“CAC” stands for “Carrier Advisory Committee.” It is actually an outdated term, since there are no longer Carriers under Medicare, but the term has stayed in usage. Several years ago, CMS decided that instead of each state having a Carrier which dealt with Part B claims, and a Fiscal Intermediary which dealt with Part A claims, they would combine the responsibilities of each and call them Medicare Administrative Contractors (MACs). One of the bigger benefits to this switch is that the same contractor is working with both types of claims, so one can expect any LCDs they come out with to be consistent for both Part A and Part B claims. Under the old system, a state could have one organization as their Carrier and a different organization as their Fiscal Intermediary, which could at times give rise to inconsistent LCDs.

Note: The following information was taken almost exclusively from the Medicare Program Integrity Manual, Chapter 13, which can be found on-line at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf)

- Purpose of the CAC - The purpose of the CAC is to provide:
  - A formal mechanism for physicians in the State to be informed of and participate in the development of an LCD in an advisory capacity;
  - A mechanism to discuss and improve administrative policies that are within carrier discretion; and
  - A forum for information exchange between carriers and physicians.

- The CAC is not a forum for peer review, discussion of individual cases or individual providers.

- While the CAC shall review all draft LCDs, the final implementation decision about LCDs rests with the Contractor Medical Director (CMD.)

- Membership on the CAC - The CAC is to be composed of physicians, a beneficiary representative, and representatives of other medical organizations.

- Participation in the CAC is considered a service to physician colleagues. Carriers [MACs] do not provide an honorarium or other forms of compensation to members. Expenses are the responsibility of the individuals or the associations they represent.

- Role of CAC Members - CAC members serve to improve the relations and communication between Medicare and the physician community. Specifically, they:
  - Disseminate proposed LCDs to colleagues in their respective State and specialty societies to solicit comments;
  - Disseminate information about the Medicare program obtained at CAC meetings to their respective State and specialty societies; and
  - Discuss inconsistent or conflicting MR policies.

Each specialty shall have only one member and a designated alternate with approval of committee co-chairs. Additional members may attend when policies that require their expertise are under discussion.

Carriers [MACs] have discretion to establish the duration of membership on the committee. The term should balance the duration of time needed to learn about the process to enhance the level of participation and functioning with the desire to allow a variety of physicians to participate. Consider a 2-3 year term.

The CAC shall be co-chaired by the contractor medical director (CMD) and one physician selected by the committee. The co-chairs:
- Run the meetings and determine the agendas;
- Provide the full agenda and background material to each committee member at least 14 days in advance; and
- Encourage committee members to discuss the material and disseminate it to interested colleagues within their specialty and to clinic or hospital colleagues for whom the item may be pertinent. The members may bring comments back to the meeting or request that their colleagues send written comments to the CMD separately.

Attendance at the meeting is at the discretion of the committee members. If the item is of importance to their specialty, encourage members to attend or send an alternate.

The CAC meeting is the primary forum for discussion of proposed LCDs developed by the CMD. The 45-calendar-day comment process required for all LCDs starts when the draft LCD is distributed to the committee members.

Co-chairs present all proposed LCDs to the CAC for discussion. If the need arises to develop and implement LCDs before the next scheduled meeting, they solicit comments from committee members by mail or e-mail.

Location - Carriers [MACs] work with the State medical society and committee members to select a meeting location that will optimize participation of physician committee members.

Frequency of Meetings - a minimum of 3 meetings a year will be held, with no more than 4 months between meetings.

Each meeting should include a discussion and presentation of comparative utilization data that has undergone preliminary analysis by the carrier [MAC] and relates to discussion of the proposed LCD. Carriers [MACs] solicit input from CAC members to help explain or interpret the data and give advice on how overutilization should be addressed. The use of data to illustrate the extent of problem billing (e.g., average number of items or services per 100 patients) might help justify the need for a particular policy. The comparative data should be presented using For more information on AAPM&R MAC activities, please visit http://beta.aapmr.org/advocacy/reimbursement-advocacy/dmepos-racs-macs-and-other-cms-contractor-activity.
graphs, charts, and other visual methods of presenting data. Carriers MACs may present egregious individual provider's data as long as the provider's identification is not disclosed or cannot be deduced.

- **Carriers** [MACs] keep minutes of the meeting and distribute them to members.