CMS-1533-P-101 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Jane Gurley **Date & Time:** 06/05/2007

Organization : Jane Gurley

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

My husband David Gurley is a brain tumor patient with glioblastoma multiforme, and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!
Jane Gurley
1703 Haywood Rd.
Hendersonville, NC 28791

CMS-1533-P-102 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : sharon klawansky **Date & Time:** 06/05/2007

Organization : sharon klawansky

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a family member of a brain tumor patient, and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-103 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : **Date & Time:** **06/05/2007**

Organization :

Category : **Individual**

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am a friend of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter

CMS-1533-P-104 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Douglas Mault **Date & Time:** 06/05/2007

Organization : Mr. Douglas Mault

Category : Individual

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am the father of a young woman with a malignant brain tumor and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-104 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Douglas Mault **Date & Time:** 06/05/2007

Organization : Mr. Douglas Mault

Category : Individual

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am the father of a young woman with a malignant brain tumor and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-105 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : alice foster **Date & Time:** 06/05/2007

Organization : alice foster

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

as a family member who has lost a brother to brain cancer and a nephew who is dying from the same brain cancer, I beg you not to make any changes. We need all the help we can get to give patients a chance to live.

CMS-1533-P-106 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Dr. Barry Kanner **Date & Time:** 06/05/2007

Organization : White Plains Hospital

Category : Radiologist

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a friend of a brain tumor patient as well as an interventional radiologist and I would like to request a change to the structure of proposed MS- DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

AS AN INTERVENTIONAL RADIOLOGIST, I AM ACUTELY AWARE WHAT A DIFFERENCE CUTTING EDGE TECHNOLOGY CAN MAKE IN THE TREATMENT OF MOST MEDICAL CONDITIONS. THIS MUST BE A PRIORITY - YOU NEVER KNOW WHEN IT WILL BE YOU OR A LOVED ONE THAT WILL NEED IT!

Thank you for your consideration of this important matter!

CMS-1533-P-107 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Michael Mroz **Date & Time:** 06/05/2007

Organization : Michael Mroz

Category : Individual

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

This is a very important treatment for many afflicted with brain tumors.

CMS-1533-P-108 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Jill Contreras **Date & Time:** 06/05/2007

Organization : Mrs. Jill Contreras

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a wife of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-109 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Miss. Jennell Hedges **Date & Time:** 06/05/2007

Organization : Miss. Jennell Hedges

Category : Nurse

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am a daughter of a brain tumor patient and a registered nurse, and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

Sincerely,

Jennell Rene Hedges

CMS-1533-P-110 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Lavenia LaGrone-Koi **Date & Time:** 06/06/2007

Organization : Mrs. Lavenia LaGrone-Koi

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a caregiver of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-111 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Jennifer McAuliffe **Date & Time:** 06/06/2007

Organization : Ms. Jennifer McAuliffe

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-112 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Daniel Monsowitz **Date & Time:** 06/06/2007

Organization : Daniel Monsowitz

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am a friend of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-113 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Marilyn Kinsey **Date & Time:** 06/06/2007

Organization : Marilyn Kinsey

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a sister of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter! Glioblastoma is a near hopeless diagnosis for survival beyond a year - we need every treatment option available until a cure is found.

CMS-1533-P-114 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Elnora Morgan **Date & Time:** 06/06/2007

Organization : Mrs. Elnora Morgan

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am the wife/caregiver of a brain tumor victim. I'm opposed to the change to the structure of MS-DRG 23 and MS-DRG24. The proposed titles do not include the costs of implantation of Gliadel Wafer. This is standard treatment of malignant brain tumors. You must continue to cover the Gliadel Wafer and other drugs that are being developed to treat brain cancer. These poor patients should not be denied their access to treatment because of a change in wording your MS-DRG's. I'm also addressing my concern to my congress representatives.

CMS-1533-P-115 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Laura Tayerle **Date & Time:** 06/06/2007

Organization : Mrs. Laura Tayerle

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am the friend of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-116 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : **Miss. Tina McIntire** **Date & Time:** **06/06/2007**

Organization : **Miss. Tina McIntire**

Category : **Individual**

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Please do not recode the using of Gliadel under Medicare

CMS-1533-P-117 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Kelly Meyer **Date & Time:** 06/06/2007

Organization : Mrs. Kelly Meyer

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

We should all have the opportuntity for the best care reqardless of anyone's situation. We have the right to the best treatment, and also be informed of all the treatments available regardless of our situation.

Submitter : Annemarie Brownmiller **Date & Time:** 06/06/2007

Organization : Annemarie Brownmiller

Category : Individual

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am the wife of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

Annemarie Brownmiller

CMS-1533-P-119 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Kelly Miller **Date & Time:** 06/06/2007

Organization : HCR-Manor Care

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a friend of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-120 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : **Ms. Cynthia Baumberger** **Date & Time:** **06/06/2007**

Organization : **Ms. Cynthia Baumberger**

Category : **Individual**

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a concerned citizen, and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-121 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. meryl linder ledwitz **Date & Time:** 06/06/2007

Organization : Mrs. meryl linder ledwitz

Category : Consumer Group

Issue Areas/Comments

MGCRB

MGCRB

i am a brain tumor survivor and it is necessary to implant gliobel during surgery and have medicaire cover the expense

CMS-1533-P-122 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Dr. john busch **Date & Time:** 06/06/2007

Organization : Dr. john busch

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24__I am a family of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.__You propose the following titles for these MS-DRGs:__MS- DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC __MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC __I would like to suggest that the DRGs be restructured so that their titles are the following: __MS- DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant __MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC __Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors. __When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!) __The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS- DRG 23, even without a MCC. __Thank you for your consideration of this important matter!

John Christian Busch
200 s. Tremont dr.
Greensboro, nc 27403

CMS-1533-P-123 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Faith Teeple **Date & Time:** 06/06/2007

Organization : Faith Teeple

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

As the mom of a son terminally ill with a son with brain tumors, I am asking that you change the structure of the proposed MS-DRGs 23 and 24 so that ALL craniotomy cases that involve the insertion of the chemotherapeutic agent (ICD-9-CM procedure code 00.10) be assigned to MS- DRG 23.

