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1. 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 is capable of responding 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, 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
- Beneficiary eligibility (Part A and B entitlement dates, **current and previous calendar year Part B deductible**, Medicare Advantage Plan enrollment, home health information, and Medicare Secondary Payer information)
- Skilled Nursing Facility (SNF)/Inpatient hospital stay and hospice information
- **Hospice 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)**
- Pricing information (fee schedules)

- Check information (Outstanding check dates and amount and the last five checks issued)
- Offset information
- EFT application status (pending, approved, or rejected)
- General information

The IVR is available 24 hours a day, seven days a week with the exception of periodic system upgrades or routine maintenance. The IVR menu options which require system access are available Monday through Friday 6:00 am – 8:00 pm CT and Saturday 6:00 am – 4:00 pm CT.

Customer Service Representatives (CSRs)

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, Health Insurance Claim Number (HICN), 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 through Friday from 7:00 am to 5:00 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 first Thursday of every month from 8:30 am to 12:30 pm 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. A ListServ message will be sent out informing you of additional closings or changes in availability. To join the ListServ, visit our website at www.cgsmedicare.com.

Customer Service Representatives are 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 Service Representatives are *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 866.813.7878)
- Answer questions about supplier enrollment (please call the National Supplier Clearinghouse at 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 866.311.9184)
- Answer inquiries from beneficiaries or their representatives (please call 1.800.MEDICARE – 800.633.4227)

Before You Call...

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

- Consult your Remittance Advice (RA)
- Consult the [ANSI Denial Guide](#) 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), also known as your Legacy number or NSC number
- The last five digits of your tax identification number (TIN)
- Beneficiary's HICN, name, date of service, and/or date of birth (if appropriate)

Three Levels of Customer Service

When calling Customer Service, 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 Service, 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.

2. 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., your NPI, PTAN, last five digits of your TIN, and supplier name, and, if appropriate, the beneficiary's name and HICN. This will

allow us to respond more specifically to your inquiry. Please also include your name and phone number.

Please send all general written inquiries to:

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

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

3. 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. Each method offers providers the latest and most up-to-date Medicare information. Provider Relations representatives are available for training and educational seminars, online education, and workshops. Visit our website at www.cgsmedicare.com for a complete listing of seminars, online training, and workshops.

4. 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 in filing the claim, which, in turn, caused the claim to be denied. 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 can request a reopening for minor errors or omissions either by telephone or in writing. You have one year to request a reopening from the date on your Remittance Advice (RA). See Chapter 17 of this manual for more information about RAs.

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
- Denial of claims as duplicates which you believe were incorrectly identified as a duplicate
- Incorrect data items, such as the use of a modifier or date of service

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:

- Redetermination requests, which must be submitted via the appeals process
- Untimely filing – reopenings requests must be made within one year from the date of initial determination
- Unprocessable/Returned claims (i.e. ANSI code 16) – resubmit the claim with the corrected information
- Addition, change, and/or removal of KX, GA, GY and/or GZ modifiers

You can request a reopening either by telephone or by writing. Detailed instructions are provided below.

Telephone Reopenings

The DME MAC telephone reopening number is 1.866.813.7878. The line is available Monday through Friday, from 8 am to 10:30 am and from 12 noon to 3:30 pm CT.

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, and GZ modifiers)
 - Place of service
 - Claim incorrectly denied as duplicate charges
2. Wait to call the telephone reopening line until you receive your Remittance Advice (RA). No action can be taken until a final claim determination is issued.
3. Consult this Supplier Manual and applicable medical policy guidelines before calling. Failure to have appropriate information available when you call the telephone reopening line may result in an unfavorable decision.
4. Questions about the status of a claim or general Medicare payment and coding should not be directed through the telephone reopening line. You can obtain a claim status report through the Interactive Voice Response (IVR) unit or by using Claim Status Inquiry (CSI). See Chapter 8 of this manual for information about CSI.

5. 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 HICN
 - 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.

