

**CMS-1533-P-1 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Ms. Gail Rhoades

**Date & Time:** 04/19/2007

**Organization :** Hilo Medical Center

**Category :** Nurse

**Issue Areas/Comments**

**DRGs: Hospital Acquired Conditions**

DRGs: Hospital Acquired Conditions

This comment refers to the list of potential high-volume, hospital-acquired conditions that hospitals could have reasonably prevented and proposed financial penalties for when they occur. I would recommend the sentinel event items, specifically Object Left in Surgery (998.4), Delivery of ABO-incompatible blood products (999.1) and Surgery on Wrong Body Part, Patient, or Wrong Surgery (E876.5). I disagree with using Methicillin-resistant staphylococcus aureus infection (V09.0) and Patient Falls (no code) as those two items are unpredictable, difficult to prevent and would penalize all hospitals.

**CMS-1533-P-2**

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

**Submitter :** Dr. William Haik

**Date & Time:** 04/25/2007

**Organization :** DRG Review, Inc.

**Category :** Physician

**Issue Areas/Comments**

**DRG Reform and Proposed  
MS- DRGs**

DRG Reform and Proposed MS-DRGs

April 25, 2007

Department of Health and Human Services  
Attention: CMS-1533-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

RE: DRG Reform and Proposed MS-DRGs

Dear Sir or Madam:

Thank you for requesting comments on the issue of  DRG Reform and Proposed MS-DRGs.  After reading your proposed methodology and having worked with the DRG system for twenty years, I believe your proposal is an excellent attempt to define severity of illness based on DRGs for the Medicare population.

However, I am highly perplexed you would propose to adopt the MS-DRGs for FY08 while the Rand Corporation is deciding this year between your methodology and five other vendors for subsequent adoption probably in FY09.

I am unsure if you realize this would create enormous cost for hospitals as they  educationally gear up  for the MS-DRGs and then potentially for another system one year later. I am aware of hospitals where the coding supervisors are already taking time out of their work days to study the proposed notice. Although this only amounts to a few hours, if multiplied by the number of hospitals in the country, it is a significant loss of productivity.

Additionally, undoubtedly, hospitals will be bombarded by consultants (of which I am one) who will charge hospitals educational hours to get ready for a system which may only be in place for one year. As you know, hospitals commonly expend educational dollars attempting to legitimately optimize the current CMS-DRG Grouper.

In summary, although I applaud your methodology, I am opposed to any new system occurring in FY08, unless it is deemed to be the final system adopted from the ones which are currently being studied.

Thank you.

With kindest regards,

WILLIAM E. HAIK, M.D.

WEH/ddm

CMS-1533-P-2-Attach-1.DOC

April 25, 2007

Department of Health and Human Services  
Attention: CMS-1533-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

RE: DRG Reform and Proposed MS-DRGs

Dear Sir or Madam:

Thank you for requesting comments on the issue of "DRG Reform and Proposed MS-DRGs." After reading your proposed methodology and having worked with the DRG system for twenty years, I believe your proposal is an excellent attempt to define severity of illness based on DRGs for the Medicare population.

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Additionally, undoubtedly, hospitals will be bombarded by consultants (of which I am one) who will charge hospitals educational hours to get ready for a system which may only be in place for one year. As you know, hospitals commonly expend educational dollars attempting to legitimately optimize the current CMS-DRG Grouper.

In summary, although I applaud your methodology, I am opposed to any new system occurring in FY08, unless it is deemed to be the final system adopted from the ones which are currently being studied.

Thank you.

With kindest regards,

WILLIAM E. HAIK, M.D.

WEH/ddm

**CMS-1533-P-3**

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

**Submitter :**

**Date & Time:** 05/07/2007

**Organization :**

**Category :** Hospital

**Issue Areas/Comments**

**Patient Safety Measures**

Patient Safety Measures

While I understand and support most the new measures that are being added to SCIP, I would like to request SCIP-CARD-2 not be required. This measure has good intentions, but as written is very difficult to abstract. If the definition of peri-operative end time is edited to be more consistent, then I would welcome this measure. Until then, I fear it would only cause more problems than it would solve. We do give beta-blockers after surgery - but not likely within the nebulous end time of the peri-operative period. With this convoluted definition, we have no easy way to create policies or procedures to address this measure in a reasonable and logical manner. Please do not include SCIP CARD-2 as a required measure to qualify for the full market basket update.  
Thank you for taking the time to read my comment.

CMS-1533-P-3-Attach-1.PDF

**Notes for Abstraction continued:**

- **To determine when the end of the perioperative period occurred for patients discharged from surgery and admitted to locations other than the PACU (e.g., ICU):**
  - The recovery period would end a maximum of six hours after arrival to the recovery area unless the anesthesiologist signs off before the six hours has elapsed.
  - If the anesthesiologist signs off before the patient enters the non-PACU recovery area, allow up to six hours for the recovery period.
  - Examples:
    - The anesthesiologist signed off at 08:45. The patient arrived in ICU for recovery at 09:00. The post anesthesia care/recovery area period would end a maximum of six hours later or 15:00. Select “Yes” if a beta blocker was received prior to the end of the recovery period.
    - The patient arrived in the ICU for recovery at 23:00 on 01-04-2006. After allowing six hours for the recovery period, the recovery end time would be 05:00 on 01-05-2006. Select “Yes” if a beta blocker was received prior to the end of the recovery period.

**Suggested Data Sources:**

- Anesthesia records
- Consultation notes
- History and physical
- Medication administration record
- Nursing admission assessment
- Operative report
- Preoperative record
- Procedure notes
- Progress notes

**Guidelines for Abstraction:**

<b>Inclusion</b>	<b>Exclusion</b>
Refer to Appendix C, Table 1.3 for a comprehensive list of Beta Blocker medications.	Eye drops containing beta-blocker (e.g., Cosopt)

**CMS-1533-P-4**

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

**Submitter :** Mr. David Garland

**Date & Time:** 05/08/2007

**Organization :** National Government Services (fiscal intermediary)

**Category :** Health Plan or Association

**Issue Areas/Comments**

**Wage Index**

Wage Index

I work with the National Government Services, the intermediary servicing hospitals in Massachusetts. It appears the Wage Index Value listed in Table 2 for provider # 22-0051 (North Adams Hospital) is incorrectly listed as .9739. North Adams Hospital is located in Berkshire County (MA) which is CBSA Code # 38340. According to Table 4a (urban wage indices), the corresponding wage index for this county is 1.0071. For some reason, the Federal Register has used the Rural Massachusetts's value when listing provider # 22-0051 in Table 2. I have made the hospital aware of this apparent oversight, so they may be submitting a comment too. I'd expect this would be corrected for the Final Rule in August. Thank you,