The following titles are proposed for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

To best serve and meet the needs of brain tumor patients please restructure the DRGs so that their titles are as follows:
MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Your proposed titles do not seem to be aware of the tremendous costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered one of the primary standards of care for treatment of malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, access to this standard of care will be lost. Please correct this by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

More and more Americans are getting brain tumors; little monies are devoted to research and treatments...this is one area where you can help brain tumor folks. Please make the changes and let Medicare continue its good work to help a medical population that is sorely neglected despite the efforts of many brave doctors fighting to save their patients...thank you, faith teeple

CMS-1533-P-124 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Jimmy Fang **Date & Time:** 06/06/2007

Organization : Central NJ Brain Tumor Support Group

Category : Individual

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

My name is Jimmy Fang and I reside in Princeton, NJ. I am 33 years old and have been fighting GBM grade IV since October 2005. I underwent two left frontal lobe craniotomies (October 2005 and February 2006). At the time, Gliadel and other high-tech drug delivery systems/implants were not covered under my health insurance plan. I often wonder if I had access to Gliadel after my first surgery, if the tumor would have grew back three months later requiring another surgery. Unfortunately, after my second craniotomy all of the tumor could not be removed. I am currently taking oral chemotherapy and working hard through exercise and healthy living in the hope that one day I will get a clean MRI! Although, my prognosis weighs heavily on my mind, I will never stop believing that I am the one who will prove the statistics wrong. Eventually, my body will become resistant to my current chemotherapy. I would greatly appreciate it if you could promote access to new delivery systems/implants to treat brain tumors. I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for

such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter and allowing access to brain cancer drugs with high-tech delivery systems/implants so that I have the opportunity to live my best life!

Best regards,

Jimmy Fang
jimmyfang74@yahoo.com
Member of the Central NJ Brain Tumor Support Group
U.S. Army Reserve (353D Civil Affair Command) 1994 to 2000
World Wide Civil Affairs Soldier of the Year 1997
Running in the ING NYC Marathon, November 4th 2007.
Fighting GBM grade IV since October 2005 and I am still happy and hopeful!

CMS-1533-P-124-Attach-1.PDF

#124

He only sees the life ahead

Grad tries to beat cancer odds

By CATHARINA EVANS
SPECIAL TO THE TIMES

PRINCETON BOROUGH — While his fellow Rutgers University graduates consider their budding careers this month, Jimmy Fang will be thinking of new ways to keep taking pleasure in his life, which doctors say will last only another few months because of an aggressive tumor in his brain.

For the moment Fang is not dying of brain cancer — he is living with brain cancer.

Fang began to complain of headaches in October 2005. The ultra-fit athlete, who said he rarely catches colds, had little idea his continual headaches were a sign of something sinister. Being cautious, Fang went to the Robert Wood Johnson Hospital emergency room and described his symptoms to a physician. What was intended to be a short precautionary visit turned into a weekend-long stay at the hospital, where Fang underwent several CAT scans and MRIs.

Fang was told he had a malignant tumor the size of a small orange in his brain which had to be immediately removed.

"I was shocked," said Fang. "But it was a silent shock. I thought, OK, I'll deal with this. But as with any surgery on the head, it was quite scary."

Within a month of his diagnosis, Fang endured a complex and risky surgery that removed the cancerous mass. Three weeks later, Fang was working out at his local health center and eager to get back onto the tennis court, a sport he plays with real passion.

"I told him he couldn't play tennis with staples in his head," said Debbie Persaud, Fang's longtime girlfriend. "He wanted to get right back out there on the court."

Fang had little time to recuperate before his doctors discovered a second brain tumor, just three months after his initial surgery. Fang ultimately was diagnosed with a rare brain cancer called glioblastoma multiforme, the most aggressive form of all primary brain cancers. Fang is

See FANG, A4

FANG

Continued from Page A3

afflicted with a grade IV tumor, the type that grows the most rapidly. Mean survival after diagnosis is six to 10 months, with less than 10 percent survival after two years.

Fang underwent his second craniotomy in February. A month later he completed his bachelor of arts studies in computer science at Rutgers University. It never occurred to him to stop going to class or to even notify his professors of his condition.

"I had done really well in the beginning of the semester, so I just had to pass my classes in order to graduate," Fang said. "I am the only member of my family to have graduated high school and college."

Fang last month completed 42 consecutive days of chemotherapy in conjunction with 30 days of radiation in hopes that the treatment would retard the growth of his current tumor.

A native of China and lover of ethnic cooking, the only complaint Fang had about enduring chemotherapy five days a week was that his taste buds weakened and he no longer found enjoyment in traditionally spicy foods.

While he waits for the day he receives a clean MRI, Fang is happily honing his tennis skills, spending time with his girlfriend and occasionally going on job interviews. Although his prognosis weighs heavily on Fang's mind, he believes he will be the one to prove the statistics wrong.

"You don't know who is going to break that barrier," Fang said. "I could be the one. I will never stop believing I may be the one."

To celebrate Fang's graduation, he and Persaud are traveling to California, where they are looking forward to indulging their love of sushi at a favorite West Coast restaurant and enjoying the sun at the beach.

"We are a team," said Persaud. "Don't worry about us — we got this."

STANLEY BRICK/THE TIMES

Girlfriend Debbie Persaud gives Jimmy Fang a kiss on his shaved head in their Princeton Borough home.

STANLEY BRICK/THE TIMES

Persaud and Fang get ready to have dinner together in their

CMS-1533-P-125 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : JILL HORSLEY **Date & Time:** 06/06/2007

Organization : JILL HORSLEY

Category : Individual

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a friend of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.
My friend was diagnosed with a brain tumor in February of 2007. He had surgery on March 19th. The tumor was far worse than his doctor had

suspected. The family was called into conference within a half hour of surgery. This is when we were informed about the severity of the tumor. His doctor told us of a procedure where they placed a chemo wafer directly into the area where the tumor was removed. We later discovered this was the Gliadel wafer. I thank God this procedure was made available to Mercy Medical, and to the doctors and their patients who desperately need it. Please do not interfere or change the structure of the DRG□s Leave this in the hands of our wonderful doctors who treat these patients and work so hard at saving lives.

