CMS-1533-P-47 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Nancy Musser Larson **Date & Time:** 06/05/2007

Organization : Mrs. Nancy Musser Larson

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 daughter of a deceased 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.

CMS-1533-P-48 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Christopher McDonald **Date & Time:** 06/05/2007

Organization : Mr. Christopher McDonald

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

My father is 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-49 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Robert Godbey **Date & Time:** 06/05/2007

Organization : Mr. Robert Godbey

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 colleague and 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.

CMS-1533-P-50 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Emily Shiel **Date & Time:** 06/05/2007

Organization : N.A.

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

One can only assume that overlooking full payment for gliadel for brain tumor patients was a mistake and that you will see that the mistake is quickly corrected. The odds against GBM patients are so high no possible weapon should be denied on account of cost. It is too late for my daughter. She has died.

CMS-1533-P-51 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Susan Giannoni **Date & Time:** 06/05/2007

Organization : The Giannoni Family

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

My husband was diagnosed with glioblastoma multiforme on 6/26/06 and it has reoccurred. His neurosurgeon is recommending a craniotomy with the insertion of gliadel wafers to treat his condition. It is imperative that this be funded under Medicare and other insurances. His father died of glioblastoma multiforme in 1996. The medical costs of brain tumors are astronomical and lives can be saved! Please do not this get lost in the shuffle of new legislation!

CMS-1533-P-52 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Mohini Peters **Date & Time:** 06/05/2007

Organization : Physicians Medical Group of Santa Cruz County

Category : Nurse

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 nurse, a caregiver, and the mother 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!

Sincerely,

Mohini Peters RN CLNC
PO Box 143
Felton, CA 94018

CMS-1533-P-53 **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

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

My twin sister is 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.

CMS-1533-P-54 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Karen Paulson **Date & Time:** 06/05/2007

Organization : none - other than for all Brain Tumor Survivors

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! Brain Tumors patients are so often neglected, and this is a very important treatment that I may need in the future, if my tumor continues to grow. Please help the thousands of us that need this treatment.

Karen Paulson

CMS-1533-P-55 **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

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.

CMS-1533-P-56 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Marlene Pratto **Date & Time:** 06/05/2007

Organization : Ms. Marlene Pratto

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 died from a brain tumor as did two women and three men that I knew. Another friend has a brain tumor at this time. Medicare brain tumor patients who are able to have craniotomies (not all tumors can be resected) should have the option of one of the currently available treatments, the gliadel wafer. There are so few treatments for this dangerous and always life threatening disease that to deny any treatment is not right. 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,

CMS-1533-P-57 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Jessica Tabor **Date & Time:** 06/05/2007

Organization : Mrs. Jessica Tabor

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-58 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Bret Silberman **Date & Time:** 06/05/2007

Organization : Mr. Bret 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 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-59 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : **Mrs. Barbara Berner** **Date & Time:** **06/05/2007**

Organization : **Mrs. Barbara Berner**

Category : **Nurse**

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.

Please allow my husband and so many others in need of accessibility of this drug to have it available.

Thank you for your consideration of this important matter!

Barbara Berner,
North Canton, Ohio

CMS-1533-P-60 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Alison Dunton **Date & Time:** 06/05/2007

Organization : Community Hospital of the Monterey Peninsula

Category : Other Health Care Professional

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 Quality Management professional and the sister 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 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-61 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Maria John **Date & Time:** 06/05/2007

Organization : Ms. Maria John

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 propsed MS-DRGs 23 and 23 so that all crainotomy 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-62 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

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

Organization : Dan Baldwin

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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

My brother is 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-63 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. chris mckenna **Date & Time:** 06/05/2007

Organization : tacoda

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-64 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Gary McClure **Date & Time:** 06/05/2007

Organization : Mr. Gary McClure

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

When Gliadel was first approved by the FDA, Medicare did not pay for it, and as a result, many patients were denied access to it. We fought Medicare on the issue (the first major legislative victory by the brain tumor community) and won - Medicare created a new billing code for Gliadel cases. However, Medicare is changing the entire in-hospital payment system, and the code that we worked so hard to get was lost in the shuffle. They published a proposed rule which results in most Gliadel cases being assigned to a code that pays so little that many hospitals would not be able to use Gliadel. We want them to change the wording of the codes to allow hospitals to use Gliadel in those cases where it is indicated.

