Proposed Changes to American College of Surgeons CoC Standards

Representing ACCC, Immediate Past-President, Luana R. Lamkin, RN, MPH, attended a recent meeting of the American College of Surgeons (ACoS) Commission on Cancer (CoC), which proposed several key changes to its current standards. A number of the new standards focus on patient support and quality measurement. The May 2010 meeting marked the culmination of two years of work, including the Cancer Program Standards revision project and two National Cancer Data Base (NCDB) programs.

While all standards, revisions, deletions, and additions are available on the CoC website, ACCC members may want to look specifically at the following proposed additions, deletions, and changes.

Proposed Additional Standards

- Seventy-five percent of the appointed physician and non-physician members, respectively, attend each meeting of the cancer committee, or other appropriate leadership body, annually.
- Palliative care services are available onsite or by referral.
- Cancer risk assessment, genetic counseling, and testing services are provided onsite or by referral.
- The cancer committee, or other appropriate leadership body, develops a policy and procedure to provide a clear scope of activities, roles, and responsibilities of patient navigation services within the healthcare team. The policy is reviewed at least annually.
- The cancer committee, or other appropriate leadership body, develops a process to monitor screening of cancer patients for psychosocial distress.
- The cancer committee, or other appropriate leadership body, works with the psychosocial representative to monitor the effectiveness of psychosocial activities on an annual basis. The activities and findings are documented in a Psychosocial Services Annual Summary Report presented to the cancer committee annually.
- The cancer committee, or other appropriate leadership body, develops a process to implement and monitor dissemination of a comprehensive care summary and follow-up plan to cancer patients completing cancer treatment. The process is monitored, evaluated, and presented at least annually to the cancer committee, or other appropriate leadership body, and documented in minutes.
- A Cancer Liaison Physician serves in a leadership role within the cancer program and is responsible for evaluating and interpreting the facility's performance using the National Cancer Data Base (NCDB) data and reporting to the cancer committee at least every three months.
- It is recommended that each program develop a Cancer Program Activities Manual that describes the activities of the cancer program. The description of this manual should be included in the introduction section of the Cancer Program Standards Manual.
- It is recommended that each program develop a Cancer Registry Policy and Procedure Manual that describes the activities of the cancer registry.

Proposed Deleted Standards

- Standard 2.3: Based on category requirements, one coordinator is designated for each of the specified areas of cancer program activity.
- Standard 2.6: The cancer committee, or other appropriate leader-

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President Obama to Appoint Harold Varmus, MD, to Lead NCI

On May 17, President Barack Obama announced his intent to appoint Harold Varmus, MD, to serve as Director of the National Cancer Institute (NCI).

In an email to NCI staff, Francis Collins, MD, PhD, Director of the National Institutes of Health (NIH), said that Varmus "brings unmatched expertise at all levels—not only in cutting edge scientific research, but also as a leader in the development of strategies for improving patient care, in scientific education and training, and in the design of novel public-private partnerships." He also stated, "I want to express my appreciation to John Niederhuber, MD, for his dedicated service and fine leadership of NCI over these past years."

Dr. Varmus, a former Director of NIH, is co-recipient of the 1989 Nobel Prize in Physiology or Medicine for studies of the genetic basis of cancer and is recent co-chair of President Obama's Council of Advisors on Science and Technology (PCAST).

Dr. Varmus has served as the president of Memorial Sloan-Kettering Cancer Center (MSKCC) since January 2000. At MSKCC, Varmus has united clinical care and laboratory activities, expanded faculty and facilities, developed inter-institutional research programs, led a $2 billion dollar capital campaign, and started a new graduate school in cancer biology.

ship body, establishes the cancer conference frequency and format on an annual basis.
- Standard 2.11: Each year, the cancer committee, or other appropriate leadership body, analyzes patient outcomes and disseminates the results of the analysis.
- Standard 4.5: Nursing provides leadership for oncology patient care.