Thank you for your consideration of this important matter!

Sincerely,

Jill Horsley

CMS-1533-P-126 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. shannon rinestine **Date & Time:** 06/06/2007

Organization : Ms. shannon rinestine

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am against the plan to stop offering Gliadel Wafers to brain tumor patients.

CMS-1533-P-127 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Nancy Vassallo **Date & Time:** 06/06/2007

Organization : Mrs. Nancy Vassallo

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am a nurse of, a brain tumor patient,and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

Nancy Vassallo, RN, CNRN

CMS-1533-P-128 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Nancy Payne **Date & Time:** 06/06/2007

Organization : Allina Hospitals and Clinics

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-1533-P-128-Attach-1.DOC

#128

Allina Hospitals & Clinics
Compliance and Regulatory Affairs
PO Box 43 Mail Route 10105
Minneapolis, MN 55440-0043

ALLINA.
Hospitals & Clinics

June 6, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1533-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Proposed Rule. (*Vol. 72 No. 85 Federal Register, May 3, 2007*)

Dear Ms. Norwalk;

On behalf of Allina Hospitals & Clinics (Allina), I appreciate the opportunity to comment on the proposed changes identified in the 2008 Proposed Inpatient Prospective Payment Rule. Allina is a family of urban and rural hospitals, clinics, and care services that believes the most valuable asset people can have is their good health. We provide a continuum of care, from disease prevention programs, to technically advanced inpatient and outpatient care, to medical transportation, pharmacy, durable medical equipment, home care and hospice services. Allina serves communities around Minnesota and in western Wisconsin.

Allina supports meaningful improvements to Medicare's inpatient prospective payment system. The system should be simple, predictable and stable over time. A base requirement is the ability to estimate payments in advance to inform our budgeting, staffing, marketing and other operational decisions. We are concerned that CMS continues to project the expectation of payment reform and enhancements without creating and providing the underlying data, in detail, to support their conclusions. It is imperative that these changes be analyzed and reviewed for greater clarity to ensure that the resulting actions are both accurate and reasonably necessary to bring the intended payment system reforms. This review demands more time and requires that implementation be managed effectively to assure data accuracy and integrity.

Although this proposed rule calls for a 3.3% market basket update, CMS has essentially eliminated out any favorable financial impact with the proposed implementation of the 2.4% reduction for behavioral adjustment and the reductions to capital IPPS payments for large urban hospitals. We have grave concerns about the major changes CMS has proposed and are impaired in completing a

rigorous analysis of specific organizational impact due to numerous issues with the limited data presented and the lack of detail to review specifically how the MS-DRG program will impact the financial stability of our hospitals.

Our major recommendations are included below with further discussion of our key points in the text that follows.

- **Broader testing of the MS-DRG Classification System:** Additional analysis must be performed and made available to the public so that consistent understanding is gained regarding the variation within MS-DRGs. The interplay of major systems and implications for systems integrity must be tested more broadly to guarantee a smooth transition to a more complex structure.
- **Four-year Transition:** Given the magnitude of payment redistribution across MS-DRGs and hospitals, any changes should be implemented with a four-year transition to diminish the effect of payment implications in any single year and to support effective implementation.
- **Valid Cost-based Weights:** We support the continued progression to a DRG-weighting methodology based on hospital specific costs rather than charges, but the CMS method utilized is flawed.
- **Hospital Acquired Conditions:** Allina supports the use of quality data and the value based purchasing program as the vehicle to impact reimbursement for truly hospital acquired conditions that meet the mandated criteria. CMS should begin with a very small set of conditions that do not require use of the present on admission indicator.

DRG Reclassifications

We are concerned that CMS GROUPER Versions do not use all diagnoses and procedures that affect a patient's severity of illness and/or the resources utilized. The current GROUPER only considers nine diagnoses and up to six procedures. Allina hospitals submit electronic claims in the HIPAA compliant electronic transaction 837i standard format that allows up to 25 diagnoses and 25 procedures. However, our fiscal intermediary (FI) does not store or record these additional fields since they are not necessary to group claims under the current DRG system. These data elements have been provided to the FI and subsequently are edited out of the system. Capturing all diagnoses and procedures meeting the definitions of reportable secondary diagnoses and procedures will provide a more complete picture of patient complexity.

We currently code to the highest level of specificity and question the validity of the CMS perception that up-coding may become an issue and therefore stop gaps need to be installed. How will we validate that the severity is real and not just a perception when the data is deleted from the current system by the FI? This issue must be addressed prior to the implementation of a severity adjusted DRG payment structure.

We understand that CMS does not see the need to address the implications of the DRG restructuring and GROUPER versions for non-government payers, however, when over 70% of our business uses Medicare payment methodology it is vital that we consider the implications. The intensity of our concerns with the proposed changes in this rule is based upon the impact to our entire business and not just limited to the traditional Medicare population we serve.

DRG Reform and Proposed MS-DRG's:

We appreciate that CMS listened to our comments from last year and went ahead with an external review of all options being considered for DRG restructuring. However, we feel very strongly that is it inappropriate for CMS to go ahead and propose the implementation of the MS-DRG program without providers having full access to the final RAND assessment and analysis. We have reviewed the RAND study and appreciate the thorough analysis done on the other 4 options. However, we are gravely concerned that CMS would consider going ahead with the MS-DRG program in the absence of the same level of analysis.

We support the change to a system that will address severity of illness but do not support the implementation of MS-DRGs as a temporary solution. We are concerned that following the full RAND assessment and analysis of the proposed MS-DRG system, in light of today's health care environment, that CMS would see the need to propose a different program in the short term. Since this creates major implications for organizations, we ask that CMS is diligent in completing the depth of due process required for a change of this magnitude. CMS should be prepared to commit to MS-DRGs for the near future but build in the time hospitals will need to be adequately prepared for this significant change.

