request by mail, use the Medicare Reopening Request form (https://www.cgsmedicare.com/jc/forms/pdf/dme_reopening-new.pdf) available on our website at https://www.cgsmedicare.com/jc/forms/index.html. Please note this form must be typed, not handwritten.

Send it to the following address:

CGS
DME MAC Jurisdiction C
ATTN: Clerical Error Reopening Department
PO Box 20010
Nashville, TN 37202

Examples of minor errors or omissions include:

- Mathematical or computational mistakes
- Transposed procedure or diagnostic codes
- Inaccurate data entry
- Misapplication of a fee schedule
- Computer errors
- Incorrect data items, such as the use of a modifier or date of service, and capped rental denials that have received payment(s) for some months
- Claims denied for being filed after the claim filing time limit.

Because some issues are more complicated than others and may require more research or consulting medical staff, the DME MAC reserves the right to decline the clerical error reopening and request that you submit a written redetermination request.

In situations where you or the beneficiary request a redetermination and the issue involves a minor error or omission, irrespective of the request for a redetermination, the DME MAC will treat the request as a request for a clerical error reopening.

The following issues cannot be handled as a reopening:

- Not reasonable and necessary (not medically necessary) claim denials MUST be appealed through redeterminations
- Unprocessable/returned claims (i.e., ANSI code 16) – resubmit the claim with the corrected information
- Addition, change, and/or removal of KX, GA, GY, GW, and/or GZ modifiers MUST be appealed through redeterminations
- Inquiries on the status of a claim(s)

- Claims audited by an outside entity (Recovery Auditor Contractor (RAC), Specialty Medical Review Contractor (SMRC), Unified Program Integrity Contractor (UPIC), Comprehensive Error Rate Testing (CERT)
- Target Probe and Educate audits (TPE)
- Corrected PTANs
- Recoupment requests which should be submitted to overpayment recovery

NOTE: For information regarding COVID-19, visit https://www.cgsmedicare.com/jc/covid-19.html.

Telephone Reopenings

The DME MAC telephone reopening number is 1.866.813.7878. The line is available Monday–Friday, 7 am–5 pm CT. The telephone reopenings line follows the same holiday and training schedule as the Provider Contact Center—refer to the Telephone Inquiries section above for details.

NOTE: An easier and faster way to complete a clerical error request is by using the Claim Correction feature in myCGS. Refer to the myCGS User Manual https://cgsmedicare.com/mycgs/manual/dme/index.html) for instructions.

You must have the following information on-hand before placing the call for a telephone reopening:

- Your NPI, PTAN, and last five digits of your TIN
- The Medicare Claim Control Number (CCN) and reason for denial
- Beneficiary name and MBI
- Date of service
- Any additional information to support why you believe the decision is not correct. This includes having the correct procedure code(s), modifier(s), diagnoses, units of service, etc.

1. Use the telephone reopening process to resolve minor errors or omissions involving:

- Units of service
- Service dates
- Healthcare Common Procedure Code System (HCPCS) coding
- Diagnosis codes and diagnosis reference
- Modifiers (excluding the KX, GA, GY, GW, and GZ modifiers)
- Place of service
- Claim incorrectly denied as duplicate charges

2. The following issues are examples of what cannot be handled on the telephone reopening line:

- Claims denied for being filed after the claim filing time limit
- Unprocessable/returned claims (i.e., CO-16 denials)
- Medicare Secondary Payer (MSP)/other insurance involvement issues—A secondary payer is an insurance plan that covers medical expenses only after a primary insurer has made payment on a claim

- Any claim that requires additional documentation
- Reopening requests for break in service issues
- CMN or DIF issues or changes
- Claims audited by an outside entity
- Claims denied for medical necessity

3. Consult this *Supplier Manual* and applicable medical policy guidelines before calling.

Because some issues are more complicated than others and may require more research, the DME MAC reserves the right to decline a telephone reopening. These requests should be submitted using the myCGS web portal or by sending a written reopening request.

To effectively service all callers, each call is limited to five claim issues.