CMS-1533-P-65 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Cameron Mitchell **Date & Time:** 06/05/2007

Organization : Mr. Cameron Mitchell

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I would like to reccommend that the Proposed MS-DRGs be reconsidered. Knowing first hand the positive results of using the Gliadel Wafers, I can't imagine why it would not remain a standard of care for brain tumor patients.

CMS-1533-P-66 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. frances Zorn **Date & Time:** 06/05/2007

Organization : Ms. frances Zorn

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am the caregiver to my mother who died in April from a glioblastoma multiforme grade IV brain tumor and am writing to request a change to the structure of proposed MS-DRGs 23 and 24 so that all crainiotomy cases involving the implementation ofa chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You proposed the following titles for these MS-DRGs:
MS DRG 23 (crainotomy w/major devise implant or acute complex CNS PDX w/MCC), MS-DRG 24 (crainiotomy with major devise implant or acute complex CNS PDX w/o MCC) and I would like to suggest that the DRGs be restructured so that their titles are the following:
MS-DRG 23: crainiotomy with acute complex CNS PDX with MCC or major device implant, and MS-DRG 24: Crainiotomy withacute complex cns pdx w/o MCC

The proposed titles do not take into effect the costs involved in implanting a device such as the Gliadel Wafer(and other treatmerts that will be forthcoming). The Glaidel wafer which slowly releases chemo into the brain is now considered standard treatment for malignant brain tumors.

Without the revised DRG above, the payment for brain tumor surgery will be lower and many community hospitals will not be able to afford the treatments. The proposed rule removes a DRG that provided access to Gliadel teatment, and put the decision to use it in the hands of doctors. Please consider changing the structure of the new MS-DRGs to allow all cases involving the implantation of devises to be assigned to MS DRG- 23, even without an MCC.

In the case of my mother the brain tumor was difficult to diagnose, and it was quite large by the time it was proper;y identified. I think this is often the case with glioblastomas. Given that, and the fact that effective treatments are still in trials, physicians should have all therapeutic tools available to them to treat this cancer without having to worry about whether insurance will pay for the procedures.

CMS-1533-P-67 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Dr. Maciej Lesniak **Date & Time:** 06/05/2007

Organization : The University of Chicago

Category : Physician

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Gliadel is an FDA approved drug for malignant brain tumors. The proposed change to the DRG would prevent adequate reimbursement and the hospitals could not afford to pay for the drug. This would hurt our patients.

CMS-1533-P-68 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Linda Nickels **Date & Time:** 06/05/2007

Organization : Mrs. Linda Nickels

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 has a 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.

CMS-1533-P-69 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. AUTREY LOCKLEAR **Date & Time:** 06/05/2007

Organization : Mr. AUTREY LOCKLEAR

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 who would have died without immediate, intense medical intervention, 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-70 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Dr. William Knox **Date & Time:** 06/05/2007

Organization : University of NC @ Greensboro

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

My Dear Servants of the people: We must support with adequate funding the implantation of Gliadel Chemotherapy wafers in the tumors of those suffering from the dreaded glioblastoma multiforme brain cancer. These wafers are standard of care and vital to help those who suffer from this kind of almost inevitably fatal tumor. The currently proposed legislation cuts funding to almost nothing. Let's get funding up to an adequate level. It is the only humane thing to do.
Respectfully submitted,
Professor William E. Knox

CMS-1533-P-71 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Christina Ratzel **Date & Time:** 06/05/2007

Organization : Mrs. Christina Ratzel

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 surviving 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-72 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

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

Organization : Steven Sermarini

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

This is the code that we fought hard for - and won - a few years ago.

Before we got this code, many hospitals refused to use gliadel due to the expense.

If we lose the code, many patients will lose access to Gliadel.

It is our responsibility to help and protect these patients.