All medical information provided to the DME MAC must be documented in the patient's file and available to the DME MAC should an audit be required.

If a previous reopening decision has been issued, a redetermination must be made in writing. If a previous redetermination decision has been issued, a reconsideration must be filed. See below for more information about redeterminations and reconsiderations.

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

Written Reopenings

Written requests for reopenings should be mailed to:

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

Written requests for a reopening with an underpayment may also be faxed to 615.782.4649. For a reopening with an overpayment, requests may be faxed to 615.782.4477.

Written reopening requests should be made using the [Medicare Reopening Request](http://www.cgsmedicare.com/jc/forms/index.html) form available on our website at <http://www.cgsmedicare.com/jc/forms/index.html>. If you wish to send a written request instead of using the Medicare Reopening Request form, be sure to include the following information:

- The beneficiary's name and HICN
- The specific services(s) and/or item(s) for which the reopening is being requested and the specific date(s) of service, and
- The name and signature of the person filing the request

5. 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.

Suppliers who provide services to Medicare Part B beneficiaries may appeal an initial claim reimbursement determination. Beneficiaries also have the right to appeal any claim 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 redetermination notice	C2C Solutions, Inc.	None
Administrative Law Judge (ALJ)	60 days from the date of receipt of the reconsideration notice	HHS Office of Medicare Hearings and Appeals (OMHA) field office	For requests filed on or after January 1, 2010, at least \$130 remains in controversy
Departmental Appeals Board (DAB) Review/Appeals Council	60 days from the date of receipt of the ALJ decision/dismissal	DAB or ALJ Hearing Office	None
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 after January 1, 2012, at least \$1,350 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); 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. The following information must be included on a written statement:

- The name, address and phone number of the individual.
- The individual's Medicare number when the party making the appointment is the beneficiary.
- A specific individual named as the representative. An organization or entity may not be named as the representative, but rather a specific member of that organization or entity must be named. The representative must sign and date the form and list his/her name, address and phone number. A statement that he/she accepts the appointment needs to be included.
- The representative's signature; the representative must sign the appointment within 30 calendar days of the party's signature.
- A statement that the party authorizes the representative to act on her or his behalf for the claims at issue and a statement authorizing disclosure of individually identifying information to the representative.
- Signature of the party making the appointment **and** the date signed.

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 beneficiary specifically withdraws the representative's authority. However, if during an appeal the appointment of representative expires, a new form is necessary.

6. 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 complete re-examination of all information submitted with the original claim. 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 (e.g., calling the beneficiary or his/her representative or the physician who prescribed the equipment). The redetermination specialist is someone who did not participate in the original decision. The opinion of medical consultants specializing in the services being reviewed may also be requested.

The denial on a duplicate line item is not a denial of service. There are no appeal rights on the duplicate submission. Appeal requests on duplicate claim denials will be treated as inquiries and not as appeals for this reason. If you wish to request an appeal, you must request the appeal on the original denial.

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 DME MAC redetermination staff will determine if the request was filed timely or if good cause was established for a request not filed timely. The CGS website includes an Appeals Time Limit Calculator to aid you in determining the timelines of your Redetermination Requests.

The DME MAC Redetermination staff has 60 days to complete a redetermination. If additional documentation has to be requested by phone, the processing time limit is 74 days from the date of initial receipt.

Redetermination Requests

The payee, (i.e., the beneficiary or his/her representative), or the supplier of an assigned claim may complete a request for redetermination, CMS-20027 (05/05) form, which may be obtained on the CMS website at <http://www.cms.gov/cmsforms/downloads/cms20027.pdf>. (A supply of the CMS-20027 form can be ordered by writing to Superintendent of Documents, United States Government Printing Office, Washington, DC, 20402.)

