# Listening Session on MAC Opportunities to Enhance Provider Experience

**Moderated by: Leah Nguyen**
**January 29, 2020 — 2:00 pm**

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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the feedback session. Today's call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Leah Nguyen. Thank you. You may begin.

## Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS. And I am your moderator today. I'd like to welcome you to this Medicare Learning Network Listening Session on MAC Performance and Request for Feedback on Opportunities to Enhance Provider Experience and Beneficiary Quality of Care. Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL, go.cms.gov/mln-events. Again, that URL is go.cms.gov/mln-events.

Today's event is not intended for the press. And the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the question-and-answer session. If you have inquiries, contact press@cms.hhs.gov.

At this time, it's my great pleasure to introduce our CMS Administrator, Seema Verma, who will provide opening remarks. Administrator Verma.

Seema Verma: Thank you. And welcome to all of you that are participating today. We appreciate you taking time out of your busy day.

Today's call is really an opportunity for us to hear from you, those of you that are on the frontlines. We work a lot with our MACs. And they're our front-end representatives. But we wanted to take some time to hear from providers about the experiences that they're having with MACs as an effort as part of our Patients Over Paperwork Initiative. We want to make sure that we're hearing from providers on the frontlines, things that we can do to strengthen the program and make sure that we're not creating unnecessary burden.

So would appreciate today if you're candid with us, honest and open. We're very eager to hear some of your suggestions and ideas, things that you have concerns about, and any suggestions about how we can improve the program with the eye on our main goal, which is patients and making sure we're putting them first, improving their lives and their health.

So, with that, I would turn it over to the team. Thank you.

Leah Nguyen: Thank you, Administrator Verma. I would now turn the call over to Larry Young, Director of the Medicare Contractor Management Group in the Center for Medicare.

## Presentation

Larry Young: Thank you, Leah. So again, happy to have you all here and welcome your thoughts. The – I'm going to go through our, kind of, the framing presentation here that we'd sent out quickly, because I want – I want to spend most of the time listening to what you all have to say.

So, I'm going to start on slide 2 – actually slide 3 just to cover what we're going to talk about as far as giving a brief overview of what the MACs do, what they do for us, where their jurisdictions are located, how they interact with other Fee-for-Service contractors, give you an idea of the workloads that they deal with, and how we think they are performing from our perspective.

## What is a MAC?

Just really quickly, what is a MAC? So, the MACs are the administrative contractors that we, CMS, contract with to provide all the administrative services for the Medicare Fee-for-Service program. That's as opposed to the Medicare Advantage program. So, people get the folks, sorry, the two confused from time to time.

The – by intent, it's the MACs are intended to be the primary focal point of the Fee-for-Service provider community with the Medicare program. In other words, it's designed to be kind of one-stop shopping to handle all of your needs and interactions with the Fee-for-Service program, as opposed to a kind of fractured experience that we're trying to avoid where people are having to deal with multiple entities.

## Two Types of MACS

There's two primary types of MACs. We have what we call the A/B MACs. They're the ones that are responsible for dealing with all the Part A and Part B providers. We do – we do have another subset we call our DME MAC providers. They deal with primarily durable medical equipment suppliers and whatnot.

There's a – there's another subset of A/B MACs – A/B MACs that we have also dealing with just home Health and Hospice Providers. So that's – you'll hear about them referred to as well. We call them HH+A – HH+H, excuse me, Medicare Administrative Contractors. They are a subset of the A/B MACs.

Roughly – the A/B MACs process roughly 95% of the Fee-for-Service claims. The DME MACs process right around 5%.

## What Do MACs Do?

Moving to slide 6, quickly, just to give you a schematic of what the MACs do at a high level, dealing with the credentialing providers, I know, their enrollment needs, handling provider questions through the customer service lines, processing claims, that's a big part. They also conduct some program integrity functions for us, medical review, for example, hospital audit reimbursement, cost reports, also debt collection and management services.

A key thing to remember is they do not provide the beneficiary customer service function for the community. That's a function handled by 1-800-MEDICARE. Some people confuse the two.