CMS-1533-P-73 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. McMullen **Date & Time:** 06/05/2007

Organization : Ms. McMullen

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 and caregiver of a brain tumor patient. We are continually hopeful for research giving improved treatment options. One of these important treatments of late is the implantation of a chemotherapeutic agent at the time of surgery. The remarkable thing about this is that it attacks the cancer cells directly where it is implanted where as most chemotherapeutic agents would attack generally in the hopes of killing all cancer cells in the body, getting healthy tissue as well.

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.

The financial impact of this change, would it occur, would be devastating to brain tumor patients and their families. Brain cancer has surpassed leukemia as the #1 cancer disease in children and is the #3 to cause death by disease in adults. Join us in the fight against brain cancer. Change 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-74 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

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

Organization : D Mishler

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 support system for a very special 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.

CMS-1533-P-75 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Claudia Sangster **Date & Time:** 06/05/2007

Organization : Ms. Claudia Sangster

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 and caregiver of a brain tumor patient□he is the love of my life and fighting for his life after being diagnosed with a glioblastoma multiform brain tumor less than a year ago. Dealing with this disease has turned our world upside down emotionally, physically and financially. It is difficult to cope with the effects of this disease but one of the most frustrating aspects is fighting for coverage through the insurance companies and medicare systems. 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.

Please rethink the proposed rule and consider the needs of these brain tumor patients and their families who are fighting a very aggressive and malignant cancer□do not remove access to this very important treatment. Our spouses, fathers, mothers, brothers, sisters, other family members and friends need the hope that is offered by having this treatment protocol available. Thank you for your consideration of this important matter!

CMS-1533-P-76 **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 brain tumor caregiver of my husband 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-77 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Mark Schultz **Date & Time:** 06/05/2007

Organization : Mr. Mark Schultz

Category : Individual

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

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-78 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. seth pachino **Date & Time:** 06/05/2007

Organization : Mr. seth pachino

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am 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!

CMS-1533-P-79 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

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

Organization : Cancer Services of Northeast Indiana

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 client advocate 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.
The proposed changes in the code for paying for gliadel wafers would result in denying many people the opportunity to be treated with this more

effective medicine, which was not the intended purpose of the change. Please correct this problem before many are effected by this error.
Thank you for your consideration of this important matter!

CMS-1533-P-80 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. sharon smith **Date & Time:** 06/05/2007

Organization : TACODA

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

We must have this coverage.

CMS-1533-P-81 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Sherry Burdette **Date & Time:** 06/05/2007

Organization : Mrs. Sherry Burdette

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

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

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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!

Sherry Burdette

CMS-1533-P-82 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Frank Stien **Date & Time:** 06/05/2007

Organization : AARP

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

When Gliadel was first approved by the FDA, Medicare did not pay for it, and as a result, many patients were denied access to it. We fought Medicare on the issue (the first major legislative victory by the brain tumor community) and won - Medicare created a new billing code for Gliadel cases. However, Medicare is changing the entire in-hospital payment system, and the code that we worked so hard to get was lost in the shuffle. They published a proposed rule which results in most Gliadel cases being assigned to a code that pays so little that many hospitals would not be able to use Gliadel. We want them to change the wording of the codes to allow hospitals to use Gliadel in those cases where it is indicated.

CMS-1533-P-83 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Dale Baker **Date & Time:** 06/05/2007

Organization : Baker Healthcare Consulting, Inc.

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1533-P-83-Attach-1.WPD

#83

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PRESIDENT

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June 4, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: CMS-1533-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems in Fiscal Year 2008 Rates; Proposed Rule (Vol. 72, No. 85), May 3, 2007

Dear Ms. Norwalk:

We represent approximately 300 hospitals in Medicare geographic reclassification matters, work with numerous hospital associations and individual hospitals on wage index issues, and along with legal counsel, work with hospitals throughout the U.S. on Medicare payment matters before the Provider Reimbursement Review Board and various courts.

Our comments are limited to the areas in which we concentrate our practice. Our comments are in the order in which they are published in the Federal Register (using the DHHS/CMS numbering system).

