ABU Report

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Message from the President

Margaret S. Pearle, M.D., Ph.D.
President

In 2000, the American Board of Medical Specialties (ABMS) and the 24 medical specialty Member Boards it oversees agreed in principle to evolve their recertification program from one of periodic reassessment to one of life-long learning and continuous professional development. In 2009, they approved the standards that comprise the Program for Maintenance of Certification (MOC), incorporating the 6 Core Competencies adopted by the ABMS and ACGME (Accreditation Council for Graduate Medical Education). These core competencies provide the basis for the four-part process that comprises continuous certification, including, I) licensure and professional standing, II) life-long learning and self-assessment, III) cognitive expertise and IV) practice performance assessment.

The ABMS recently released a document entitled "Proposed Standards for the ABMS Program for Maintenance of Certification (MOC)"[1] for public comment. This document revises and refines the standards initially set forth in 2009 that comprise the framework for the "education, practice improvement, and assessment of activities of diplomates who have achieved initial certification from one or more of the…Member Boards". This document places additional responsibility on the Member Boards to assure that its diplomates engage in quality improvement and continued assessment of practice outcomes and that they adhere to standards of professionalism.

Part IV of MOC focuses on Practice Performance Assessment, with the intention of improving patient outcomes through ongoing assessment of practice. Individual Member Boards satisfy Part IV of MOC through a variety of activities, including participation in surgical registries, completion of practice assessment modules and involvement in quality improvement projects. One of the ways in which the ABU satisfies this requirement is through submission of a 6-month practice log at Level 4 (years 7-9) of MOC. The submitted practice logs are derived from electronic billing records and encompass any encounter that generates a bill under the diplomate's name, including office visits, procedures, laboratory testing, imaging and mid-level provider activity billed as 'incident to'. Although many view this process as cumbersome and without clear merit, the purpose of the logs is to assure that a diplomate has sufficient practice experience to maintain skill and to allow the ABU to adequately assess practice patterns and management decisions. The ABU is unique among the Member Boards in its review of practice logs, a process that is viewed favorably by the ABMS because of the rigor of the review process and the potential for favorably changing practice patterns.

The submission of practice logs satisfies Part IV of MOC because it promotes improvement in patient care and professionalism by monitoring for practice patterns that suggest overt failure to conform to accepted practice standards, and in the process, by informing and educating those diplomates about their outlier status. The logs are reviewed by a subcommittee of the ABU Trustees that assesses the logs for volume of practice and identifies CPT codes that are billed with a frequency that falls far outside the norm for their peers. These codes are scrutinized within the context of the volume of practice and declared subspecialty focus. For example, if a diplomate who completed an oncology fellowship and has a high volume practice focused on prostate cancer submits a practice log with an annualized frequency of TRUS biopsies that falls at the 99th percentile compared with his/her peer group, the committee would likely not subject this code to further scrutiny. On the other hand, a diplomate who bills for complex uroflow (CPT 51741) 1000 times in the setting of 1800 annualized patients visits, placing him at the 98th percentile for his peer group, will likely raise concern. In this case, complex uroflow is performed as a part of more than half the patient encounters, leading to suspicion of unnecessary testing, which is both fraudulent and unprofessional. As such, this finding would likely prompt a

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letter of inquiry from the committee requesting clarification about the practitioner's indications for this procedure as well as submission of randomly selected de-identified office records associated with these codes in order to determine if sufficient documentation has been provided to support its use.

From 2008 to 2013 a total of 472 letters of inquiry were sent to diplomates among 3048 applying for recertification, averaging 79 letters per year. Among those whose justification and documentation for the use of the CPT code is considered acceptable, no further action is taken, and the diplomate is permitted to sit for the recertification examination. On the other hand, those with questionable indications or with documentation that fails to support proper use of the code are invited for a face-to-face interview to further justify their practices to the Recertification Committee. The possible outcomes of the face-to-face interview include permission to proceed with the examination, deferral of the examination pending remediation and/or review of future unannounced practice logs, or revocation of certification. In the last 5 years, only 2 candidates have been outright denied re-certification. The intention of this process is not to scare diplomates into billing for fewer procedures or encounters, but rather to encourage them to practice according to established practice guidelines and sound medical principles.

