

# ASTRO

*news* SPRING 2013



## NAVIGATING OUR FUTURE

**OUTLINING  
ASTRO'S PRIORITIES  
FOR THE YEAR AHEAD**

**PLUS:**

TRIBUTE TO STANLEY E. ORDER, MD, FASTRO  
CROSSING BORDERS TO EASE PATIENT BURDEN

AMERICAN SOCIETY FOR RADIATION ONCOLOGY

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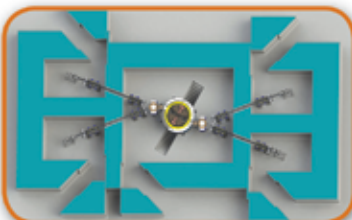
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VOLUME 16 • NUMBER 1

# ASTRO news

AMERICAN SOCIETY FOR RADIATION ONCOLOGY

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## ADVOCATING FOR OUR PATIENTS

WHEN THE *ASTRONews* EDITORIAL BOARD and staff met a couple months ago to brainstorm for the *ASTRONews* you are now reading, we decided to focus on specific themes for upcoming issues. The summer issue will be devoted to international radiation oncology, and the winter edition will center on emerging technology. The fall publication is typically devoted to the Annual Meeting and will remain as such. The focus of this issue, however, is on ASTRO's goals and objectives for 2013, including government relations and advocacy, a crucial aspect of the Society's ongoing commitment to representing the interests of both our patients and our membership.

Reflecting back on that first Advocacy Day in March 2004, one of my first thoughts was "Where has the time gone?" *Tempus fugit*, according to Virgil, and indeed, time has flown by. But thinking back to what ASTRO was facing a decade ago, a more apropos phrase might be taken from Horace: *carpe diem*. Seize the day.

What was the political landscape like in the early part of the new decade? In terms of health policy,

the Medicare Physician Fee Schedule had completed its 10-year phase-in by 2002. The Sustainable Growth Rate, or SGR, initially added to the conversion factor (CF) formula in 1996, was already becoming an issue. In the Final Rule published by the Centers for Medicare and Medicaid Services (CMS) on December 31, 2002, a 4.4 percent cut in the CF was announced, effective March 31, 2003. Furthermore, poor SGR projections by CMS for FY 1998 and 1999 had resulted in a \$16.5B SGR "deficit." In mid-February 2003, however, Congress passed a bill that enabled CMS to retroactively adjust the projected errors and eliminate the shortfall. The 4.4 percent cut became a 1.6 percent increase, but the solution offered little durable comfort for the house of medicine. Likewise, it was abundantly clear to ASTRO leadership that the specialty ran the risk of becoming an irrelevant afterthought unless steps were taken—and quickly. Something would need to be done to insert ASTRO and radiation oncology into the conversation when it came to the business of health care. ASTRO needed a presence.

The first step was the formation of ASTRO PAC in 2003. For the overwhelming bulk of the membership, this was a foreign concept. Several brave souls, however, opened their wallets and made the initial down payment on our own political action committee. Equally important was distilling the essence of radiation oncology to create a distinct and concise description of who we are, what it is we do and the integral role that we have in the management of

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## EDITOR'S *notes*

cancer patients on a daily basis. Next, more universal issues were incorporated into our list of concerns: increased funding for the NIH, the NCI and the CDC; petitioning Congress for support of the Patient Safety and Quality Improvement Act of 2005; and requesting that Congress revise the reimbursement formula to reflect increases in practice costs. An identity and a message had been created. The final step in the process was telling our story. ASTRO leadership decided that its own members were best equipped to tell our story to their legislators. Advocacy Day was born.

On Tuesday, April 27, 2004, 35 ASTRO members representing 20 states and the District of Columbia, led by George Laramore, MD, PhD, FASTRO, Maria Kelly, MB, BCh, FASTRO, and Albert Blumberg, MD, met at the Phoenix Park Hotel in Northwest Washington for a day-long refresher course devoted to the legislative process. A number of guest speakers were on hand, including Herb Kuhn, director for the Center for Medicare Management at CMS, and Rep. Mike Rogers (R-Mich.), Deputy Majority Whip and member of the House Energy and Commerce Health Subcommittee. ASTRO staff spent the afternoon drilling the attendees on the current political environment, how

ASTRO interacts with CMS and a review of the principal issues germane to radiation oncology to be discussed with their legislators. The day ended with a crash course from a political consultant on how to effectively lobby a member of Congress while being succinct and not straying off message.

Following breakfast and some last minute instructions on Wednesday, the members trekked to their representatives' and senators' offices to introduce themselves and lobby on behalf of the specialty. These meetings were arranged well in advance of Advocacy Day and were, more often than not, with a health policy advisor, although some members were fortunate enough to meet with their congressman. While this was unfolding on Capitol Hill, a small subcommittee of members and ASTRO senior staff met with attorneys to discuss the burgeoning self-referral issue. The entire group re-assembled at the Rayburn House Office Building for a lunch where ASTRO members educated Hill staffers on the nuts and bolts of radiation oncology and established valuable contacts for the future.

After two very intense days, ASTRO members returned to their respective states with a renewed sense of dedication to the specialty and a far greater understanding of the complex

issues facing radiation oncology. Much has been accomplished since that first Advocacy Day 10 years ago (see "After 10 years, Advocacy Day vets look back on progress" on page 21). ASTRO PAC has deeper roots and wider wings than it had in 2003, although it still lags far behind ACR, the American Urological Association and other specialties in money raised and spent. However, the Society has established contacts with a number of key legislators who understand and support the positions staked out by ASTRO.

Perhaps most importantly, Advocacy Day has matured into a robust annual event that unites members from about 40 states for the common good of the specialty, in order to educate Hill staffers and legislators on the critical role played by radiation oncologists in the broad spectrum of cancer care. *Participation* is the coin of this realm. It's not too late to sign up for Advocacy Day 2013, taking place April 29-30 in Washington. The specialty has been very good to all of us. Isn't it time for you to give something back? *Carpe diem!*

*Dr. Eichler is the medical director of radiation oncology at the Thomas Johns Cancer Hospital in Richmond, Va. He welcomes comments on his editorial at [astronews@astro.org](mailto:astronews@astro.org).*







**A FEW MONTHS BACK**, in my day job role, I found myself in a meeting with executives of a large health care conglomerate—the kind of sophisticated organization that is becoming commonplace in the health care industry now in this era of consolidation and reform. Although there were a number of physician health care executives in the room, most were non-physician health care professional managers with many years of corporate experience—a sophisticated crowd to say the least. The conversation turned to their organization's successful development over the years and their preparation for the future. It turns out that a few years ago they had taken a close look at their strategic direction and at the sustainability of their organization. What they said caught me by surprise. By all outward measures and appearances at the time, they were highly successful and extremely well managed.

### ARE WE A GENERATION AWAY FROM EXTINCTION?

Nevertheless, their leadership said they realized that without certain adjustments in their direction, they were “a generation away from extinction.”

Their problem, as they saw it, was twofold. First, their organizational structure as a hospital company, although fine for the moment, would not sustain in the health care delivery environment of the future that would be characterized by horizontal and vertical integration across the continuum of care. They concluded that they needed to reframe their business approach. Secondly, and to the point of this column, they recognized that although their leadership was highly focused and extremely effective, the development of their future leadership was tenuous, particularly when they considered their organization's increasingly complex trajectory. They concluded that they needed a new way to develop and prepare their leaders for the new health care paradigm and the changes that were sure to come.

I began to think: what about us, and what about radiation oncology? Is our specialty standing on feet of clay? Are we a generation away from extinction? And if so, what can we do about it? Now, with regards to radiation oncology's future path in the new health care environment, I wrote a bit about

that in my last column (“Medicare Cuts Aren't the Question, Value Is,” *ASTROnews* Winter 2012), and I will write more about that topic in a future Chairman's Update.

Instead, let's consider the second theme: the development of leaders for our organization. How does radiation oncology develop its leadership? I suppose it all starts with junior members who are appointed and advance through the ASTRO committee structure. ASTRO does have a reasonable process, although with some flaws, that for the most part is consistently and fairly carried out allowing young and other interested members to participate in the various committees within our Council Structure (Education, Science, Health Policy, Government Relations, and Quality and Clinical Practice). New committee members engage in the work with some showing particular dedication. From this process leaders inevitably emerge. These volunteer leaders write white papers, set coverage policies, plan exceptionally high-quality educational meetings, represent radiation oncology's interest in the house of medicine in venues like the CPT Editorial Panel and the RUC as well as advocate for our specialty with Congress and various governmental agencies. And in so

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doing, they gain valuable experience with ASTRO's mechanisms for policy and program development—all with the goal of benefiting our patients and our specialty. Having shown excellent judgment along the way as well as dedication through their hard work, these stalwart volunteers are sometimes offered the opportunity to serve as committee chairmen.

Then, after further service and hard work, some of these dedicated members are offered the prospect of serving on our organization's Board of Directors. Now, there was a time when our Board of Directors was apportioned by a combination of venues of practice (academic vs. community practice) and to cover representation from various component radiation oncology professional societies (ACR, CARROS, etc.). Board members represented a defined constituency and did not carry a substantive portfolio focused on identified needs related to ASTRO's Strategic Plan. Subsequently, ASTRO realigned the Board representation to positions associated with the specific portfolio of each Council. These Board members are expected not only to have expertise in the workings of their Council, but they must also be exceptional contributors to the broader deliberations of the Board.

To become a member of the ASTRO Board of Directors, a Nominating Committee works diligently to identify possible candidates. The vetting process is rigorous. There are serious discussions about qualification and service, as well as a lot of time spent considering balance of representation. But in the end, what the Nominating Committee must do is select two very similar people in terms of

I think it is time we think past the alluring notion of elections and give serious consideration to our organizational sustainability in these times of tumultuous health care reform.