III. Proposed Changes to the Hospital Wage Index.

B. Core-Based Statistical Areas for the Hospital Wage Index. CMS has consistently referred to Metropolitan Statistical Areas (MSAs) as Core-Based Statistical Areas (CBSAs) since adopting the new metropolitan areas effective for Federal Fiscal Year 2005. The term "Core-Based Statistical Area" actually includes both Metropolitan Statistical Areas and Micropolitan Statistical Areas. Micropolitan Statistical Areas are considered by CMS to be a part of "statewide rural areas". It was an excellent idea at the time for CMS to differentiate the 2000 census data by using the term CBSAs from the terminology used for the 1990s of "MSAs". However, to be more technically correct CMS should now consider returning to the use of MSAs or Metropolitan Statistical Areas rather than using the looser term CBSAs.

D. Worksheet S-3 Wage Data for the Proposed FY 2008 Wage Index. CMS is including indirect contract labor for the administration and general cost center, and housekeeping and dietary cost centers for inclusion in the Federal Fiscal Year 2008 Wage Index Data. Based on the formulas that are used it is not clear if CMS has added these amounts from the applicable lines of worksheet S-3 into the

underlying data (similar to Line 9 for Clinical Contract Labor). CMS should ascertain that the hours and amounts paid to these clinical contractors have been included in the base data used to compute the wage index.

F. Wage Index for Multi-Campus Hospitals. The solution proposed by CMS to "carve out" a multi-campus hospital with one or more campuses in a different MSA (or statewide rural area) is an excellent policy. It may, however, require some additional clarification. A number of hospital employees in multi-hospital campuses may work at a single location but provide services to the other locations. Thus, CMS should include a provision that would allow for either the elimination of employees that are serving more than one campus but are working on one campus, or acknowledge an appropriate methodology would be to allocate these employees to the various campuses based on the number of direct employees working in each of the campuses (perhaps on the basis of the number of direct hours worked).

CMS should consider utilizing an alternate methodology for the FFY 2008 multi-campus hospital to allocate wage data between campuses based on beds at each campus, Medicare discharges at each campus or on the basis of total Medicare revenues if a hospital is unable to perform a complete analysis of its employees in the short time frame of the proposed rule.

G. Computation of the Proposed FY 2008 Unadjusted Wage Index.

1. Application of Rural Floor Budget Neutrality. For the first time CMS is proposing a positive budget neutrality adjustment for the impact of the rural floor provisions on the Wage Index pursuant to Section 4410 of the Balanced Budget Act of 1997. This is an adjustment that has needed to be made for several years and we agree with the concept of making this adjustment for Federal Fiscal Year 2008.

   CMS proposes to make this adjustment as a part of the Wage Index calculation, rather than the traditional methodology of adjusting the standardized amount. However, as proposed in the rule, it appears that CMS has bifurcated this adjustment and would add back the effect of one or more the prior years' rural floor adjustment in a standardized amount adjustment in the amount of 1.002214 (see pages 24839 of the May 3, 2007 Federal Register). It is not clear if this 1.002214 is a single year's budget neutrality adjustment (for FFY 2007) or if this adjustment is to correct the cumulative adjustment of the prior years adjustments from FFY 1999 through FFY 2007. We ask that CMS quantify the computation of this adjustment by year for each year from FFY 1999 through FFY 2007 to allow for the testing of the reasonableness of the CMS calculations.

   Additionally, on page 25123 of the proposed rule the effect of the FFY 2008 rural floor adjustment of 0.997084 - which CMS proposes to apply to the wage index - is included in the footnotes to Table I. In the

calculations of the wage indexes, CMS has inflated the national average hourly wage in order to recompute wage indexes and apply the FFY 2008 portion of the budget neutrality adjustment (the negative portion of the adjustment) even though the prior year's positive adjustment is made to the standardized amount. As CMS noted in the proposed rule, this affects hospitals with a wage index of lower than 1.0000 differently than it affects hospitals that have a wage index of 1.0000 or more because the labor related share is only .62 for the lower wage indexes compared to .697 for the wage indexes of 1.0000 and higher.

Further, CMS provides no justification as to why CMS proposes to make only a portion of the budget neutrality adjustment in the wage index. This treatment creates a further complication of the already difficult computation of the wage index – and further reduces transparency. We ask CMS to report the amounts of the rural floor standardized amount adjustments from 1999 through 2007, as well as provide the amount of the adjustment applicable to FFY 2008. In the interest of promoting further transparency, these adjustments should be fully explained and the prior year adjustments should be enumerated for each year in making the cumulative adjustment that is needed to correct prior inequities.