6. Appeals

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29

The Medicare program offers suppliers and beneficiaries the right to appeal claim determinations made by the DME MAC. The purpose of the appeals process is to ensure the correct adjudication of claims. A party to the appeal or their representatives may appeal an initial claim reimbursement determination.

The Medicare law consists of five levels of appeal. The appellant must begin at the first level after receiving an initial determination. Each level after the initial determination has procedural steps that must be taken before an appeal may be taken to the next level. The following table lists the types of appeal, the order in which appeals must be followed, and the filing requirements for each.

Appeal Level	Time Limit for Filing Request	Where to File an Appeal	Monetary Threshold
Redetermination	120 days from the date of receipt of the initial determination or overpayment demand letter	CGS Jurisdiction C DME MAC	None
Reconsideration	180 days from the date of receipt of the Medicare Redetermination Notice	Follow the instructions in your Redetermination decision letter.	None
Administrative Law Judge (ALJ)	60 days from the date of receipt of the reconsideration notice	Follow the instructions in your Reconsideration decision letter.	For requests filed on or after January 1, 2026, at least $200 remains in controversy.
Departmental Appeals Board (DAB)	60 days from the date of receipt of the ALJ	Follow the instructions in	None

Review/Appeals Council	decision/dismissal	your ALJ decision letter.	
Federal Court (Judicial) Review	60 days from the date of receipt of the Appeals Council decision or declination of review by DAB		For requests filed on or before December 31, 2026, at least $1,960 remains in controversy. For requests filed on or after January 1, 2027, at least $2,000 remains in controversy.

Parties to an Appeal

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §260

An appeal request must be submitted by someone who is considered a party to the appeal. The appeal will be dismissed if the person requesting is not a proper party. Any of the following are considered proper parties to an appeal:

- A beneficiary;
- A participating supplier;
- A non-participating supplier taking assignment for a specific item or service;
- A non-participating supplier of DME potentially responsible for making a refund to the beneficiary under Section 1834(a)(18) of the Act;
- A supplier of medical equipment and supplies not taking assignment and who is responsible for making a refund to the beneficiary under Section 1834(j)(4) of the Act;
- A Medicaid State agency or party authorized to act on behalf of the State; or
- Any individual whose rights may be affected by the claim being reviewed.

Appointment of Representative

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §270

A person/supplier/physician who files an appeal request on behalf of a beneficiary is not, by virtue of filing the appeal, a representative. To act as the beneficiary's representative, a person/supplier/physician must submit a properly executed appointment of representative form—Form CMS-1696 (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf); however, the appointment of representative form is not necessary. A written statement containing all the required elements is also acceptable as a valid appointment of representative. A valid appointment of representative statement must:

- Be in writing, signed (handwritten or electronic, digital, and/or digitized), and dated by both the party and the individual agreeing to be the representative;

- Provide a statement appointing the representative to act on behalf of the party, and authorizing the adjudicator to release identifiable health information to the appointed representative;
- Include a written explanation of the purpose and scope of the representation;
- Contain both the party's and appointed representative's name, phone number, and address;
- Contain a unique identifier of the party being represented. If the party being represented is the beneficiary, the Medicare number must be provided. If the party being represented is a provider or supplier, the National Provider Identifier number must be provided;
- Include the appointed representative's professional status or relationship to the party; and
- Be filed with the entity processing the party's initial determination or appeal (i.e., the DME MAC).

The appointment of representative is valid for one year from either: (1) The date signed by the party making the appointment, or (2) The date the appointment is accepted by the representative—whichever is later.

The appointment remains valid for any subsequent levels of appeal on the claim/service in question unless the party specifically withdraws the representative's authority. However, if during an appeal the appointment of representative expires, a new form is necessary.

The appeal will be dismissed if the person making the request is not a proper party.

7. Redeterminations – First Level of Appeal

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §310

The first step in the appeals process is the redetermination which is conducted by the DME MAC. The redetermination process provides a re-examination of the initial claim decision. Any new information or medical evidence should be submitted with the request for redetermination and will be evaluated fully in accordance with the Medicare law regulating the redetermination process. Every effort will be made by the redetermination specialist to clarify any questions that may arise in the course of the redetermination by requesting additional information/documentation from the beneficiary, supplier, or the appointed representative. The redetermination specialist is someone who did not participate in the original decision.

