THE CANCER LETTER

Vol. 16 No. 14
April 6, 1990

Price $195 Per Year US, Canada.
$220 Per Year Elsewhere

P.O. Box 15189 Washington, D.C. 20003 Telephone 202-543-7665

CPT Code Changes Confuse Oncologists, Appear To Block Some Chemotherapy Payments

Revisions in the Current Procedural Terminology (CPT) codes dealing with cancer chemotherapy, sought by the American Society of Clinical Oncology, were designed to streamline and simplify the process of reporting and billing for reimbursement. Instead, the revisions have

(Continued to page 2)

In Brief

Jennifer Guy ACCC President, Everson President Elect; CTEP Recruits M.D. Anderson's Parkinson

JENNIFER GUY, administrator for oncology at St. Anthony Medical Center in Columbus, OH, became the first woman and the first RN to head the Assn. of Community Cancer Centers when she assumed the presidency of the organization at its annual meeting last month. She replaced **Irvin Fleming**, Memphis. **Lloyd Everson**, director of the Indiana Regional Cancer Center in Indianapolis, was elected president elect. **Albert Einstein**, Virginia Mason Cancer Center, Seattle, was elected secretary, and **Robert Clarke**, Memorial Medical Center, Springfield, IL, was reelected treasurer. Elected to the Board of Trustees were **Albert Brady**, Denver; **Simeon Cantril**, San Francisco; **Leroy Fass**, Long Beach; **Carl Kardinal**, New Orleans; and **Diane Van Ostenberg**, Grand Rapids. . . . **DAVID PARKINSON**, who has been chief of biological therapy of solid tumors at M.D. Anderson Cancer Center, has been recruited to head the Biological Evaluation Section of the Investigational Drugs Branch of NCI's Cancer Therapy Evaluation Program. CTEP is actively recruiting for other positions, including someone to head the Surgical Oncology Section of the Clinical Investigations Branch, and disease coordinators for pediatric cancer, hematologic malignancies, melanoma, and sarcoma, among others. Contact Michael Friedman, MD, Div. of Cancer Treatment Associate Director and Director of CTEP, EPN Rm 742F, NCI, Bethesda, MD 20892, phone 301/496-6138. . . . **BERT VOGELSTEIN**, Johns Hopkins Univ., is the winner of the 1990 Bristol-Myers Squibb award for Distinguished Achievement in Cancer Research. He was cited for his discovery of three of the four to six genetic changes believed responsible for colon cancer. The award carries a cash prize of $50,000. . . . **VINCENT LOMBARDI** Cancer Research Center at Georgetown Univ. will receive a $500,000 research grant from Bristol-Myers. Lombardi Director Marc Lippman said the funds will enable the center to expand a new program in cancer growth regulation, invasion and metastasis. About 25 senior faculty are involved in the program. Bristol-Myers also awarded a $500,000 grant to the National Cancer Center in Tokyo, Japan.

New CPT Codes Baffle Oncologists, Appear To Block Hospital Payments

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created confusion among medical oncologists and their staffs, led to confrontations with third party payers, and could bring on widespread litigation.

The revisions involved consolidation of the various procedures into fewer but more complex codes. Some offices have retained outside advisors to assist them in working their way through the maize of new codes.

As if that were not enough of a problem, the American Medical Assn. in its preamble to the new CPT included language which seemed to preclude payment for cancer chemotherapy administered in hospitals or in home health care settings.

ASCO officials exploded when they saw that, and President Robert Young demanded that it be corrected. AMA subsequently sent out a letter clarifying the preamble, stating that there had been no intent to interfere with in hospital chemotherapy reimbursement.

It remains to be seen whether the "clarification" will have its intended effect.

The Assn. of Community Cancer Centers added a special session on CPT coding at its recent annual meeting in Washington. Advice can be summarized as follows, offered by a panel of experts which included Joseph Bailes, chairman of ASCO's Clinical Practices Committee; Samuel Turner, Washington attorney who acts as special counsel to ASCO; Norman Brooks, a CPT coding expert whose firm assists medical practices with billing and reimbursement matters; and Cavan Redmond, a coding specialist with ELM Services:

--Have patience, make up your mind to work with the codes because they are here to stay, and try to get your billing done in a timely fashion.

--Consider bringing in outside help in applying the codes to your patients.