We fully understand the timing challenges in getting a proposed rule published but have major issues with our limited ability to complete the complex financial analysis this major change requires.

Integrity of Systems

We recommend that prior to implementation of any change in the DRG structure; there should be a testing period to guarantee systems integrity. As a test site for APC implementation, we understand the significant value of testing on a small scale. We were able to identify a number of systemic issues that further delayed implementation until August 1, 2000. Additionally, there are a number of major system changes that are scheduled to be implemented in the near future, such as value based purchasing, national provider identifier (NPI), present on admission indicator, ICD-10 coding, and transition to the MAC contractors, that may have significant impact on our cash flow if systems issues occur that must be addressed. Couple these major system stressors with the implementation of an electronic health record and we could see systems stretched so tightly that we experience chaos.

It is imperative that CMS assess the impact of implementing all of the major regulatory changes in conjunction with a severity-adjusted DRG system.

Implementing ICD-10

We support AHIMA's May 10, 2007 testimony before the Ways and Means Committee calling for implementation of ICD-10-CM and ICD-10-PCS. Implementing a more refined DRG system can only be accomplished with more specific clinical classification systems, capable of painting a more complete picture of a patient's condition and the services provided to treat that condition. Implementing the MS-DRG system with a coding system that is already ineffective in capturing severity of illness is a mistake. CMS should not implement the proposed MS-DRG system until we have a coding system that can capture the level of specificity required to reflect true patient severity of illness.

We are concerned about the ability of CMS to implement add-on payments for new services and technologies in the near future. Recognizing new technology in a payment system

requires that a unique procedure code be created and assigned to recognize this technology. We are experiencing significant challenges with coding of new technology. The ICD-9-CM classification system is close to exhausting codes to identify new health technology and is in critical need of upgrading. Since the early 1990s, there have been many discussions regarding the inadequacy of ICD-9-CM diagnoses and inpatient procedure classification systems. ICD-10-CM and ICD-10-PCS were developed as replacement classification systems. CMS should work toward implementation of ICD-10 as a necessary means to handle codes required to support billing for new technology.

Proposed Medicare Severity Adjusted DRGs

While we appreciate the movement to capture the most complex cases with a major CC, we are concerned about the significant number of DRGs where CC's no longer exist. This has the potential for major financial impact to all of our hospitals, both urban and rural. Further analysis must be undertaken to assess the true impact of the secondary diagnosis subclass assignment and modifications. After completing a high level review of the potential impact of the case mix changes for our facilities we are deeply concerned about the number of DRGs that will take double digit reductions. We believe that CMS should follow the "no more than 5% reduction" rule that was implemented last year to mitigate the significant reductions in the DRG revisions finalized for 2007.

We disagree with the logic that CMS uses to eliminate chronic conditions from the CC list. Patient care resources are utilized to prevent acute exacerbation of a chronic condition. To not include these conditions on a CC list until they are acute is a major flaw in logic. We support inclusion of chronic conditions on the CC list as means to recognize the resources utilized to manage these conditions effectively whether they are currently in an acute phase or not.

Transition

We recommend that a four-year transition plan is provided blending old DRG weights and the new DRG weights. In the first year; emphasis should be on preparation for and testing of the new payment system, with no payment changes. This would give hospitals time to implement and test the new system and adjust operations and staffing for predicted revenues. This will also allow CMS, vendors and state agencies to train fiscal agents, and to incorporate changes into respective software and information systems. For FY2009, DRG weights should be computed as a blend derived from one-third MS-DRGs and two-thirds from traditional DRGs. In FY2010, DRG weights should be computed as a blend of two-thirds from MS-DRGs and one-third from traditional DRG's. In FY2011, DRG weights should be derived using only MS-DRGs. The weights could be established by CMS running the current GROUPER for 2008 without any changes to the CC list to establish where cases originated and running the new GROUPER from 2009 with the new CC list, then blending the two weights based on the schedule noted above.

We further believe that a stop loss should be instituted as part of this transition. This would be similar to the approach currently used under the Inpatient Psychiatric PPS whereby no hospital can receive less than 70 percent of what they would otherwise have been paid under the old system. In combination with the DRG blend or dampening, this would result in less significant losses in the first year than in the last year of the transition.

DRG Relative Weight Calculations

Allina supports MedPAC's recommendation to move to a cost-based relative-weight methodology based on an individual hospital's claims and cost data for the purpose of weighting MS-DRGs. However, we strongly oppose the methodology that is being implemented and believe that it is fatally flawed for the following reasons:

Data Integrity

The data is not based on hospital-specific cost but rather a national geometric mean ratio. In order to determine a hospital-specific cost each hospital's PS&R crosswalk, which is submitted with the filed cost report as an attachment to the CMS 339 form, would need to be used. The proposed formula derives a national average charge based on all hospitals being weighted equally. This affects hospitals that have historically been low charge states, such as Minnesota, negatively and allows a small rural hospital to carry the same weight as a large, urban hospital.

The data that is being used is out-dated and does not include the cost of new technology that is commonly used today. In order to accurately determine the DRG weights and reimbursements these costs need to be included in any analysis that is being performed.

CMS is omitting in excess of 25% of the costs from "high cost" hospitals from the cost base, while leaving in all of the charges from those same "high cost" hospitals and assigning a relative value on reduced costs. Since the costs are being excluded, but not the charges, there is a corresponding mismatching of revenues and costs.

The data contains only audited data. Hospitals that have not been audited would not be included in the data.

Cost Centers

CMS currently aggregates charges into 13 cost centers, with a proposal to expand this to 19, for each DRG, then applies a national cost-center level CCR (derived from the cost reports) to charge figures (from claims data). The use of two different data sources creates a flawed methodology. Please note that because hospitals often report charges on the cost reports differently than charges on the claims, the cost-center level CCRs are calculated based upon a different set of charges than the charges to which the CCRs are later applied. For example, revenue code 480 Cardiology could be reported on cost report line 53 EKG or as a subscript to line 37 if the hospital has a Cardiac Cath Lab.