Proposed Changes to Existing Standards

- Under Eligibility Requirements, the language of "Board Certified or Board eligible" revised to: "Board Certified or in the process of being Board Certified."
- Standard 2.5: The definition has been changed to indicate that only a clinical and programmatic goal is required. All programs will set an annual goal in each of these areas. The status of each goal is evaluated and documented at least twice annually. Goals can carry over from one year to the next as long as new goals are also established each year.
- Standard 2.8: The standard and documentation have been changed to increase the percentage of cases presented annually at cancer conference (from 10 percent to 15 percent), to specify that 80 percent of the cases discussed involve planning the first course of treatment, and to include the discussion of site-specific prognostic indicators. A Commendation rating is given if 25 percent or more of the annual analytic caseload is discussed at conference annually.
- Standard 2.10: The standard and definition have been changed to specify that the cancer committee, or appropriate leadership body, will address data inequities identified by the quality control review.
- Standard 3.1: The standard has been changed to require abstracting by a cancer tumor registrar (CTR). The standard will be phased in over three years. After that time, abstracting by non CTRs is not permitted.
- Standard 4.4: The definition has been changed to indicate that the nursing service or department verifies the credentials of the nurses and reports this finding to the cancer committee at least annually.
- Standard 5.2: The standard has been changed to increase the required clinical trial accrual rate and the Commendation clinical trial accrual rate for most categories. The increased rates will be phased in over three years. Proposed minimum accrual would be as follows: Integrated (network) programs, 6%; NCI-designated programs, 15%; teaching (academic) programs, 6%; VA Programs, 2%; pediatric programs, 30%; community programs (>500 cases) 4%; community programs (<500 cases), 2%; and freestanding programs, 2%.
- Standard 6.2: The standard has been changed to focus on annual development of a screening or early detection program by the cancer committee and includes a process to follow up on positive findings identified during the program.
- Standard 6.3: The standard has been changed to focus on the cancer committee's monitoring of community outreach activities through the preparation of a community outreach annual summary report, which is prepared by the community outreach coordinator and presented to the committee at least annually. The standard will be moved to the quality improvement chapter.
- Standard 7.2: The Commendation rating has been changed to include CTR attendance at a national, regional, or state cancer-related meeting once during the three-year survey cycle.
- Standard 8.2: The standard has been changed to strengthen the role of the quality improvement coordinator in quality improvement activities and to focus on the implementation of improvements that are directly related to completed studies of quality. The existing Commendation for this standard has been deleted.

While final review will take place this summer, comments were accepted through June 30.

Multiple Procedure Payment Reduction Issued by CMS

The Centers for Medicare & Medicaid Services (CMS) issued a one-time change notification regarding the multiple procedure payment reduction on the technical component of certain diagnostic imaging procedures. Effective July 1, 2010, for implementation on

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FDA to Examine Genetic Testing Kits?

As reported in the May 13, *BNA Health Care Daily Report*, the Food and Drug Administration (FDA) is considering requiring Pathway Genomics to seek agency approval for its personal genetic testing kits, after the company announced it had made a deal with Walgreens to sell Insight Saliva Collection Kits directly to consumers. FDA spokeswoman Karen Riley said the kits were not approved by the agency and that the FDA is "exercising its regulatory discretion because the company has overstepped the bounds of traditional laboratory developed tests by marketing the tests directly to consumers in a retail store," according to the May 13 *BNA Health Care Daily Report*.

Currently, the FDA regulates diagnostic tests only if they are developed and sold by device manufacturers as diagnostic kits, regardless of whether they were developed by clinical laboratory companies for in-house testing or by manufacturers for use in kits. Lab tests that are developed internally by a company generally are not subject to FDA review. Instead CMS regulates those types of lab tests under the Clinical Laboratory Improvement Amendments (CLIA).

Walgreen's has since reversed its decision to carry the genetic test.

PHOTOGRAPH/BIGSTOCKPHOTO

July 6, CMS reduced the technical component of certain multiple imaging procedures to 50 percent. Prior to this change notification, CMS was paying 75 percent of the physician fee schedule for the technical components of the second and subsequent procedures. In other words, CMS will pay in full the technical component of the highest priced procedure; the agency will pay 50 percent of the physician fee schedule for the technical components of the second and subsequent procedures. Table 1 provides an example of the new payment methodology.