THE CANCER LETTER

Editor: **Jerry D. Boyd**
Associate Editors:
Kirsten B. Goldberg, Patricia Williams

Editorial/Subscriptions Office
PO Box 15189, Washington, DC 20003
Tel: (202) 543-7665 Fax: (202) 543-6879

ISSN 096-3917. Published 48 times a year by The Cancer Letter Inc., also publisher of The Clinical Cancer Letter and AIDS Update.

--Think carefully before initiating legal action, but seek legal counsel if problems appear unresolvable.

--Be creative in using the codes.

--Help put pressure to bear when needed on the Health Care Finance Administration to make reasonable adjustments in its reimbursement practices, including contacts with members of Congress.

Bailes noted that the 1990 CPT code and the preamble "seem to restrict chemotherapy to the office setting. It impacts on our ability to provide chemotherapy to adult and pediatric patients." He described ASCO's response and said that "no doubt AMA would like to rapidly resolve this issue within the confines of AMA and ASCO. . . The code changes have caused confusion to practicing oncologists and to the insurance carriers. . . The code changes are here to stay. AMA people feel they have done as asked and will be reluctant to change them. We will have to work with them."

Turner said he was "struck by how low many of your reimbursements are. It is difficult to get a handle on a nationwide basis because there is so much variety. I don't think it hinges on codes. I suspect that if a lawyer looks at it carefully, he may find many carriers in some areas not following HCFA rules. Be patient and understanding with ASCO and AMA. This is a difficult job.

"As for legal remedies, specifically litigation over the codes or other matters, I would not encourage a hasty resort to that. Many avenues would then be closed. Contact ASCO first and we [as ASCO's attorney] will discuss the problem with your or your lawyers. If the coding issues are not resolved, there may be some legal approach we can consider." An example, he said, could be the determination in the new codes that chemotherapy administration does not involve a professional component. "I don't believe a court would agree with that."

Turner urged ACCC members to communicate with HCFA, "and get Congress to put pressure on HCFA. The first step will be to get a decision from the AMA coding panel. They feel they are in a tough spot, particularly with the preamble. They are probably trying to find a graceful way out."

Brooks noted the extreme variations in charges for the same procedures in different locations around the country. A particular procedure is charged at $53 in North Dakota and $1,200 in Philadelphia, he said.

"Be creative," Brooks said. "Find other codes which are reimbursable. Review a slide, or look at x-rays. If you use the proper codes and can document it and bill properly, you will be paid. You need to look at the entire clinical picture."

Brooks said that if physicians carefully review remittance statements, follow up, and maintain proper records, "when a reimbursement is refused because it is, quote, beyond the normal charge, end quote, you can say, 'The hell it is.'"

Brooks insisted that under the global provisions of the new codes, "you can still be reimbursed for a physician or his employee administering chemotherapy in a hospital."

Redmond disagreed. "The code says they won't be reimbursed, and reports from individual offices indicate they won't."

Lee Mortenson, ACCC executive director and moderator of the session, said that Brooks was suggesting physicians should try for that reimbursement anyway, especially considering the support from the AMA letter.

Turner said that while he did not agree with all of Brooks' points, "I do agree you should try to maximize reimbursement. There are opportunities, but perhaps they are not as numerous or as easy to use as he suggested."

"If you try to take on the carriers by yourselves, you can be blind sided," Redmond said.

ACCC To Take In State Chapters, Establishes Clinical Trials Group

In a move explicitly aimed at increasing the Assn. of Community Cancer Centers' ability to deal with national and regional issues, the association has created a new category of membership to encourage development of state chapters.

ACCC members have approved bylaws changes to establish a new category of membership, chapter members, in addition to general, sustaining and delegate members. Delegate members are institutional members who make up the House of Delegates, the governing body of the organization.

The new bylaws defines chapter members as "groups of 25 or more general ACCC members" who petition for chapter membership.

"Chapter members shall fulfill the purposes of ACCC at the local level. The structure and function of the chapter shall be consistent with the bylaws and policies and procedures of ACCC. Each chapter shall appoint a representative to the House of Delegates."

Chapter representatives to the House of Delegates will be entitled one vote each, equivalent to that of other delegate members.

Addition of state chapters has been in ACCC planning for more than a year. The Executive Committee and Board of Trustees agreed last fall to submit the proposal to the membership at the annual meeting this year.

In a statement explaining the rationale for state chapters, ACCC said:

"Over the past two years there has been a steady deterioration in reimbursement for quality cancer care. As ACCC has sought ways to combat the trends that are sharply limiting cancer care, the association has recognized the potential power of locally organized cancer care givers.