You may also request a redetermination by submitting a completed Jurisdiction C Redetermination Request Form. This form is available on our website at <http://www.cgsmedicare.com/jc/forms> or by the following link:

[Redetermination Request Form](#) (141K)  PDF

If you wish to send a written request instead of using the Medicare Redetermination Request or CMS-20027 form, your written request **must** contain the following elements:

- The beneficiary's name;
- The Medicare health insurance claim number (HICN) 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; and
- The name **and** signature of the person filing the 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 the 120 day timely filing limit. Incomplete requests that are resubmitted past the 120 day timely filing limit will be dismissed.

Additional information that you wish to be considered during the redetermination should be mailed with the written redetermination request. Redetermination requests should be mailed to:

CGS
DME MAC Jurisdiction C
P. O. Box 20009
Nashville, TN 37202

Redetermination requests may also be submitted via fax through our appeals fax line at 615.782.4630. Please be sure to include the Redetermination Request Form with your fax.

Please note that there is a separate fax line for you to use to respond to a request for additional documentation regarding a redetermination request that you have submitted. This fax line is 615.664.5957. Do not send redetermination requests to this number. Only use this number to respond to requests for additional redetermination documentation.

Submitting Appeals for Overpayments

When submitting a redetermination request regarding an overpayment, please be sure to include the following elements in your request:

- A copy of the audit results letter (for example, a notification letter from the contractor who audited your claims, such as the ZPIC, RAC, or Medical Review)
- A copy of the overpayment demand letter (the official demand letter that is issued by CGS or the RAC, containing the total amount of the overpayment, information on where to send payment, and appeal rights)
- Beneficiary's name, date of service, and HCPCS code of the item(s) that you wish to 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 Additional Documentation with the Redetermination Request

When submitting a redetermination request, it is important that you submit all of the facts available concerning the issues involved. All medical documentation must be signed and dated by a health care professional. If the beneficiary has signed an Advance Beneficiary Notice (ABN), please submit a copy of the ABN along with your request. If you received a letter requesting additional documentation on your claim from a Zone Program Integrity Contractor (ZPIC), DME MAC Medical Review, or any other Medicare contractor, always include each item that is listed on the request for additional documentation letter when requesting a redetermination.

The following are category-specific examples of recommended additional documentation that you should submit with your redetermination request. *Note: Please refer to the appropriate Local Coverage Determination (LCD) to determine all documentation requirements for an item.*

Surgical Dressings

- A dated wound evaluation that gives the stage, drainage and size of the wound
The evaluation should be dated within 30 days of the date of service in question.
- A detailed written order from the patient's physician
- For a miscellaneous or not otherwise classified (NOC) HCPCS code: include a detailed description of the item, such as the product name and product number

Urological Supplies

- Nurses notes and patients daily care records
If the patient requires additional quantities of catheters, the reason for the need must be documented.
- Documentation from the patient's doctor providing information about the patient's medical condition, including episodes of pyuria, fevers and/or urinary tract infections

Wheelchairs, Attachments, and Accessories

- Physician's order/Detailed written order
- Physical or Occupational Therapist's notes
- Medical records which explain the need for the wheelchair and each individual accessory
- Manufacturer name and product number, invoice/suggested retail price included in the detailed product description
- Description of the patient's routine activities outside the home
- For code K0005: description of the K0005 features needed compared to the features of a K0004 or K0003 wheelchair and description of the patient's activity levels that warrants the K0005

Prosthetics and Replacement Sockets

- A new order signed by the physician
- Measurements of residual limb changes
- Medical documentation that explains the need for socket replacements or new prosthetic
This information should include any weight changes, level of activity, length of time since amputation, and number of sock plies used.
- Documentation of the prosthesis or prosthetic component replaced, the reason for replacement, and a description of the labor involved irrespective of the time since the prosthesis was provided to the beneficiary

Orthotics

- Detailed written order
- Treatment plan from the physician and supplier
- Documentation about the patient's condition which explains the need for new or replacement orthotics

Pneumatic Compression Devices

- Certificate of Medical Necessity
- Documentation of patient's diagnosis and prognosis
- Symptoms and objective findings, including measurements which establish the severity of the condition
- The reason the device is required, including the treatments which have been tried and failed
- The clinical response to an initial treatment with the device

The clinical response includes the change in pre-treatment measurements, ability to tolerate the treatment session and parameters, and ability of the patient (or caregiver) to apply the device for continued use in the home.