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qualifications and service to ASTRO ... and then we, as an organization, do something unbelievably perverse, in my view. We run these two dedicated and qualified individuals against each other in a contested election! In so doing, we offend the ego of the losers (that always happens), and also risk alienating the losers. In fact, some do not run for office again when asked and still others have walked away from further ASTRO involvement. I suppose you could say that is the risk of our democratic process. But I contend that leaders in medicine and in radiation oncology are not so plentiful that we should allow that to happen at all, if we can help it. You see, our current process routinely risks shrinking our potential pool of excellent future Board members. Why do we do that?

Back in the day, ASTRO had a small Nominating Committee of three people (two elected members and the Chairman of the ASTRO Board) who vetted potential Board members prior to election. At the time, ASTRO's only task was to plan the Annual Meeting. ACR was handling everything else, including all things related to Health Policy and Government Relations. Basically, we were electing leaders to run our Annual Meeting. At the time, in some ways, the contested election may have made sense. Participation in ASTRO educational leadership had ramifications in the development of one's academic portfolio and academic advancement.

These benefits of leadership needed to be passed around because they had academic value.

Subsequently, in 2002, through a bylaws change, a much larger, more comprehensive Nominating Committee and committee process was put in place that included the participation of 13 members. Although the "democratic" electoral process continued, for the five years from 2004 to 2009, the Nominating Committee selected only a single candidate for the Health Policy and the Government Relations Council seats. The election was contested between the candidate and "other," allowing a write-in candidate. By all accounts and in my view, the experiment in uncontested elections worked out well, but the trial period lapsed and ASTRO reverted back to contested elections for all positions.

There are a few other things one should take into account when considering this issue of contested elections in our volunteer-run professional society. First and foremost, ASTRO has changed dramatically as a professional society. We are now about much more than an Annual Meeting. From a small staff of 10 and a \$2 million budget 10 years ago, we are now a staff of 75 with a budget of \$20 million. Also, you should know that out of the more than 5,000 members who are eligible to vote, typically less than 900 actually do vote. And although informally electioneering and campaigning are

*Continued on Page 30*

# SOCIETY NEWS

## ASTRO accepting nominations for 2013 recognition awards

ASTRO HAS OPENED NOMINATIONS for its annual recognition awards. Presented at the Awards Ceremony at the Annual Meeting, these three categories of awards honor individuals that have made substantial contributions to the field of radiation oncology, as well as leaders in other oncology disciplines.


The Society's highest distinction is the Gold Medal. This award honors members who have made outstanding contributions to the field of radiation oncology, including research, clinical care, teaching and service. Gold Medal Award recipients may be selected from any of the scientific disciplines represented by ASTRO's members. The nomination submission deadline for the Gold Medal Award is April 30, 2013.

The ASTRO Fellow designation is granted based on length of ASTRO membership and commendable service to ASTRO and to the field of radiation oncology. To be considered, nominees must have at least 15 years of active ASTRO membership and significant service to ASTRO. Other factors considered in Fellow designations include leadership and service, research, patient care and education. The nomination submission deadline for the Fellows program is May 15, 2013.

Honorary Membership in ASTRO is the highest recognition the Society confers on notable cancer



researchers and leaders in disciplines other than radiation oncology, radiation physics or radiobiology. The nomination submission deadline for Honorary Membership is May 15, 2013.

For more information on ASTRO's recognition awards, visit [www.astro.org/recognition-awards](http://www.astro.org/recognition-awards). 

## In Memoriam

ASTRO has recently learned that the following members have passed away.  
Our condolences go out to their families and friends.

Stanley E. Order, MD, FASTRO

Michael E. Robbins, PhD

Todd H. Wasserman, MD, FASTRO

The Radiation Oncology Institute (ROI) gratefully accepts gifts in memory of or in tribute to individuals.  
For more information, call 1-800-962-7876 or visit [www.roinstitute.org](http://www.roinstitute.org).




## ASTRO begins development of a practice accreditation program

BY ZOE ANN AMEY-MCCLEARY, MANAGER FOR PRACTICE ACCREDITATION, ZOEANNA@ASTRO.ORG

ASTRO'S BOARD OF DIRECTORS approved the development of an independent practice accreditation program in September 2012. The development of this accreditation program provides a unique opportunity for ASTRO to integrate all of the Society's quality improvement efforts. This program is designed to be objective, transparent, scalable, efficient and enduring. After conducting a strengths, weaknesses, opportunities and threats (SWOT) analysis, ASTRO believes the Society can build a best-in-class accreditation program that reflects reliable evidence and professional consensus.

The program will provide objective reviews, measurement of important elements of the provision of radiation therapy, performance feedback and focused results to improve quality and safety. ASTRO hopes the knowledge gained in the accreditation process will provide value to participants by supplying data outcomes and ongoing feed-

back to assist with performance improvement, particularly in the area of patient safety. As a result of the consensus work that will be done throughout the program development cycle, ASTRO is confident that there will be documented quality improvement in radiation oncology.

Launching this program is a significant undertaking, and a workgroup of volunteers representing all members of the radiation oncology care team has been assembled. This workgroup is guiding the development of the standards that will be used. Program development is set to occur throughout the year, and the goal is to have the accreditation standards and beta testing of the program completed by the end of 2013. The standards will provide objectivity and lead to ongoing safety and quality improvement. ASTRO plans to post the standards for public comment this spring, so watch for the opportunity to provide your feedback on this critical element of the new program. 



This volunteer group is working on the practice accreditation program.

**Back row (from left):** Liza Greenberg (Consultant), Nadine Eads, ASTRO, Yan Yu, PhD, MBA, Jim Hayman, MD, MBA, Laura Thevenot, ASTRO, Sandra Hayden, RT(T), MA, Dan Ayer, RT(T), Constantine Mantz, MD, and Sarah Thurman, MD

**Front row (from left):** Prabhakar Tripuraneni, MD, FASTRO, Richard Emery, MS, MDBA, DABR, Zoe Ann Amey-McCleary, ASTRO, and Liz Brunton, RN, MSN, OCN

**Not pictured:** Jeffrey Limmer, MS, DABR, Lukasz Mazur, PhD, Amy Mumo, ASTRO, and Emily Wilson, ASTRO

# 2013 Ambassador Recognition

ASTRO proudly recognizes our 2013 Corporate Ambassadors  
for their outstanding year-round leadership and support of radiation oncology.



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## Three companies re-elected to Corporate Advisory Council

ASTRO'S CORPORATE MEMBERSHIP has re-elected the following companies to serve on the Corporate Advisory Council: Alliance Oncology, Elekta and Revenue Cycle. Council seats are held for three-year terms and are categorized based on sales volume in radiation oncology.

Through a synergistic relationship between ASTRO and its corporate members, the Council focuses on issues and initiatives of mutual concern in radiation oncology to increase awareness of radiation therapy and advance the science and practice of cancer treatment and patient care. Together with ASTRO leadership, the Council convenes several times a year via conference call and holds an in-person meeting at the ASTRO Annual Meeting. Past discussion topics have included the Centers for Medicare and Medicaid Services final rule, the IHE-RO (Integrated

Health Care Enterprise in Radiation Oncology) program and the National Radiation Oncology Registry.

The Council is a representative group of the corporate membership at-large, with an appropriate proportional mix from the corporate membership base. Seats on the Council are held by high-level decision makers within the corporations and are equally balanced between large and small corporations to represent a broad cross section of the industry.

All corporate members can nominate their company to serve on the Council. Nominations are accepted every fall with elections conducted during the winter. For more information about the Council and/or Corporate Membership, please contact Andrea Rupp at 703-839-7398 or [andrear@astro.org](mailto:andrear@astro.org). 

COMPANY	REPRESENTATIVE	TERM EXPIRES
Accuray	Joshua Levine	2013
Brainlab	Mark Bruseski	2013
D3 Radiation Oncology Solutions	Kathleen Lokay	2013
Qfix	Daniel Coppens	2013
Bogardus Medical Systems, Inc.	Jeffrey Carlin	2014
IntraOp Medical	Donald A. Goer, PhD	2014
Philips Healthcare	Susan Wallace	2014
Standard Imaging	Raymond Riddle	2014
Sun Nuclear	Jeff Simon	2014
Varian Medical Systems	Kolleen Kennedy	2014
Alliance Oncology	Greg Spurlock	2015
Elekta	James Hoey	2015
Revenue Cycle, Inc.	Ron DiGiaimo	2015



# Remembering Stanley E. Order, MD, FASTRO

BY GUSTAVO S. MONTANA, MD, FASTRO

**STANLEY E. ORDER, MD, FASTRO**, former ASTRO chairman, passed away January 19, 2013.

He was born in 1934 in Vienna, Austria, where his parents emigrated to escape Nazi persecution in Germany. His family later settled in Philadelphia after his father graduated from the University of Vienna Medical School. Influenced by his father, who practiced general medicine, both Dr. Order and his sister, Sucha Asbell, MD, FASTRO, became radiation oncologists.

Dr. Order attended Albright College in Reading, Pa. where he received his BS in 1956. He went on to attend Tufts University School of Medicine in Boston where he received his MD in 1961. Dr. Order began training in pathology in 1962 at the Peter Bent Brigham Hospital in Boston (now the Brigham and Women's Hospital), but was inspired by Luther W. Brady Jr., MD, FASTRO, to become a radiation oncologist after being impressed by Dr. Brady's talks regarding cancer.

After fulfilling his military obligation, he went to the Yale School of Medicine in New Haven, Conn. in 1965 for training in radiotherapy and cancer research with Morton Kligerman, MD. During his four-year fellowship at Yale, Dr. Order worked with Dr. Kligerman to reconstruct tumors with tomography using X-ray tomographs lined up in a model system of glass to see the tumor in 3-D, a

reconstruction and tumor imaging process that was ahead of its time.