"In order to further fulfill its mission to provide advocacy for cancer patients, to promote standards of excellence for high quality cancer care, and to provide leadership to influence the political, cultural, and economic forces that affect cancer care, ACCC's leadership has set several national goals. Among these goals is altering deleterious policies that impact progress in new cancer treatments through clinical trials and conventional cancer patient management. The Board of Trustees recognizes that many of these problems vary from state to state and that organizing, assisting, and supporting cancer care providers at the state level through the formation of state chapters is a means of addressing these problems."

Members approved the bylaws changes without dissent.

Executive Director Lee Mortenson estimated that 30 to 40 states have enough medical oncologists to meet the 25 general member minimum chapter size. Applications from two state chapters are already pending.

Membership is not limited to medical oncologists; radiation oncologists and surgeons have always been prominent in the association and among its leaders. Some of the groups being organized in various states are mixed, outgoing President Irvin Fleming said. "We decided to let them define their membership. ACCC welcomes all elements."

The new chapters evidently will consist largely of medical oncologists. "There aren't enough surgical oncologists to organize state by state, and the radiation therapists are already so well organized they don't need anything like this," an ACCC leader commented to **The Cancer Letter.**

New President Jennifer Guy said that chapters would not be permitted to include more than one state in its membership, but that in some cases, two chapters might be formed in one state. She cited California as an example.

Representatives of three state oncology societies described their organizations at an earlier session on state chapters.

John Burrows, Michigan Society of Hematology &

Oncology, said that his is a "reimbursement oriented state society. We were getting beat up individually by HCFA and other third parties." His group was instrumental in getting legislation through the Michigan legislature ("after a great deal of snarling") which requires reimbursement for off label uses if approved by a panel established to advise third party carriers.

The panel has established good communication and rapport with the third parties, Burrows said. "They determine who pays what and when, and the third parties comply. It works very well."

One of the main goals of the society is to get medical oncology recognized as a subspeciality, Burrows said. "We don't want to form a third or a fourth national group. We are looking to ASCO and ACCC, looking at how to organize fragmented state societies."

Lloyd Everson, representing the Indiana Medical Oncology Society, said that group has already voted to join ACCC as a state chapter. "It's a natural. ACCC has always been concerned about grass roots."

The American Society of Clinical Oncology, which Mortenson said has indicated it does not want to become involved in state activities, is focusing on national and regional issues, through its Clinical Practices Committee and other elements.

Everson warned of possible liability and economic issues that directors and officers of state societies may face. He suggested they use legal counsel, and noted that as ACCC chapters, they would be under ACCC's nonprofit status.

James Wade, representing the Illinois Medical Oncology Society, said that reimbursement in that state "is not a major problem. What brought us together is the CPT code changes."

Wade said that "what codes will work and what won't" are among the problems his group is tackling. Reimbursement for different modes of cancer care is also an issue. "We feel that the best quality care is hospital based or hospital related."

Another is reimbursement for clinical trials. Sixty to 70 percent of the society's members are involved in clinical trials, including phase 1 and 2. "We're taking the position that all trials should be covered, including phase 1."

ACCC members also ratified formation of the association's Collaborative Research Group, which will act as a broker between companies sponsoring clinical trials and physicians carrying them out.

The group has already lined up its first two trials, sponsored by Adria Laboratories. Adria will pay investigators $3,000 per case for two phase 3 studies in metastatic breast cancer: one testing the addition of ADR 529 (ICRF 187) to the FAC regimen (5-FU, adriamycin, cyclophosphamide); the other testing tamoxifen against toremifene, "a tamoxifen look alike," according to Robert Enck, director of medical affairs, oncology products, for Adria.

Enck, who had been director of oncology at Riverside Methodist Hospital in Columbus, OH, is a past president of ACCC.

Approval of the Collaborative Research Group was not without some controversy. The ACCC Board of Trustees had determined that management of the group, including data collection, staffing, cash flow, marketing, and negotiations with industry, would be offered to ELM Services Inc. ELM's fee will be paid separately by sponsoring firms, and, presumably, will provide a profit for the company.

ELM contracts with ACCC for management services, and Lee Mortenson serves both as ELM president and ACCC executive director.

Some members felt that the association should manage the group entirely and take any profit that might be made.