David Garland

National Government Services

Tel: (207)-253-3312

email: david.garland@anthem.com

**CMS-1533-P-5**

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

**Submitter :** Mrs. Rebecca Hawley

**Date & Time:** 05/09/2007

**Organization :** Univeristy of Toledo Medical Center

**Category :** Hospital

**Issue Areas/Comments**

**IME Adjustment**

IME Adjustment

The proposal by the Centers for Medicare & Medicaid (CMS) to disallow time associated with vacation and sick time is ludicrous for the following reasons:

1. Residents work at least 80 hours each week and a full time equivalent is 40 hours, which is the time CMS reimburses hospitals for medical education. Hospitals do not receive payment for 2 FTEs when the resident works the equivalent of two FTEs. Under the proposed rules, the sick and vacation time should come out of the second tier of 40 hours which makes the disallowance of such time a mute point.
2. Both sick and vacation time were part of the base year costs and should be continue to be included to be consistent.
3. Record keeping would be disastrous at best for those residents that rotate to more than one hospital for the academic year. An agreement as to which hospital would recognize paid time off is not a simple procedure. It is often difficult to resolve duplicate residents let alone trying to come up with a mechanism to allocate paid time off. It should also be established that different programs as well as the year in the program will determine the amount of vacation the resident earns. This benefit will vary from hospital to hospital and to keep track of which resident receives which vacation and then to allocate this amount rotating hospitals would be a record keeping nightmare.
4. Female residents would be negatively affected by the potential change as they are more likely to carry their vacation time over from year to year to be used as a maternity benefit.

In conclusion, it should be noted that by not recognizing this time as part of the FTE the Medicare program never fully reimburses the hospital for the resident rotation.

**CMS-1533-P-6**

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

**Submitter :** Dr. Calvin Maestro

**Date & Time:** 05/10/2007

**Organization :** Dr. Calvin Maestro

**Category :** Physician

**Issue Areas/Comments**

**DRG Reform and Proposed  
MS- DRGs**

DRG Reform and Proposed MS-DRGs

Dear Sirs,

Part of the proposed rule would implement a provision of the Deficit Reduction Act of 2005 (DRA) that takes the first steps toward preventing Medicare from giving hospitals higher payment for the additional costs of treating a patient that acquires a condition (including an infection) during a hospital stay. Beginning in FY 2009, cases with these conditions would not be paid at a higher DRG unless they were present on admission. My issue is that, given the short hospital stays now common, many preventable infections that are acquired during the hospitalization do not show up until after the patient is discharged. These result in re-hospitalization, for which, under your proposed rule, the infection would now be present upon admission, thus allowing the hospital to bypass the intent of the proposed regulation. Please consider. Thanks. CJM

CMS-1533-P-7

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

Submitter : Mrs. Debra Ellis

Date &amp; Time: 05/14/2007

Organization : Thomson Healthcare

Category : Other Health Care Professional

**Issue Areas/Comments****DRGs: Intracranial Stents**

DRGs: Intracranial Stents

The proposal is to move procedure code 00.62 from CMS DRGs 533 & 534 to CMS DRGs 1 & 2 as well as 543. This section indicates that CMS DRGs 1 & 2 go to proposed MS-DRGs 37 (Extracranial Procedures With MCC), 38 (Extracranial procedures with CC) and 39 (Extracranial procedures without CC/MCC). However, it appears that three new MS-DRGs were created to replace CMS DRGs 1, 2, and 3. These are MS- DRGs 25, 26, and 27 (Craniotomy & Endovascular Intracranial Procedures With MCC, With CC and Without CC/MCC, respectively). Also, later in section II. J, 4   New Technology  section about add-on payments, the proposed change of moving 00.62 to MS-DRGs 25, 26, and 27 as well as 23 and 24 is referred to  as discussed &  These were not actually discussed.

**DRGs: Spinal Procedures**

DRGs: Spinal Procedures

The proposal is to add diagnosis codes for tuberculosis and osteomyelitis (015.02, 015.04, 015.05, 730.08, 730.18 and 730.28) to the principal diagnosis list for proposed MS-DRGs 456-458. However, there is no proposal to redefine the MS-DRG titles to reflect these diagnoses. (note that these titles are also being revised to include 9+ Fusions (procedure code 81.64) in an earlier part of this proposal.) The redefined MS-DRG titles should be:

MS-DRG 456 Spinal Fusion Except Cervical With Spinal Curvature, Malignancy, Tuberculosis or Osteomyelitis or 9+ Fusions With MCC

MS-DRG 457 Spinal Fusion Except Cervical With Spinal Curvature, Malignancy, Tuberculosis or Osteomyelitis or 9+ Fusions With CC

MS-DRG 458 Spinal Fusion Except Cervical With Spinal Curvature, Malignancy, Tuberculosis or Osteomyelitis or 9+ Fusions Without CC/MCC

**Medicare Code Editor**

Medicare Code Editor

There is one code missing from your list of codes to remove Medicare Code Edit 7  diagnosis code 01595 is a current  Non-specific diagnosis  that is not included in the list printed in the Federal Register.

CMS-1533-P-7-Attach-1.DOC

CMS-1533-P-7-Attach-1.DOC

CMS-1533-P-7-Attach-1.DOC

Debra A. Ellis, RHIT, CCS  
Nosologist  
Thomson Healthcare  
5400 Data Court, Suite 100  
Ann Arbor, MI 48108

May 23, 2007

Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Sir or Madam:

These comments are regarding the Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates [CMS-1533-P] published in the *Federal Register*, May 3, 2006.

Section II. G, 2, b. "DRGs: Intracranial Stents"

The proposal is to move procedure code 00.62 from CMS DRGs 533 & 534 to CMS DRGs 1 & 2 as well as 543. This section indicates that CMS DRGs 1 & 2 go to proposed MS-DRGs 37 (Extracranial Procedures With MCC), 38 (Extracranial procedures with CC) and 39 (Extracranial procedures without CC/MCC). However, it appears that three new MS-DRGs were created to replace CMS DRGs 1, 2, and 3. These are MS-DRGs 25, 26, and 27 (Craniotomy & Endovascular Intracranial Procedures With MCC, With CC and Without CC/MCC, respectively). Also, later in section II. J, 4 – "New Technology" section about add-on payments, the proposed change of moving 00.62 to MS-DRGs 25, 26, and 27 as well as 23 and 24 is referred to "as discussed..." These were not actually discussed.