While a radiation oncology resident, Dr. Order furthered his lifelong research interest in immunology—which had begun during his military service—under the guidance of Byron Waksman, MD. The two worked on the transplantation of F1 hybrid marrow into a parent that had been irradiated, tracing the cells to

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**TOP:** Dr. Stanley Order  
**CENTER:** Prominent ASTRO leaders (from left) Lawrence W. Davis, MD, FASTRO, Rodney R. Million, MD, FASTRO, Dr. Order and Carl R. Bogardus Jr., MD, FASTRO, gather for a moment.  
**BOTTOM:** Fran Glica (left), ASTRO executive secretary for more than 20 years, joins Dr. Order and his wife, Mary.



**ABOVE:** Dr. Order, then-chairman of ASTRO, presents Herman D. Suit, MD, DPhil, FASTRO (left), with the ASTRO Gold Medal in 1990.

**RIGHT:** Dr. Order presents John A. Majda, MD, with a plaque for completing his ASTRO research fellowship in 1990.



see how the cells repopulated the lymphoid system. In this work, Dr. Order learned that antibodies could be used for both tissue recognition and cancer recognition.


Dr. Order began his faculty academic career at the Joint Center for Radiation Therapy in Boston, headed by Samuel Hellman, MD, FASTRO, in 1969. In 1975, he was appointed chairman of the newly created department of radiation oncology at The Johns Hopkins University School of Medicine in Baltimore where he continued his work with radiolabeled antibodies for hepatomas and other tumors. In 1991, Dr. Order was appointed to the faculty of the Robert Wood Johnson Medical School in New Brunswick, N.J. and became director of the Institute for Systemic Therapy of Cooper Hospital University Medical Center in Camden, N.J. In 1997, he became clinical professor of radiation oncology at Stony Brook University Hospital and Medical Center in Stony Brook, N.Y. where he finished his active clinical and academic career.

Dr. Order was an active member of ASTRO, and he worked on several committees and helped shape the direction of the Society. He served as

ASTRO's president in 1988, and he started the tradition of the Presidential Address at the Annual Meeting, which allows the president to address attendees on a topic of the president's choice. As ASTRO's chairman the following year, Dr. Order encouraged all radiation oncologists to take an active role in ASTRO and the American College of Radiology (ACR) and to be a strong voice in all matters concerning the specialty.

He also was appointed to committees of other societies and organizations, including ACR, Radiation Therapy Oncology Group (RTOG), National Cancer Institute (NCI) and National Institutes of Health (NIH). He received many honorary degrees and awards, including Honorary Doctor of Science degrees from Albright College and Elizabethtown College in Elizabethtown, Pa. and the ASTRO Fellow designation. Dr. Order was an engaging speaker with an inimitable and spontaneous sense of humor. He delivered numerous invited lectures on a wide range of subjects in this country and abroad, particularly in Asia where his work with hepatocellular carcinomas was followed with great interest.

Dr. Order was a prolific writer as well. He contributed more than 200 articles, book chapters and books to the scientific literature. His name first appeared as co-author of a paper in the *American Journal of Medicine* while he was still an undergraduate in 1954. In the ensuing years, he wrote extensively, particularly on the subject of immunotherapy, radiolabeled antibodies for hepatocellular carcinoma, Hodgkin's lymphoma and other malignant diseases. He also published on the use of radiation for the treatment of benign diseases. While actively engaged in his professional career, he found time to be a serious and committed fisherman.

He is survived by his devoted and always supportive wife of 54 years, Mary, his two children, Paul Order and Leanne Gabriel, his son-in-law, Michael Gabriel, his sister Dr. Asbell, and her spouse, Michael, and one grandson, Roman. 

*Dr. Montana, a long-time friend and colleague of Dr. Order, is a professor of radiation oncology at Duke University Medical Center in Durham, N.C. and chairman of ASTRO's History Committee.*



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Radiation Oncology



# Strengthening the specialty

## ASTRO's 2013 priorities work to secure the field's path forward

BY BRITTANY ASHCROFT, COMMUNICATIONS MANAGER, BRITTANYA@ASTRO.ORG

### IN THE CURRENT ERA OF HEALTH

**CARE REFORM**, ASTRO is working diligently to ensure a strong path forward for the Society's members and to secure the future of the radiation oncology field.

"The challenge before us as radiation oncologists—and the entire health care industry—can be summarized in the traditional health services triad promise of cost, access and quality of care," said Michael L. Steinberg, MD, FASTRO, chairman of ASTRO's Board of Directors. "We are also facing the societal demand to show value in the care we give."

Based on this challenge, ASTRO's major focus areas in 2013 emphasize a continued investment in the future of the field, while addressing current issues of the Society's members and the specialty. These areas of attention include the Choosing Wisely initiative, the Payment Reform Task Force, an update of the Performance Assessment for the Advancement of Radiation Oncology Treatment (PAAROT) program, the development of a radiation oncology Patient Safety Organization and the creation of the ASTRO practice accreditation program.

"All of these priorities are tied directly to ASTRO's mission and strategic plan," Dr. Steinberg said. "We are addressing issues for our members and for the specialty, and working on strengthening the foundation for radiation oncology."

### CHOOSING WISELY

The Choosing Wisely initiative, a multi-year effort led by the American Board of Internal Medicine (ABIM) Foundation, works to help physicians become better stewards of health care resources and to promote conversations between physicians and patients about the overuse or misuse of medical tests and procedures that either provide little benefit or, in some cases, harm. ASTRO has joined the initiative, along with more than 30 other health organizations and medical specialty societies, and the Board of Directors has selected the procedures the Society will focus on as part of this endeavor. ASTRO's official list of "Five Things Physicians and Patients Should Question" for radiation oncology is scheduled to be released in late 2013.

### PAYMENT REFORM TASK FORCE

ASTRO's Payment Reform Task Force, led by Brian Kavanagh, MD, MPH, along with representatives from key areas of the field, is a major ongoing effort to help manage and protect patient access to care by addressing the issues of cost and value of health care to meet the changing national health care infrastructure.

"This task force addresses the challenges of the health care reform changes that are coming, including the value proposition, which is something that is difficult for health care provid-

ers to understand," Dr. Steinberg said.

As the health care delivery system adjusts and adapts, ASTRO is looking to the Payment Reform Task Force to develop models to ensure appropriate payment for radiation oncology without compromising the quality of patient care.

"Delivering value is the most important aspect of adapting to and evolving with these changes, while continuing to make progress toward improved patient outcomes," Dr. Steinberg said.

### PAAROT ADVANCEMENTS

Developed in 2007, ASTRO's PAAROT program, an online practice quality improvement program, was designed as a mechanism to satisfy the American Board of Radiology's reporting requirements for diplomates' Maintenance of Certification (MOC). The program provides members with the capability to monitor patient care and to evaluate practice achievements on quality indicators related to processes of care.

The first review of data obtained through PAAROT from 2010 to 2011 was recently completed, demonstrating achievement of more than 80 percent of the indicators for quality patient care, as published in a manuscript in *Practical Radiation Oncology (PRO)*. Read the article in press at [www.practicalradonc.org/article/S1879-8500\(12\)00191-9/abstract](http://www.practicalradonc.org/article/S1879-8500(12)00191-9/abstract).



ASTRO's 2013 priorities focus on addressing issues facing the Society's members and the specialty overall. Here, the radiation oncology team from Virginia Hospital Center in Arlington, Va. reviews a file.

Members can access vital tracking and measurement tools. PAAROT is now undergoing a comprehensive enhancement that will streamline physician participation in the program and emphasize ASTRO's dedication to patient care and safety.

### **PATIENT SAFETY ORGANIZATION**

Expanding on the Society's patient care and safety priority, ASTRO is continuing to move forward with the design and implementation of a radiation oncology Patient Safety Organization (PSO). This effort originated from the Target Safety campaign and ASTRO's Board of Directors' recognition of the need for a national radiation oncology error reporting system.

The PSO endeavor furthers ASTRO's focus and priority on quality patient care by providing an avenue to collect data on misses and near-misses and to analyze errors in a secure, non-punitive environment.

Building on The Patient Safety and Quality Improvement Act of 2005,

ASTRO is working closely with a certified vendor to create this first-ever patient safety database for radiation oncology. Data gathered through the PSO will be used to detect errors and near-misses to identify national trends in radiation oncology.

PSOs provide privilege and confidentiality protections backed by federal law, allowing for the gathering of important information while protecting those who are reporting events. The radiation oncology PSO is expected to be in beta testing by the end of 2013.

"The safe delivery of radiation therapy treatment is our number one priority because any error is one too many," Dr. Steinberg said.


### **PRACTICE ACCREDITATION**

After extensive research, ASTRO is launching its own radiation oncology practice accreditation program. Currently in the program development stage, ASTRO aims to have accreditation standards and beta testing of the program completed by fall 2013