The board determined, however, that the association did not have the resources to carry out the management tasks and negotiated the arrangement with ELM.

A CRG Steering Committee of ACCC members, which reports directly to the Board of Trustees, will control membership of the group, evaluation criteria, and protocol selection. Its expenses will be paid by ELM.

The House of Delegates approved the new group without dissent.

Technology Transfer Is Theme For The 1990s, Broder Says

The 1980s was a decade of tremendous advancement in cancer research and the 1990s will build on that success through the application of research results, NCI Director Samuel Broder told a meeting of science writers last week.

"The hallmark of the new decade of the 1990s will be the application of research results, of technology transfer. This is possible because the last decade has been a period of significant accomplishment in cancer research," Broder told the annual American Cancer Society Science Writers' Seminar, held in Daytona Beach, FL, last week.

"In a sense, the 1980s were marked by the achievements of molecular biologists with important

genetic discoveries and developing proficiency in genetic engineering.... While we are committed to basic research, the time has come for inspired application of the findings of cancer research.

"Ironically, as our ability to detect, diagnose and treat improves, those with access to the technology generated by NCI show better incidence and mortality statistics than those who lack such access," Broder wrote in a paper presented at the seminar.

"So today, we require a unified approach, an expeditious approach, an egalitarian approach, a human approach--in short, a committed and revitalized public health approach to cancer research and application.

"No one can reasonably dispute that enormous progress has been made against cancer. In young children, in adults under age 65, we have made advances. These advances came out of major achievements in cancer research during the past decade."

Broder listed what he thought were some major advances in the past 10 years:

--Significant development of the science and application of cancer prevention and early detection.

--An understanding of the genetic and molecular basis for cancer, including identification of broad families of genes that accelerate or retard the development of cancer.

--The characterization of physiologic growth factors and their receptors.

--The elucidation of new families of viruses, such as the human retroviruses involved in AIDS and some leukemias.

--Understanding of the ways that cells evade the effects of cancer drugs and consequent methods to reduce drug resistance and improve therapies.

--A better understanding of natural biological substances and their potential applications.

--Improved adjuvant therapy, use of supercomputer technology and increased expertise in using genetically engineered products to treat patients with advanced cancer and AIDS.

In the 1990s, Broder said, expect to see expansions in natural products research, improvements in quality of life, even if there is no survival benefit, and continued survival improvement in patients under age 65.

Some of Broder's other observations:

--Non-Hodgkin's lymphoma will be a major tumor in the 1990s because the incidence is going up in the population in general and because of AIDS.

--Poverty predisposes one to cancer.

--In prevention and control, emphasis should be on transferring technologies that are known now, such as pap screening for cervical cancer and mammography screening for breast cancer.

"Learning how to apply technology is a research question," Broder said. "What works for cervical or mammography screening in an urban area may not work in a rural area."

John Laszlo, ACS senior vice president for research, also provided science writers with a series of predictions for the future of cancer research.

"The stage has been set for a decade of clinical applications in the areas of prevention, early diagnosis and treatment" as well as treatments as a result of molecular biology, he said.

Laszlo's predictions:

--Advances in understanding oncogenes will continue as scientists map out the series of mutational events required to trigger cancer. "It will not be long before scientists develop blood tests to identify people who are cancer-prone because of their genetic susceptibility," Laszlo said. This can already be done to predict which family members who have familial polyposis are likely to develop colon cancer.

--"Look for new vaccines that prevent the viral infections that lead to certain forms of cancer, such as cervix, liver, nasopharynx. There is little doubt that liver cancer, one of the most common causes of cancer deaths, particularly in third world countries, can be markedly reduced by existing technology using hepatitis B vaccines."

This approach is also likely for human papilloma viruses, associated with cervical cancer, and the Epstein-Barr virus of nasopharyngeal cancer.

"For patients who already have had a resection of the primary cancer, we will see vaccines that improve their chances for cure by decreasing recurrences."

--In cancer prevention, there will continue to be an emphasis on lifestyle changes such as smoking cessation, nutrition, and avoiding excessive sun exposure.

--More behavioral research is needed on ways to get people to make lifestyle changes, as well as on ways to deal with the addictive properties of tobacco. ACS data shows that tobacco accounts for 90 percent of lung cancers, 75 percent of cancers of the mouth, larynx and esophagus and 50 percent of bladder and pancreas cancers.

