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FROM THE *Secretary*

Dr. Johannes Vieweg Named New AUA Foundation Research Council Chair



Dr. Robert C. Flanigan
AUA News Editor in Chief
Maywood, Illinois

At its recent fall meeting the AUA Board of Directors (BOD) unanimously elected Dr. Johannes

Vieweg to serve as the next chair of the AUA Foundation Research Council Office of Research. The BOD formally approved the recommendation of the AUA Search Committee headed by Dr. Paul Schellhammer. Doctor Vieweg currently serves as professor

and chair of the Department of Urology at the University of Florida College of Medicine, Executive Director of the University of Florida Prostate Disease Center, and program leader of the University of Florida Experimental Therapeutics Program.

Johannes was born in Neuendettelsau, Germany on May 11, 1958. He completed his postdoctoral fellowship at the Center for Genetic and Cellular Therapies and his urology residency training, both at Duke University. His academic career continued at Duke, where he became asso-

ciate professor of Urology and the vice chief of research before moving to the University of Florida and the Malcom-Randall VA Medical Center.

Doctor Vieweg's research interests are in applied genetics and immunology. He has been well funded at a national level and has served on multiple National Institutes of Health (NIH) and National Cancer Institute grant review panels. Critically important to his new position Johannes has also served as a successful mentor to a large number of research fellows and trainees. The AUA Search Committee and the BOD were impressed by his considerable strategic insight into what



Dr. Johannes Vieweg

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Urological Imaging: The Current State of Affairs



Dr. Pat Fulgham
Dallas, Texas

Imaging has a vital role in the management of most complex urological conditions including stone disease and

urological malignancies. The overall use of imaging has increased precisely because urologists depend on it to guide therapy and monitor for disease recurrence. The relatively high cost associated with the increased use of complex imaging studies (eg computerized tomography and magnetic resonance imaging) has drawn the attention of third-party payers.

Since imaging constitutes a high percentage (16% in 2007) of the overall payment to physicians by the Centers for Medicare and Medicaid Services (CMS), it has become a focal point in the debate on health care reform. The increase in office based imaging services provided by nonradi-

ologists has led to some contention about which specialists are most qualified to provide those services. In addition to the increased costs associated with imaging, there is a growing concern among the medical community and the public about the secondary risks associated with diagnostic radiation.

The problem of high imaging costs appears different depending on the vantage point of the involved parties. From the perspective of CMS, complex imaging represents an overwhelming cost to the Medicare program. The Government Accountability Office and the Medicare Payment Advisory Commission have made repeated reports to Congress suggesting that the proper strategy for reducing imaging costs is to decrease use by restricting access¹ or by cutting the unit price.²

Restricting access to imaging (and thereby reducing utilization) can be accomplished through credentialing providers, certifying facilities and

requiring prior authorization. Decreasing the unit price can be achieved by disallowing multiple procedures, increasing equipment utilization assumptions and bundling payments for episodes of care. Other payers have adopted similar strategies for reducing utilization by restricting credentialing in their programs for common procedures (ultrasound)

based on specialty. For example, a Blue Cross Blue Shield carrier in New Jersey (Horizon) has notified urologists that they will not be paid for certain ultrasound procedures including limited pelvic ultrasound (bladder), limited retroperitoneal ultrasound (renal) and scrotal ultrasound. This decision is

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From the Secretary

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the AUA should accomplish to enhance its research infrastructure going forward and the energy he would bring to this effort.

Doctor Vieweg will assume this position following the AUA annual meeting in San Francisco in June 2010, replacing Dr. Anthony Schaeffer, who has served the AUA tirelessly in this position for the last 7 years.



Dr. Anthony J. Schaeffer

Serving in a voluntary capacity, Tony has spent countless hours and days working with the AUA Foundation, the NIH and other research bodies to improve urological research and, importantly, to bring new resources to the young urological investigators who are our future. He has faithfully served as a source of expertise and advice to the NIH, particularly in his role as a member of the Advisory Council of the National Institute of Diabetes and Digestive and Kidney Diseases (see article on page 16 in this issue.)