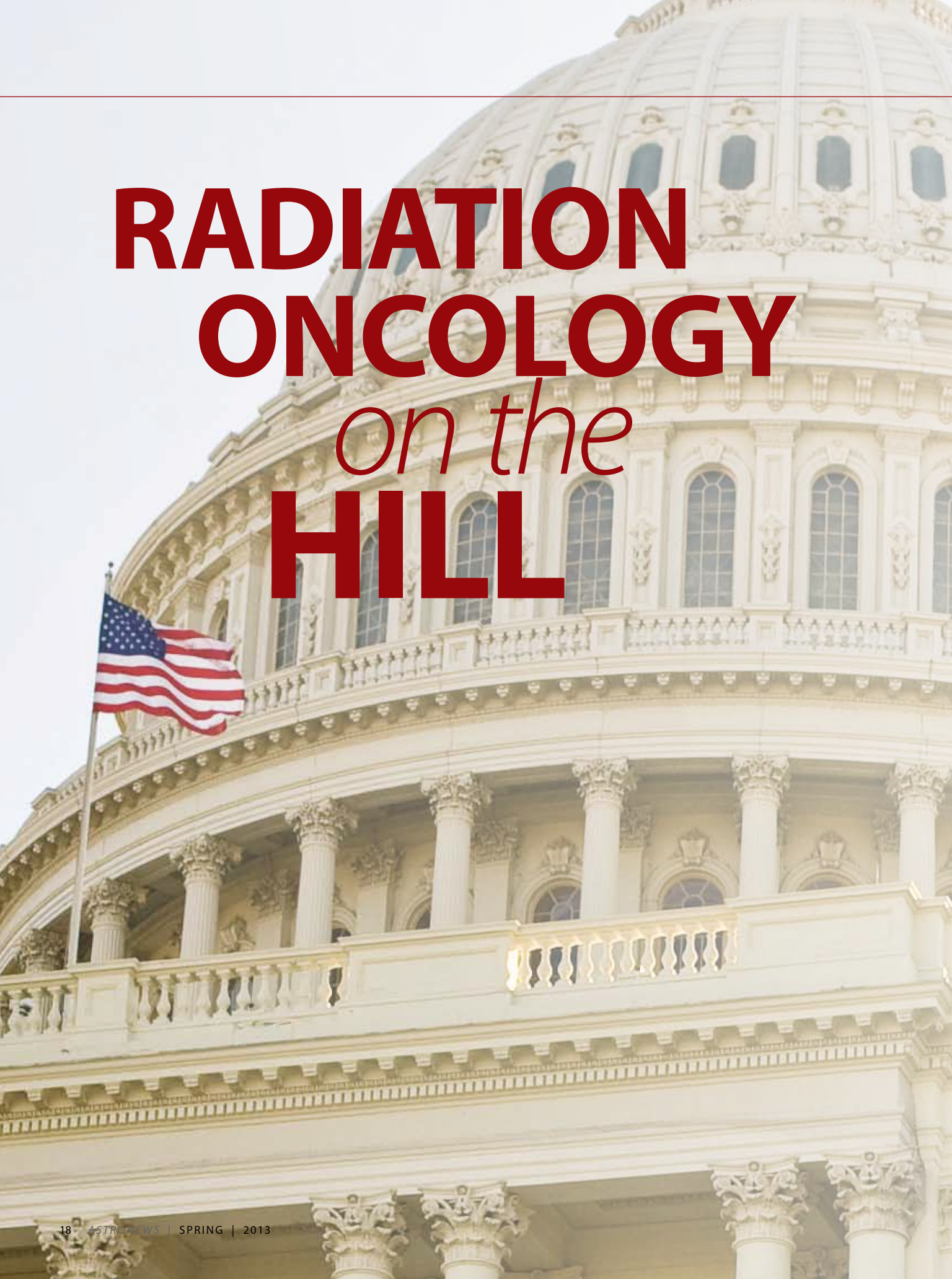
(see "ASTRO begins development of a practice accreditation program" on page 10).

This program provides the opportunity for ASTRO to integrate all of the Society's quality-related activities. By combining existing quality initiatives including MOC, clinical guidelines, measure development and education programs, the practice accreditation program will allow the sharing of data to help eliminate gaps in education, guideline and measure development activities.

"We believe ASTRO's practice accreditation program will rapidly become the industry standard," Dr. Steinberg said.

As ASTRO moves forward in these and other areas throughout the year, Dr. Steinberg encouraged members to take an active role in the Society's efforts. "Embrace the dialogue; get involved in committees," he said. "As these products and initiatives are developed, participate and use them and give us feedback on how they are working." 



The background of the entire page is a photograph of the United States Capitol dome. The dome is a large, white, neoclassical structure with a prominent central dome and a series of smaller domes and arches. It is surrounded by a colonnade of tall, white columns. An American flag is visible on the left side of the image, flying from a tall pole. The sky is a pale, overcast blue.

# **RADIATION ONCOLOGY** *on the* **HILL**



# NEW CONGRESS WILL TACKLE MEDICARE ISSUES THAT HIT CLOSE TO HOME

BY DAVE ADLER, DIRECTOR OF GOVERNMENT RELATIONS, DAVEA@ASTRO.ORG

**AS THE CLOCK STRUCK MIDNIGHT ON DECEMBER 31, 2012,** radiation oncology had managed to navigate the treacherous waters of the 112th Congress without wrecking on the rocks of payment cuts. However, that changed in the early morning hours of January 1, 2013—the final day of the 112th Congress—when the Senate approved legislation, ultimately signed by President Barack Obama, with a last-minute provision to cut \$300 million over 10 years from radiation oncology, specifically, radiosurgery.

Unfortunately for radiation oncology and other physician specialties and hospitals caught up in Washington's deficit reduction debate, the worst may be yet to come with the new 113th Congress.

While resolving—at least temporarily—the “fiscal cliff,” Democrats and Republicans largely left spending cuts for another day. After ceding ground on taxes to avert the fiscal cliff, Republicans in particular are looking for payback in the form of spending cuts, mostly on entitlements such as Medicare. There are ample opportunities for Congress to consider Medicare cuts as well as reductions in funding for cancer research in 2013, leading up to the expiration of the latest Medicare sustainable growth rate (SGR) formula patch on December 31, 2013.

“For the entire health care industry, particularly radiation oncology, the new Congress’ focus on reducing the deficit presents serious challenges,” said Laura I. Thevenot, ASTRO’s CEO and a veteran of Washington’s health policy battles. “We’ve matured as an advocacy organization over the last 10 years, and we’re going to have to capitalize on our advocacy resources this year to ensure the specialty’s voice is heard.”

Cuts to medical technologies, such as imaging and radiation therapy, were rumored throughout

last year. Ultimately, it was Medicare officials, not Congress, that provided the greatest threat to cancer patients’ ability to access radiation therapy services when the agency proposed massive cuts to intensity modulated radiation therapy (IMRT) and stereotactic body radiation therapy (SBRT) in its annual summer payment regulations. Proton therapy also was targeted for significant payment cuts in 2012.

ASTRO’s comprehensive advocacy campaign, which featured more than 130 members of Congress objecting to the cuts, led directly to Medicare significantly scaling back the level of cuts to radiation oncology. Even though the crisis was somewhat mitigated, Centers for Medicare and Medicaid Services (CMS) officials are skeptical about whether radiation oncology’s code family accurately represents the costs of providing services. CMS targeted several radiation oncology codes for review (see “Medicare scrutinizes radiation oncology reimbursement” on page 28), sending a powerful message to the radiation oncology community and other policymakers, including Congress, that the agency would be keeping a close eye on the specialty.

*Continued on Page 20*





“We’ve matured as an advocacy organization over the last 10 years, and we’re going to have to capitalize on our advocacy resources this year to ensure the specialty’s voice is heard.”

Recognizing that the threat to radiation oncology Medicare payments was stalled and not defeated, ASTRO pivoted from the campaign to halt the proposed cuts from CMS to bolster its standing on Capitol Hill. ASTRO thanked those members of Congress for backing the specialty against the cuts with the goal of creating stalwarts against future cuts. The Society sent thank you letters to its champions, issued press releases in support of senators and representatives to their local media and utilized ASTRO PAC to support key candidates for Congress in their re-election efforts.


These efforts to maximize congressional resistance to any radiation oncology Medicare cuts will be essential in the new Congress as well. ASTRO will be calling on volunteers to educate their members of Congress about the value of radiation therapy by inviting legislators to visit their cancer centers or by visiting lawmakers in their Washington offices. ASTRO provides radiation oncology treatment team members an opportunity to learn in-depth about the issues facing radiation oncology and lobby their lawmakers through the Society’s annual Advocacy Day, which marks its 10th anniversary this year (see “After 10 years, Advocacy Day vets look back on progress”). The event continues to focus on giving radiation oncology a voice on Capitol Hill.

ASTRO also worked throughout the winter to advance its top legislative priority: ending self-referral abuses of radiation therapy. Not only is closing the loophole in the physician self-referral law for radiation therapy good for cancer patients, it also matches well with many lawmakers’ goals of reducing Medicare spending without limiting

benefits to Medicare beneficiaries. Self-referral represents a way to reduce Medicare spending in lieu of arbitrarily cutting payments to radiation therapy services.

ASTRO’s self-referral advocacy received key boosts in November 2012 when the Government Accountability Office (GAO) issued a report condemning self-referral for advanced imaging services; the influential Center for American Progress recommended closing the self-referral loophole for radiation therapy and other services; and *Bloomberg News* published an investigative report demonstrating the negative consequences for patients when physicians are involved in self-referral schemes.

While ASTRO has learned that self-referral was considered by lawmakers developing the final fiscal cliff deal, it was ultimately left on the cutting room floor. Nonetheless, the issue lives on in the new Congress and will receive significant boosts in 2013 with the expected publication of an additional GAO report and the ASTRO-funded Georgetown University study, both of which are focused on self-referral for radiation therapy services.

ASTRO stands ready to mount an aggressive campaign in the new Congress to advance ASTRO’s priorities and to protect against any new Medicare policies that could jeopardize safe and effective care for cancer patients. To be successful, ASTRO needs its membership active and engaged in 2013 and beyond. ASTRO members must be willing to meet with lawmakers and educate them about how to help—and not hurt—the lifesaving work performed by radiation oncology treatment team members every day. 



## After 10 years, Advocacy Day vets look back on progress

This year's ASTRO Advocacy Day reaches an important milestone in the specialty's efforts to advocate on behalf of cancer patients and their health care providers. The annual legislative conference and lobby day celebrates its 10th anniversary April 29-30, and several longtime participants are looking back on the evolution of the event and ASTRO's legislative achievements.

"I remember the first Advocacy Day," said ASTRO's Government Relations Committee Chairman Sameer R. Keole, MD, of the Mayo Clinic in Phoenix. "There were only about 35 of us there in D.C. We had little idea why we were there or what we were supposed to be doing. But we all caught the advocacy bug and most of us have been back every year. It's so fulfilling now to be joined by more than 100 colleagues every year, representing the very best of the specialty."

ASTRO CEO Laura Thevenot organized the first Advocacy Day in 2004. After beginning with only about 35 members representing a handful of states, Advocacy Day now regularly draws more than 100 participants—physicians, physicists, nurses and administrators—who meet with hundreds of representatives and senators from more than 40 states.