Laszlo also predicted areas for advances in treatment:

--Drug resistance: "One or more approaches for making cancer cells less able to become resistant to

chemotherapy will succeed during the next decade... A major crack in this huge problem of drug resistance could rapidly change the picture of cancer treatment so that we could begin to cure some patients with advanced breast and lung cancers."

--Immunotherapy: We will see better use of immune cells and other forms of immunotherapy in treatment of cancers such as melanoma and kidney.

--Growth factors will revolutionize treatment of patients with bone marrow disorders. This will permit lesser toxicity from chemotherapy, administration of higher doses of chemotherapy--possibly replacing bone marrow transplantation as a way to support the patient during massive treatment.

--Anti-growth factors: There will be advances in the development of anti-growth factor antibodies that will halt the growth of some cancers. Blocking specific growth factors for breast cancer or other epithelial cells are being pursued.

"The next decade may witness the beginning of the cure of the more common forms of cancer, such as metastatic breast cancer and forms of lung cancer, as well as their earlier detection," Laszlo said.

The major impediment to cancer research now is funding, Laszlo said. "In the research community, there's a sense of urgency, even desperation about how few applications are being funded," he said.

Smoking Decline Begins To Affect Lung Cancer Mortality Rates

The long term downtrend in cigarette smoking is beginning to show up in a decrease in lung cancer mortality rates among men and women under age 55, according to data compiled by the American Cancer Society.

Cigarette consumption per capita has dropped 29 percent since 1973, the beginning of the "non-smokers rights movement" and the growth of laws restricting smoking in public places, Lawrence Garfinkel, vice president of epidemiology and statistics for ACS, told the annual ACS Science Writers' Seminar, held in Daytona Beach, FL, last week.

The National Health Survey found that from 1965 to 1987, the percent of men who smoke dropped from 50.2 percent to 31.2 percent. In women the decrease was smaller, from 31.9 percent to 26.5 percent.

Garfinkel noted that in 1989, the U.S. had the lowest cigarette consumption per capita since 1942.

The survey showed that the most important factor related to smoking is education. There was little change in the percentage of smokers among those with less than a high school education: 36.5 percent in 1965 and 35.3 percent in 1987. Among college graduates, the smoking rate decreased more than 50 percent over the same period; 33.7 percent smoked in 1965, compared to 16.3 percent in 1987.

It takes 15 to 20 years for changes in cigarette smoking to be reflected in lung cancer mortality rates, Garfinkel said, but the mortality rates in the youngest age groups are going down.

"We'll actually see a downturn in the lung cancer mortality rate in males by 1990," Garfinkel said. These data will not be available for three years.

In women, however, the mortality rate is still increasing and probably will continue to increase for a few years, he said.

The risk of lung cancer drops with years of cessation compared to those who never smoked, but even 16 or more years after quitting, the risk is still higher than in those who never smoked, Garfinkel said.

Lung cancer mortality rates in men rose from 11 per 100,000 in 1940 to 73 per 100,000 in 1982. Since then, the rate has leveled off; in 1987 it was 75 per 100,000.

According to data from NCI's SEER program, the incidence rate of lung cancer in men rose an average of 1.6 percent a year between 1975 and 1979, but decreased by an average of 0.8 percent a year between 1982 and 1986.

Lung cancer mortality rates for men ages 35-44 and 45-54 have started to decline, and those in ages 55-64 and 65-74 have leveled off.

"It is only in those 75 years or older, those who have smoked for the longest time, that the increase has continued," Garfinkel wrote in a paper presented at the seminar. "As these men die, we will see a decrease in the overall age-standardized rate."

Among women, the lung cancer mortality rate continues to increase overall. However, the rate has started to fall in women under age 55, and has begun to level off in those age 55-64.

Lung cancer incidence rates for women increased an average of 6.3 percent per year between 1975 and 1979, but only by 2.8 percent per year between 1982 and 1989.

While domestic cigarette consumption is in a steady decline, cigarette production has increased due to larger exports. In 1989, cigarette exports were up 230 percent over 1984, and comprised 19 percent of total cigarette production.

This week, ACS and other volunteer agencies are scheduled to launch a program to curb this trend. The program, called Trade for Life, is designed to exert pressure to change present U.S. trade policies on

tobacco exports and to develop tobacco control strategies overseas.

ACS President Robert Schweitzer is to announce the program at the World Conference on Smoking and Health in Perth, Australia.