The log review process provides the ABU with an opportunity to identify individuals who may be overusing or overbilling for particular procedures. For example, with the introduction of point-of-service auto-analyzers that perform urinalysis as well as measure protein-to-creatinine ratio, the ABU observed an marked increase in the frequency of CPT code 82570 (urine creatinine) among submitted practice logs. Protein-to-creatinine ratio is a sensitive marker of chronic kidney disease (CKD), and indeed, the National Kidney Foundation Clinical Practice Guidelines[2] recommend screening for proteinuria in patients at high risk of CKD, such as those with diabetes and hypertension, which can be accomplished with albumin-specific dipstick analysis or albumin- or protein-to-creatinine ratio. From 2008 to 2009 there was a more than 3-fold increase in the number of letters of inquiry sent to recertification candidates regarding the frequent use of this CPT code, reflecting only the most egregious

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Mission Statement

The mission of the American Board of Urology is to act for the benefit of the public to insure high quality, safe, efficient, and ethical practice of Urology by establishing and maintaining standards of certification for urologists.

ABU Policy Updates

- **ABU Policy on Initial Certification Exam Attempts:** Applicants approved by The American Board of Urology (ABU) to enter the certification process must successfully complete both a Qualifying (Part 1) Examination and a subsequent Certifying (Part 2) Examination to become certified. Assessment of clinical practice through review of practice logs and peer review will also be performed prior to admission to the Certifying (Part 2) Examination. Certification must be achieved within six years of the successful completion of an ACGME accredited urology residency. An applicant will have no more than three attempts to pass the Qualifying (Part 1) Examination and no more than three attempts to pass the Certifying (Part 2) Examination. Applicants who have not successfully completed the certification process within six years of completion of their urology residency or who have failed either the Qualifying (Part 1) Examination or Certifying (Part 2) Examination three times must repeat and successfully complete the urology portion of an ACGME accredited urology residency program in order to re-enter the certification process.
- **ABU Policy on Subspecialty Certification Exam Attempts:** Candidates seeking subspecialty certification have 3 opportunities to pass the examination, and must do so within six years of completing the fellowship process. All cases will be reviewed on an individual basis by the appropriate subspecialty certification committee. In order to re-enter the process, candidates who have "timed-out" or failed three attempts at certification, will require completion of an additional fellowship year in an ACGME accredited fellowship.
- **"Board Eligible" Status Policy:** The American Board of Urology recognizes the term Board Eligible in reference to its applicants and candidates. A candidate is not certified until all components of the certification process have been successfully completed. However, in the case of initial general specialty certification, the period from July 1 or the date of completion of residency training for 6 years or until successful completion of the certification process or failure to pass the Qualifying (Part 1) Examination or Certifying (Part 2) Examination in three attempts, whichever comes first, is considered the "board eligible" timeframe. If certification is not completed in that timeframe or within three attempts at either exam, or if the Board eligible timeframe ends, the candidate will cease to use that term further. There is no board eligible timeframe for subspecialty certification.
- **Restatement of ABU Policy on Alternate Pathway for Certification:** Internationally trained urologists in very specific educational roles and with exceptional clinical skills may apply to The American Board of Urology to

enter an alternate pathway for the certification process. The ABU views this situation to be extraordinary and will approve this pathway on a case-by-case basis. To be considered for such a pathway, the applicant must have provided extraordinary clinical and educational full-time service for at least 7 years in an RRC-approved participating institution within an ACGME-approved urology residency program; achieved the rank of full professor through a credible university promotion process; in the eyes of the Board demonstrated outstanding academic achievement in the field of urology and urologic education with expectation for continued contributions; and received the written endorsement of the urology chair and the program director from any program with which they were affiliated. This variance is not intended as an alternate pathway to routine ABU certification. It is intended as a very exceptional path for internationally trained urologists to bring extraordinary clinical skills and teaching talents to residency training programs (GME) and to thereby advance urologic education. The American Board of Urology reserves the right to alter or reverse this policy at any time.

- **MOC Examination Attempts:** In order to maintain consistency with other ABU examinations, the Trustees have increased the number of examination attempts for MOC Diplomates from two years to three years; therefore, MOC Diplomates may apply for their final level of MOC, which includes the cognitive exam, in year 7, 8, or 9 of their MOC cycle.

In Memoriam

The office of the American Board of Urology regretfully reports receiving notification in 2012-2013 that the following Diplomates have passed away:

Robert Lee Allen MD
Bruce G. Belt MD
Charles Kazys Bobelis MD
Ronald L. Brown MD
Eugene V. Cattolica MD
Mark J. Chelsky MD
Arthur J. Clinton MD
Richard H. Engelbart MD
Arch W. Fees MD
Bernard M. Hochberg
George E. Hurt, Jr., MD
Aaron G. Jackson, MD
Jack Applebaum Jaffe MD
Jaroslav "Jerry" Jilek MD
Lucien C. Kavan MD
Leo M. King MD
George Rufus Maloney Jr MD
Bogdan Roman Marcol MD
Irving Melnick MD
Rowe P. Moore MD
John Anthony Mordente MD
John D. Pumphrey MD
Cyrus M. Robinson MD
Thomas E. Tossberg MD
Ely C. Wagshul MD
Joseph N. Ward MD
Mary Christine Webster MD
Norman Robert Zinner MD

2013 Qualifying (Part 1) Examination

294 candidates sat for the 2013 Qualifying (Part 1) Examination on July 25 and 26 at Pearson VUE Test Centers across the country. 273 candidates passed (93%) and 21 candidates failed (7%). The 2014 Qualifying (Part 1) Examination is scheduled for July 14-15.