I. Revisions to the Proposed Wage Index based on hospital redesignations (other issues)

We welcome the opportunity to address the issues of individual and group reclassifications. In Nassau county, New York, several hospitals qualify individually for reclassification to use the New York-White Plains-Wayne, NY-NJ Metropolitan Division wage index. Additionally, the county has been approved for a countywide reclassification.

Nassau County hospitals have received three year individual reclassifications that overlap with the three year group reclassification. If, however, the individual reclassification requests are submitted for a year that is already covered by the group reclassification the Medicare Geographic Classification Review Board and the Office of the Attorney Advisor will not approve the overlapping individual hospital reclassification request.

The computation of a diluted New York-White Plains-Wayne, NY-NJ wage index including all the Nassau County hospitals can result in a diluted wage index that is lower than the Nassau-Suffolk wage index. However, it is quite possible that the alternative individually reclassified hospitals would result in a diluted wage index that would be higher than the Nassau-Suffolk wage index.

The current policy, effectively, precludes the individual hospitals eligible fore reclassification from accepting a reclassification simply because of the existence of countywide reclassifications that may not benefit the hospitals of the county.

We recommend that CMS clarify that both individual and group reclassifications can overlap and be approved for hospitals for any of the three years in the reclassification cycle, to

allow the group and the individually reclassified hospitals to choose the most favorable reclassification for the group and for the individual hospitals.

J. Proposed FY 2008 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees. CMS proposes to use the post-reclassified wage indexes (which may be the same as the MSAs wage index if the cumulative dilution of all reclassified hospitals is less than .0100) rather than using the full MSA wage index as a basis for determining the amount of the out-commute adjustment to be added to hospitals in counties eligible under Section 505 of the MMA. In some cases, this would result in a mismatch of the wage indexes compared to the commuting patterns of the employees. For example, there are a number of counties that are reclassified into the Boston-Quincy Metropolitan Division. By using a diluted Boston-Quincy Wage Index to compute the out commuting adjustment, CMS matches wage indexes derived from counties that are not included in the underlying census data resulting in a mismatch that certainly violates the spirit of the Section 505 provisions of the MMA. The use of the diluted wage index requires the underlying assumption that workers are out-commuting from an MSA's surrounding areas to work in other areas surrounding the MSA, which is not at all what Congress intended to address with Section 505 of the MMA. We recommend that CMS continue to use the full wage index of the MSA rather than the post-reclassification wage index in computing these adjustments. Historically, CMS has computed the out-migration adjustment for one year and applied the adjustment, without update to years two and three. The out-migration adjustment would be much more accurate if it was computed annually based on each year's pre-reclassification wage indexes.

The combination of the use of the post reclassification wage index with an out-migration adjustment updated only once every three years could produce some interesting anomalies.

Assume Sample Hospital is located in County A and County A is eligible for an out-migration adjustment to adjacent MSA B which has a higher wage index and there is over a 10% out-migration from County A into MSA (and County) B.

Assume that for FFY 2008, Sample Hospital is reclassified to MSA B, further diluting an already diluted MSA B reclassified wage index. For FFY 2009 and 2010, Sample Hospital is not reclassified and is therefore eligible to receive the out-migration adjustment.

If the FFY 2009 and 2010 out-migration adjustment is not recomputed each year based on the current year reclassification configuration to MSA B for those two years then the out-migration adjustment that Sample A Hospital receives for FFYs 2009 and 2010 has been used to further reduce the post migration MSA B reclassified wage index even through Sample Hospital is not reclassified to MSA B for these two years and is receiving an out-migration adjustment. Certainly Congress did not intend to create a formula where Sample Hospital's data would be used to adjust both of the two wage indexes used to compute the out-migration

adjustment for the FFY 2009 and 2010 example.

Lastly, if CMS uses the pre-reclassification wage index pursuant to our recommendation, a special provision to allow an extension of time for additional possible terminations of wage indexes reclassification is needed as a result of the re-computation for FFY 2008 out-migration adjustments is needed.