Therefore, it is impossible to make assumptions related to revenue codes across all hospitals without the assistance of the PS&R crosswalk. We believe this may materially distort the DRG weights and needs to be thoughtfully considered and accounted for in any methodology. If CMS is going to continue the transition to cost-based weights, regardless of the methodology, hospitals will need time to align their mapping of cost centers into departments or cost categories for purposes of cost reporting with that of claims reporting.

CMS has provided no detailed analysis to validate that the proposed changes result in better payment policy. While measuring improved payment accuracy is difficult, the large degree to which the weights fluctuate given methodological changes alone indicates the need for further analysis and study. CMS should construct a process to test the sensitivity of weights

to various methodological assumptions and publicly share the resulting data and reports. CMS should strive for creating a system that improves payments based on data that does not include the obvious flaws listed above.

Behavioral Adjustment Factor

CMS has noted that case mix index (CMI) can be impacted by a number of changes including admitting and treating patterns, costs of services provided, shifts in where services are provided and changes in documentation. CMS uses only "changes in documentation" as the means to support the 2.4% payment reduction as a behavioral adjustment. There is no precedent in other payment systems for making a prospective adjustment of this magnitude without evidence of actual changes in coding. There is no empirical data to support this significant reduction in payments. MedPAC identifies that there is a 3 year time lag between the implementation of a new payment structure and true improvements in documentation and coding, therefore CMS should delay implementing any behavioral adjustment until data exists to substantiate the need for a reduction.

We currently code to the highest level of specificity and report all 25 diagnoses and 25 procedure codes on our electronic claims, of which 16 diagnosis codes and 19 procedure codes are dropped from the data by the FSS system. CMS should not assume that "upcoding" needs to be addressed when we currently code to this level but should address the systems issues that disallow contractor systems from utilizing all of the codes we report.

We vehemently oppose this backdoor budget cut as it will further deplete scarce resources, ultimately making our mission of caring for patients even more challenging. CMS is not mandated by law to impose a behavioral offset in the IPPS regulation, yet, has chosen to do so. These draconian cuts in reimbursements, in the absence of solid data justification, will impose an added burden on all hospitals. Most hospitals operate on very thin margins and may be forced to reduce services. This unnecessary payment reduction could have a significant impact on access to necessary services for Medicare beneficiaries.

Capital IPPS

The proposed rule would freeze and/or eliminate altogether reimbursements to large urban hospitals for capital related costs of inpatient hospital services. The double hit our large hospitals would experience is of grave concern. Payments of this magnitude would make it difficult for our hospitals to purchase advanced technology and equipment and would slow clinical innovation in the hospitals most likely to conduct cutting-edge research. Additionally, freezing capital payments would stall the much needed health information technology and jeopardize the long-term commitments we have made to capital acquisitions in support of the electronic health record.

The CMS shift from fee for service to value based purchasing is predicated on our ability to improve the quality and efficiency of care through technological advances, including health information technology. In cutting these capital funds, CMS is acting against Federal and State efforts to support expansions of the electronic health record as a major vehicle to improve the quality and efficiency of care.

The rationale that CMS presents in the proposal to eliminate the large urban capital add on payment doesn't make sense. The large urban centers have become the locations of service for many high technology diagnostic, treatment, and surgical procedures. To cut the capital funding in the locations where the purchasing of the equipment and new technology is greatest is illogical. We are

very concerned about the reduction in the capital portion of the IPPS payment structure and feel strongly that CMS should reconsider this proposed change and the impact it will have on the large urban center's ability to provide the tertiary level of care that is expected.

IME Adjustment

We do not support the proposed change to exclude vacation and sick leave from the total resident time to account for an FTE. This proposed change is operationally impractical. We recommend that CMS treat sick leave and vacation the same as it proposes to address orientation time. We do not believe that it is necessary for CMS to break down each hour of resident's time when the vast majority of time that is counted in the FTE is related to patient care. We see this as a means for CMS to reduce our FTE counts and create additional administrative burden when it is not necessary.

Hospital Quality Data

We appreciate and support the focus on quality but feel strongly that CMS does not understand the resources and internal systems requirements not only to report but to actually do the work of improving care. The number of measures is growing too quickly, from 10 to 21 to 27 to 32 in 4 year's time, without any recognition for the work it takes to report **and** improve care. While we appreciate the full year notice for new measures, we are very concerned about the number of new measures being added each year. CMS must consider what it means for hospitals to garner the resources necessary to assess and improve care processes and to influence clinical practice changes to align with the evidence.

Please understand the implications of the implementation of the MS-DRG program on quality reporting. The changes in titles and DRG numbers will create significant work to modify systems and reports to align appropriately with the new system. We have major concerns that we will do all the work to create this alignment and then be faced with making changes again next year if CMS decides that MS-DRG's will not be the right infrastructure in the long term. MS-DRG's do not only impact the payment system but also the care providers who are being tasked with the quality challenge and also need to be fluent in this documentation and payment language.

We fully support mortality rate reporting and would like to see additional diagnoses included. Our hospitals would appreciate receiving reports on a quarterly basis to further inform our care improvement efforts.

As CMS is moving forward in the development of the value based purchasing program we ask for stability in the measure set. As we work to enhance our electronic health record to support good care and mitigate the administrative burden of reporting, we find ourselves in a continual reactive mode versus being able to be planful. While we support the appropriateness of the measures slated for 2009, we are concerned about the rapid expansion of the measure set. It feels like CMS is trying to get as many measures implemented as fast as it can before the commencement of a value based purchasing program. Please stop and allow the system to stabilize before we move into a pay for performance structure. We request that you do not add the additional measures slated for 2009.

We support the attestation process for the new 2008 SCIP measures.

Patient Safety Measures

It's important to reflect on the underlying reason for the proposed changes in this section of the rule, physician–owned specialty hospitals. The safety concerns that have been raised result from

physician-owned specialty hospitals that operate outside of the traditional network of care delivery. They are free standing facilities, are generally not part of a larger system of care, most often have no transfer agreements and tend to specialize in one type of care delivery, challenging their ability to treat unexpected events or emergencies. It makes no sense to apply these special requirements to all hospitals.