2013 Certifying (Part 2) Examination

288 candidates challenged the February 2013 Certifying (Part 2) Examination in Dallas, TX. 263 (91%) passed and were certified while 25 (9%) failed. The Board uses the multi-faceted Rasch model and the Fair Average for scoring the standardized oral examination. This methodology adjusts for differences in the difficulty of various protocols and in examiner severity. The candidates were scored on four clinical skill categories including diagnosis, management, follow up, and overall ability. The Board believes this scoring methodology results in increased statistical reliability. The 2014 Certifying (Part 2) Examination is scheduled for February 21-22.

2013 Female Pelvic Medicine and Reconstructive Surgery Examination

The American Board of Urology received 177 applications for the inaugural examination for subspecialty certification in Female Pelvic Medicine and Reconstructive Surgery. Following a review of practice logs submitted by applicants, 154 ABU Diplomates were approved to sit for the examination. A total of 853 candidates (urologists and gynecologists) sat for the June 21, 2013 examination. The pass rate on the examination was 86%. Like general urology certificates, all subspecialty certificates issued are ten-year time limited certificates and subject to MOC. The next FPMRS examination will be administered on June 20, 2014.

2012 Recertification Examination

567 Diplomates sat for the Recertification Examination at Pearson VUE Test Centers in October 2012. 558 Diplomates (98%) passed and were recertified and 9 Diplomates (2%) failed. The pass rate was consistent with previous years. 592 Diplomates are registered for the 2013 Recertification Examination administered on October 24 or 25, 2013. The recertification process as it currently exists will be discontinued by 2019 when Maintenance of Certification is fully implemented. ■

The Board Welcomes...

New Trustees: Mark S. Austenfeld, M.D. and Stephen Y. Nakada, M.D.

Dr. Mark S. Austenfeld is a staff urological oncologist at St. Luke's Hospital in Kansas City, Missouri and Clinical Associate Professor of Urology at the University of Missouri, Kansas City. His six-year term began on February 28, 2013. Dr. Austenfeld was nominated to the ABU by the American Association of Clinical Urologists. Dr. Austenfeld specializes in urological oncology. His interests include genitourinary reconstruction and urinary prosthetics and he continues to conduct clinical research studies. He is a partner in Kansas City Urology Care, a single specialty urology group practice in greater Kansas City. Dr. Austenfeld earned his medical degree at the University of Kansas and completed his urology residency training at the University of Utah. He went on to complete a fellowship in Oncology at the Mayo Clinic, Rochester. Following fellowship, Dr. Austenfeld became the Director of Urological Oncology at the University of Kansas School of Medicine from 1989 to 1996. Dr. Austenfeld is a Diplomate of the American Board of Urology and a Fellow of the American College of Surgeons. He is a member of the American Urological Association, serving as both the Secretary and the President of its South Central Section. Dr. Austenfeld is also a member of the Society of Urological Oncology and the American Association of Clinical Urologists, where he currently serves as President. He has authored or coauthored over fifty scientific publications.

Dr. Stephen Y. Nakada is the David T. Uehling Professor and Chairman of the Department of Urology at the University of Wisconsin School of Medicine and Public Health in Madison. His six-year term began on February 28, 2013. Dr. Nakada was nominated to the ABU by the American Urological Association. Dr. Nakada specializes in the surgical and medical management of kidney stones and minimally invasive renal surgery. Dr. Nakada has been the Chairman of Urology at Wisconsin since 2001. Dr. Nakada received his undergraduate degree in Biology from Dartmouth and completed his medical degree at the University of Rochester School of Medicine and Dentistry. He completed his urology residency training at Strong Memorial Hospital in Rochester, NY. Dr. Nakada went on to complete a fellowship in Endourology and Minimally Invasive Surgery at Washington University prior to joining the faculty at the University of Wisconsin in 1995. Dr. Nakada is a Diplomate of the American Board of Urology and a member of the American Urological Association, where he serves on the Board of Directors, the American Association of Genitourinary Surgeons, and the Clinical Society of American Association of Genitourinary Surgeons. Dr. Nakada is the Secretary General of the Endourology Society and a member of the Urology Residency Review Committee. He currently serves as an Associate Editor for Urology, an Editorial Consultant for *Urology Times*, and an Assistance Editor for the *Journal of Endourology*. ■