## Primary Functions of the MACS

Moving to slide 7 real quick, just a look at further detail of the activities they handled for us around processing claims, enrolling providers, handling first-level appeals – we call them redetermination requests – medical record review, hospital cost report reviews, education about the Medicare Fee-for-Service billing requirements, establishing local coverage determination policies. They also support a number of our demonstration projects around new payment models coming from our CMMI area and coordinating with other CMS and Fee-for-Service contractors.

## MAC Jurisdictions

Slides 8 through 10 will give you a graphic illustration of the different jurisdictions of the MACs. The first slide is the A/B MACs. The next one is the Home Health and Hospice MACs. Again, they're a subset of the A/B MACs. And slide 10 will give you an illustration of the Durable Medical Equipment MACs.

## The Operational Scale of the MAC Program

Turning quickly to the – give you a sense of the operational scale of that Medicare Administrative Contractor program, they're processing claims and managing the Fee-for-Service program for roughly two-thirds of the entire Medicare population, about 38 million individuals, a little higher now, about 66 percent of the population.

They process more than 1.2 billion claims annually servicing about 2.1 million providers, paying out roughly $400 billion in benefit payments each year, over a billion dollars a day.

## More MAC Program Metrics

On slide 12, gives you a little bit more information around the size of the provider enrollment transactions, roughly 1.2 provider enrollment transactions, 2.8 million first-level appeals. They handle more than 19 ½-million provider telephone calls through their contact centers. Roughly 7.6 of those are handled by customer service representatives. The rest are handled by their portals and call centers. Roughly 700,000 medical reviews and settling around 44,000 cost reports annually.

They do all that for right around a little less than a dollar per claim as using claims as a – as a way to allocate cost necessarily. So roughly, that's around 33 percent less than we spent administering the Fee-for-Service program almost 15 years ago. So, we're processing more and doing it with less, if you will.

## Trends in MAC Performance

On page 13, just to give you an illustration of how we think they've been doing from a performance standpoint in terms of meeting our service-level agreement requirements. We refer to those as our Quality Assurance Surveillance Plan metrics.

You'll see the term QASP score in the left-hand side of the graph. This just illustrates how they've progressed over the last several years and their abilities to meet our service-level requirements.

Over the last 4 years, we've been very pleased with their ability to meet over 90% year-over-year of our program metrics necessarily, which is good from our perspective. But you know, you never want to rest on your laurels. And it's kind of what's brought us here as the Administrator suggested today, is trying to pay attention to the Patients Over Paperwork and ask you directly what are things we could do better under the Fee-for-Service Medicare Administrative Contractor program to make your experience better and enhance beneficiary quality of care. So, with that, I will stop talking and turn it over to you, good folks.

## Feedback Session

Leah Nguyen: Thank you, Larry. During the session, we want to hear your feedback so we can improve our processes and quality of care. Although we do not have subject matter experts on hand to respond to specific questions, you can email them to the resource mailbox on slide 15.

As a reminder, this event is being recorded and transcribed. In effort to get as much feedback as possible, each caller will have a maximum of 3 minutes to provide input.

All right, Dorothy. We are ready for our first caller.

Operator: To provide your feedback, press "star" followed by the number "1" on your touchtone phone. To remove yourself from the queue, press the "pound" key.

Remember to pick up your handset to assure clarity. Once your line is opened, state your name and servicing MAC or state. Please note your line will remain open during the time you are providing your feedback. So, anything you say or any background noise will be heard in the conference. Please hold while we compile the roster. Please hold while we compile the roster. Your first comment comes from the line of Mark Alson.

Mark Alson: Hello. I don't know if I'm live yet. Hard to tell. This is Mark Alson. I'm a radiologist in California in JE with Noridian. And I've been involved with the MAC process for many, many years probably since – oh, god, at least 15 years I've been a CAC representative here in California.

And I understand the concept of wanting to make things like LCDs and the CACs more transparent. But in the process of attempting to make things more transparent, recently, we've actually made them much more opaque and much harder to work with.