"It was a no-brainer, really," Thevenot said. "An organization and specialty that is so intertwined with federal policy, particularly Medicare, is lost without a strong presence on Capitol Hill. That's why we started Advocacy Day, launched ASTRO PAC and built a strong lobbying team backed by committed volunteers that recognize time spent lobbying is an essential complement to their work in the clinic."

Thevenot praised the then-Board of Directors for acting to set up a strong advocacy function to protect the field. In the last five years alone, she said, radiation oncology has been under the constant threat of Medicare payment cuts that could have decimated radiation therapy. Advocacy Day, ASTRO PAC and all of the advocacy tools in ASTRO's arsenal have been critical in protecting the specialty, she said.

**"...there's no doubt in my mind that advocacy is part of my professional responsibility. It's my commitment to protecting the quality of radiation oncology for our future patients."**

ASTRO Government Relations Council Vice-chairman Geraldine M. Jacobson, MD, MBA, MPH, of West Virginia University in Morgantown, W.Va., agreed.

"I wasn't sure about the value of radiation oncology advocacy, but after attending the first Advocacy Day, I was convinced of its value and necessity," Dr. Jacobson said. "Looking back over what we've accomplished—better understanding of radiation oncology on the Hill, preventing devastating payment cuts, getting traction against self-referral abuse—there's no doubt in my mind that advocacy is part of my professional responsibility. It's my commitment to protecting the quality of radiation oncology for our future patients."

Thanks to years of hard work and training, Advocacy Day veterans agreed that their sophistication on the issues and lobbying skills have grown considerably. Participants benefit from keen policy and political insight from speakers who are leading health policy thought leaders, senior members of Congress and top congressional and administration staff.

Government Relations Council Chairman Bharat B. Mittal, MD, FASTRO, from Northwestern University in Chicago, urged more of his colleagues to come to Advocacy Day and find ways to get engaged in advocacy.

"In those early years, we would talk to junior Hill staff who had no idea who we were and what we did. Now, it's very different," Dr. Mittal said. "We've been trained on how to make convincing points that appeal to Democrats and Republicans alike. We frequently meet directly with the member of Congress. They know who we are and are engaged with our issues. It's very satisfying and rewarding to see how far we've come."





## CROSSING BORDERS

# Germany and Denmark collaborate to ease patient burden in radiation oncology project

BY HANS-JÜRGEN BRODERSEN, MD, HEAD OF THE DEPARTMENT OF RADIATION ONCOLOGY, MALTESER ST. FRANZISKUS-HOSPITAL, FLENSBURG, GERMANY AND DIRK RADES, MD, HEAD OF THE DEPARTMENT OF RADIATION ONCOLOGY, UNIVERSITY-HOSPITAL SCHLESWIG-HOLSTEIN, CAMPUS LÜBECK, GERMANY

This article is part of the “News from the Old World” series, created by *ASTRONews* Editorial Board member Dirk Rades, MD, to help build a bridge between radiation oncologists in Europe and North America.

**RADIOTHERAPY OF DANISH PATIENTS IN FLENSBURG, GERMANY** began in 1998 and has continuously increased since then. This project is one of the most successful collaborations in the German-Danish region Sønderjylland-Schleswig and is becoming a European model project.

Flensburg is the second-most northern city of Germany situated at the German-Danish border at the Flensburg Fjord. The name Flensburg was mentioned for the first time in 1248, and it has alternatively belonged to either Denmark or Germany. Flensburg is famous for its historic buildings, such as the North Gate and Glücksburg Castle. Today, it belongs to the German federal state of Schleswig-Holstein, and it is the state's third largest city with about 90,000 inhabitants. Due to its location and history, it is a center for collaboration in many areas, including medicine.

A very important collaboration was achieved in the discipline of radiation oncology. However, it was not politicians, hospital managers or physicians who initiated a German-Danish radiation oncology collaboration but a patient. In 1997, a Danish patient living close to the German border visited the department of radiation oncology in Flensburg and asked for radiation treatment. Flensburg was much closer to his home town than Odense, Denmark, where the nearest Danish radiation oncology department was situated. He did not want to drive 200 miles a day for six weeks.

His visit to Flensburg had relevant consequences. Several days later, the medical director of the health board of the Danish region Sønderjylland visited the department of radiation oncology in Flensburg for a first discussion. The people in Flensburg learned about limited capacities at the six central radiation oncology departments in Denmark, which resulted in long travel distances for patients from Sønderjylland for each treatment and wait times of longer than six weeks. Spontaneously, Flensburg offered “neighborly assistance.”

*Continued on Page 24*



PHOTOGRAPHS BY DR. BRODERSEN



**Opposite page:**  
View of Flensburg

**Left:** The Department of  
Radiation Oncology team at Malteser  
St. Franziskus-Hospital in Flensburg

**Below:** The famous Glücksburg Castle





## Germany and Denmark collaborate to ease patient burden

### Careful Preparation

First, the differences between Germany's and Denmark's national norms, procedures and concepts had to be compared and matched, and legal questions clarified. After these goals had been successfully achieved, a pilot project was started in 1998 to evaluate the feasibility and acceptance of a cross-border radiation oncology program. Patients from Sønderjylland were offered adjuvant radiotherapy following breast conserving surgery in Flensburg instead of in Odense. This project led to public debates, accompanied by historically motivated resentments. However, the participating teams on both sides of the border were well prepared. For example, all Danish breast cancer patients were treated according to the protocols of the Danish Breast Cancer Cooperative Group (DBCG) in order to preserve the data for Danish studies. Language courses have been organized, and cross-border contacts have been expanded.

### Favorable Response

The results of the project's first year were remarkable. More than 80 percent of the Danish breast cancer patients in Sønderjylland chose to be treated in Flensburg and were very satisfied with their treatment. These positive results encouraged both sides to expand their collaboration and offer more radiation treatments to Danish patients living close to the German border. Both sides benefited from this new structure. The Danish patients help ensure the financial viability of the department of radiation oncology in Flensburg.

### Public Support

The additional patients from Sønderjylland led the German federal state of Schleswig-Holstein to offer greater financial support for radiation oncology in Flensburg, including new linear accelerators. The success of the cross-border treatment concept led to an expansion of an unusual European project. In 2001, an agreement between Flensburg and Sønderjylland was negotiated, which included the treatment of 400 Danish patients per year. The Danish government also provided financial support for a new linear accelerator. Carl Holst, the *Amtsborgmester* (regional president) of Sønderjylland, stated that Sønderjylland wished to allow their patients to receive the best treatment without traveling several hours per day. Over the past 14 years, more than 2,500 Danish patients have been treated in Flensburg.

### A Benefit for Both Sides


Between 2002 and 2003, the department of radiation oncology in Flensburg received two new linear accelerators. In 2011, a third linac with image guided radiation therapy and respiratory gating was added. Since more than 1,500 patients per year can be treated with these linacs, the wait times for patients have been considerably reduced, and the treatment quality and spectrum of indications also have improved.

### Cooperation with Heart and Soul

The dissatisfaction of a single patient was the initial spark for cross-border cooperation between two different national health care systems. It is important to understand that patients suffering from life-threatening diseases, such as cancer, are burdened when asked to drive several hours each day for treatments. Receiving therapy

in a reasonably close radiation oncology department is very important but required cross-border cooperation. However, it is also important to participate in this cooperative venture with heart and soul. Cancer patients are in a very precarious situation, and their treatment requires optimal coordination between the treatment teams. Learning the language and cultural habits of the neighboring country is mandatory to optimally treat patients and to overcome historical misunderstanding and resentment.

There is little doubt that the outcome of this venture is positive. This cross-border radiation oncology project is often cited by politicians as a sample project for the region Sønderjylland-Schleswig. Today, the life in the department is characterized by bilingualism and better cultural understanding. Both patients and staff benefit from regular bi-national meetings, which include treatment guidelines from both Germany and Denmark. The Danish patients are treated within the Danish health care system according to the Danish regulations. In 2005, the DBCG met in Flensburg for the first time.

Radiotherapy in Flensburg for Danish patients is identical to treatment in Denmark. Bi-national norms have been put into place, which ensure high-quality treatment. Additionally, the staff members are highly motivated and consider the treatment of Danish patients an interesting challenge and positive experience. Mutual understanding from both sides makes an important contribution to peace in a region that has suffered from many conflicts. In the near future, the cross-border radiation oncology cooperation will likely pave the way for the first bi-national German-Danish Cancer Center funded by the European Union. 



## IGRT CODING AND PHYSICIAN SUPERVISION GUIDELINES

**IMAGE GUIDED RADIATION THERAPY (IGRT)** involves the use of imaging technology to localize the intended target volume immediately prior to the administration of radiation therapy. In IGRT, the external beam radiation treatment setup is facilitated via an ultrasound, X-ray or other image of the target volume, implanted fiducial markers and/or adjacent anatomical structure(s). These guidance images are compared to the images expected to be seen based on the planning scans obtained at the time of initial simulation. An adjustment in table position and/or patient orientation may then be required to deliver the radiation dose accurately within the target volume inside the patient.

ASTRO has received a number of inquiries regarding the appropriate use of this technology. In response, the Health Policy Code Utilization and Application Committee developed a coding guidance document. The following is an executive summary of that document.

IGRT is typically used in patients whose tumors are directly adjacent to critical structures and where conventional means of targeting are deemed to be inadequate. IGRT must be performed by the radiation oncologist, medical physicist or trained radiation therapist under the supervision of the radiation oncologist. The physician must supervise and review the procedure, as the guidance may show a shift beyond standard tolerances.

Stereotactic treatments, such as stereotactic radiosurgery (SRS) or stereotactic body radiation therapy

(SBRT), require the use of IGRT with each treatment for the precise localization of the intended treatment target. IGRT is considered to be an inherent part of the SRS and SBRT procedure; for that reason, IGRT should not be billed with SRS or SBRT treatments.

### COMMON CLINICAL INDICATIONS

IGRT may be performed when using the following types of radiation treatment delivery:


- Three-dimensional conformal radiation therapy.
- Intensity modulated radiation therapy (IMRT).
- Particle beam therapy (proton beam therapy or neutron beam therapy).
- Brachytherapy.