Section II. G, 4, b. "DRGs: Spinal Procedures"

The proposal is to add diagnosis codes for tuberculosis and osteomyelitis (015.02, 015.04, 015.05, 730.08, 730.18 and 730.28) to the principal diagnosis list for proposed MS-DRGs 456-458. However, there is no proposal to redefine the MS-DRG titles to reflect these diagnoses. (note that these titles are also being revised to include 9+ Fusions (procedure code 81.64) in an earlier part of this proposal.) The redefined MS-DRG titles should be:

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MS-DRG 457 Spinal Fusion Except Cervical With Spinal Curvature, Malignancy, Tuberculosis or Osteomyelitis or 9+ Fusions With CC

MS-DRG 458 Spinal Fusion Except Cervical With Spinal Curvature, Malignancy, Tuberculosis or Osteomyelitis or 9+ Fusions Without CC/MCC

Section II. G, 6, b. "Medicare Code Editor"

There is one code missing from your list of codes to remove Medicare Code Edit 7 – diagnosis code 01595 is a current "Non-specific diagnosis" that is not included in the list printed in the *Federal Register*.

Sincerely,

Debra A. Ellis, RHIT, CCS  
Nosologist

**CMS-1533-P-8 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Lori Howard

**Date & Time:** 05/15/2007

**Organization :** Kansas Foundation for Medical Care

**Category :** Health Care Industry

**Issue Areas/Comments**

**Hospital Quality Data**

Hospital Quality Data

Starting with 3rd quarter 2006, hospitals are required to submit data on PCI received within 90 minutes of hospital arrival, vs. the previous 120 minute criteria for the AMI topic. The current document lists RHQDAPU program measures for 2007(pg 466), 2008 and 2009 (pg 468)and includes the previous criteria of 120 minutes instead of the updated 90 minute criteria. Please clarify.

**CMS-1533-P-9**

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

**Submitter :** Mr. Kevin Frodyma

**Date & Time:** 05/19/2007

**Organization :** St. Peter's Hospital

**Category :** Hospital

**Issue Areas/Comments**

**Replaced Devices**

**Replaced Devices**

Regarding reduction in payment for replacement devices where the hospital received full or partial credit for the device, I feel it inappropriate to reduce the payment under either scenario. Under the current system, hospitals are prohibited from billing charges associated with devices obtained at no cost and are required to offset credits or other rebates received from vendors against its cost basis for Medicare Cost Reporting purposes, or in the case of recalls/warranties, there is no cost incurred in the first place. Therefore, charges on cases included in the MedPAR data and costs from the cost reports used determine the relative value units are already netted in the basis to develop the DRG relative values.

It would seem that in a system based on averages in which the cases receiving the  free  devices are not subject to billed charges and there is no cost in the cost report for the replacement device, that to provide for specific recoupment of the replacement device would result in a duplicative recovery of the device cost by the Medicare program. Once by paying all device cases at a lower rate and once by specific case recovery for those cases that actual receive the replacement device.

**CMS-1533-P-10**

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

**Submitter :** Dr. Mary Ann Clemens

**Date & Time:** 05/22/2007

**Organization :** Advocate Health Care

**Category :** Hospital

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1533-P-10-Attach-1.DOC



205 W. Touhy Avenue, Suite 117  
Park Ridge, IL 60068

Medical Education & Research

## MEMORANDUM

To: Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
[www.cms.hhs.gov/eRulemaking/](http://www.cms.hhs.gov/eRulemaking/)

From: Advocate Executive Medical Education Council  
Ann Errichetti, MD  
Chief Academic Officer  
Mary Ann Clemens, EdD *Mary Ann Clemens*  
Vice President, Medical Education and Research

Date: May 22, 2007

Re: Advocate Health Care's Response to "Part II, Department of Health and Human Services, Centers for Medicare & Medicaid Services 42 CFR Parts, 411, 412, 413, and 489. Medicare Program; Proposed Changes to The Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Proposed Rule."

File Code: CMS-1533-P

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We thank you for the opportunity to respond to "Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Proposed Rule." This response relates specifically to **413.75** Direct GME Payments: General Requirements and **413.78** Direct GME payments: Determination of the total number of FTE residents in Part 413 *Principles of Reasonable Cost Reimbursement*.

The following response represents the Medical Education leadership of Advocate Christ Medical Center, Advocate Illinois Masonic Medical Center, and Advocate Lutheran General Hospital and our reimbursement officer. Our position is in alignment with the Association of American Medical Colleges (AAMC.)

**Definition of Orientation Activities (p. 24833 of the Federal Register, Vol. 72, No. 85, Thursday, May 3, 2007)**

**Orientation activities** means activities that are principally designed to prepare an individual for employment as a resident in a particular setting, or for participation in a particular specialty program and patient care activities associated with that particular specialty program.

**Patient care activities** mean the care and treatment of particular patients, including services for which a physician or other practitioner may bill, and orientation activities as defined in this section.

Therefore, orientation counts in the determination of resident FTEs.

***Advocate:** We appreciate the inclusion of this important activity in the FTE count.*

**Vacation Time and Sick Leave (p. 24833)**

**(b) \*\*\*** Effective for cost reporting periods beginning on or after October 1, 2007, vacation leave and sick leave (that do not prolong the total time a resident is participating in the approved program beyond the normal duration of the program) are not included in the determination of full-time equivalency.

In a communication from Association of American Medical Colleges (AAMC), the rationale for the non-consideration of vacation and sick leave time is that they are neither part of patient care time or non-patient care time, and that they belong in a distinct third category of time. You also state that it is more appropriate to remove the time altogether from the FTE calculation for each resident for both IME and DME payments.

***Advocate:** Concerns about removing both vacation and sick leave from calculations are numerous. First, with vacation time, both the numerator and denominator changes from 52 weeks to 52-minus the allotted vacation time which results in a reduced count. In the case of IME, we already are unable to count time for research and other activities. This places additional burden on the hospital. Another challenge is determining how vacation will be assigned and if it will be prorated between the hospitals with the rotation before the vacation and the hospitals following the rotation. Vacation policies from the sites of rotations would have to be known in order to calculate. Not all programs our hospital interacts with get the same amount of vacation. For the twenty-five programs within our system that interact with numerous other rotation sites, this type of record-keeping is cumbersome, complicated and unnecessary. It would create a morass of paperwork. We recommend that vacation be treated as orientation, left in the count, and a third category not be created.*

*Regarding sick leave. The concerns about use of sick leave and the record keeping necessary to correlate the time away resident-by-resident with the FTE count is too*

*onerous to consider feasible. Sick leave is already regulated through employee benefits.  
We ask that you treat sick leave as you have treated orientation and leave it in the count.*

**Contributors:**

**Steve Pycioch  
Director, Reimbursement**

**Advocate Christ Medical Center**

- **Robert Stein, MD, Vice President, Medical Management**
- **Loreta Krutulis, Manager, Medical Education**