Disclosure of Emergency Services Capability

While we can support the disclosure of emergency services capability for all hospitals providing inpatient services, it is unnecessary and costly. At minimum, we ask that CMS make it clear as to the impact of this rule on provider based settings that are not open 24 hours a day, 7 days a week and/or are not providing any inpatient services. We have numerous off provider based campus locations with limited hours that provide only outpatient services. We have policies and procedures in place addressing what to do in case of an emergency but feel that disclosure of emergency services capabilities in the registration process will create greater confusion for patients.

Improving Emergency Services Capability

While we support delivery of high quality health care through qualified health care professionals, we are concerned that CMS make thoughtful decisions when establishing mandated competencies for professional staff. Mandating ACLS certification is very costly and may not be practical as staff proficiency is only achieved through utilization of the skills. In a number of settings, ACLS skills would be used very infrequently and competency at a BLS level is more appropriate.

DRG's Hospital Acquired Conditions

We appreciate and support CMS efforts to reduce serious complications and adverse events for Medicare beneficiaries. Allina Hospitals & Clinics is working diligently to address many of these same issues through our care improvement initiatives. Allina supports CMS in their effort to identify appropriate conditions that should not occur in our hospitals, thereby meeting criteria defined by Congress and also ensuring accuracy in the billing data that enables the appropriate identification of cases. However, the implementation of the MS-DRG system requiring implementation of "present on admission (POA)" codes will demand enormous resources in a very short time period for training and education of clinical and coding staff.

We feel that CMS should begin this new payment change with a focus on conditions that have widely accepted and non-debatable prevention guidelines with single codes to identify the presence of the condition on admission. Of the six serious preventable events identified by CMS, we can support the following: number 3, object(s) left during surgery; (4) air embolism, and (5) blood incompatibility, whereas these conditions have been identified and supported by NQF; are identifiable by discrete ICD-9 codes and can be coded for by hospitals without dependence on POA codes. These extremely harmful events have widely acceptable methods of prevention.

Allina does <u>not</u> support the following three preventable events identified: number 1, catheter-associated urinary tract infections; (2) pressure ulcers and (6) Staphylococcus aureus septicemia, because each condition depends on the ability to identify them properly as well as accurate use of POA codes. Hospitals face significant challenges in diagnosing these conditions accurately on admissions and coding for them at that time.

Allina supports an approach that is <u>not</u> dependent on POA codes but rather requires coding and cross referencing or the identification of a hospital acquired condition through a unique ICD9-CM

code. Due to CMS systems issues we have not been able to implement the POA Indicator. The addition of the POA will create significant additional work for our coders and will result in delays in claims processing, impacting our cash flow. Two states currently using POA codes report a minimum of two years needed to achieve reliability—much longer than the timeframe proposed by CMS. It doesn't make sense that we are mandated to identify POA's on all codes when only a very small number of conditions would be impacted for payment. This is an unnecessary administrative burden utilizing a key resource in our revenue stream.

There must be an opportunity for hospitals to appeal a CMS decision if an error in coding occurs and if a particular patient falls under the hospital-acquired conditions policy and is not eligible for a higher complication or co-morbidity DRG payment. In addition, there is good evidence to suggest that even when reliable science and appropriate care processes are applied in the treatment of patients, not all infections can be prevented. Therefore, we suggest that CMS would not penalize a hospital if, despite their best efforts, an infection occurs. For example, if a hospital's performance on the surgical wound infection prevention measures show that it reliably performs the necessary infection prevention steps all or nearly all of the time, CMS might not make any change to the current payment system for that hospital.

We ask that CMS thoughtfully consider the potential unintended consequences in the additional diagnostic testing that may take place to identify whether or not these any of these conditions are present on admission, such as excessive urine analyses on patients coming in with indwelling catheters. Additionally, the necessity to complete diagnostic tests before the patient is admitted could lead to delayed admissions for some patients and disrupt efficient patient flow.

We are deeply concerned that CMS would implement a payment methodology tied to administrative data alone when we are clear that this data alone does not present a valid indication of cause. Using coding data for POA would result in a significant number of infections deemed as "hospital-acquired" when they may not be, thus leading to CMS non-payment for legitimate complications. We suggest that this issue be approached from a quality standpoint rather than from a cost savings perspective and that administrative data is not utilized as the only factor to accurately identify a hospital acquired infection.

It seems to us that hospitals could take a double hit financially for hospital acquired conditions, once through the POA reporting process and the elimination of the CC/MCC and secondly through the future value based purchasing program. We feel very strongly that CMS is moving ahead too quickly with a payment reduction program without consideration of the impact of the quality mandates.

Replaced Devices

The changes that are proposed addressing reduced payments for replaced devices describe our current billing approach. We apply the conditions codes as appropriate. However, we have major concerns with the process of claims suspension and FI manual adjustments. We feel this is unnecessary micro management and will create significant administrative burden and delays in claims adjudication. We are submitting electronic claims and the manual work of copying and sending invoices draws a paper process into an electronic billing system for no purpose. All of this data is reported through the registries and cost report and can be monitored as necessary with processes that already exist. We do not support a process that creates a claim suspension, FI manual adjustment or a requirement to send paper copies of an invoice and ask CMS to reconsider this direction.

If CMS implements this policy, we agree that it should limit the number of DRGs to which the policy applies. In addition, we agree that insignificant credits or refunds should not trigger this policy. CMS should consider raising the proposed threshold from 20% to greater than 50% or the majority of the cost of the device.

Beneficiaries in Custody

We are very concerned about the proposed broad definition of "in custody". We vehemently disagree that "custody" should include anything beyond physical confinement. Probation, parole or supervised release should **not** be included in the definition. This would be extremely difficult to identify and would require that we seek criminal history information and do background checks on all patients being registered. We are concerned about the impact that this proposed definition change would have on mental health patients who are residing in half way houses or mental health facilities. These patients must have access to health care services. We expect that State regulations and Law Enforcement agencies may have conflicts with this definition as well. Currently we experience major administrative burden in billing the counties or municipalities for services provided when the "confined" patients require health care services. Please do not make this situation worse by expanding the definition way beyond the boundaries of the legal system.