During this time Tony has also served as professor and chair of the

Northwestern University Department of Urology, leading it to a level of great prestige among the finest of United States urology residency programs and enhancing its leadership role in the national urology research effort. I have had the pleasure of watching Tony firsthand and can testify to the untiring efforts that he has given in support of urological research. Tony, you have done a wonderful job for all of us in urology and we owe you a great debt of gratitude. Thank you so very much for your wonderful service! ♦

Urological Imaging

▼ Continued from page 1

being actively opposed by New Jersey urologists who believe that patients will be disadvantaged by the policy.

The provision of imaging services in physician offices is an economic threat to radiologists who have previously been able to capture the technical as well as the professional component of payments for imaging. Up to 72% of complex imaging equipment is owned directly by radiologists or indirectly through joint ventures and hospital partnerships.³ Therefore, radiologists have lobbied Congress to overturn the Stark exemption which allows in-office imaging by physicians.

“The provision of imaging services in physician offices is an economic threat to radiologists who have previously been able to capture the technical as well as the professional component of payments for imaging.”

Urologists want to retain the ability to perform and interpret urological imaging studies. There is no question that immediate access to diagnostic imaging studies benefits urological patients by reducing missed time from work and providing a more rapid diagnosis.

Regardless of the personal and professional interests of those who provide imaging services, the 2 observations that must be addressed are 1) imaging use has unequivocally increased and 2) data from multiple sources show a positive correlation between equipment ownership and use. However, there is no direct evidence that increased use associated with ownership of imaging equipment is inappro-

priate. The implication that ownership of imaging equipment causes urologists to perform more imaging studies in the pursuit of ancillary revenue needs to be confronted and refuted.

Organized urology has aggressively responded to these challenges. As part of the core curriculum initiative developed by Dr. Robert Flanigan, the curriculum for urological imaging has been substantially upgraded. The AUA Practice Guidelines Committee has been asked to consider integrating more specific recommendations for imaging into existing practice guidelines. The American Board of Urology has ensured that the certification, recertification and Maintenance of Certification processes specifically and thoroughly test a candidate's knowledge of imaging.

The AUA Office of Education is supporting an expanded educational program on urological imaging (see article on page 24 in this issue.) The annual meeting now offers a didactic course in diagnostic radiology conducted entirely by urologists. An extensive curriculum in urological ultrasound courses offered at the annual meeting covers pediatric, abdominal, male genitalia and transrectal ultrasound in the popular dry lab, hands-on venue. In addition, annual courses on urological training are offered which cover all aspects of urological ultrasound. The educational offerings in ultrasound are unique in that participants are tested and provided an AMA Level II Verification of Skills Certificate for successful completion of the training.

There is abundant evidence that imaging by all specialties has increased during the last 2 decades. Much of the increased use has been driven by changes in practice patterns and improvements in technology. It behooves urology to develop rigorous recommendations for imaging use

based on clinical and cost-effectiveness data. Although there are programs to assess the characteristics of individual imaging studies (eg the American College of Radiology Appropriateness Criteria®), these programs are not a substitute for the assessment of the clinical effectiveness of each imaging study. The criteria for the proper use of imaging need to be developed by the clinicians who treat the patients and order the studies.

“The implication that ownership of imaging equipment causes urologists to perform more imaging studies in the pursuit of ancillary revenue needs to be confronted and refuted.”

Finally we need to continuously upgrade our educational offerings, and extend imaging education into residency training and even into the medical school curriculum. Thus, we will reinforce the reality that imaging is not an additional service to be offered by urologists but an integral part of the practice of urology. ♦

1. United States Government Accountability Office Report to Congressional Requesters: Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices, GAO-08-452, June 13, 2008. Available at <http://www.gao.gov/new.items/d08452.pdf>.
2. MedPAC Report to the Congress: Medicare Payment Policy, Section 2B, March 2009. Physician services and ambulatory surgical centers: changing payments for expensive imaging services, pp 105-110. Available at http://www.medpac.gov/chapters/Mar09_Ch02B.pdf.
3. Levin DC and Rao VM: Turf wars in radiology: updated evidence on the relationship between self-referral and the overutilization of imaging. *J Am Coll Radiol* 2008; **5**: 806.

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