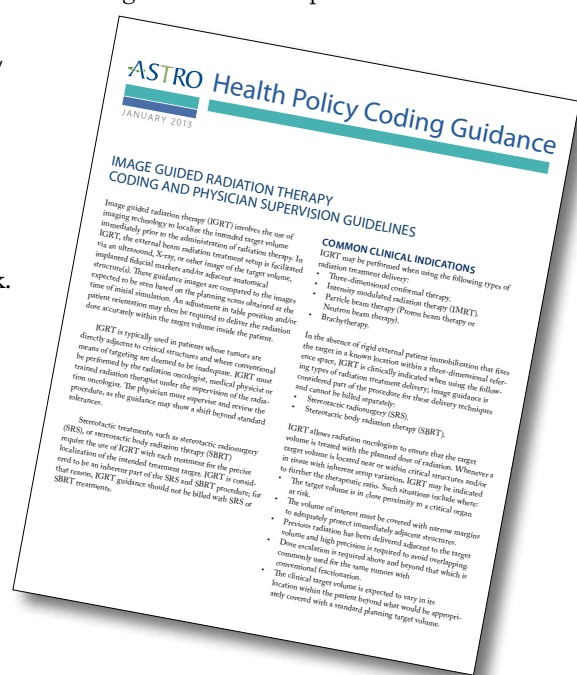
IGRT allows radiation oncologists to ensure that the target volume is treated with the planned dose of radiation. Whenever a target volume is located near or within critical structures and/or in tissue with inherent setup variation, IGRT may be indicated to further the therapeutic ratio. Such situations include where:

- The target volume is in close proximity to a critical organ at risk.
- The volume of interest must be covered with narrow margins to adequately protect immediately adjacent structures.
- Previous radiation has been delivered adjacent to the target volume and high precision is required to avoid overlapping.
- Dose escalation is required above

and beyond that which is commonly used for the same tumors with conventional fractionation.

- The clinical target volume is expected to vary in its location within the patient beyond what would be appropriately covered with a standard planning target volume.

Image guidance can be performed with various technologies including ultrasound, CT (either kV or MV) or stereoscopic imaging. The physician supervision requirements depend on the type of guidance used. Specific information regarding the performance of IGRT, the supervision requirement and coding guidance is available in the Committees' guidance document, posted online at [www.astro.org/uploadedFiles/Main\\_Site/Practice\\_Management/Radiation\\_Oncology\\_Coding/Coding\\_FAQs\\_and\\_Tips/Coding%20Guidelines.pdf](http://www.astro.org/uploadedFiles/Main_Site/Practice_Management/Radiation_Oncology_Coding/Coding_FAQs_and_Tips/Coding%20Guidelines.pdf). 



## RADIATION ONCOLOGY INSTITUTE ISSUES FIRST SAFETY AND QUALITY RESEARCH AWARD IN IMRT TREATMENT DELIVERY ACCURACY

CALVARY MATER NEWCASTLE HOSPITAL in Newcastle, Australia, has been awarded the Radiation Oncology Institute's (ROI's) first Research Grant for Safety and Quality: IMRT Treatment Delivery Accuracy in the amount of \$200,000 over two years for its proposed study titled, "Ensuring Safe Delivery of IMRT Using EPID-Based Real-Time Verification." The study will be led by Peter Greer, PhD, MSc, a medical physicist and conjoint associate professor in the school of mathematical and physical sciences at the University of Newcastle.

Dr. Greer's study proposal outlines the development of a real-time verification system that enables detection of gross intensity modulated radiation therapy (IMRT) treatment delivery errors prior to delivery of substantial radiation to patients. The top-rated study proposal was reviewed by the ROI Research Committee and an expert panel review team and approved by the ROI Board of Trustees.

"This is an exciting opportunity for the ROI to further its mission of validating the safety and effectiveness of radiation therapy," said ROI President Theodore Lawrence, MD, PhD, FASTRO. "We are hopeful that Dr. Greer's research will foster the development of powerful new tools to advance the field of radiation oncology in our care of patients."

All ROI research initiatives stem from the prioritized National Research Agenda, which was developed during the ROI's formative years to identify areas of need and the importance of research to demonstrate the significant


medical expertise and value that radiation oncology brings to cancer care around the world.

### ADDITIONAL RESEARCH PROJECTS IN THE PIPELINE:

- In 2010-11, ROI awarded a \$139,000 grant to the Radiation Therapy Oncology Group for analysis examining patient outcomes from prostate cancer treatment with IMRT vs. high dose 3-D CRT. Study results were presented at ASTRO's 2012 Annual Meeting, and the final manuscript has been submitted to a peer-reviewed journal for publication.
- ROI has issued a Request for Proposal (RFP) for a \$20,000 grant for one year for a study to address best practices for toxicity management in cancer survivorship. Study proposals must identify the most effective strategies for managing

both acute and late radiation toxicity, establish symptom management strategies and prioritize them by effectiveness and the levels of evidence that support them.

- ROI has partnered with ASTRO to issue an RFP for two study grants for \$100,000 each over two years on comparative-effectiveness in radiation oncology treatment. Grant winners will identify comparative-effectiveness research leaders in radiation oncology and stimulate research focused on evaluating the effectiveness, complication profile, cost and cost-effectiveness of various radiation therapy treatments, as well as the comparative-effectiveness when compared to other therapies.

For more information on ROI research initiatives, contact Maryam Mojarrad at [maryamm@astro.org](mailto:maryamm@astro.org). 

## ROI'S NATIONAL RADIATION ONCOLOGY REGISTRY (NROR) IS MAKING PROGRESS

A CONTINUOUS THEME heard throughout ASTRO's Annual Meeting in Boston was the need for data and the need for a registry. Without evidence-based data, the risks are high for the profession. Presentations by Anthony L. Zietman, MD, FASTRO, ASTRO Health Policy Council Chairman Najeeb Mohideen, MD, and Annual Meeting keynote presenter Professor Michael Porter, PhD, MBA, of Harvard Business School, singled out the Radiation Oncology Institute's (ROI)

NROR as the most important initiative for the future of the profession.

The NROR, a collaborative initiative between ROI and ASTRO, will improve quality by benchmarking radiation therapy facilities across selected radiation practice metrics, identify patterns of care at various facilities and determine the barriers to site participation and participant enrollment by collecting reliable information on treatment delivery and

*Continued on Page 30*

## DEVELOPMENTS IN COMPACT PROTON THERAPY UNITS

**ADVANCES IN COMPACT PROTON THERAPY UNITS** are offering more opportunities to consider the use of these treatment facilities. The higher initial investment required to install a proton therapy unit compared to a photon therapy unit has hindered the widespread use of proton beams for radiation therapy. Consequently, access to proton beams is still very limited. The clinical benefit of protons depends on the tumor location, but certainly holds true, for example, for the pediatric patient population. Thus, we are currently not able to offer the most promising treatment option for all patients.

Many proton therapy centers currently in operation could only be realized by fully or partly depending on private investors, joint ventures or by accepting significant debts. The financial ramifications with the pressure of treating a large number of patients has led to the use of proton therapy resources for sites where the benefit of proton therapy is unclear based on currently available data, e.g., prostate cancer.

Realizing the market value of lowering the cost of building and operating a proton facility has lead several companies to develop or propose lower cost and, in some cases, more compact proton therapy solutions. The first installations will likely start treating patients in 2013. Such facilities have the potential of bringing proton therapy closer to the availability of mainstream radiation therapy.

Whether a proton therapy installation is labeled compact depends on the point of view. It is possible and on the

agenda of vendors to reduce the size of current proton facilities. The potential reduction in operating costs and building costs of a compact solution depends on the number of treatment rooms. A reduction in size and cost can be achieved by focusing on a single treatment room. Current operating proton therapy facilities typically have an accelerator serving multiple treatment rooms via beam lines. Some compact designs use a small accelerator to deliver beam to a single treatment head in an adjacent room and others offer a horizontal beam line instead of a 360-degree gantry. There are also single-room solutions, which aim at having an entire proton therapy delivery system in one single treatment room, a concept similar to photon therapy. Note that the size of a proton gantry and the design of the proton accelerator might require a substantial room size for such a single-room facility.

However, some existing designs with fixed angle beam delivery show proton treatment machines that can fit into a conventional photon clinic linac room or with a gantry fitting into the same footprint but with three times the volume.

Single-room facilities can be expected to gain a significant market share, especially in areas where patients travel long distances to receive treatment at one of the large treatment centers. In densely populated areas, large treatment centers might be able to operate more cost-effectively. Furthermore, multi-room facilities based on a single accelerator can potentially be expanded with greater ease and less cost.

*Continued on Page 31*



(Top to Bottom) IBA ProteusONE; Sumitomo Heavy Industries compact gantry; Protom compact gantry treatment room; Mevion Medical Systems.



## MEDICARE SCRUTINIZES RADIATION ONCOLOGY REIMBURSEMENT

MEDICARE IS CONTINUING to closely examine reimbursement of radiation oncology services. While the focus in 2012 was on intensity modulated radiation therapy (IMRT), this year the Centers for Medicare and Medicaid Services (CMS) has cast a skeptical eye on a wide range of services from external beam therapy and radiosurgery to brachytherapy. ASTRO is working diligently to respond to the challenges raised by CMS and other stakeholders. Nonetheless, the specialty should be prepared for significant changes to radiation oncology's coding structure and potential reductions in reimbursement rates for radiation oncology services.

### Changes Seem Likely

Although proportionately radiation oncology is only a small portion of the physician fee schedule allowed charges (less than 3 percent, see Figure 1), the

high rates of utilization growth of radiation oncology services attracted the attention of CMS. This point is illustrated in an article published in the *New England Journal of Medicine* in January 2012<sup>1</sup>. The article found that between 2003 and 2009 radiation oncology overshot its sustainable growth rate (SGR) target by nearly 300 percent. This was the highest percent growth of any specialty.