M. Wage index study required under Pub L. 109-432. MedPAC has approved recommendations to Congress which will be transmitted before June 30, 2007 in accordance with the above cited statutory provision.

We have serious reservations about the workability of MedPACs recommendation to use the Bureau of Labor Statistics data for computation of acute care hospital wage indexes. Our concerns are as follows:

A. BLS data is sampled data and unaudited, existing hospital data is for a full year and has been subjected to a 100% desk review by fiscal intermediaries.
B. BLS does not differentiate between full time and part time employees – part time wage x 2080 – this creates distortion
C. BLS does not accumulate wage related costs which range up to 47% of wage costs and vary substantially throughout the country.
D. Contract labor (physician, clinical and certain other non-clinical) currently in the wage index is not captured by BLS.
E. If BLS, as a part of its sampling procedures, should capture some agency nursing data it would be recorded in the county where the agency is located, not necessarily where the nurse works. Example: New Orleans is highly dependent on agency nurses and this could have huge implications in the aftermath of Hurricane Katrina, if the nurse agency is headquartered in, for example, Houston (BLS would consider this Houston data not New Orleans).
F. Certain salaried and contract physician Part A non-teaching data are currently included in the wage index. BLS cannot accumulate this data.
G. Critical Access Hospital (CAHs) data is currently excluded from the wage index data. BLS includes CAHs in their sampling. Major county by county BLS distortion will result in counties with IPPS hospitals and one or more CAHs.
H. Lack of transparency of MedPAC process. Congress legislated $2 million for additional analysis; MedPAC has not released any wage indexes computed using BLS data.
I. Lack of transparency of the underlying data. Currently CMS releases hospital specific detailed wage index data three times annually in Public Use Files (PUF) published by CMS in October, February and May each year. BLS data is confidential, participating institutions are not identifiable and the data is therefore "secret" from CMS, from the hospitals and from public scrutiny.

J. BLS collects average hourly wage data by profession from hospitals (including VA, Acute Care and CAHs). Nationally 77% of the BLS RNs are working in hospitals, 53% of LPNs. MedPAC has noted that RNs outside of hospitals are paid considerably less than hospital RNs. Including non-hospital RNs penalizes counties that have appropriately relocated services formerly provided in hospitals to other less costly sites of care this reduces the counties RN average hourly wage. This provides a perverse incentive to areas providing more services outside of a hospital in a more cost effective setting.

K. Acute care hospitals in rural settings believe the Veterans Administration federal pay schedule overpays RNs in rural areas. This can significantly distort BLS county level wage index data. VA data is not currently in the wage data CMS uses.

L. BLS confidentially of participating employers provides an incentive to "game the system". Communities could discourage nursing homes, lower paying hospitals and physicians group practices from voluntarily providing data to the BLS to improve the wage index, which in addition to hospital payments, is used for nursing homes, hospices, and other providers.

M. MedPAC acknowledges that BLS data is less accurate than hospital data currently accumulated by CMS but dismisses this criticism as not being material. Ask hospital executives how material say a 2% change in wage index is on their operations.

N. MedPAC acknowledges that currently reclassified hospitals will be the "losers" if the BLS system is adopted. For now, MedPAC proposes no geographic reclassification system. Forty percent of all rural hospitals are currently reclassified and 12% of the urban hospitals. Rural Referral Centers (RRCs) are the most sophisticated rural hospitals offering an urban like range of services. Eighty-six percent of the nations 290 RRCs are reclassified and would be extremely vulnerable under the MedPAC proposal.

As CMS studies proposals to revamp the wage index for publication in the FFY 2009 proposed IPPS rule, we ask that you consider the following:

There are alternative proposals that will largely meet the objectives of Congress, MedPAC and the Administration and probably receive broad support from the hospital industry. Much of the frustration with the existing wage index system comes from the volatility of sudden negative changes to the annually recomputed wage indexes.

Last year, the Connecticut Hospital Association asked Baker Healthcare Consulting, Inc. (BHC) what the cost would be of a stop loss that would limit the annual decrease in a wage index for each individual hospital throughout the U.S. to a maximum of 1.5% per year. This would guarantee all hospitals an increase in Medicare payments assuming an increase in standardized amount from 3% to 3.5% annually.