For redeterminations of claims denied following a complex prepayment review, a complex post-payment review, or an automated post-payment review by a contractor, CMS has instructed MACs to limit their review to the reason(s) the claim or line item at issue was initially denied. Prepayment reviews occur prior to Medicare payment, when a contractor conducts a review of the claim and/or supporting documentation to make an initial determination. Post-payment review or audit refers to claims that were initially paid by Medicare and subsequently reopened and reviewed by, for example, a Unified Program Integrity Contractor (UPIC), Recovery Auditor, MAC, Specialty Medical Review Contractor (SMRC), or Comprehensive Error Rate Testing (CERT) contractor, and revised to deny coverage, change coding, or reduce payment. Complex reviews require a manual review of the supporting medical records to determine whether there is an improper payment. Automated reviews use claims data analysis to identify improper payments. If an appeal involves a claim or line item denied on an automated pre-payment basis, MACs may continue to develop new issues and

evidence at their discretion and may issue unfavorable decisions for reasons other than those specified in the initial determination.

The time limit for requesting a redetermination is 120 days from the date of issuance of the Medicare Remittance Advice (RA) or the date of the overpayment demand letter. The CGS website includes an Appeals Time Limit Calculator (https://cgsmedicare.com/medicare_dynamic/jc/time_limit_calculator/time_limit_calculator.aspx) to aid you in determining the timelines of your redetermination requests.

NOTE: If you are submitting a request that is past timely filing, please provide good cause for late filing.

The DME MAC Redetermination staff has 60 days to complete a redetermination. If additional documentation is requested or if the appellant submits additional documentation after the redetermination request is submitted, the processing time limit is 74 days from the date of initial receipt.

Appeal Requests for Providers/Suppliers Affected by a Natural Disaster

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §240.3

Good cause for an untimely appeal may be found due to unavoidable circumstances such as major floods, fires, tornados, and other natural catastrophes. If you were affected by a natural disaster and are unable to file a timely appeal, include the following information in your appeal request: "Extension requested due to natural disaster exception and include the name of the natural disaster."

Definition of Disaster

A disaster is defined as any natural or man-made catastrophe (such as hurricane, tornado, earthquake, volcanic eruption, mudslide, snowstorm, tsunami, terrorist attack, bombing, fire, flood, or explosion) which causes damage of sufficient severity and magnitude to partially or completely destroy medical records and associated documentation that could be needed and/or requested by the MACs in the course of the adjudication process, interrupts normal mail service (including US Postal delivery, overnight parcel delivery services, etc.), impacts ability to file appeals in a timely manner, and/or otherwise significantly limit the provider's/supplier's daily operations.

A disaster may be widespread and impact multiple structures (e.g., a regional flood) or isolated and impacts a single site only (e.g., water main failure). The fact that a provider/supplier is located in a presidentially declared disaster area under the power of the Stafford Act is not sufficient in itself to justify administrative relief, as not all structures in the disaster area may have been subject to the same amount of damage. Damage must be of sufficient severity and extent to compromise retrieval of medical records. The provider/supplier needs to state that they were impacted by the disaster.

Redetermination Requests

The easiest way to submit a redetermination request is by using the Redeterminations Form Submission feature in myCGS. Refer to the myCGS User Manual (https://cgsmedicare.com/mycgs/manual/dme/index.html) for instructions.

The party to the appeal or their representative may submit a request for redetermination using the current Medicare DME Redetermination Request Form, which is available on the Forms page (https://www.cgsmedicare.com/jc/forms/index.html) of our website or at the following link:

Medicare DME Redetermination Request Form
(https://www.cgsmedicare.com/jc/forms/pdf/dme_redetermination.pdf) PDF

If you wish to send a written request instead of using the Medicare DME Redetermination Request Form, your written request **must** contain the following elements:

- The beneficiary's name;
- The Medicare ID of the beneficiary;
- The specific service(s) and/or item(s) for which the redetermination is being requested and the specific date(s) of service (listing the CCN alone is not sufficient to meet this requirement); and
- The name of the party or the representative of the party filing the request.