Barney Lepovetsky Dead At 64; Was Longtime Training Branch Chief

Barney Lepovetsky, director of NCI's Office of Technology Development, died March 24 at his home in Ijamsville, MD, of lung cancer. He was 64.

Lepovetsky, a microbiologist and lawyer by training, spent most of his 15-year career at NCI as chief of the Cancer Training Branch, responsible for NCI's extramural research training and education activities. During his 12 years there, the branch grew from administering only three award programs in 1975 to its present 12 programs, most of which Lepovetsky designed.

These include postdoctoral research fellowships for oncology nurses, the Clinical Investigator Award for younger MDs, the Preventive Oncology Academic Award to establish young faculty members and preventive oncology scientists, the Cancer Education Grant program to support oncology curriculum development, and a series of short courses for updating researchers, physicians and nurses.

During Lepovetsky's tenure, the branch made nearly 600 grants and awards representing an annual investment of $43 million supporting 1,700 long term trainees per year.

For the past two years, as head of the Office of Technology Development, Lepovetsky was responsible for NCI implementation of regulations and activities related to collaborative agreements, inventions, patents and royalties.

In 1989, he received the NIH Director's Award.

Lepovetsky first came to NCI in 1974 as deputy chief of the Review & Referral Branch, where he helped organize and operate the grants peer review system that evaluated large and complex applications for program project and cancer center support.

Lepovetsky began his NIH career at the National Institute of Dental Research, where he held several positions from 1965 to 1974. His most recent title there was chief of the Office of Collaborative Research.

Lepovetsky received a PhD in microbiology from Ohio State Univ. in 1954 and a law degree from Ohio Northern Univ. in 1963.

He is survived by his wife, Eloise; a son, Charles, a daughter, Patti; a grandson, Chuckie; and his father, Barney H. Lepovetsky.

NCI, CCSG Collaborating On Study Of Electromagnetic Field Exposure

NCI and the Children's Cancer Study Group are collaborating on a large scale investigation to determine if low frequency electromagnetic field exposure contributes to the development of acute lymphocytic leukemia.

Low frequency EMFs are the electric and magnetic fields created by electric charges in the 60 herz alternating current supplied to U.S. households. ALL comprises 85 percent of all childhood leukemias in the U.S.

The four year study, directed by the Epidemiology & Biostatistics Program, was begun last September and is part of a larger CCSG investigation evaluating the risk of ALL associated with a number of factors including the extent of prenatal x-rays, childhood and maternal diseases, maternal drug use, maternal smoking, parental occupations, household chemical exposures and family genetic histories.

The EMF evaluation will study a subgroup of 1,000 ALL cases and 1,000 matched controls in six states--Illinois, Indiana, Michigan, Minnesota, Ohio and Pennsylvania.

The subjects, all under age 15, will be selected from the 2,000 pediatric leukemia patients and 2,000 matched controls participating in the comprehensive CCSG study between September 1989 and December 1993.

Parents will be interviewed about their child's EMF exposure, nearby external power lines and residential wiring will be diagramed, spot and 24-hour measurements of EMF in areas frequented by children, in and outside of homes, schools and day care centers, will be conducted, and personal dosage assessments will be conducted with selected subjects.

The individual EMF data will be collected into an exposure matrix, which should provide one of the first comprehensive measures of EMF exposures in childhood environments.

Results of the study are expected to be available in early 1995.

RFPs Available

Requests for proposals described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. NCI listings will show the phone number of the Contracting Officer or Contract Specialist who will respond to questions. Address requests for NCI RFPs, citing the RFP number, to the individual named, the Executive Plaza South room number shown, National Cancer Institute, Bethesda MD 20892. Proposals may be hand delivered to the Executive Plaza South Building, 6130 Executive Blvd., Rockville MD. RFP announcements from

other agencies will include the complete mailing address at the end of each.

RFP NCI-CP-05629-61
Title: Repository for storage and distribution of biological research resources
Deadline: Approximately May 21

NCI is releasing a solicitation and is interested in receiving proposals from contractors interested in performing the following tasks:

a) receiving reagents shipped to the repository for storage and distribution, b) receiving orders for materials by telephone and written requests, c) retrieving correct materials from freezers, packaging materials appropriately for shipping and making shipments to fill requests, d) storing materials at proper temperatures, e) collecting charges for reagents as set by NCI and for shipping and handling, f) maintaining current accurate inventories of reagents, g) aliquoting bulk polyclonal antisera, h) obtaining proper assurance and release and indemnity forms from recipients of materials, i) supply electrical power to accommodate approximately 40 government owned refrigerators/freezer units, j) supply liquid nitrogen to 18 nitrogen freezers, k) security maintenance of all storage facilities and continuous monitoring of the central temperature alarm system for all refrigerators/freezers.

