ACS CSSP
Cancer Surgery Standards Program
American College of Surgeons

ACS CoC
Commission on Cancer
American College of Surgeons

Implementation of CoC Operative Standards Webinar
FAQ Document

The CAnswer forum has responded to questions that we are responsible for procedures done in affiliated MD offices.	Correct--we recommend identifying whether the surgery center in question is included in your accredited hospital's Tax ID. If the office where the procedure is performed is included in your hospital's accreditation, then the procedure would be included in the scope of these standards.
Can you share best practices regarding the format of dictated op notes?	For surgeons that still dictate the op note, the best practice would be to post the Operative Standards and specific required elements and responses near the physician dictation station. This way they have easy access to the CoC-required elements and responses when dictating their op note.
We have many surgeons that use smart form op notes and templates that have been developed in EMR. However, we have a few surgeons that will only dictate.	A uniform synoptic reporting format is ideal for surgeons at the same site. We understand that this might be difficult to implement, so this is a strong recommendation. Surgeons that use dictation should use the same wording as the CoC required elements and responses. The synoptic section must be distinct and have all elements/responses together in synoptic format.
Do surgeons who are performing surgery at dermatology clinics of our main health systems need to comply with the melanoma synoptic reporting?	Regardless of whether a surgical oncologist or dermatologist performs the wide local excision, if the procedure was done at your accredited facility (or at a location included in your hospital's accreditation) the case will need to comply with all requirements of Standard 5.5.
Can the required CoC elements and responses be added to the bottom of an operative report dictation transcript?	Yes. The required elements/responses can be part of a dictated operative note as long as they use the same wording as the standard and are in synoptic format.

Does "uniform across all surgeons" mean each disease team (each breast surgeon using the same) must be the same or across all of them (all breast, melanoma, and colon surgeons using the same structure)?	Ideally, a uniform synoptic reporting format should be used by all surgeons at the facility. However, we understand implementation across disease sites might be difficult so at this point this is a strong recommendation.
Has anyone pursued changes to their Medical Staff rules and regulations or department specific i.e., surgery rules and regulations to reinforce the need to document in synoptic reporting? If so, was it successful or pushback/or unsuccessful in passing as a change?	Suggestion from panelists - when the synoptic report was initiated, it was placed on the required EHR template for Op Notes following a required element that defined infection risk. While the synoptic template is not required—it falls in a place that is interpreted as “required” by the surgeon when completing the note. In addition, the surgeons can attach their templates for the cases in the same area as the synoptic templates so everything is pulled up as a single list and the templates can be opened with single clicks. Ease is provided and attention to the task is created.
If we have a plan in place at the end of the year but then have to modify it as we move forward, will that meet compliance with the standards?	As long as sites have an implementation plan in place in time for their site review, they will be compliant. If adjustments are needed, the reasons for the changes and revisions to the plan should be documented in the Cancer Committee minutes.
For panelists using a smart phrase, do you rely on CPT codes to pull the smart phrase in, or do you pull it in/have it added to your template for each of the surgeries?	Sites can rely on providers to embed the synoptic smart phrases into their OP report templates. Sites can use PCS codes instead of CPT codes to generate reports to identify cases for auditing purposes. PCS codes are used because coders code both PCS and CPT codes on outpatient surgery claims and want to make sure procedures that are done on patients in the inpatient setting are captured.
How are facilities validating that cases aren’t getting through without the physician completing the templates?	A suggestion from panelists for incomplete cases - the cancer committee manager can identify the gaps and the Cancer Liaison Physician will facilitate completion with a one-on-one request.

If a program is using the CoC-provided templates, and they are scanned into the EMR repository with the dictated operative and become a part of the legal operative report, does that meet the standard as a stopgap measure for 2023?	Yes – sites using the CoC-provided templates will be compliant with Standards 5.3-5.6. This solution is intended as a stopgap measure for institutions that cannot otherwise create synoptic reports to meet these standards.
Is completing the operative report within 30 days acceptable?	Yes – this is acceptable as compliance will not be judged until the relevant site visit. We recommend referring to the institutional policy regarding when the operative report should be finalized in the EMR.
Can surgeons amend operative reports?	Correct, reports should only be amended when the change will affect clinical care.
Can medical residents complete the synoptic surgical template if it is signed off by the attending surgeon?	The CoC/CSSP has laid out specific requirements regarding the content of the operative note, but how the operative note is prepared/completed is under the purview of the site, provided the site follows CMS and/or other requirements.