Please include all CCNs per beneficiary on your redetermination request.

Incomplete requests will be dismissed with an explanation of the missing information. You will be instructed to resubmit the request with all of the missing information. Incomplete requests that are resubmitted for appeal must be submitted within 120 days from the date of the Medicare Remittance Advice (RA) or the overpayment demand letter. Incomplete requests that are resubmitted past the 120-day timely filing limit will be dismissed.

There are three ways to submit a redetermination request: the myCGS Web Portal, fax, or mail.

- To submit a redetermination request through myCGS, refer to the myCGS User Manual (https://cgsmedicare.com/mycgs/manual/dme/index.html).
- Send redetermination requests via fax through our appeals fax line at 615.782.4630.
- If you prefer to mail your request, send your redetermination to:

  CGS
  DME MAC Jurisdiction C
  PO Box 20009
  Nashville, TN 37202

If you need to send more than one redetermination request in a single fax transmission, you can do so by using the CGS Separator Sheet (https://www.cgsmedicare.com/jc/forms/pdf/jc_separator_sheet.pdf), which is available on the Forms page (https://www.cgsmedicare.com/jc/forms/index.html) of our website. Doing so will ensure each individual request is recognized and handled in the most timely and efficient manner. Whether you have two, three, or more separate redetermination requests, simply insert the Separator Sheet in between each of the requests in your fax. When we receive the fax, our scanning technology will detect the Separator Sheet and know to separate each section of the fax automatically.

There are two ways you can use the Separator Sheet depending on how you send faxes:

- If you send faxes electronically, download the Separator Sheet and insert it in between each of your requests.
- If you use a traditional fax machine (i.e., you print your request and then fax it), print the Separator Sheet and insert it in between each of your requests.

Note that the Separator Sheet is only for use with redetermination requests.

Please send your redetermination request to the correct contractor (and correct jurisdiction). CGS often receives **misdirected redetermination requests**, which creates delays. Sending requests to

the correct contractor helps you receive your decision faster and saves costs for the Medicare program.

You can use myCGS or the Interactive Voice Response (IVR) system to verify receipt of your redetermination request. Verification via the myCGS and IVR is available 10 days after CGS receives the request. myCGS and the IVR will provide confirmation and a status of your request. Duplicate submissions of your redetermination request will not accelerate the review and decision process.

Submitting Redetermination Requests for Overpayments

If you disagree with a request to refund an overpayment, you have the right to a first level (redetermination) appeal. Take these actions when you receive the initial demand letter to refund an overpayment:

1. It is in your best interest to **immediately refund** the requested amount. This will help you avoid an offset and accruing interest.
2. **File your appeal** using the Medicare DME Redetermination Request Form on our website.*
    a. Select YES in the Overpayment Appeal section of the form.
    b. Indicate who requested the overpayment—Medical Review, Unified Program Integrity Contractor (UPIC), Comprehensive Error Rate Testing Contract (CERT), Recovery Auditor (RAC), Supplemental Medical Review Contractor (SMRC), Office of Inspector General (OIG), etc.

**Using the Medicare DME Redetermination Request Form is not required, but it is highly recommended for faxed or mailed requests. You can access the Redetermination Request Form on our website by visiting https://www.cgsmedicare.com/jc/forms/index.html.*

When submitting a redetermination request regarding an overpayment, it is very important that you:

- Complete the Redetermination Request Form in its entirety
- Provide the CCN of the adjusted claim that reflects the overpayment
- Include a copy of the audit results letter (for example, a notification letter from the contractor who audited your claims, such as the UPIC, RAC, Medical Review, etc.)
- Include a copy of the CGS overpayment demand letter (containing the total amount of the overpayment, information on where to send payment, and appeal rights)
- Submit one redetermination request per demand letter.
- When preparing your request for an extrapolated appeal, it is very helpful if you prepare the documents in the following order:

    Page 1: A letter identifying supplier, contact information, ARDCN, Invoice Number or Letter Number, reason for appeal, etc.