Mandatory qualification: Offeror must have or provide evidence that they can establish prior to contract award, adequate facilities in which the Biological Carcinogenesis Branch Repository can be maintained; where orders and requests can be received within five working days after contract award; and, from which reagents can be shipped within 10 working days after contract award.

In order to be responsive to the needs of investigators who need reagents that are critical to their cancer related research, the delivery of the repository reagents must continue within the limits set above.

Also, it is essential that the contractor provide proper storage space in order not to jeopardize this irreplaceable resource. The incumbent contractor is Microbiological Associates Inc. A five year award is anticipated.

The proposed contract is a 100 percent small business set-aside. The Standard Industrial Classification code is 8731 with a size standard of 500 employees.

Contract Specialist: Charles Jackson
RCB Executive Plaza South Rm 620
301/496-8611

RFP NCI-CO-03886-59
Title: Assessment of PDQ as a model system to disseminate information about effective therapy
Deadline: Approximately May 29

NCI and the new Agency for Health Care Policy and Research are collaborating on a project to evaluate Physician Data Query, an NCI clinical cancer treatment information resource, as a model system to disseminate information about effective therapy, as evidenced by modified physician behavior.

The purpose of this project is to determine if the use of explicit standards of care and guidelines, as represented by PDQ, by physicians will modify their behavior and increase the delivery of what is judged as treatment most likely to be effective. The areas of examination should include the characteristics of the physicians and their practice settings.

The contractor shall identify a way or ways to provide PDQ information to physicians in community practice settings, i.e., communities outside an academic medical center or major teaching hospital, and shall examine physicians' behavior when PDQ is implemented in the different community practice settings (office, clinic, hospital, etc.) at the point of decision making.

The central question to be answered by this study is whether physician treatment plans become more congruent with treatment options in PDQ after physicians are presented with treatment information from PDQ.

Success will thus be measured by modification in physician behavior and patient enrollment in clinical trials.

It is anticipated that a cost reimbursement type contract will be awarded for three years, beginning Sept. 30, 1990. This is a full and open competition and all responsible sources may submit a proposal.

Contracting Officer: Christine Virts
RCB Executive Plaza South Rm 608
301/496-8628

NCI Contract Awards

Title: Operation and maintenance of the DTP biological data processing system
Contractor: Capital Technology Information Services Inc., Rockville, MD; $2,895,152

Title: Case-control study of residential exposure to radon and lung cancer among nonsmoking women in Missouri
Contractor: Survey Research Associates, Baltimore, MD; $607,101

Title: Operational systems development in support of the Developmental Therapeutics Program
Contractor: ARC Professional Services Group Inc., Rockville, MD; $1,683,117

Title: Cancer Information Service
Contractors: Seventeen awards were made:

Dana Farber Cancer Institute, Communications Office, Boston, MA, $1,079,626;

Johns Hopkins Univ. School of Medicine, Baltimore, MD, $989,800;

Univ. of Kentucky Research Foundation, Lexington, KY, $725,000;

Univ. of Texas M.D. Anderson Cancer Center, Houston, TX, $1,923,740;

Ohio State Univ. Research Foundation, Columbus, OH, $1,174,040;

Illinois Cancer Council, Chicago, IL, $1,371,000;

Fox Chase Cancer Center, Philadelphia, PA, $1,569,960;

Univ. of Utah, Salt Lake City, UT, $770,000;

Fred Hutchinson Cancer Center, Seattle, WA, $1,600,000;

Yale Univ. School of Medicine, New Haven, CT, $1,533,210;

Duke Univ. Medical Center, Durham, NC, $777,000;

Memorial Hospital for Cancer and Allied Diseases, New York, NY, $1,700,000;

Univ. of Miami Sylvester Comprehensive Center, Miami, FL, $1,346,426;

Penrose-St. Francis Healthcare System, Colorado Springs, CO, $740,629;

Health Research Inc., Roswell Park Div. and New York State Dept. of Health, Buffalo, NY; $1,685,1100.

West Virginia Univ. School of Medicine, Morgantown, WVA, $1,685,1100.

Univ. of California (Los Angeles), $1,685,1100.