**Advocate Illinois Masonic Medical Center**

- **William Werner, MD, Vice President, Medical Management**
- **Rebecca Mammoser, Director, Medical Education**

**Advocate Lutheran General Hospital**

- **Kris Narisimhan, MD, Vice President, Medical Management**
- **Diane O’Gara, Manager, Medical Education**

**CMS-1533-P-11 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Ms. Leatrice Ford

**Date & Time:** 05/23/2007

**Organization :** ConsultCare Partners, LLC

**Category :** Nurse

**Issue Areas/Comments**

**ICD-9-CM Coding System**

ICD-9-CM Coding System

I don't agree with the arbitrary elimination of 428.0 Congestive heart failure NOS from the CC list. As a nurse and certified coding specialist, I believe that code is not benign, nor does it indicate a chronic condition. It is an appropriate code for congestive heart failure, an acute condition that may not warrant another diagnosis code. I also disagree with 428.1 Left heart failure being assigned as a CC, but not a MCC. It is the correct code for pulmonary edema, an acute condition that is a medical emergency. Both of those codes were considered to be major cardiovascular conditions in the 2006 revision of the cardiovascular DRGs. Obviously statistics showed they were significant diagnoses and consumed additional resources. I would like to see whether there are data showing these codes do not qualify as CC or MCC per their resource use. It's noteworthy that 45% of patients who grouped to MCV or CC DRGs in MDC 5 per the 2006 grouper will fall into the lowest severity of illness DRGs in 2008. I estimate the savings to CMS to be at least \$866 million. Hopefully the decision to eliminate 428.0 as a CC was based on statistics, not on financial savings. Please reconsider whether 428.0 should be added to the CC or MCC list. Please reconsider the status of 428.1 left heart failure as a MCC. Thank you

**CMS-1533-P-12 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Sarah Glass

**Date & Time:** 05/23/2007

**Organization :** St. Luke's Episcopal Hospital

**Category :** Hospital

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

Regarding DRG 385 (current) and MS-DRG 789 (proposed) - Neonates, died or transferred to another acute care facility:

When the appropriate discharge disposition is used for newborn transfers to children's hospitals, the DRG currently does not group to DRG 385. Please take the opportunity to address this issue in the new rule so there will not be an issue with MS-DRG 789.

According to the National Uniform Billing Committee (NUBC), discharge status 05 is to be used when a patient is transferred to a non-Medicare facility that is exempt from the inpatient prospective payment system. They include psychiatric, CHILDREN'S HOSPITALS, cancer hospitals and psychiatric distinct part units of a hospital. They do not include SNFs or acute care facilities/units that have specific patient status codes. According to Section 1886(d) of the Social Security Act the following hospitals and hospital units are excluded from the prospective payment systems: psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals.

For example, currently when a newborn is TRANSFERRED to a children's hospital that provides acute care, and the discharge disposition of "05" is used, the DRG does not group to the transfer DRG 385 (Neonates Died or Transferred to Another Acute Care Facility)--it groups to the DRG for prematurity. If a newborn expires, the discharge disposition of "20" causes the DRG to group appropriately to DRG 385, and we would expect that to continue with MS-DRG 789. Is the intent for all newborns transferred to a children's hospital with discharge disposition "05" to group to MS-DRG 789 (or the old DRG 385 if CMS-DRGs are not adopted)? If so, all newborn DRGs would need to be adjusted to group to DRG 385 or MS-DRG 789 when the discharge disposition "05" is assigned.

Please address this in the new rule. Thank you.

**CMS-1533-P-13 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Dr. James Kennedy

**Date & Time:** 05/25/2007

**Organization :** VP-MA Health Solutions

**Category :** Physician

**Issue Areas/Comments**

**DRG Reform and Proposed**

**MS- DRGs**

**DRG Reform and Proposed MS-DRGs**

Thank you for allowing me to comment upon the proposed MS-DRGs.

I am in favor of a more refined DRG system. I believe that MS-DRGs are a good start. I believe, however, that some of its logic is "illogical".

For example, the coding and grouping of sepsis is illogical. ICD-9-CM requires that all patients admitted with sepsis have the underlying systemic infection to be coded as principal diagnosis. Invariably, this is 038.xx, grouping to MS-DRG 872 (Septicemia w/o MV 96+ hr w/o MCC). The SIRS codes, 995.91 and 995.92 are excluded as CCs under the proposed rule.

However, since the underlying causes are NOT excluded, those that qualify as a MCC will always group to MS-DRG 871. For example, all SIRS due to pneumonia, even those without organ dysfunction, will group to MS-DRG 871 since pneumonia is a MCC. Since SIRS has relatively loose criteria (WBC over 12,000, Temp above 101, "left shift") and since most pneumonias requiring hospitalization meet these criteria, I see a major push to document SIRS due to pneumonia on even the simplest case that have only a 2-3 day length of stay.

I also have read in the Federal Register that CMS wants coders to differentiate between Sepsis (995.91) and Severe Sepsis (995.92). Since both Sepsis and Severe Sepsis are categorized as MCCs, coders have no incentive to go the extra mile to make this differentiation.

I would like to suggest the following:

1) That for DRGs 871 and 872 that the underlying infections that are present on admission be excluded from qualifying as CCs or Major CC. Since septicemia or systemic infection has an underlying cause, the underlying cause should not count. This would prevent all the SIRS due to pneumonia from automatically grouping to DRG 872.

2) That 995.91 be categorized as a CC whereas 995.92 be categorized as a MCC. This logic was applied to 995.93 and 995.94; why it was not applied to 995.91 and 995.92 is a mystery to me.

3) That 995.92 be considered to be only a CC since there is no differentiation between organ dysfunction and organ failure in this code. Should the patient have organ failure, this should be coded and can count as the MCC. The same logic should apply to 995.93 and 995.94 - these should only be CCs, not major CCs.

3) That for DRGs 871 and 872, that only 995.91 be excluded as a CC. If the patient has an organ dysfunction (which does not have to be organ

failure under ICD-9-CM) due to SIRS (such as acute renal insufficiency, acute hypoxemia, transient liver dysfunction), then 995.92 can count as a CC (not a major CC). Should the patient have an organ failure (such as acute respiratory failure, acute renal failure, septic encephalopathy), then these conditions can count as the MCC, changing 871 to 872.

I would also like to suggest that 995.93 and 995.94 not be excluded as CCs with pancreatitis. I believe that patients with systemic inflammatory response due to pancreatitis meet Ranson's criteria and are sicker. Those that have acute organ dysfunction are even sicker than those without. I believe that for burns, major trauma, and pancreatitis, 995.93 and 995.94 should qualify as a CC. Should they develop acute organ failure, then they would qualify for a DRG with a MCC.