    Page 2: A copy of the original demand letter that has the beneficiary names listed OR a complete list of beneficiary names, Medicare IDs, DOS, and items appealed.

    Page 3: Documentation needed to support the appeal.

Note: Please specify in your request if you wish to appeal the entire amount of the overpayment demand letter or only certain claims. For cases involving multiple beneficiaries, it may be helpful to include a spreadsheet or list containing all of the items identified in bullet three above for each claim you wish to appeal.

Submitting Documentation with the Redetermination Request

Original claim denials are often upheld at the redetermination level of appeal due to the lack of documentation supporting the medical necessity of services rendered. Before requesting a redetermination, consult the appropriate LCD(s) and/or supplier bulletins on our website at https://www.cgsmedicare.com/jc/index.html. These resources contain all applicable medical policy and documentation guidelines for each piece of equipment/supply. Failure to include all appropriate documentation with the appeal may result in an unfavorable appeal decision.

When submitting a redetermination request:

- Include documentation that is relevant to the reason why your claim denied.
- If you received a letter requesting additional documentation for your claim from a UPIC, DME MAC Medical Review, RAC, CERT, SMRC, OIG, or any other Medicare contractor, always include each item that was requested on the letter with your redetermination request.
- All medical documentation must be signed and dated by a health care professional.

For detailed instructions on submitting documentation with your redetermination request in myCGS, refer to the myCGS User Manual (https://cgsmedicare.com/mycgs/manual/dme/index.html).

Redetermination Decisions

The redetermination decision will result in one of three dispositions:

Affirmation (Unfavorable)

A Medicare Redetermination Notice (MRN) will be sent to the appellant explaining the decision and the grounds on which the affirmation is based. A copy of all decisions will be sent to all parties of the appeal.

Reversal (Favorable or Partially Favorable)

A fully favorable reversal will result in an adjusted claim with an accompanying Medicare Summary Notice (MSN) sent to the beneficiary and Remittance Advice (RA) sent to you, serving as notice of the decision. A partially favorable decision will result in an adjusted claim with an accompanying MSN and RA, as well as an MRN to the appellant explaining the reason for the partially favorable decision. The DME MACs have 30 days to initiate the effectuation or to determine the payment amounts from the date of the decision. Once the payment amount has been determined, the effectuation has 30 days to complete.

Dismissal

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §200.C

A dismissal letter will be sent if the redetermination request was not filed timely, was missing required elements of a redetermination request, was submitted in response to an action not considered an initial determination, or the proper Appointment of Representative documents are not received.

If you would like to request that we vacate a dismissal, you must file a request within six months of the date of receipt of the dismissal notice. In your request, please explain why you believe you have good and sufficient cause for filing late or for not including all required items in your request.

Parties to the redetermination have the right to appeal a dismissal of a redetermination request to the Qualified Independent Contractor (QIC) that conducts level 2 appeals (reconsiderations—see below) if they believe the dismissal is incorrect.

The reconsideration request must be filed at the QIC within 60 days of the date of the dismissal letter. When the QIC performs its reconsideration of the dismissal, it will decide if the dismissal was correct. If it determines that the DME MAC incorrectly dismissed the redetermination, it will vacate the dismissal and remand the case to the DME MAC for redetermination.

8. Reconsideration – Second Level of Appeal

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §320
MLN Matters Article SE1521

The second level in the appeals process is a reconsideration. The reconsideration is conducted by the Qualified Independent Contractor (QIC). A redetermination must be issued on the date of service and item/service in dispute before requesting a reconsideration.

The reconsideration process will provide a re-examination of the reason(s) stated in the redetermination decision letter. Any new information or medical evidence must be submitted with the request for reconsideration and will be evaluated fully in accordance with the Medicare law regulating the reconsideration process.

The adjudicator performing the reconsideration is an independent reviewer of the appeal. Requests on claims that were denied due to medical necessity will be reviewed by a panel of physicians and other health professionals.

The QIC has 60 days to render a reconsideration decision.