It used to be that as a CAC representative, if I had issues, if we needed to discuss an LCD, we could talk directly to our carrier medical directors and we'd be able to get feedback, and we could actually have a medically-informed discussion about the pros and cons of a different coverage or a different policy or a different LCD.

It's very hard to do that now, because now all the MACs are being basically asked to work together, if you will, to come up with policies that are the same. And, so, these CACs are now multijurisdictional CACs that we have to call in to. They're not face-to-face anymore. And it's much harder to get our points across. And it's much harder to be involved.

And when an LCD then comes out, that it needs additional fine tuning. And we call our carrier medical directors. We're basically told that somebody else wrote it from another jurisdiction and everyone kind of has to be the same. And it's a – it's a much more opaque process. It's much harder to get things fixed. We have to put in for reconsiderations.

And it's a lot more work. And it's a lot less taking care of patients now because now, it's just all this extra work to get things done. And it is no longer transparent.

Larry Young: So, Dr. Alson, appreciate those thoughts. I can't tell you – I – I'm thinking you're alluding to the changes we went through with the 21st Century Cures Act, which by intent was designed to be more transparent and whatnot. But those are certainly some good thoughts we'll take back.

But I'd gotten a similar comment last week from another former CAC member, I believe with Novitas. It's something that we do need to look at then as far as the multijurisdictional impact and trying to force people into large CACs, if you will. I think there's a balancing act there that we need to work towards.

Mark Alson: Yes. And if I may make one other comment, I mean that what's happening, unfortunately, because all these MACs are being – working together, these are basically becoming de-facto NCDs. And so, rather than the old LCD or what used to be an LMRPU forever ago when I started, where there are differences in practice in different areas.

California was famous years ago for having Medicare beneficiaries having 100 anal manometries done in L.A., which obviously was clearly wrong. And – or Noridian I think was the MAC at the time, had an LCD specifically for that, which other care – MACs did not need. But you know, if it's all going to be a de-facto NCD, why are we actually even having LCDs?

Larry Young: Thank you, sir. We will take that back to our coverage analysis group certainly. Appreciate it.

Mark Alson: I really appreciate the chance to provide feedback. Thank you very much.

Leah Nguyen: Thank you.

Operator: Your next comment comes from the line of Holly Louie.

Holly Louie: Good morning. Thank you. I have 3 quick comments that I think would greatly help your beneficiaries and your providers. The first is, the October 1 updates to some of the LCDs are still not implemented by your MACs. So, every claim with your instruction to update has not been implemented as yet, which causes a lot of problems for the beneficiaries and for the providers because they are coded correctly consistent with your October 1 update. So, I'm not sure why the MACs can't do that on time.

Second is, I think many of us are concerned because if we do call provider services for assistance with a question either we get totally contradictory answers, or the customer service people for providers really don't know your rules or are able to help.

As an explicit example, multiple people with Noridian jurisdiction Part B told me that incident-to applies to every PA service no matter the site of service or the – or their logic or supervision or anything else. So, they don't understand that in a hospital incident-to for an office is not applicable, and the question was not related to that. That they said that was the CMS position, that every PA service has to be billed incident-to.

And then lastly, there has been another problem with Noridian where a programming whoops is adjudicating patient responsibility versus CO write-offs under certain LCDs. Now, for a billing company, that's an automated process. When that remit hits with those messages, it automatically drops a statement to the patient.

And when the patients are calling Noridian, they're being told that if your provider just coded it correctly, we would pay it. So that's wrong. And it seems as though we should not have to point that out to the MACs that if patients start calling, questioning, surely, the customer service people can look at the remit and notify that there is an error and convey that in addition to the providers who get caught up in this. That's a great inconvenience to your patients.

So those are my suggestions for improvement today. Thank you, Larry.

Larry Young: So very much appreciate that. It – I will ask you we do have a mailbox set up, CMS Listens. It's on the slide deck. And I would invite you please if you could provide me with a little more detail on – particularly around those LCD updates that you mentioned, send in to the mailbox, we can get you – we can dig into that a little more deeply I think, and get you a meaningful response.