In closing, I would again thank CMS for the opportunity to respond to the proposed rule. The gravity of these changes will create significant financial and systems implications, of which we cannot assess due to the lack of a solid data foundation utilized in building the proposed modifications to the core components of the IPPS program. With an inability to determine the real impact of these changes, we are ill prepared to implement the final rule within the established 60-day timeframe. We again urge CMS to delay full implementation of MS-DRGs and transition slowly using real experience and data to create the foundation for long term change. It is wrong to compare the Maryland experience with APR-DRGs as the foundation for change. MS-DRGs and APR-DRGs are not comparable systems. There is so much more to learn through a comprehensive testing approach than to rely on the small sample of independent review that has been done with the limited resources available to this point.

Additionally, we are concerned about the ability of all of the non-government payers who follow the current DRG structure to make necessary adjustments to their systems and processes in the 60-day timeframe between the publishing of a final rule and the implementation date.

If you have any questions regarding these remarks, please feel free to contact me at 612-262-4912.

Sincerely,

Nancy G. Payne

Nancy G. Payne, RN, MA
Director Regulatory Affairs

CMS-1533-P-129 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Dr. Robert Reid **Date & Time:** 06/06/2007

Organization : Cottage Health System

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Attachment

CMS-1533-P-129-Attach-1.DOC

CMS-1533-P-129-Attach-2.DOC

We support meaningful improvements to Medicare's inpatient PPS. While we believe that the MS-DRGs provide a reasonable framework for patient classification, a transition is necessary given that the change redistributes between $800 million and $900 million among hospitals.

CAPITAL PAYMENT UPDATE

The proposed rule would eliminate the capital payment update for all urban hospitals (a 0.8 percent cut) and the large urban hospital capital payment add-on (an additional 3 percent cut). **These changes would result in a payment cut of $880 million over five years to urban hospitals.**

We are opposed to these unnecessary cuts, which ignore how vital these capital payments are to the ongoing maintenance and improvement of hospitals' facilities and technology. In California, especially, we face a mandate to rebuild our facilities by 2013 to comply with state requirements for earthquake resistance. As a community teaching hospital we also oppose your consideration of possible future cuts to the indirect medical education and disproportionate share hospital adjustments under the capital system. CMS should not make any cuts or other adjustments to the capital PPS.

CMS has gone well beyond its charge by recommending arbitrary and unnecessary cuts in this proposed rule. These backdoor budget cuts will further deplete scarce resources, ultimately making hospitals' mission of caring for patients even more challenging.

Sincerely,

Ron Werft, CEO
Robert A. Reid, MD, Director of Medical Affairs

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Ron Werft, CEO
Robert A. Reid, MD, Director of Medical Affairs

CMS-1533-P-130 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Debbie Persaud **Date & Time:** 06/06/2007

Organization : Central NJ Brain Tumor Support Group

Category : Academic

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

My name is Debbie Persaud and I am a Clinical Scientist and Caregiver of a GBM grade IV survivor. There are very few drug options that are available for brain tumor patients. The brain is quite unique from other organs because it has a protective barrier called the blood brain barrier which reduces the risk of pathogens entering the brain. Unfortunately, this protective blood brain barrier also makes it difficult for chemotherapy drugs to penetrate the cavity at optimal concentrations to effectively kill cancer cells. That is why novel slow release drug delivery systems/implants that can be placed directly in the cavity site after tumor resection are highly valued among the brain cancer community. I would greatly appreciate it if you could promote access to new delivery systems/implants to treat brain tumors. I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors.

(Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter.

Best regards,

Debbie Persaud, M.S.
persaude@umdnj.edu
Member of the Central NJ Brain Tumor Support Group

CMS-1533-P-131 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Diane Raymond **Date & Time:** 06/06/2007

Organization : Mrs. Diane Raymond

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

My husband diagnosed in 6/03 with a glioblastoma and we are celebrating his fourth anniversary tommorow. Father, husband, partner, church member and above all fellow human being is alive today because of work done by people involved in the battle against glioblastoma. Many more people are being diagnosed with this devastating disease - please don't tun your backs on this important battle.

CMS-1533-P-132 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Shaun Farrell **Date & Time:** 06/06/2007

Organization : Shaun Farrell

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a son of brain tumor victim (my father lost his 13-month battle with a grade IV GBM in Nov2003). I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

Thank you

CMS-1533-P-133 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Eva Illyes **Date & Time:** 06/06/2007

Organization : Eva Illyes

Category : Individual

Issue Areas/Comments

DRG Reclassifications

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The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

Hospital Reclassifications and Redesignations

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Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-134 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Tonya Burwell **Date & Time:** 06/06/2007

Organization : Ms. Tonya Burwell

Category : Individual

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a {brain tumor patient or family of, caregiver of, doctor of, nurse of, a brain tumor patient, etc} and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-135 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Rebecca Silberman **Date & Time:** 06/06/2007

Organization : Rebecca Silberman

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a the younger sister of a brain tumor patient, and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-136 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Jessica Aust **Date & Time:** 06/06/2007

Organization : Mrs. Jessica Aust

Category : Nurse

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am family of a brain tumor patientand I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-137 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Miss. Tracey Kilcullen **Date & Time:** 06/06/2007

Organization : Miss. Tracey Kilcullen

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a friend of a brain tumor survivor and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-138 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Dr. Todd Kelly **Date & Time:** 06/06/2007

Organization : Memorial Hermann Healthcare System

Category : Physician

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

The proposed MS-DRG finally allows for more equitable reimbursement for cases of severe illness with high risk of death or significant morbidity. It's about time.