Reconsideration Requests

To exercise your right to a reconsideration, you must file a request in writing to the QIC contractor within 180 days of receiving the MRN. You may submit the request by any of the following ways:

- Complete the Reconsideration Request Form included with the MRN;
- Complete the Jurisdiction C Reconsideration Request Form located on the CGS website at https://www.cgsmedicare.com/jc/forms/pdf/JC_reconsideration_form.pdf;
- Complete CMS 20033 Medicare Reconsideration Request Form located at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20033.pdf; or
- Submit a written request containing **all** of the following information:
    - The beneficiary's name;
    - The beneficiary's Medicare health insurance claim number;
    - The specific service(s) and item(s) for which the reconsideration is requested, and the specific date(s) of service;
    - The name of the party or representative of the party; and
    - The name of the contractor that made the redetermination.

Send your request for reconsideration to the QIC at the address below. Ensuring that you send your reconsideration requests to the correct contractor reduces processing time, ensuring that you will receive a decision in a timely manner, as well as reducing administrative costs to the Medicare program. If the reconsideration request is incorrectly sent to the DME MAC, processing of that request could be delayed by up to 60 days.

Maximus Federal Services, Inc.
Medicare DME
3750 Monroe Avenue, Suite 777
Pittsford, NY 14534-1302
Phone: 585-348-3200
Toll Free: 833-974-2363 (833-9QI-CDME)

Website: https://www.medicareappeal.com/medicare-durable-medical-equipment-dme-appeals

Requests can also be submitted via the QIC Appeals Portal at https://qicappeals.cms.gov/qicportal/.

The DME MACs must be notified of the effectuation (favorable or partially favorable decisions) by the QIC. The DME MACs cannot accept copies of the decision letters from suppliers, beneficiaries, or representatives to effectuate the QIC's decision. The DME MACs have 60 days to complete the effectuation from the date of receipt of the effectuation notification from the QIC.

9. Administrative Law Judge (ALJ) Hearing – Third Level of Appeal

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §330

If you remain dissatisfied following the QIC reconsideration and the remaining amount in controversy is $200 or more for requests filed on or after January 1, 2026, you have the right to request a hearing before an Administrative Law Judge (ALJ). The request for an ALJ hearing must be made in writing within 60 days after receipt of the notice of the QIC's reconsideration decision letter. To request an ALJ hearing, use the form "Request for an Administrative Law Judge (ALJ) Hearing or Review of Dismissal - OMHA-100" found on the Office of Medicare Hearings and Appeals (OMHA) website at: https://www.hhs.gov/about/agencies/omha/filing-an-appeal/forms/index.html.

Requests for all ALJ hearings must be filed to the address listed on your reconsideration notice.

The DME MACs must be notified of the effectuation (favorable or partially favorable decisions) by the AdQIC. The DME MACs cannot accept copies of the decision letters from suppliers, beneficiaries, or representatives in order to effectuate the ALJ's decision. The DME MACs have 60 days to complete the effectuation from the date of receipt of the effectuation notification from the AdQIC.

10. Departmental Appeals Board Review

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §340

If you remain dissatisfied following the Administrative Law Judge's (ALJ) hearing decision or dismissal order, you may file an appeal requesting the Departmental Appeals Board to review it. To file an appeal, you must submit a written request to the Departmental Appeals Board within 60 days from the date you receive the ALJ hearing decision letter or dismissal order. Your ALJ decision letter outlines the proper process for requesting a Departmental Appeals Board review.

When the Departmental Appeals Board has rendered its final decision, a copy will be sent to you and the case file will be returned to the DME MAC for completion. The DME MACs have 60 days to complete the effectuation from the date of receipt of the effectuation notification from the AdQIC.

For additional information, refer to the Departmental Appeals Board website at https://www.hhs.gov/about/agencies/dab/index.html.

11. Federal Court Review

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §345

If you remain dissatisfied following the Departmental Appeals Board decision and the remaining amount in controversy is $1,960 or more for requests filed on or before December 31, 2026, or is $2,000 or more for requests filed on or after January 1, 2027, you may request a court review of the decision. The complaint must be filed with a United States District Court.