I have additional comments that I will place in another submission. If you would like to discuss this with me, please call me at 615-479-7021 or write me at JKennedyMD@vp-ma.com.

Sincerely,

James S. Kennedy, M.D., C.C.S.

CMS-1533-P-13-Attach-1.DOC

Attachment #1 to CMS-1533-P-13

Thank you for allowing me to comment upon the proposed MS-DRGs.

I am in favor of a more refined DRG system. I believe that MS-DRGs are a good start. I believe, however, that some of its logic is "illogical".

For example, the coding and grouping of sepsis is illogical. ICD-9-CM requires that all patients admitted with sepsis have the underlying systemic infection to be coded as principal diagnosis. Invariably, this is 038.xx, grouping to MS-DRG 872 (Septicemia w/o MV 96+ hr w/o MCC). The SIRS codes, 995.91 and 995.92 are excluded as CCs under the proposed rule.

However, since the underlying causes are NOT excluded, those that qualify as a MCC will always group to MS-DRG 871. For example, all SIRS due to pneumonia, even those without organ dysfunction, will group to MS-DRG 871 since pneumonia is a MCC. Since SIRS has relatively loose criteria (WBC over 12,000, Temp above 101, "left shift") and since most pneumonias requiring hospitalization meet these criteria, I see a major push to document SIRS due to pneumonia on even the simplest case that have only a 2-3 day length of stay.

I also have read in the Federal Register that CMS wants coders to differentiate between Sepsis (995.91) and Severe Sepsis (995.92). Since both Sepsis and Severe Sepsis are categorized as MCCs, coders have no incentive to go the extra mile to make this differentiation.

I would like to suggest the following:

- 1) That for DRGs 871 and 872 that the underlying infections that are present on admission be excluded from qualifying as CCs or Major CC. Since septicemia or systemic infection has an underlying cause, the underlying cause should not count. This would prevent all the SIRS due to pneumonia from automatically grouping to DRG 872.
- 2) That 995.91 be categorized as a CC whereas 995.92 be categorized as a MCC. This logic was applied to 995.93 and 995.94; why it was not applied to 995.91 and 995.92 is a mystery to me.
- 3) That 995.92 be considered to be only a CC since there is no differentiation between organ dysfunction and organ failure in this code. Should the patient have organ failure, this should be coded and can count as the MCC. The same logic should apply to 995.93 and 995.94 - these should only be CCs, not major CCs.
- 3) That for DRGs 871 and 872, that only 995.91 be excluded as a CC. If the patient has an organ dysfunction (which does not have to be organ failure under ICD-9-CM) due to SIRS (such as acute renal insufficiency, acute hypoxemia, transient liver dysfunction), then 995.92 can count as a CC (not a major CC). Should the patient have an organ failure

(such as acute respiratory failure, acute renal failure, septic encephalopathy), then these conditions can count as the MCC, changing 871 to 872.

I would also like to suggest that 995.93 and 995.94 not be excluded as CCs with pancreatitis. I believe that patients with systemic inflammatory response due to pancreatitis meet Ranson's criteria and are sicker. Those that have acute organ dysfunction are even sicker than those without. I believe that for burns, major trauma, and pancreatitis, 995.93 and 995.94 should qualify as a CC. Should they develop acute organ failure, then they would qualify for a DRG with a MCC.

I have additional comments that I will place in another submission. If you would like to discuss this with me, please call me at 615-479-7021 or write me at JKennedyMD@vp-ma.com.

Sincerely,

James S. Kennedy, M.D., C.C.S.

**CMS-1533-P-14 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter : Mr. Roy Brady**

**Date & Time: 05/25/2007**

**Organization : Accuro Healthcare Solutions**

**Category : Other Health Care Professional**

**Issue Areas/Comments**

**DRG Reclassifications**

**DRG Reclassifications**

**In the FY2007 DRG classification scheme, DRG 572 (Major Gastrointestinal Disorders and Peritoneal Infections) is assigned to MDC 8 (Musculoskeletal System). Shouldn't DRG 572 be assigned to MCD 6 (Digestive System)?**

**CMS-1533-P-15 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Terese Scollard

**Date & Time:** 05/25/2007

**Organization :** self-professional

**Category :** Dietitian/Nutritionist

**Issue Areas/Comments**

**GENERAL**

GENERAL

General personal comment: Thank you for including malnutrition in the severity rating system. Identification, documentation and the serious consideration in work processes and care plans of this 'hidden' disease remains a problem in hospitals. Rule language and structure that support inclusion and strong attention to acute care malnutrition, malnutrition risk factors and processes of care for early, timely and adequate food, tube feeding and total parenteral nutrition remain in the best interest of those paying for care. Malnutrition risk factors are present from 40-60 percent of acute care admissions, however since treatment is interdisciplinary it requires nursing, medicine and nutrition professionals to all include appropriate time and attention to this topic. Inclusion of the malnutrition codes enables leverage for legitimate attention to this topic within hospitals. Please include language that speaks to this basic right of patients to receive and have documented, adequate and safe nutrition while hospitalized. Terese Scollard RD, LD

**CMS-1533-P-16**

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

**Submitter : Dr. George MD**

**Date & Time: 05/27/2007**

**Organization : Mid-State Cardiology Associates/ St. THomas Health**

**Category : Physician**

**Issue Areas/Comments**

**DRGs: Hospital Acquired  
Conditions**

DRGs: Hospital Acquired Conditions

While we appreciate and endorse quality improvement initiatives that are logical, Elements of the hospital acquired conditions policy are not founded in scientific literature.

- 1) To think that all Staphylococcus aureus septicemia is iatrogenic is frankly foolish. This is an exceedingly common malady that affects many patients with multiple risk factors such as diabetes and renal failure. While it can be reduced by good medical practice, it can most certainly not be eliminated and should not be included here. Including it here will provide for strong discouragement for hospitals to care for the sickest of the sick.
- 2) The same is true for urinary tract infections occurring in the debilitated.
- 3) Blood reactions still occur occasionally, even if all possible compatibility testing is performed.
- 4) While significant air embolism occurring from an IV is avoidable, it is not avoidable in certain vascular procedures such as pacemaker implantation, ICD implantation and certain electrophysiological procedures requiring the use of large sheaths.