CMS-1533-P-139 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Julie Houston **Date & Time:** 06/06/2007

Organization : Brain Tumor Awareness Organization

Category : Individual

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a caregiver of a brain tumor patient and President of The Brain Tumor Awareness Organization which advocates on behalf of those affected with brain tumors and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-140 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Michael Deinert **Date & Time:** 06/06/2007

Organization : Mr. Michael Deinert

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors. This is extremely important to the extended survival rate for patients fighting this ugly disease.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. Thank you for that DRG! Thank you, thank you, thank you!

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter! It means so much to me and many of my fellow brain tumor comrades.

Sincerely,

Michael Deinert
1228 Modaff Road
Naperville, Il 60540
(630) 946-6093

CMS-1533-P-141 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : **Ms. Lynn Deinert** **Date & Time:** **06/06/2007**

Organization : **Ms. Lynn Deinert**

Category : **Individual**

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am the mother of a brain tumor patient, Michael Deinert, and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS- DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors. This is extremely important to the extended survival rate for patients fighting this ugly disease.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. Thank you for that DRG! Thank you, thank you, thank you!

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter! As a mother to a child who has suffered through so much pain and sorrow from his diagnosis and subsequent surgery and recovery, I can tell you that all measures that make it at all easier, or, increase the length of survival, are certainly worth the time and interest in care.

Sincerely,
Lynn Deinert
1228 Modaff Road
Naperville, Il 60540
(630) 946-6093

CMS-1533-P-142 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : william levine **Date & Time:** 06/06/2007

Organization : william levine

Category : Individual

Issue Areas/Comments

RRCs

RRCs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a {brain tumor patient or family of, caregiver of, doctor of, nurse of, a brain tumor patient, etc} and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-143 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Brie McMahon **Date & Time:** 06/06/2007

Organization : Ms. Brie McMahon

Category : Individual

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24.

I am a friend of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-144 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Dr. Mark Levin **Date & Time:** 06/06/2007

Organization : NJ Medical School

Category : Physician

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a physican who specialized in neuro-oncology.

I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.
When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)
The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you,
Mark Levin MD
Associate Professor of Medicine
NJ Medical School
Newark, NJ

CMS-1533-P-145 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Valerie Rinkle **Date & Time:** 06/06/2007

Organization : Asante Health System

Category : Hospital

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Asante Health System appreciates CMS' responsiveness during the Fiscal Year 2007 IPPS rulemaking to delay then proposed severity DRG changes based on provider concerns, particularly regarding a proprietary system. Therefore, we are hopeful that CMS will display the same responsiveness regarding hospital concerns with the current MS-DRG proposal. CMS proposes MS-DRGs which are a refinement of the current DRG system and do not have the concerns of a proprietary system. We support a system that is a refinement of the existing system since it builds upon the essential processes built around DRGs for the last 23 years. However, adoption of this system for October 1, 2007 is premature primarily because the MS-DRG grouper is not available to hospitals to perform financial and DRG-based assessments or to plan and prepare coders, hysicians, UR and other staff for the changes. Hospitals simply have not had time to determine action plans based on the new system without widely available MS-DRG grouper programs.

We concur with AHA that 2008 should be a year for hospitals to conduct analyses and to prepare coders, staff and physicians. Hospitals need a year with the new MS-DRG grouper available to them. MS-DRGs should be phased-in from 2009 to 2011. Therefore, CMS should make a MS-DRG grouper available as soon as possible.

We strongly object to the behavioral offset of a minus 2.4% reduction to be applied both in 2008 and 2009. This offset was based on analysis of one State hospital system under an entirely different DRG system. Hospitals are dependent upon physician documentation for coding. Hospitals will not be able to educate physicians and change physician behavior to this degree. It is inappropriate for CMS to put hospitals at risk of insolvency and beneficiaries at risk of reduced access to care by guessing at what might be an impact to the IPPS program and applying that guess as a reduction in actual payment to hospitals.

Note that the phase-in approach suggested by AHA would allow CMS to study the impact of coding changes on actual hospital claim data rather than making an inappropriate assumption that will place many hospitals at financial risk.

Asante is also concerned about MS-DRGs and the inability of CMS, and others who purchase the CMS claim file, to receive more than 10 diagnoses. Other vendors and healthcare groups make decisions about quality of care based upon the CMS claim file. CMS should make a disclaimer that this file does not contain all diagnoses provided by hospitals and may give a skewed clinical perspective of claims as a result. CMS should also commit to a timeframe when it will revise its systems to accept all 25 diagnosis codes provided via electronic transmissions.

Since hospitals are fully dependent upon physicians for orders consistent with quality and evidence-based medicine, completeness and accuracy of documentation to support specific coding, and for resource utilization, Asante also believes that CMS should align their incentives for correct reporting for both physicians and hospitals.

CMS-1533-P-146 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Catherine Kelly **Date & Time:** 06/06/2007

Organization : Ms. Catherine Kelly

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am a caretaker of a brain tumor patient. I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involing the implantation of a chemotherapeutic agent (ICD-9CM procedure code 11.10) would be assigned to MS-DRG-23.

You propose the following:

MS-DRG-23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device into the bran which slowly releases chemotherapy. It is now considered the standard of the malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem and without modifications to the new replacement MS_DRGs, we may go back to loss of access to this standard of care. This can bbe corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, evenwithout a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-147 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Karl Forge **Date & Time:** 06/06/2007

Organization : Karl Forge

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-148 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Alice Papiez **Date & Time:** 06/06/2007

Organization : personal

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I lost my husband to a GBM4 Brain Tumor 18 months ago. It was a very painful time watching him suffer. I don't like to think of others having to watch their loved ones go through this terrible diease. Please do not eliminate any proceedures that have any success rate in the treatment of Brain Tumors.
Sincerely,
Alice Papiez

CMS-1533-P-149 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Kim Boyd **Date & Time:** 06/06/2007

Organization : Doylestown Hospital

Category : Physical Therapist

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am a friend of a brain tumor patient and physical therapist, and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS- DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

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The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

CMS-1533-P-150 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Judd Chapman **Date & Time:** 06/06/2007

Organization : Judd Chapman

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am the son of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

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Thank you for your consideration of this important matter!