Holly Louie: Okay.

Larry Young: Thank you.

Operator: Your next comment comes from the line of Suzy Gua.

Suzy Gua: Hi. I work for a company that owns a long-term acute care hospital in the JJ Palmetto jurisdiction. And my suggestion is that the customer service representatives and that anyone involved with the financials gets additional training on LTAC rules and regulations.

And just for an example, just recently, Palmetto changed all LTACs over to the new payment rules that were effective October 1st. They thought that the new rules were effective October 1st. But they didn't really – they don't go into effect until the beginning of the hospital's cost report year.

And this change made our – it took like 2 months for it to finally get corrected. And it put our hospital in a financial bind. And we finally had to get CMS involved to get Palmetto straightened out. So, any kind of training on LTACs, additional training for LTACs would out – would be greatly appreciated.

Larry Young: Thank you, ma'am. We will take that back. Appreciate it.

Suzy Gua: Okay.

Operator: Your next comment comes from the line of Elvan Eosak.

Elvan Eosak: Hello, and thank you for the opportunity to participate in today's call. I am calling from a national specialty pharmacy. And we cross over 40 states. So, we do business with both Noridian and CGS. They're both a DME MAC.

There's two things that I would just like to provide as suggestions or items that we have come to learn, the first being inconsistent application of the LCDs' rules across the different DME MACs. And then secondly, even more pointed is different application when it comes to one MAC but between one medical reviewer to the next.

It's been a challenge for us to work with the medical record reviewers on that just because we have faced significant and quite often interruptions to patients' continuum of care just because of varying differences in the application of the LCDs.

The second item that I would like to also bring up is the delay in updating LCDs for new prescriptions, new medications, or new J codes that are released. If we could get a more timely update and implementation of the LCDs, I think that'd be greatly beneficial to providers when working with the DME MACs.

Larry Young: Very good sir, we appreciate that. I just – in your question about the application of the LCDs, in the inconsistency, could you give me a little bit of an example there on that?

Elvan Eosak: Yes. So, we – no, we've had to— we'll file over hundreds of reconsiderations and redeterminations. And we've just found that the decisions are not consistent. You know oftentimes they may be contradictory based on one medical record reviewer's input compared to the other. And I have multiple examples I'd be happy to share with the CMS team.

Larry Young: Please do. I invite you again, the CMS Listens mailbox, we would – any detail you could provide would certainly being helpful there. Appreciate you taking the time.

Elvan Eosak: Of course. Thank you.

Larry Young: Thank you.

Operator: As a reminder, to provide your feedback, press "star" followed by the number "1" on your touchtone phone. Remember to pick up your handset to assure clarity. Your next comment comes from the line of Jennifer McLaughlin.

Jennifer McLaughlin: Hi. This is Jennifer McLaughlin with the American Medical Association. Thank you for this listening session. My comment is about some issues that we have heard from a number of specialty societies across the country are starting to see some processing issues regarding the MIPS payment adjustments being either incorrectly included on certain services, such as the Part B drug services, Part B drug reimbursements, or simply not being applied to certain codes while being applied to certain others.

And this was an issue that also occurred last year, the beginning of the 2019 year, when those MIPS payment adjustments were first being applied. And, so, we're seeing some pretty similar problems and issues.

And of course, last year, you know practices were concerned because they had to keep fairly detailed and onerous notes of all of the claim lines that were incorrectly adjusted. And then, potentially, they needed to be repaid or were owed to them, which of course was also an issue.

And ultimately, last year CMS put out an announcement that no practice would have to go through that individual overpayment exercise and that CMS would reprocess them. But wanted to let you all know that we're starting to see a very similar problem this year.

Larry Young: So, Jennifer, we appreciate this. I was going to ask you if you can – if you could send me a couple of examples to look into. I will certainly dig into that with our provider billing group folks to see if there's something that needs to be addressed that we're not already aware of. I suspect we may be. But it's certainly we – some – there's something we need to double check.

