



Patient-Centered Imaging in Urology – The Facts on In-Office Diagnostic Tests

In-office imaging provides the fastest, most convenient and often the most reliable results — results that are routinely used by treating physicians in providing ongoing patient care. The use of office-based imaging allows for quicker diagnosis and prompt treatment.

The American Urological Association (AUA) is concerned about recent allegations that diagnostic imaging performed by physicians other than radiologists is “substandard” and “unnecessary” and that the growth in utilization is principally attributable to in-office testing by physicians other than radiologists. **None of the allegations are true.** There is no credible evidence that in-office imaging is being conducted inappropriately or is resulting in inaccurate diagnoses.

Urology residency education requires extensive training in the diagnostic imaging tests used in patient care. The Society of University Urologist’s *Objectives for Urology Residency Education: Guidelines for Educational Units* outlines the detailed learning objectives for evaluation and treatment using various imaging modalities. Residency programs adhere to these guidelines, using them as a basis for their curriculum, and the urology Residency Review Committee examines programs based on these guidelines. The review of ultrasound, CT and other imaging modalities is constant practice for urology residents and is fully integrated into their every day activities, including clinics, operating rooms, radiology suites, hospital rounds and in conferences.

Imaging modalities that are detailed in this curriculum include: urography, ultrasound of the genitourinary tract, computed tomography (CT) of the genitourinary tract, magnetic resonance imaging in urology and nuclear medicine procedures in renal and bladder disorders. These objectives include general objectives, physiological principles, indications, clinical information gained from the procedure and the causes for conditions that are detected using imaging.

Nor is there any basis for the allegation that office based imaging is the primary cause of increased utilization. Many factors have influenced growth in the volume of imaging services, including improved technology; changes in the standard of care for many illnesses; expansions in coverage for new diagnostic imaging modalities; and shifts in the site of service from hospitals to other health care settings. Much of this growth is in hospitals and Independent Diagnostic Testing Facilities (IDTFs). The improvement in quality has meant that many specialties, including urology are now using imaging for therapeutic purposes rather than simply a diagnosis tool.

The performance of diagnostic and therapeutic imaging by a patient’s physician ensures that a physician familiar with the patient’s clinical condition and medical history performs the services.

- Urologists use ultrasound to guide their performance of prostate biopsies for suspected cancer patients and are the most qualified to interpret the necessary imaging studies that provide further diagnosis. In turn, the urologist then uses such imaging to guide any necessary biopsy procedure.

- Female children often have urinary reflux that can lead to severe kidney problems including kidney failure. The worst cases undergo bilateral ureteral reimplantation. Non-invasive renal ultrasounds are performed in the pediatric urologist's office to check for hydronephrosis and ureteral obstruction. This test is also the standard screening test for reflux for any child that is having consistent urinary tract problems including infections.
- Patients with severe lower back pain suspected of having a kidney stone are very often referred to urologists from emergency rooms or other physicians. A CT Scan of the abdomen and pelvis is done ("CT stone protocol") in order to quickly diagnose and plan treatment. The CT stone protocol provides for the rapid, accurate diagnosis of the vast majority of kidney stones. Using the CT, a patient does not have to be given intravenous contrast as would be needed with the previously performed intravenous pyelogram (IVP). The CT scan also allows for the diagnosis of non-calcium stones, which is not typically the case with IVP. This type of care is more efficient for both the health care economy and the providers and patients, and it greatly enhances patient care.

According to the American College of Radiology's (ACR) own interpretation of 2001 Medicare data, 91 percent and 83 percent of Medicare claims for CT and MRI, respectively, were performed by radiologists. According to MedPAC, the advisory body to Congress, diagnostic imaging utilization increased by 9.4 percent between 2001 and 2002; however, MRI and CT increased at a substantially higher rate – about 15 percent for CT and almost 20 percent for MRI.

A prohibition on in-office diagnostic testing would reduce patient access to timely, convenient testing, and disrupt the important continuity of care. According to the ACR, there is currently a shortage of radiologists, and in certain parts of the country there are already long waiting periods for critical imaging studies, such as mammography. Restricting in-office testing could substantially aggravate the problem, resulting in significant delays and reduced quality of care. In addition, Medicare beneficiaries pay substantially more when imaging services are provided in hospital outpatient settings instead of physicians' offices. According to MedPAC, in 2002 the Medicare coinsurance rate for hospital outpatient imaging services was 53 percent. Coinsurance for these services in physicians' offices was limited to 20 percent.

For these reasons, the AUA urges states to view any proposal promising simple solutions to increased diagnostic imaging costs with great skepticism. While increased costs are a concern to physicians and patients alike, restricting patients' access to timely and accurate diagnoses by their own physicians is not the answer.

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