Individual codes have also experienced substantial growth. There was a 14 percent growth in IMRT services in freestanding centers between 2010 and 2011 in the Medicare population. In fact, IMRT, represented by CPT code 77418, was the fourth-highest code with percent increase in allowed charges for Medicare for this time period. It is not just IMRT; various other radiation oncology codes have been identified by CMS for review due

to their growth in utilization, being billed frequently with another service or the fact that they have not been reviewed recently.

### Radiation oncology services targeted for review in 2013 Final Medicare Physician Fee Schedule

In the 2013 Final Medicare Physician Fee Schedule (MPFS), CMS finalized a proposal to review and make adjustments to CPT codes with stand-alone procedure time assumptions used in developing nonfacility (freestanding) practice expense (PE) relative value units. CMS identified several codes (mostly radiation oncology codes) that have annual Medicare allowed charges of \$100,000 or more, include direct equipment inputs that amount to \$100 or more and have PE procedure times of more than five minutes. Although there are other CPT codes valued in

*Continued on Page 31*

**Figure 1** – Table 135, CY 2013 Medicare Physician Final Fee Schedule with Comment Period (1590-FC)

Specialty	Allowed Charges (mil)
Total	\$85,485
Radiation Oncology	\$1,988
Radiation Therapy Centers	\$72

**Figure 2** – Radiation oncology codes designated for review by CMS in 2013.

77280	Set radiation therapy field	77408	Radiation treatment delivery
77285	Set radiation therapy field	77409	Radiation treatment delivery
77290	Set radiation therapy field	77412	Radiation treatment delivery
77301	Radiotherapy dose plan IMRT	77413	Radiation treatment delivery
77338	Design mlc device for IMRT	77414	Radiation treatment delivery
77372	SRS linear based	77416	Radiation treatment delivery
77373	SBRT delivery	77418	Radiation tx delivery IMRT
77402	Radiation treatment delivery	77600	Hyperthermia treatment
77403	Radiation treatment delivery	77785	HDR brachytx 1 channel
77404	Radiation treatment delivery	77786	HDR brachytx 2-12 channel
77406	Radiation treatment delivery	77787	HDR brachytx over 12 chan
77407	Radiation treatment delivery		

# JOURNALS

BY KATHERINE EGAN BENNETT, MANAGING EDITOR OF SCIENTIFIC PUBLICATIONS,  
KATHERINEB@ASTRO.ORG

## ARTICLE HIGHLIGHTS FROM ASTRO'S JOURNALS

A spotlight of some top articles from recent editions of ASTRO's two official journals, the *International Journal of Radiation Oncology • Biology • Physics* (Red Journal) and *Practical Radiation Oncology* (PRO)

### From the January-March 2013 issue of *Practical Radiation Oncology*

**Evaluation of Adherence to Quality Measures for Prostate Cancer Radiotherapy in the United States: Results from the Quality Research in Radiation Oncology (QRRO) Survey**  
*by Zelefsky et al*

This paper from QRRO examines adherence to quality measures in the treatment of prostate cancer. The findings suggest that high quality radiation therapy is available throughout the United States.

### Gastric Perforation Following Stereotactic Body Radiation Therapy of Hepatic Metastasis from Colon Cancer

*by Furman et al*

This case report describes gastric perforation following stereotactic body radiation therapy. This case is a reminder that rigorous contouring of organs at risk within or near the high dose volume is an absolute requirement.

### From the January through March issues of the *International Journal of Radiation Oncology • Biology • Physics*

**January 1, 2013**

**ASTRO Late-breaking Abstracts**  
Hurricane Sandy brought disruption to the ASTRO Annual Meeting in Boston. This resulted in the cancellation of some sessions including several critically important late-breaking presentations. These late-breaking abstracts were not published in the abstract book but are now available in the Red Journal.

### Brachial Plexopathy in Apical Non-small Cell Lung Cancer Treated With Definitive Radiation: Dosimetric Analysis and Clinical Implications

*by Eblan et al*

Radiation-induced brachial plexopathy (RIBP) and tumor-related brachial plexopathy (TRBP) were studied in apical non-small cell lung cancer

patients treated with definitive radiation therapy. The results demonstrate that RIBP is a relatively uncommon complication, despite delivering doses that exceed historical dose constraints. TRBP is associated with significant debilitating morbidity and commonly occurs in patients who develop primary tumor failures. This study suggests that the clinical importance of controlling primary disease outweighs the relatively low risk of RIBP in this patient population.

**February 1, 2013**

### Probabilities of Radiation Myelopathy Specific to Stereotactic Body Radiation Therapy to Guide Safe Practice

*by Sahgal et al*

This paper reports the first logistic regression model yielding estimates for radiation myelopathy specific to stereotactic body radiation therapy.

*Continued on Page 32*



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## CHAIRMAN'S *Update*

not condoned, it cannot be stopped or prevented. It happens naturally. After all, the election is contested. Finally, some have noted that in some of our elections name recognition based on publication record or whether the candidate comes from a large institution seems to hold sway over our small electorate. We do have candidate statements, but we know most of those go unread.

In their book about best practices for professional organizations, *Race for Relevance: 5 Radical Changes for Associations*, authors Harrison Coerver and Mary Byers identify contested elections as a poor method of populating highly effective boards in high performance professional organizations. Most other medical societies have realized this and even when they state they have elections, they do not run qualified candidates against one another.

I know in elections there are winners and losers. I just hope that ASTRO and radiation oncology are not also the losers. I think it is time we think past the alluring notion of elections and give serious consideration to our organizational sustainability in these times of tumultuous health care reform. Your ASTRO Board of Directors will have serious discussions about this complex topic in its upcoming meetings. What do you think?



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*Dr. Steinberg is professor and chairman of radiation oncology at the David Geffen School of Medicine at UCLA. He was elected to the ASTRO Nominating Committee in 2000, to the Board of Directors as Chairman of the Health Policy Council (2003–2007) and to the ASTRO President-elect position in 2010. He is currently Chairman of the ASTRO Board of Directors. He welcomes comments on his editorial at [astronews@astro.org](mailto:astronews@astro.org). *

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## ROI

### NROR IS MAKING PROGRESS

health outcomes. Great progress already has been made, and ROI will keep ASTRO members apprised of the NROR's development and appeal to them for support and ownership of this effort, in conjunction with the volunteers involved with the program.

To that end, here is an update on the NROR prostate pilot program's progress to date:

- The NROR Prostate Cancer Data Dictionary Version 1, a collection of carefully defined data elements designed to characterize critical aspects of the treatment of patients with intact prostate cancer with various forms of radiotherapy, is complete.
- HealthCare IT Inc. is the vendor retained to build the electronic infrastructure.
- New England Institutional Review Board (IRB) was selected as the NROR Pilot Central IRB, and the NROR Pilot protocol is approved.
- Seven beta sites have been selected, and the selection process for the 23 additional sites has begun to bring the total number of pilot sites to 30, providing a representative mix of radiation treatment modalities, facility type, geographical setting, regional location and patient volume.
- The first set of radiation practice metrics for prostate cancer has been developed.
- The NROR was nationally recognized at the 2012 ASCO Quality Care Symposium.
- The NROR Pilot progress to date will be described in an article published in the *Journal of Oncology Practice* in 2013.
- The NROR electronic infrastructure will be ready to receive live patient data in April 2013.

To learn more, visit [www.roinstitute.org](http://www.roinstitute.org), where copies of NROR posters recently presented at ASCO's Quality Care Symposium and the latest version of the NROR Pilot Data Dictionary are available. For information on how to get involved, contact Maryam Mojarra at [maryamm@astro.org](mailto:maryamm@astro.org). 



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## PHYSICSupdate

### COMPACT PROTON THERAPY UNITS

An important aspect when assessing compact proton machines is whether these options not only differ in size but also in the beam characteristics and thus quality of the proton beam. The two main components determining the cost of a proton facility are the accelerator and, particularly, the gantry. There are developments to further reduce cost and size by limiting treatment options to one or a few beam angles only.

Another example is magnetic proton beam scanning, considered the most advanced form of proton therapy. Beam delivery at some multi-room centers is based on magnetic beam scanning and intensity modulation with sub-cm beam spot sizes. Although beam scanning might not be needed for all sites, a system with only limited or without scanning capabilities might compromise treatment quality or may be

limited to certain disease sites. Whether all single-room facilities can offer comparable characteristics to state-of-the-art multi-room installations remains to be seen. Some of the options on the market currently might not. It is important to ensure that cost-effective solutions do not significantly compromise the quality and flexibility of proton therapy.

With the increase in proton treatment centers, the radiation therapy community has to ensure that personnel are trained to utilize the potential benefits of protons and apply treatments safely. Clinical trials need to assess the benefit of protons for those sites where such a benefit cannot simply be taken for granted based on the lower integral dose and the shape of the dose distribution. The identification of the appropriate site and patient population for proton therapy will impact the cost-effectiveness of multi-room and compact centers. 

*This article was submitted on behalf of the ASTRO Radiation Physics Committee.*


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## HEALTHpolicy

the same manner, CMS is not proposing to review them at this time. The 23 radiation oncology services identified are outlined in Figure 2.

Given this mandate from CMS, there is an increasing likelihood that the radiation oncology code set will change significantly in coming years. The review of these codes has the potential to result in a negative impact on Medicare reimbursement for radiation oncology services in the short term, but also represents an opportunity to address flaws in the current code set and create longer-term payment stability.

In addition to the scrutiny of individual radiation oncology services, the specialty also is responding to calls to reform the traditional fee-for-service payment system. ASTRO recently created a Payment Reform Task Force to explore alternative payment methodologies for radiation oncology. All of these changes are occurring while the specialty is held hostage by the current political and budgetary environment of annual Medicare physician payment formula fixes and ongoing deficit reduction negotiations.

ASTRO will continue advocating for a fair and stable reimbursement environment for radiation oncologists. Radiation oncology professionals are encouraged to stay apprised of developments and engaged in these changes, which will have a direct impact on radiation oncologists and cancer patients. 