George H. Crossley, III, MD, FACC, FHRS  
President & CEO  
Mid-State Cardiology Associates  
ghcmd@comcast.net

CMS-1533-P-17

**Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates****Submitter :** Mrs. Sheila Schultz**Date & Time:** 05/29/2007**Organization :** Wheeling Hospital**Category :** Other Health Care Professional**Issue Areas/Comments****GENERAL**

GENERAL

Please reconsider implementing the MS DRG system this October 12, 2007, with the possibility of changing again for fiscal year 2009. It would make more sense to wait for the Rand Study and make a decision as to which DRG system is the best one to implement and implement it October 1, 2008 or 2009, depending on how fast the decision is made. There needs to be time for education, preparation, and software implementation. It does not make sense to implement a new DRG system this year with such short notice and then change it the following year. This would create a huge burden on hospitals, coding staff, software companies, and fiscal intermediaries, to name a few. Pushing this too fast when the information is not yet available to make a sound firm decision is irresponsible and will have a negative affect on the healthcare system. Thank you.

**CMS-1533-P-18**

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

**Submitter :** Dr. Joseph Cervia

**Date & Time:** 05/30/2007

**Organization :** Albert Einstein College of Medicine/Pall Medical

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment.

CMS-1533-P-18-Attach-1.DOC

#18

May 23, 2007

Dear Sir or Madam:

This correspondence is in response to your request for comments regarding CMS-1533-P, Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2008 Rates. In agreement with previous commenters who have noted that the death, injury, and cost of hospital-acquired infections are too high to limit this provision to two conditions, I would propose that it include Legionnaires' Disease (LD). A recognized illness complicating hospital stays at high cost, both financially and in terms of serious morbidity and mortality, LD meets each of the three criteria set forth in Section 5001(c) of Pub. L. 109-171.

**Burden (High Cost/High Volume):**

According to CDC, an estimated 8,000-18,000 cases of LD occur each year in the United States. This is particularly striking as the agency also notes that only a fraction of LD cases are reported. LD is a reportable condition in most states; however, because of under-diagnosis and under-reporting only 2%-10% of estimated cases are reported.<sup>1</sup>

Most LD cases are sporadic; 23% are nosocomial and 10%-20% can be linked to outbreaks. Death occurs in 10%-15% of LD cases, and a substantially higher proportion of fatal cases occur during nosocomial outbreaks. Disease is often attributed to inhalation of contaminated aerosols from devices such as cooling towers, showers, and faucets, and aspiration of contaminated water. Importantly Medicare beneficiaries, including the elderly, cigarette smokers, persons with chronic lung or immunocompromising disease, and persons receiving immunosuppressive drugs are at particularly high risk.<sup>1</sup>

**Prevention Guidelines:**

CDC guidelines for the prevention of LD have been available and widely distributed for years. They may be found at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm>.

**Coding/CC:**

ICD-9-CM code 482.84 defines cases of LD.<sup>2</sup>

In summary, on the basis of high disease burden, widely available, evidence-based prevention guidelines, and a distinct identifying ICD-9-CM coding that would result in higher payment to institutions not taking all necessary preventive measures, I strongly recommend that CMS include LD as a complication under CMS-1533-P.

<sup>1</sup> [http://www.cdc.gov/ncidod/dbmd/diseaseinfo/legionellosis\\_t.htm](http://www.cdc.gov/ncidod/dbmd/diseaseinfo/legionellosis_t.htm)

<sup>2</sup> <http://icd9cm.chrisendres.com/index.php?action=child&recordid=4666>

Sincerely,

Joseph S. Cervia, M.D., FACP, FAAP, FIDSA  
Clinical Professor of Medicine and Pediatrics  
Albert Einstein College of Medicine  
Medical Director and Senior Vice-President  
Pall Medical

**CMS-1533-P-19 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Dr. Kerry Willis

**Date & Time:** 05/31/2007

**Organization :** National Kidney Foundation

**Category :** Other Association

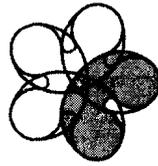
**Issue Areas/Comments**

**ICD-9-CM Coding System**

ICD-9-CM Coding System

Comments on Proposed Rule from National Kidney Foundation  
Re: CMS-1533-P

CMS-1533-P-19-Attach-1.DOC



#19

# National Kidney Foundation

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## Comments on Proposed Rule from National Kidney Foundation

Re: CMS-1533-P

On behalf of the National Kidney Foundation, I submit the following comments regarding ICD-9-CM codes in the proposed rule published in the May 4, 2007 issue of the Federal Register. Recognizing that 585.4, 585.5 and 585.6 are classified as CCs in the proposed list of CCs, we strongly recommend that 585.3 be included in this group. Stage 3 chronic kidney disease (CKD) is the stage where most of the complications of kidney disease first become evident, as kidney function declines below 60 ml/min/1.73 m<sup>2</sup> GFR. It is at this point that studies reveal that anemia of CKD begins, secondary hyperparathyroidism of CKD begins and most of the other complications that are apparent at later stages also begin. CKD stage 3 is also associated with an increased risk of all-cause mortality and cardiovascular disease hospitalization, especially in the elderly, in whom CKD stage 3 is most common.

With 585.3 included with the group of codes that should be considered as a CC, it will also be necessary to redefine the 403.xx series, grouping 403.x0 as hypertensive renal disease with CKD stages 1 or 2 and 403.x1 as hypertensive renal disease with CKD stages 3 - 5 and ESRD. Similar attention would have to be turned to the 404.xx series to meet the above distributive needs. With respect to data collection, placing the CKD stages into this grouping would have an additional benefit in the hypertensive code categories. Prior to 2005, 403.x0 was identified as hypertensive renal disease without mention of renal failure and 403.x1 was identified as hypertensive renal disease with mention of renal failure. Redistributing the stages of CKD as above would restore a critical element of continuity between the 2005 and the soon-to-be 2008 code sets.

Thank you for your consideration.

Kerry Willis PhD  
Senior Vice President  
Scientific Activities  
National Kidney Foundation

**CMS-1533-P-20 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Daniel Williams

**Date & Time:** 06/01/2007

**Organization :** Cooper University Hospital

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**Rural Floor**

Rural Floor

Dear Ms. Norwalk:

Please note that the following comments correspond to the Imputed Floor section contained in the FFY 2008 proposed IPPS rule published in the May 3, 2007 Federal Register.

Cooper University Hospital continues to support the Centers for Medicare and Medicaid Services (CMS) proposal related to Special Circumstances of Hospitals in All-Urban States set forth in the FFY 2005 proposed Inpatient Prospective Payment System (IPPS) rule published in the May 18, 2004 Federal Register. Conversely, Cooper University Hospital objects to the proposed expiration of the imputed floor for the following reasons:

" CMS does not give any substantive rationale as to the reason the imputed floor should expire. For comparative purposes, please note the following quote from CMS in the FFY 2005 final rule:

We think it is also an anomaly that hospitals in all-urban States with predominant labor market areas do not have any type of protection, or floor, from declines in their wage index. Therefore, we are adopting the logic similar to that articulated by Congress in the BBA and are adopting an imputed rural policy for a 3-year period.