If question #1 on the CMN ("Does the patient have chronic venous insufficiency with venous stasis ulcers?") is answered yes, include the following:

1. The location of venous stasis ulcer(s)
2. How long each ulcer has been continuously present
3. Previous treatment with a compression bandage system or compression garment, appropriate dressings for the ulcer(s), exercise and limb elevation for at least the past six months
4. Evidence of regular physician visits for treatment of venous stasis ulcer(s) during the past six months

If HCPCS code E0652 is billed, include the following:

1. The treatment plan including the pressure in each chamber, and the frequency and duration of each treatment episode,
2. Whether a segmented compressor without calibrated gradient pressure (E0651) or a non-segmented compressor (E0650) with a segmented appliance (E0671-E0673) had been tried and the results,
3. Why the features of the device that was provided are needed for this patient,
4. The name, model number, and manufacturer of the device.

Multiple Ventilators

- Medical records to show the spontaneous breathing time for the patient and to demonstrate the medical need for more than one ventilator

Tracheal Suction Catheters

- Documentation describing the patient's condition and that of the tracheostomy site
- The medical reasons for any increase in catheter usage

Enteral Formula (Special Nutrient Formulas)

- Physician's order
- DME MAC Information Form
- Medical records that adequately document the specific condition and the need for the special nutrient

Parenteral Formula

- Discharge Summaries
- Operative reports
- Fecal/Fat tests
- Evidence of failed tube trials and significant malnourishment

Air Fluidized Beds

- Physician's order
- Current wound evaluation
- Additional documentation that outlines patient's condition, description of other treatments tried, the level of bed confinement, and the possibility of institutionalization in the absence of the bed

Support Surfaces

- Physician's order
- Statement of Ordering Physician
- Medical records that support Statement of Ordering Physician

Infusion Pumps for Dobutamine, Milrinone and Dopamine

- Hospital Discharge Summary
- Inotropic data form (Supplier Manual IX-41.2)
- Cardiac Catheterization report

Power Mobility Devices (PMD)

- The seven element order
- Detailed product description
- A copy of the physician's evaluation performed that resulted in the PMD prescription
- A copy of the face-to-face examination
- Specialty evaluation, if applicable
- A copy of the home assessment

Same or Similar Equipment Denials

- Certificate of Medical Necessity, if applicable
- Physician's order/Detailed written order
- Signed pick-up and delivery tickets
- A detailed outline of events (who provided what and when)
- Clinical documentation that demonstrates any changes in medical need
- Documentation of loss, theft, or irreparable damage, if applicable
This should include an explanation of how damage occurred.

Break In Service Denials

- A description of the patient's prior medical condition which necessitated the previous item
- A statement explaining when and why the medical necessity for the previous item ended
- A statement explaining the patient's new or changed medical condition and when the new need began

KX Modifier

- If the KX modifier is omitted during the initial claim submission and your case is denied, you must submit all supporting documentation with your redetermination request. See the appropriate LCD for the documentation requirements in conjunction with the KX modifier.

Redetermination Decisions

The redetermination decision will result in one of three dispositions:

Affirmation

The redetermination specialist may find the original claim disposition to be accurate and affirm the original disposition. A letter will be sent to the appellant explaining the decision and the grounds on which the affirmation is based. A carbon copy of all decisions will be sent to the beneficiary if the appellant, on an assigned claim, is the supplier.

Reversal

The redetermination specialist may find in favor of the appellant and will take action to reverse the original decision. 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 a letter to the appellant explaining the reason for the partially favorable decision.

Dismissal

The redetermination specialist may determine the request was not submitted timely. The redetermination specialist will dismiss the request and send a letter to the appellant explaining the dismissal.