<sup>1</sup> Alhassani, A, Chandra, A, Chernew, M. The Sources of the SGR "Hole." *N Engl J Med*, 2012; 366;4: 289-291.

### CHICAGO - Rush University Medical Center Radiation Oncologist

The Department of Radiation Oncology at Rush University Medical Center (RUMC) is seeking an academically oriented, Board certified/Board eligible, radiation oncologist to focus on the evaluation and management of prostate cancer and other GU malignancies. Necessary skill sets will include training and experience in prostate brachytherapy and stereotactic body radiotherapy. The recruitment for this position supports an increase in clinical faculty within the Department. Management of GU malignancy will likely comprise one half to two thirds of the incumbent's clinical effort. This recruitment is part of a key strategic growth initiative in our multidisciplinary GU Oncology program. Salary will be consistent with AAMC guidelines based on academic rank and experience. The Department of Radiation Oncology currently includes 5 Board Certified Radiation Oncologists, 5 Ph.D Medical Physicists, and 3 Dosimetrists. Treatments including IMRT, IGRT, and SBRT are delivered using Tomotherapy, True Beam Sx, Trilogy, and 21 EX Linear accelerators. Institutional affiliation in national trials includes RTOG, NSABP, and COG. The Department has an ACGME accredited program for training radiation oncology residents and a CAMPEP approved program for training medical physics residents.

RUMC is a 1000 bed tertiary care, academic medical center located in downtown Chicago serving adults and children and is consistently ranked as one of the nation's top hospitals by *U.S. News & World Report*. Rush is ranked in 11 of 16 categories in the 2012 *U.S. News & World Report's* annual "America's Best Hospitals" issue and is ranked higher than any other program in Illinois for orthopedics, geriatrics and nephrology. Rush was the first hospital in Illinois serving adults and children to receive Magnet status – the highest honor in nursing – and the first in Illinois to earn a third four-year designation.

Interested applicants should respond with current CV's and statements of interest to:

Ross A. Abrams, MD, Chairman  
Department of Radiation Oncology  
Ross\_A\_Abrams@rush.edu



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## JOURNALS

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The authors recommend limiting the cal sac Pmax (maximum point volume) doses to 12.4 Gy in 1 fraction, 17.0 Gy in 2 fractions, 20.3 Gy in 3 fractions, 23.0 Gy in 4 fractions, and 25.3 Gy in 5 fractions to reduce the risk of radiation myelopathy to less than 5 percent.

### Prospective Study of Functional Bone Marrow-sparing Intensity Modulated Radiation Therapy With Concurrent Chemotherapy for Pelvic Malignancies

by Liang *et al*

Acute hematologic toxicity is a common complication of chemo-radiation therapy for pelvic malignancies that leads to poor treatment tolerance and reduced treatment intensity. This group describes a technique using 18-Fluorodeoxyglucose-PET/CT and MRI in conjunction with IMRT, to reduce radiation dose to functional pelvic bone marrow sub-regions.

**March 1, 2013**

### Radiation Therapy for Neovascular Age-related Macular Degeneration

by Kishan *et al*

Given the enormity of the public health burden imposed by age-related macular degeneration (ARMD), much effort has been directed toward identifying effective and efficient treatments. Currently, anti-VEGF injections have demonstrated considerable efficacy in treating neovascular ARMD, but patients require frequent treatments to fully benefit. The evidence suggests that modern radiation modalities can provide a dose-dependent benefit in the treatment of ARMD. In addition, it appears radiation can be employed in conjunction with anti-VEGF therapeutics to reduce the frequency of anti-VEGF injections required.



### Evaluating Swallowing Muscles Essential for Hyolaryngeal Elevation by Using Muscle Functional Magnetic Resonance Imaging

by Pearson Jr. *et al*

Elevation of the larynx is critical to swallowing function, an observation supported by the fact that radiation therapy induced dysphagia is associated with reduced laryngeal elevation. In this study on healthy subjects, the muscles underlying hyolaryngeal elevation were assessed using muscle functional MRI. Whole muscle T2 signal profiles of preswallowing, postswallowing and after performing swallowing exercises were used to illustrate the muscles essential to laryngeal elevation and the exercises that target them. The influences of this work on the practice of radiation therapy is discussed in an accompanying editorial by Vainshtein and Eisbruch.

### Randomized Trial of Pentoxifylline and Vitamin E vs Standard Follow-up After Breast Irradiation to Prevent Breast Fibrosis, Evaluated by Tissue Compliance Meter

by Jacobson *et al*

The combination of pentoxifylline and vitamin E has been demonstrated to reverse chronic radiation fibrosis.

This randomized clinical trial used these drugs with the aim of preventing breast fibrosis following radiation therapy. Fibrosis was measured by a tissue compliance meter in treated patients and compared with controls. Pentoxifylline/vitamin E may prove useful in preventing the development of radiation-induced fibrosis.

**March 15, 2013**


### Proton Beam Therapy and Accountable Care: The Challenges Ahead

by Elnahal *et al*

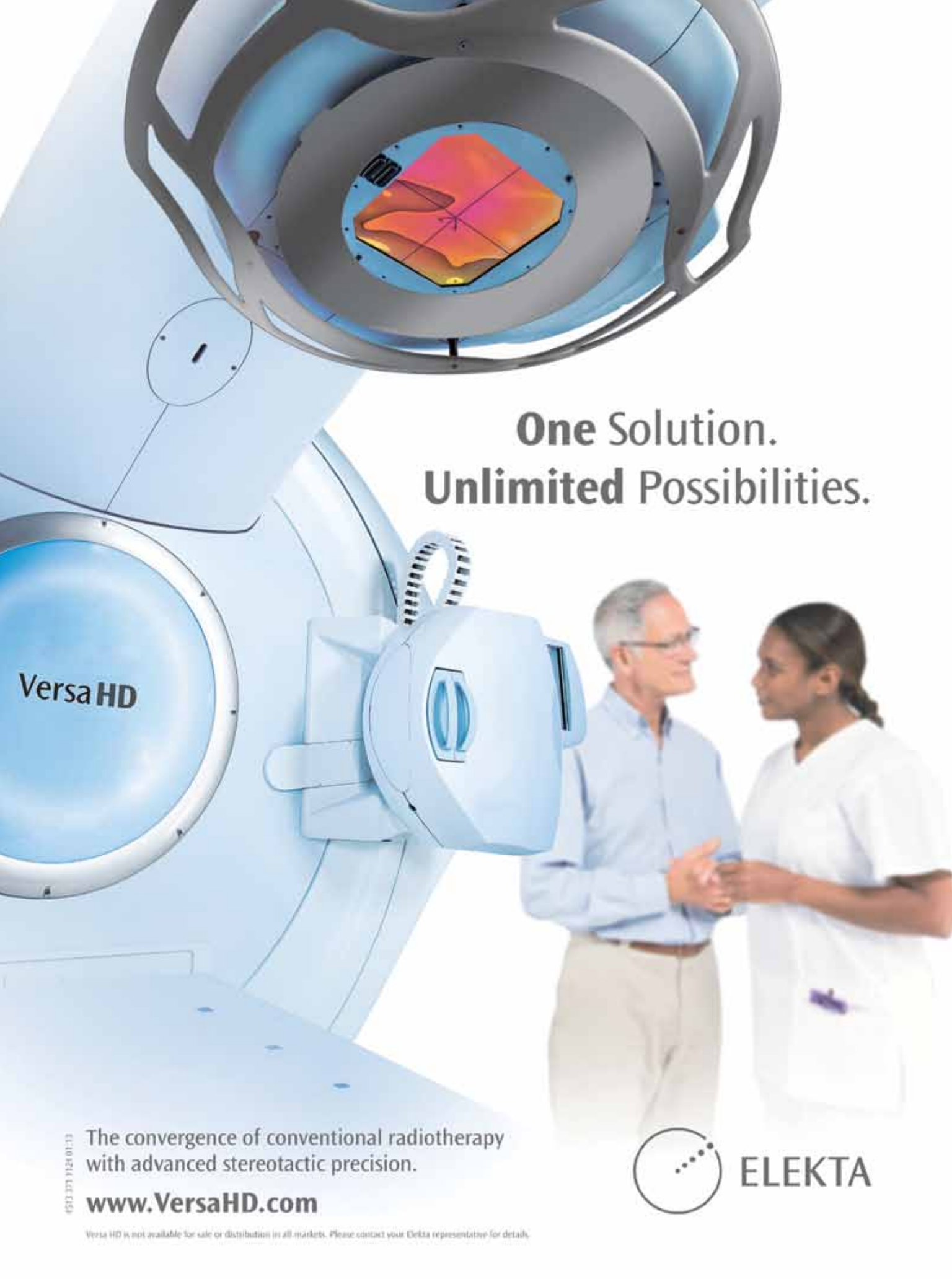
Proton beam therapy (PBT) centers have drawn increasing public scrutiny for their high cost. The behavior of such facilities is likely to change under the Affordable Care Act. This study modeled how accountable care reform may affect the financial standing of PBT centers and their incentives to treat complex patient cases.

### Diversity Based on Race, Ethnicity and Sex of the US Radiation Oncology Physician Workforce

by Chapman *et al*

This report analyzes United States radiation oncology physician workforce diversity, and finds that minorities are traditionally underrepresented in medicine (URM) and women are underrepresented as practicing physicians, faculty and residents in radiation oncology when compared with their U.S. population and medical school proportions. Resident URM and female representation has remained unchanged over the past eight years. The causes and implications are discussed in a separate editorial by Winkfield and Gabeau. 

You can now read ASTRO's journals via your smartphone or tablet via the HealthAdvance mobile application. Visit [www.practicalradonc.org/webfiles/images/journals/prro/ASTRO\\_Claiming\\_and\\_mobile\\_instrux.pdf](http://www.practicalradonc.org/webfiles/images/journals/prro/ASTRO_Claiming_and_mobile_instrux.pdf) for specific instructions.



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# PATIENTS

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