" CMS does not provide in the FFY 2008 proposed rule any change in either the existence or effect of the aforementioned anomaly; therefore, CMS does not provide any substantive support for the elimination of the imputed floor.

" We believe that it would be improper for CMS to include in the final rule any empirical analysis regarding the imputed floor, as that would constitute avoidance of public commentary.

" CMS has contradicted itself by stating in the FFY 2008 proposed rule that we believe the policy should apply only when required by statute. However, in the FFY 2005 final rule, CMS responded to commenters' contention at that time that any special provision for urban-only States should be subject to legislative action. Citing Social Security Act (SSA) section 1886(d)(3)(E) as the authoritative basis for establishing the imputed floor, CMS correctly noted that the agency does have the discretion to adopt a policy that would adjust wage areas in the manner established by CMS at that time; that is, the policy reflected in the imputed floor regulation.

" In addition, in the past CMS has repeatedly utilized SSA section 1886 (d)(5)(I)(i) to implement wage index adjustments absent specific statutory authority. Furthermore, CMS is currently relying on this section of the SSA for another proposed wage index matter in these proposed regulations.

" CMS notes in the proposed rule that Urban providers in & the Mid-Atlantic Region (NJ) will experience a decrease & by 0.2 percent & from the imputed rural floor no longer being applied in New Jersey. We respectfully request that CMS provide the public, during the public comment period, with the rationale that supports the agency's conclusion in this regard. We request that the agency furnish this information during the public comment period so that interested parties will have due opportunity to review the rationale and comment, as they deem appropriate.

" On an individual hospital level the reduction in funds under the expiration of the imputed floor is estimated to result in a decrease in our DRG payments by approximately \$3.4 million dollars on an annual basis.

" As noted above, the expiration of the imputed floor would have a detrimental impact on Cooper University Hospital. As such, Cooper University Hospital does not support the expiration of the imputed floor due (among other things) to the fact that the rationale for implementing the imputed floor three years ago has not changed since the inception of the imputed floor regulation. Therefore, we urge CMS to extend the imputed floor regulation.

Thank you for considering these important comments and we look forward to your response.

Respectfully submitted,

Daniel Williams  
Director of Reimbursement

**CMS-1533-P-21 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Andrew Guarni

**Date & Time:** 06/01/2007

**Organization :** Our Lady of Lourdes Health Care Services, Inc.

**Category :** Hospital

**Issue Areas/Comments**

**Imputed Floor**

Imputed Floor

The removal of the Imputed Rural Floor will have a significant detrimental impact on New Jersey hospitals.

CMS-1533-P-21-Attach-1.DOC

# 21

**OUR LADY OF LOURDES HEALTH CARE SERVICES, INC.**  
**1600 HADDON AVENUE**  
**CAMDEN, NJ 08103**

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June 1, 2007

Ms. Leslie V. Norwalk, Esq.  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
**Attention: CMS-1533-P**

**Re: File Code CMS-1533-P**

Dear Ms. Norwalk:

Please note that the following comments correspond to the "Imputed Floor" section contained in the FFY 2008 proposed IPPS rule published in the May 3, 2007 Federal Register.

Our Lady of Lourdes Health Care Services, Inc. (OLLHCS) continues to support the Centers for Medicare and Medicaid Services (CMS) proposal related to "Special Circumstances of Hospitals in All-Urban States" set forth in the FFY 2005 proposed Inpatient Prospective Payment System (IPPS) rule published in the May 18, 2004 Federal Register. Conversely, OLLHCS objects to the proposed expiration of the imputed floor for the following reasons:

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- CMS does not give any substantive rationale as to the reason the imputed floor should expire. For comparative purposes, please note the following quote from CMS in the FFY 2005 final rule:

We think it is also an anomaly that hospitals in all-urban States with predominant labor market areas do not have any type of protection, or "floor", from declines in their wage index. Therefore, we are adopting the logic similar to that articulated by Congress in the BBA and are adopting an imputed rural policy for a 3-year period.

- CMS does not provide in the FFY 2008 proposed rule any change in either the existence or effect of the aforementioned "anomaly"; therefore, CMS does not provide any substantive support for the elimination of the imputed floor.
- We believe that it would be improper for CMS to include in the final rule any empirical analysis regarding the imputed floor, as that would constitute avoidance of public commentary.

- CMS has contradicted itself by stating in the FFY 2008 proposed rule that “we believe the policy should apply only when required by statute.” However, in the FFY 2005 final rule, CMS responded to commenters’ contention at that time that “any special provision for urban-only States should be subject to legislative action.” Citing Social Security Act (SSA) section 1886(d)(3)(E) as the authoritative basis for establishing the imputed floor, CMS correctly noted that the agency “does have the discretion to adopt a policy that would adjust wage areas” in the manner established by CMS at that time; that is, the policy reflected in the imputed floor regulation.
- In addition, in the past CMS has repeatedly utilized SSA section 1886 (d)(5)(I)(i) to implement wage index adjustments absent specific statutory authority. Furthermore, CMS is currently relying on this section of the SSA for another proposed wage index matter in these proposed regulations.
- CMS notes in the proposed rule that “Urban providers in ... the Mid-Atlantic Region (NJ) will experience a decrease ... by 0.2 percent ... from the imputed rural floor no longer being applied” in New Jersey. We respectfully request that CMS provide the public, during the public comment period, with the rationale that supports the agency’s conclusion in this regard. We request that the agency furnish this information during the public comment period so that interested parties will have due opportunity to review the rationale and comment, as they deem appropriate.
- On an individual hospital level the reduction in funds under the expiration of the imputed floor would cause a net revenue decrease of \$6.5 million between our two hospitals.

As noted above, the expiration of the imputed floor would have a detrimental impact on OLLHCS. As such, OLLHCS does not support the expiration of the imputed floor due (among other things) to the fact that the rationale for implementing the imputed floor three years ago has not changed since the inception of the imputed floor regulation. Therefore, we urge CMS to extend the imputed floor regulation.

Thank you for considering these important comments and we look forward to your response.