Appeal Rights for Dismissals

Parties to the redetermination have the right to appeal a dismissal of a redetermination request to the Qualified Independent Contractor (QIC). A party to the redetermination may appeal the dismissal 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 reopening. It is mandatory for the DME MAC to reopen any case that is remanded to it and issue a new decision. The QIC's reconsideration of a DME MAC's dismissal of a redetermination request is final and not subject to further review.

7. Reconsideration – Second Level of Appeal

CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 29, §320

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 claim(s) in dispute before requesting a reconsideration.

The reconsideration process provides a complete reexamination of the information contained in the redetermination case file. 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 adjudication staff has 60 days to complete a reconsideration decision.

Reconsideration Requests

To exercise your right to a reconsideration, you must file a request in writing within 180 days of receiving the redetermination letter. You may request the reconsideration one of three ways:

- Complete the Reconsideration Request form included with the Redetermination letter;
- Complete CMS 20033 Medicare Reconsideration Request Form located at <http://www.cms.gov/cmsforms/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 and signature of the party or representative of the party; and
 - The name of the contractor that made the redetermination.

Your request for reconsideration should be mailed to:

C2C Solutions, Inc.
ATTN: DME QIC
P.O. Box 44013
Jacksonville, Florida 32231-4013

Physical address for overnight mail :
532 Riverside Avenue
6 Tower
Jacksonville, FL 32202

Website: www.C2Cinc.com

8. Administrative Law Judge (ALJ) Hearing Officer – Third Level of AppealCMS 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 \$130.00 or more, you have the right to a hearing before an Administrative Law Judge (ALJ). The request for ALJ hearing must be in writing and must be received within 60 days from the date of the reconsideration. The ALJ hearing may be requested by submitting a written request or by using the CMS 5011A/B form located on the CMS website at <http://www.cms.gov/cmsforms/downloads/cms5011a-b.pdf>.

Requests for ALJ hearings must be filed to the Office of Medicare Hearings and Appeals (OMHA) at the following locations depending on the place of service (for DMEPOS claims, the place of service is defined as the beneficiary’s address of record):

OMHA Field Office Locations**Arlington, Virginia**

1700 N. Moore St., Suite 1600
Arlington, VA 22209
Phone: 866-231-3087

Cleveland, Ohio

BP Tower, Suite 1300
200 Public Square
Cleveland, OH 44114-2316
Phone: 866-236-5089

Irvine, California

27 Technology Drive, Suite 100
Irvine, CA 92618-2364
Phone: 866-495-7414

Miami, Florida

100 SE 2nd Street, Suite 1700
Miami, FL 33131-2100
Phone: 866-622-0382

Field Office Jurisdictions

Field Office	States
Miami, FL Field Office	Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina and Tennessee, Texas, and Virgin Islands
Cleveland, OH Field Office	Connecticut, Delaware, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Puerto Rico, Rhode Island, Vermont, Virgin Islands, Wisconsin, and West Virginia

Irvine, CA Field Office	Alaska, Arizona, California, Colorado, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, Trust Territory of the Pacific, and American Samoa
Arlington, VA Field Office	District of Columbia, Maryland, Virginia

9. 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) decision or dismissal, you may file an appeal requesting the Departmental Appeals Board to review it. To file an appeal, you must request the Departmental Appeals Board to review the order in writing within 60 days from the date you receive the ALJ decision. 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. Favorable or partially favorable decisions will be adjusted for payment within 60 days of receiving the case file from the Departmental Appeals Board.

10. 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 \$1,260.00 or more, you may request a court review of the decision. The complaint must be filed with a United States District Court.

11. Documentation in the Appeals Process

Original claim denials are often upheld at the redetermination or reconsideration level of appeal due to the lack of documentation supporting the medical necessity of services rendered. Before requesting a redetermination or reconsideration, consult this Supplier Manual, the appropriate Local Coverage Determination(s), and/or supplier bulletins on our website at <http://www.cgsmedicare.com/jc/pubs/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.