Jennifer McLaughlin: Okay. Yes. I'll send you. And I have raised this with a number of CMS colleagues but wanted to make sure that you are also aware on this call.

Larry Young: Okay.

Jennifer McLaughlin: Thank you.

Larry Young: Thank you.

Operator: As a reminder, to provide your feedback, press "star" followed by the number "1" on your touchtone phone. Your next comment comes from the line of Edward Prikaszczikow.

Edward Prikaszczikow: Yes. Thank you for listening to my comments. Yes. This is Edward Prikaszczikow. And I represent the American Podiatric Medical Association and the Health Policy and Practice Committee.

And one of the items that has not been touched on yet is the nurse reviewers, when it comes to prepayment review and review of medical records or on the redetermination appeal. We as providers are expected to know and understand all the Medicare rules, regulations, and policy. But it does not appear that the reviewers are held to the same standards.

And the reason I say that is because there are oftentimes where a certain service or a supply was covered but was inadvertently denied for whatever reason. And, so, when an appeal is made or if this was in a prepayment review, the reviewer has some erroneous information or interpretation on the LCD or the policy article. That then they tend to uphold their opinion, which then causes providers to have to go to the second-level appeal, a process which then of course mandates more work and effort on the – on the part of the provider.

But the point I'm trying to make here is that the reviewer should be held to the same standards as providers in knowing and understanding all aspects of the rules and policies. Another comment I want to make is just to also reiterate what the other commenters have said regarding the customer service representatives giving inaccurate information.

And then the patient subsequently calls the office and tells our office that we had coded it wrong or it should had been covered, we should have done something different. So, I think again, this has to do with education and understanding of the rules and regulations. And I thank you for giving me the opportunity to speak on this matter.

Larry Young: Edward, we appreciate you giving those thoughts as well. I will say if you – for anyone, you know we do have the ability to actually record some of our CSR phone calls. So, anyone ever runs into a situation where they feel like they'd been given inaccurate or conflicting information, they can certainly bring that up to our attention. And we can – we can look into that specifically.

That said, there is always a need and we always strive for making sure our call center folks are consistent and they're well educated. So, we'll take that – take that back as well.

Operator: As a reminder, to provide feedback, press "star" followed by the number "1" on your touchtone phone. That is "star," "1" to provide your feedback. Your next comment comes from the line of Christine Reynolds.

Christine Reynolds: Hi. We'd been having some problems with PECOS and Novitas not communicating properly. The application will say one thing. And the processer will not update it according to what PECOS says. And we've gone back and forth with PECOS as well as going to Novitas.

And specifically, this happens when an address, whether if the provider moves or adds a secondary location. Usually, whenever we're adding a secondary location, there is not a button to add a new location. When you're trying to specify primary and secondary, you have to delete it and then re-add the primary and secondary.

And 90 percent of the time, they delete the primary address and only add the secondary. So, then the secondary address now looks like it's the primary. And Novitas is telling us that it's coming from PECOS that way. And PECOS just tells us to print out and – print out the application before we submit it to Novitas – I mean, to PECOS so that we can prove to Novitas that we're actually submitting it a certain way.

And it just seems like there should be a better way to solve this issue than us having to – I mean, we're having to submit it multiple times whenever there is an – a new address. It just seems like there would be a better way to fix this problem.

Larry Young: So, Christine, thank you for that. The – if you would – if you would care to send that to me in the CMS Listens mailbox, I can take that specifically up. We could – that's certainly not what we want. Sounds like you're bouncing back and forth between the PECOS system and Novitas. And I agree with you.

Christine Reynolds: Yes.

Larry Young: You've got to have a better answer than that.

Christine Reynolds: Okay. Yes. I submitted that there as well. I just wanted to make sure that you guys were aware. I didn't know if maybe you had heard back from them on that yet or not.

Larry Young: I don't believe we have yet. But we're accruing all of these comments and farming them out certainly. But we'll get back to you.