13 ACCC-Member Cancer Programs Added to NCCCP

The National Cancer Institute Community Cancer Centers Program (NCCCP) has added 14 new hospitals to its current network. Of these, 13 are ACCC-member cancer programs:

- Albert Einstein Medical Center, Philadelphia, Pa. (Einstein Cancer Center and Einstein Center One)
- Geisinger Medical Center, Danville, Pa. (Geisinger Medical Center Cancer Institute)
- Gundersen Lutheran Medical Center, La Crosse, Wisc. (Gundersen Lutheran Center for Cancer & Blood Disorders)
- Lehigh Valley Hospital, Allentown, Pa. (John and Dorothy Morgan Cancer Center)
- Maine Medical Center, Portland, Maine (Maine Medical Center Cancer Institute)
- Mercy Medical Center, Des Moines, Iowa (Mercy Cancer Center)
- Northside Hospital, Atlanta, Ga. (Northside Hospital Cancer Care Program)
- Norton Suburban Hospital, Louisville, Ky. (Norton Cancer Institute)
- Providence Portland Medical Center, Portland, Ore. (Providence Cancer Center)
- The Queen's Medical Center, Honolulu, Hawaii (The Queen's Cancer Center)

CMS Reminds Providers about Reduction in Deadline for Submitting Medicare Claims

An article published in the May 7, 2010, *MLN Matters* stated that claims with dates of service on or after Jan. 1, 2010, and received later than one calendar year beyond the date of service will be denied by Medicare. The maximum period for submitting claims was reduced to not more than 12 months as a result of the Patient Protection and Affordable Care Act (PPACA).

Prior to PPACA, the regulations stated the service provider or supplier must submit claims for services furnished during the first nine months of the calendar year on or before Dec. 31 of the following calendar year. For services rendered during the last quarter of the calendar year, the provider or supplier was required to submit the claim on or before Dec. 31 of the second following year, according to the article.

PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service. Additionally, PPACA mandates that all claims for services furnished prior to Jan. 1, 2010, must be filed with the appropriate Medicare claims processing contractor no later than Dec. 31, 2010.

Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

- Claims with dates of service prior to Oct. 1, 2009, will be subject to pre-PPACA timely filing rules and associated edits
- Claims with dates of service Oct. 1, 2009, through Dec. 31, 2009, received *after* Dec. 31, 2010, will be denied as being past the timely filing deadline and;
- Claims with dates of service Jan. 1, 2010, and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

To read the full article, go to: *http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf*.

Table 1. Multiple Procedure Payment Reduction on the Technical Component of Certain Diagnostic Imaging Procedures

	Procedure 1	Procedure 2	Current Total Payment	Revised Total Payment
Professional Component	$100	$80	$180 (no reduction)	$180 (no reduction)
Technical Component	$500	$400	$800 ($500 + [.75 x $400])	$700 ($500 + [.5 x $400])
Global	$600	$480	$980 ([$600 + $480-$400] + [.75 x 400])	$880 ([$600 + $480-$400] + [.75 x 400])

Source: CMS Change Request 6965 Transmittal 694
To view the transmittal, go to ACCC's website at: *www.accc-cancer.org*.

- St. Joseph Mercy Hospital, Ann Arbor, Mich. (St. Joseph Mercy Cancer Care Center)
- St. Luke's Regional Medical Center, Boise, Idaho (Mountain States Tumor Institute)
- Saint Mary's Health Care, Grand Rapids, Mich. (The Lacks Cancer Center).

Waukesha Memorial Hospital, Waukesha, Wisc. (Waukesha Care Regional Cancer Center) was the fourteenth site added in 2010.

NCI, part of the National Institutes of Health (NIH), is using $80 million from the American Recovery and Reinvestment Act (ARRA) to expand research benefitting patients at the 16 NCCCP member hospitals and to add 14 new hospitals to the current network. The expansion uses approximately $40 million of ARRA funds to support additional research opportunities within the original network of 16 NCCCP sites and another $40 million of ARRA funds to expand to a total of 30 sites in 22 states (see Figure 1 below).