The BHC report, issued March 5, 2007 estimated the stop loss provision would cost $287 million for FFY 2007 for inpatient and outpatient PPS payments. At least one prominent legislator considered this a doable fix. This could be structured as a legislated new money fix or as a budget neutral provision that might not require legislation.

Secondarily, the MedPAC proposal would use three years BLS survey data in determining the annual wage index. This rolling average reduces the volatility of data changes.

The Medicare Geographic Classification Review Board currently uses three years average hourly wage (AHW) data for determining if hospitals meet the AHW criteria for reclassification. CMS could simply use two or three years hospital data in computing the wage index. This would eliminate a lot of the volatility and probably reduce the cost of the $287 million stop loss measure suggested above.

The above two steps would likely receive broad support from the hospital industry and accomplish the major objectives of the MedPAC proposal and meet Congressional concerns. Implementation would likely result in a significant reduction in hospital administrators lobbying for better wage indexes to legislators and CMS executives.

We appreciate the opportunity to submit these comments for your consideration. Should you have any questions regarding our comments please do not hesitate to contact us.

Sincerely,

BAKER HEALTHCARE CONSULTING, INC.

Dale E. Baker

Dale E. Baker
President

DEB/kks

2660DEB

CMS-1533-P-84 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

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

Organization : New Jersey brain tumor support

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I survived two crainiotomies in 2003 and 2004 i need the freedom to elect the most effective treatment optiond for the medicare coverage of the gliadel treatment

matt gubala 7 mohawk ave lake hiawatha nj07034

CMS-1533-P-85 **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

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

I am a colleague of a brain tumor paitent 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:

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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.

CMS-1533-P-86 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : **Ms. Heather Hulscher** **Date & Time:** **06/05/2007**

Organization : **Iowa Hospital Association**

Category : **Hospital**

Issue Areas/Comments

Capital IPPS

Capital IPPS

See attachment

DRG Reclassifications

DRG Reclassifications

See attachment

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

See attachment

DRGs: Hospital Acquired Conditions

DRGs: Hospital Acquired Conditions

See attachment

DRGs: Relative Weight Calculations

DRGs: Relative Weight Calculations

See Attachment

GENERAL

GENERAL

See Attachment

Hospital Quality Data

Hospital Quality Data

See Attachment

IME Adjustment

IME Adjustment

See attachment

Occupational Mix Adjusted Wage Index

Occupational Mix Adjusted Wage Index

See attachment

Occupational Mix Adjustment

Occupational Mix Adjustment

See attachment

Patient Safety Measures

Patient Safety Measures

See attachment

Value-Based Purchasing Plan

Value-Based Purchasing Plan

See attachment

Wage Data

Wage Data

See attachment

Wage Index

Wage Index

See attachment

CMS-1533-P-86-Attach-1.PDF

CMS-1533-P-86-Attach-1.PDF

CMS-1533-P-86-Attach-1.PDF

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CMS-1533-P-86-Attach-1.PDF

CMS-1533-P-87 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Michael Baehl **Date & Time:** 06/05/2007

Organization : Mr. Michael Baehl

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 brother of a a brain tumor patient who had Gliadel Wafers implanted and is still alive to this day.
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.

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Thank you for your consideration of this important matter!

CMS-1533-P-88 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. Elinor Ziv **Date & Time:** 06/05/2007

Organization : Mrs. Elinor Ziv

Category : Individual

Issue Areas/Comments
DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

I am the mother 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!
Elinor Ziv

CMS-1533-P-89 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mr. Steven Kowske **Date & Time:** 06/05/2007

Organization : Aurora Health Care

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1533-P-90 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

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

Organization : Mr.

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

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-91 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Miss. Katherine Mishler **Date & Time:** 06/05/2007

Organization : Miss. Katherine Mishler

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

The costs of medical care, especially for long term issues like cancer, is frustrating when certain therapies become less available. As my dear uncle is currently being treated with Gliadel. Please keep Gliadel an option for so many brain tumor patients. It is literally a Life Saver!