Christine Reynolds: Okay. Thank you.

Larry Young: Thank you.

Operator: As a reminder, to provide your feedback, press "star" followed by the number "1" on your touchtone phone. Remember to pick up your handset to assure clarity. Once your line is opened, state your name and servicing MAC or state. Your next comment comes from the line of Alisa Keith.

Alisa Keith: Good afternoon. My name is Alisa Keith. I'm with the California Hospital Association. I appreciate the agency for making available to providers this listening session. I think this is very complementary to the efforts that you've undertaken as part of your request for information earlier this year around program integrity efforts.

And I just wanted to highlight a couple of areas that we thought would be helpful in this discussion as well. And I also want to thank Noridian in particular for working with the hospital associations like CHA on an effort to improve provider–MAC relationships.

We do have an opportunity on a regular basis to check in, identify issues, and work to try and problem-solve. We recognize we are not always going to agree. But the fact that we have a table to come to and have a conversation and problem-solve together to the best of our collective abilities, I think it has built trust and an opportunity for dialogue.

I am hopeful that these types of dialogues can grow within the provider–MAC community, I think, and be inclusive of CMS. I harken back to the days where we used to have many more forums and roundtables to sit together at, as was alluded to by an earlier commenter where you build shared understanding, vocabulary, and understanding of the other perspective. We have a lot that has changed in revenue cycle, in the audit process, in the accounting side. These are complex issues that are very difficult to articulate in a letter to the agency.

So, one of our comments is really asking for a table – multiple tables to continue to engage in these important dialogues whether it be medical review, provider audit, claims processing issues, LCDs, et cetera.

And we recognize there are opportunities for public comment. But sometimes, having a place to go where you can meet face to face, there's a trust that is built over time. And we'd – and we don't talk past each other. But there really is an effort to have a shared understanding of various perspectives.

The other issue or area that I think the agency has made great strides in is actually on the survey and certification side where you actually made available to providers all the surveyor training that is used for the Medicare Conditions of Participation.

So, providers actually have access to that training. And they understand what surveyors are being taught about the Conditions of Participation. So, if you're new to your job and you don't know a whole lot about them, you can log onto the website and at least view what CMS has taught the surveyors about.

And – but we don't have – that we're aware of, similar types of transparency on the MAC side, with regard to the CMS education of the MACs. And this goes to some of the comments around that have been made related to needing to – seeking accountability and – of our nurse reviewers or claims processers about these complex regulations.

We know there is a lot of education that is done by CMS to the MACs. And that doesn't necessarily translate to the provider. But if we had a place where all this was transparent, I think it would again facilitate that shared understanding.

So, I just want to harken back to that importance of dialogue. And that is also across silos. So, the last comment that I would have is that we are a little bit siloed as you all know. And we are in a – working in a Fee-For-Service world where we are moving towards alternative payment models. And one of the challenges I think providers are feeling as we try and navigate these still very complex Fee-For-Service payment and medical review regulations is that we are also being asked to do and participate in alternative payment models.

And so, to the extent that we have an opportunity to break down some of the silos with various agency staff, bring them all together with MACs so that folks are actually really working in a – in a collaborative way to problem-solve together as we make this transition, because again so much of this still is built on that Fee-For-Service infrastructure.

But as we move to alternative payment models, the silo structure that we have that we are working with becomes increasingly more challenging for a provider to operate.

And, so, as the agency thinks through its next steps, we'd like to be helpful about how we could best streamline that – those efforts as well. Thank you for the opportunity to comment.

Larry Young: Thank you very much for your thoughts. We will take that back.

Operator: Your next question – your next comment comes from the line of Frank Harrington.

Frank Harrington: Hello. My name is Frank Harrington, representing the American Association of Nurse Practitioners. Just want to echo what a lot of the other folks have said today. Really thank you all for hosting these listening sessions. I mean, we've gotten some great feedback from our MAC partners recently.