The NCCCP began as a pilot program in 2007 as a network of community hospital cancer centers that is working to provide the most current, research-based cancer care spanning the full cancer continuum—from prevention, screening, diagnosis, treatment, and survivorship through end-of-life care, with an emphasis on minority and underserved populations. The program is designed as a community-based platform to support basic, clinical, and population-based initiatives that are working to produce effective new prevention strategies and treatments for cancer patients.

NCCCP centers have seven areas of focus:

1. Reducing healthcare disparities
2. Improving quality care at community hospitals
3. Increasing participation in clinical trials
4. Enhancing cancer survivorship and palliative care services
5. Participating in biospecimen research initiatives to support personalized medicine
6. Expanding use of electronic health records and connecting to a cancer research data network
7. Enhancing cancer advocacy.

For more information, go to the NCCCP website at: *http://ncccp.cancer.gov.*

Figure 1. NCCCP Participating Community Hospitals and Health Systems

Portland, ME
Hartford, CT
Allentown, PA
Philadelphia, PA
Newark, DE
Danville, PA
Towson, MD
Waukesha, WI
Milwaukee, WI
Ypsilanti, MI
Grand Rapids, MI
Indianapolis, IN
Louisville, KY
Spartanburg, SC
Atlanta, GA
Savannah, GA
La Crosse, WI
Des Moines, IA
Sioux Falls, SD
Nebraska (coordinated regional program)
Austin, TX
Billings, MT
Colorado Springs, CO
Portland, OR
Boise, ID
Orange, CA
Honolulu, HI

NCI Launches Centers of Quantitative Imaging Excellence Program

NCI is launching a new program to qualify existing NCI-designated Cancer Centers with an added attribute—as Centers of Quantitative Imaging Excellence. This program will significantly decrease potential variability in imaging procedures done while a patient is undergoing treatment as part of an NCI-sponsored clinical trial. Advanced imaging plays a pivotal role in cancer care by providing the ability to detect tumors early and to guide therapy, as well as subsequent disease monitoring and surveillance. The American College of Radiology Imaging Network (ACRIN) and the American College of Radiology will coordinate this program for NCI.

Currently significant delays exist in the time required to open a clinical trial with advanced imaging as an essential component. In order to try to shorten the process, NCI and its partners will develop standard operating procedures and a corresponding guideline for the qualification of a NCI-designated Cancer Center as a Center of Quantitative Imaging Excellence. The procedures will include both brain and body imaging for volumetric computed tomography (vCT) or MR (vMR), positron emission tomography (PET), and dynamic contrast-enhanced magnetic resonance imaging (DCE-MRI).

For more information on NCI's cancer imaging program, go to *http://imaging.cancer.gov*.

CMS Proposes Change in Coverage of PET Scans for Most Solid Tumor Cancers

On May 6, 2010, CMS released a proposed decision memo that will alter a previous coverage decision for an initial diagnostic test with positron emission tomography (PET) for beneficiaries being treated for most solid tumor cancers. After careful review, the agency believes that the current absolute restriction is not supported by the available evidence and therefore proposes to amend 220.6.17 of the National Coverage Determinations Manual as follows:

1. The NCD will be changed to remove the current absolute restriction of coverage to 'only one' FDG PET scan to determine the location and/or extent of the tumor for the therapeutic purposes related to the initial treatment strategy as described above;
2. CMS will continue to nationally cover one FDG PET scan to determine the location and/or extent of the tumor for the therapeutic purposes related to the initial treatment strategy as described above; and
3. Local Medicare administrative contractors will have discretion to cover (or not cover) within their jurisdictions any additional FDG PET scans for the therapeutic purposes related to the initial treatment strategy as described above.

Public comments on the proposed decision memo were accepted until June 2010. The proposed decision memo can be found online at: *http://www.cms.gov/mcd/viewdraftdecisionmemo.asp?id=237.*