CMS-1533-P-92 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Dr. GARY MITCHELL **Date & Time:** 06/05/2007

Organization : Newman Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1533-P-92-Attach-1.DOC

#92

June 5, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1533-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Proposed Rule (Vol. 72, No. 85), May 3, 2007

Dear Ms. Norwalk:

On behalf of Newman Memorial Hospital, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the fiscal year (FY) 2008 hospital inpatient prospective payment system (PPS).

While we support many of the proposed rule's provisions, we oppose the proposed "behavioral offset" cuts related to the move to severity-adjusted diagnosis-related groups (DRGs) and the cuts to capital payments. We support the concerns outlined in the American Hospital Association letter submitted for your review. Their document outlines numerous issues of concern and we will comment on just two.

DRGs

The proposed rule would create 745 new Medicare-Severity DRGs (MS-DRGs) to replace the current 538 DRGs, and would overhaul the complication or comorbidity list. The proposed rule also **includes a 2.4 percent cut to both operating and capital payments in both FYs 2008 and 2009 – $24 billion over five years** – to eliminate what is claimed to be the effect of classification changes that do not reflect real changes in case-mix. In addition, the rule proposes continuing the three-year transition to cost-based relative weights, with two-thirds of the FY 2008 weight based on costs and one-third based on charges. The individual impact on our facility is a **4% reduction** in payments for services provided.

Even with the DRG changes proposed by CMS, physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoid serving uninsured, Medicaid and other low-income patients, practice similar forms of selection for outpatient services and drive up utilization. We urge CMS to address the real issue of self-referral: to rigorously examine the investment structures of physician-owned, limited-service hospitals and consider our comments on CMS' interim report on the strategic plan required by the *Deficit Reduction Act of 2005*.

The hospital field supports 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 have no specific values for our facility but any reduction in capital payments will further restrict the ability of our facility to provide needed improvements in equipment and structure.

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. 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.

Thank your for the opportunity to provide input into this process.

Gary W. Mitchell, FACHE
Chief Executive Officer
Newman Memorial Hospital
905 South Main
Shattuck, OK 73858

CMS-1533-P-93 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Miss. Mary Schorr **Date & Time:** 06/05/2007

Organization : Brain Tumor Charities of Central Ohio

Category : Pharmacist

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/disabled pharmacist 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-94 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Mary Wessling **Date & Time:** 06/05/2007

Organization : Ms. Mary Wessling

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

When Gliadel was first approved by the FDA, Medicare did not pay for it, and as a result, many patients were denied access to it. We fought Medicare on the issue (the first major legislative victory by the brain tumor community) and won - Medicare created a new billing code for Gliadel cases. However, Medicare is changing the entire in-hospital payment system, and the code that we worked so hard to get was lost in the shuffle. They published a proposed rule which results in most Gliadel cases being assigned to a code that pays so little that many hospitals would not be able to use Gliadel. We want them to change the wording of the codes to allow hospitals to use Gliadel in those cases where it is indicated.

CMS-1533-P-95 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

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

Organization : Kris Campbell

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 brother died from Glioblastoma in Dec 2005. 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

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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-96 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Ms. Gail Story **Date & Time:** 06/05/2007

Organization : Ms. Gail Story

Category : Pharmacist

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 widow of a brain tumor patient, as well as an infusion pharmacist 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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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-97 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Miss. Beth Rosenthal **Date & Time:** 06/05/2007

Organization : Central NJ Brain Tumor Support Group

Category : Individual

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Beth Rosenthal
203 Prestwick Way
Edison, NJ 08820
June 5, 2007

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

I am 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.

I propose the following titles for these MS-DRGs:

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(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,

Beth Rosenthal

CMS-1533-P-98 **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

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

I am a friend 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.

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Thank you for your consideration of this important matter!

CMS-1533-P-99 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

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

Organization : Andrea Lavine

Category : Social Worker

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 hospital Social Worker and the 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:

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Thank you for your consideration of this important matter.

Sincerely,
Andrea Lavine

CMS-1533-P-100 **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter : Mrs. LORI BENTZ **Date & Time:** 06/05/2007

Organization : Mrs. LORI BENTZ

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 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.

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