One of the issues that we've seen popping up occasionally is in the LCD development process, we've seen some instances where local coverage determinations seems to be primarily for diagnostic testing, indicates that the diagnostic test would have to be ordered or performed by a physician.

However, the diagnostic test benefit for Medicare and generally all the Medicare benefit categories are covered when – when provided by a nurse practitioner if they'd also be covered by a physician and if the NP is authorized to do that under state law, perform that test or that service.

And we would just ask that that language would be standardized throughout the LCD development process. We've seen many LCDs that are developed with that language in mind using terms like treating clinician or understanding physicians and other qualified providers.

So, we want to just ensure that as these are developed, they're not done in a way that would prevent nurse practitioners from performing services they are authorized to perform under state law, and which are generally covered by the Medicare program.

Larry Young: Frank, thank you for that. I will – I will certainly take that back.

Operator: As a reminder, to provide your feedback, press "star" followed by the number "1" on your touchtone phone. Remember to pick up your handset to assure clarity. Once your line is opened, state your name and servicing MAC or state. Your next comment comes from the line of Claudia Parrales. Claudia, your line is open.

Claudia Parrales: Hi. My name is Claudia Parrales, Compliance Manager at Synergy Orthopedics, DME supplier in Eastern Pennsylvania. Thank you for the opportunity for us to call in and give our feedback and our thoughts and experience with the – with the service.

One of the things that I wanted to remark was kind of going back to one of the caller's experience between the disconnect and between MAC and Palmetto and PECOS. There seems to be a disconnect between the communication.

If there's any issues in terms of updating our credentials or updating our information, we can get verification from Palmetto and PECOS. And then MAC may not be seeing that information. And we keep getting thrown back and forth between one and the other without having anybody help us find the resolution.

One, Palmetto can say the information is updated. We go back to MAC, and we can't speak with anybody in regards to if they are seeing their correct information, if they're not. Customer service is not trained enough to or cannot – does not have access to the database to see our information. But, yet, supervisors are not available to be able to provide that support either.

We say we're going to get a call back. To this day, no calls yet. So, there's really nobody that we can speak with that can help us with certain processes in terms of our update of credentials.

The other thing that I wanted to mention was in terms of the LCD. There are certain specific details that when we have experience reviews through audits that we are being held accountable for certain details on the medical documentation that it's not specifically that married in the LCD. And, so, when we have asked, they just give us some information about what their expectation is. But it's not really in the LCD.

An example of that is for [inaudible] that they require 30 days for surgical or injury. In the LCD, it really doesn't say 30 days. But they go back and they request that that is the standard that we have to follow when it's not outlined. And there are still other circumstances like that.

So I just wanted to make sure that I voiced my thoughts on – in needing the assistance and that the LCD is also updated timely that meets when they expect us to fulfill those standards, and that if we are being held accountable to certain documentation requirements, that it is specifically detailed in the LCD. That's all I – and so I thank you at – again, for the opportunity to give our thoughts about what we are experiencing.

Larry Young: Claudia, we appreciate you taking the time. I would – again, for you as well, if you would like to send me some details around that, particularly around the bouncing back and forth between PECOS and the MAC and not being – not being able to get a resolution there, I mean, certainly we want to make sure we're doing what we can on our end to make sure our CSRs have the information that they can help resolve things for you. If you have any more details about that specific situation that you would – could send me to the CMS Listens mailbox, we'll look into it further.

Claudia Parrales: Sure. Thank you. Have a nice day.

Larry Young: You too.

Operator: As a reminder, to provide your feedback, press "star" followed by the number "1" on your touchtone phone. Remember to pick up your handset to assure clarity. Once your line is opened, state your name and servicing MAC or state.

And there are no further questions at this time. I will turn the call back over to you, Leah.

## Additional Information

Leah Nguyen: Thank you. An audio recording and transcript will be available in about 2 weeks at go.cms.gov/mln-events. Again, my name is Leah Nguyen. I would like to thank our presenters, and also thank you, for participating in today's Medicare Learning Network listening session on MAC Opportunities to Enhance Provider Experience. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters please hold.