Respectfully submitted,

\_\_\_\_\_  
Andrew R. Guarni  
Chief Financial Officer  
\_\_\_\_\_  
Lourdes Health System

**CMS-1533-P-22 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Dr. Gary Ross

**Date & Time:** 06/01/2007

**Organization :** St John Health

**Category :** Physician

**Issue Areas/Comments**

**DRGs: Hospital Acquired  
Conditions**

DRGs: Hospital Acquired Conditions

Regarding the proposal to not pay for nosocomial infections, I have concerns that this is very one sided for CMS to save money and will hurt the hospitals that are already in financial trouble. It is not realistic to think all nosocomial infections are preventable. For Catheter associated UTI, Ventilator associated pneumonia, C. Diff, MRSA and surgical site infections there are a base rate in the best facilities. Some infection rate is to be expected. The CDC has a National Healthcare Safety Network (NHSN previous NIS) rate for many infections and if above their base rate than you are not living up to expected standards. Since this rule has already been mandated, at least create a base rate that is realistic. Then is the hospital exceeds that rate they can be financially penalized.

Gary Ross DO MS FAAEM  
System Director, Clinical Utilization  
St John Health  
AH Lead Author & Editor eCare Ordersets  
28000 Dequindre  
Warren, MI 48092

Gary.Ross@Stjohn.org

**CMS-1533-P-23 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Ms. Shirley Sayles

**Date & Time:** 06/01/2007

**Organization :** St. John North Shores Hospital

**Category :** Pharmacist

**Issue Areas/Comments**

**GENERAL**

GENERAL

Regarding the proposal to not pay for nosocomial infections, I have concerns that this is very one sided for CMS to save money and will hurt the hospitals that are already in financial trouble. It is not realistic to think all nosocomial infections are preventable. For Catheter associated UTI, Ventilator associated pneumonia, C. Diff, MRSA and surgical site infections there are a base rate in the best facilities. Some infection rate is to be expected. The CDC has a National Healthcare Safety Network (NHSN previous NIS) rate for many infections and if above their base rate than you are not living up to expected standards. Since this rule has already been mandated, at least create a base rate that is realistic. Then is the hospital exceeds that rate they can be financially penalized.

**CMS-1533-P-24 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Valerie Rinkle

**Date & Time:** 06/01/2007

**Organization :** Asante Health System

**Category :** Hospital

**Issue Areas/Comments**

**Replaced Devices**

Replaced Devices

Asante has significant concerns about the method CMS proposes to use to reduce the DRG payment for the device replacement/credit. First, because DRG payments are based on CMS calculations, it is not appropriate to discount the exact credit for each hospital. It is appropriate to discount the percentage credit. Therefore, CMS can publish the calculated amount of the device inherent in each DRG payment. The hospital should merely report the percentage credit from 100% and lower. CMS would use this percent multiplied against the calculated device cost in the DRG to reduce the DRG payment. Not the specific provider cost. Under the averaging system inherent in DRGs, this is a more appropriate discounting method.

Second, we are very concerned with the proposal to suspend a claim with condition code 49 or 50 and then require the hospital to submit invoices. This is very time-consuming for what is otherwise a clean claim. This will significantly increase the days from billing the claim to payment and requires a fax or hard copy of an invoice which is not easy for a hospital biller to obtain. An alternative would be to use a similar approach similar to what CMS has uses under OPSS for FDA approved new drugs without HCPCS codes. CMS asks hospitals to bill C9399 and then put the NDC # of the drug in the remarks field of the claim (FL 84). Using a similar approach, when condition code 49 or 50 is present on the claim, the hospital can be required to provide percentage of the device credit in the remarks field. This approach does not require invoices or paper. If CMS wants to ensure that the credit information is correct, the QIO organizations can audit samples and invoices can be pulled and provided at that time. In this fashion, electronic claim processing can proceed in a more automatic and timely fashion. This should cost both hospitals and CMS contractors less time and effort than handling faxes of invoices. Furthermore, CMS can quickly determine if the credit exceeded 20% and only make adjustments on these claims.

**CMS-1533-P-25 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Dr. James Kennedy

**Date & Time:** 06/03/2007

**Organization :** VP-MA Health Solutions

**Category :** Physician

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

I am in favor of a Medicare's efforts to refine the DRG process.

I believe that the DRG system should be clinically coherent and logical. Diseases that are better defined and/or require more resources should warrant a higher relative weight. DRGs with major CCs should have a higher weight than those with CCs alone. Likewise, DRGs with CCs should have a higher weight than those without.

The categorization of malnutrition as CCs and Major CCs is illogical. I agree that severe malnutrition and its associated conditions (ICD-9-CM Codes 260, 261, and 262) should be Major CCs.

260 Kwashiorkor  
261 Nutritional marasmus  
262 Other severe protein-calorie malnutrition

What I find confusing is that malnutrition not otherwise specified and other specified forms of malnutrition are CCs, however mild or moderate malnutrition is not.

263.0 Malnutrition of moderate degree - Not a CC  
263.1 Malnutrition of mild degree - Not a CC  
263.8 Other protein-calorie malnutrition - A CC  
263.9 Unspecified protein-calorie malnutrition - A CC  
Dystrophy due to malnutrition  
Malnutrition (calorie) NOS

The treatment of moderate malnutrition should require additional resources than malnutrition not otherwise specified. Furthermore, allowing malnutrition to remain a CC and not allowing mild or moderate malnutrition encourages physician to be less specific in their documentation.

I ask that mild and moderate malnutrition be added to the CC list.

CMS-1533-P-25-Attach-1.DOC

I am in favor of a Medicare's efforts to refine the DRG process.

I believe that the DRG system should be clinically coherent and logical. Diseases that are better defined and/or require more resources should warrant a higher relative weight. DRGs with major CCs should have a higher weight than those with CCs alone. Likewise, DRGs with CCs should have a higher weight than those without.

The categorization of malnutrition as CCs and Major CCs is illogical. I agree that severe malnutrition and its associated conditions (ICD-9-CM Codes 260, 261, and 262) should be Major CCs.

- 260 Kwashiorkor
- 261 Nutritional marasmus
- 262 Other severe protein-calorie malnutrition

What I find confusing is that malnutrition not otherwise specified and other specified forms of malnutrition are CCs, however mild or moderate malnutrition is not.

- 263.0 Malnutrition of moderate degree - Not a CC
- 263.1 Malnutrition of mild degree - Not a CC
- 263.8 Other protein-calorie malnutrition - A CC
- 263.9 Unspecified protein-calorie malnutrition - A CC
  - Dystrophy due to malnutrition
  - Malnutrition (calorie) NOS

The treatment of moderate malnutrition should require additional resources than malnutrition not otherwise specified. Furthermore, allowing malnutrition to remain a CC and not allowing mild or moderate malnutrition encourages physician to be less specific in their documentation.

I ask that mild and moderate malnutrition be added to the CC list.

Thank you.

James S. Kennedy, M.D., C.C.S.  
615-479-7021  
JKennedyMD@vp-ma.com