American Board of Urology Trustees 2013-2014

Back row *(from left)*: Ian M. Thompson, Jr. MD, H. Ballentine Carter, MD, Fred E. Govier, MD, Kevin R. Loughlin, MD, MBA, J. Brantley Thrasher, MD, Stephen Y. Nakada, MD, J. Christian Winters, MD, Mark S. Austenfeld, MD,

Front row *(from left)*: Peter N. Schlegel, MD, Michael L. Ritchey MD, Gerald H. Jordan, MD, John B. Forrest, MD, Barry A. Kogan, MD, Margaret S. Pearle, MD, PhD, Robert R. Bahnson, MD

The Board Thanks . . .

John Bennett Forrest, MD and Barry A. Kogan, MD

During their tenure as Trustees of the American Board of Urology, the ABU Maintenance of Certification (MOC) program was developed, subspecialty certification in Pediatric Urology was implemented, subspecialty certification in Female Pelvic Medicine and Reconstructive Surgery was approved and implemented, significant revision to the oral examination transpired, a mission statement and code of professionalism were developed and adopted, and significant policy changes were implemented.

Dr. John Forrest served as a Trustee of the American Board of Urology from February 2007 until February 2013 and was its President from 2012-2013. He also served as Secretary-Treasurer, Chair of the Executive Committee, and a member of both the Policy Committee and the Recertification Committee.

Of his tenure as a Trustee of the ABU, Dr. Forrest stated, "One of the greatest privileges an individual may receive is the opportunity to serve their profession to better its standing both with the public that it serves and the profession that it represents. Serving on the American Board of Urology has been my highest professional privilege. I am confident the Board will continue to serve the public and its profession at the highest level for the betterment of all. "

Dr. Barry Kogan served as a Trustee of the American Board of Urology from February 2007 until February 2013 and as Vice President from 2012-2013. He has been the ABU representative to the Residency Review Committee for Urology (RRC) since 2009 and is currently Vice Chair of the Committee. Dr. Kogan also served on the Pediatric Subspecialty Certification Committee, the Publication and Research Committee, and the Credentials Committee.

Regarding his service on the ABU, Dr. Kogan had this to say, "Being a Trustee of the ABU is a highlight of my career. I feel fortunate to have been a Trustee during a period of major change in medicine. Far more than in previous generations, each of us is being challenged to improve both the quality and safety of our patient care. During my time as a Trustee of the ABU we have instituted significant changes in the Maintenance of Certification program. We have transitioned from a model of lifetime certification with very limited documentation of maintenance of skills to a system of ongoing education, evaluation and certification. Fortunately, most all practicing urologists realize that, as both individuals and a profession, we must demonstrate to our patients that we have maintained our skills at the highest possible level. Our Diplomates can be very proud of the ABU's program of Maintenance of Certification. Though it continues to be a work in progress, I am glad to have had the opportunity to play a role in the development of this program. It will enhance the credibility of our Diplomates and more importantly will improve the care provided to our patients." ■

European Board of Urology Visits ABU Oral Examinations

Dr. Mete Cek, President of the European Board of Urology (EBU), Dr. Artur Antoniewicz, Chairman of the EBU Examination Committee, and Wilma Gietman, EBU Executive Director traveled to Dallas, Texas in February 2013 to observe the ABU oral examination process. They extended an invitation for ABU Trustees to attend a future EBU examination.

Left to right: Dr. Mete Cek, Dr. Gerald Jordan, ABU Executive Secretary, Dr. Peter Schlegel, ABU Oral Examination Chair, and Dr. Artur Antoniewicz.

From The Desk Of Gerald H. Jordan, ABU Executive Secretary

The following questions were raised by Diplomates or third party entities and addressed to the Executive secretary of the American Board of Urology. These issues are currently relevant and may impact urologists who are board certified or who are seeking board certification.

Q: I may possibly be restricted from performing routine pediatric urologic cases at my hospital because there is a urologist with ABU pediatric subspecialty certification on staff. Must I be subspecialty certified in pediatric urology in order to do circumcisions, orchidopexies, etc.?

A: The short answer is no. Diplomates of the American Board of Urology with a general certificate in urology are certified to be trained in all areas of urology, including those for which subspecialty certificates are available. This all-inclusive policy is also endorsed by the American Board of Medical Specialties in reference to all subspecialty certificates offered by ABMS member boards. Subspecialty certification in pediatric urology signifies that the Diplomate who is so certified has done additional, specialized training and has successfully met all requirements for subspecialty certification. It is in no way a statement that only they should be credentialed or allowed to practice in the subspecialty.

A urologist certified by the American Board of Urology who holds a general urology certificate is trained, qualified, and certified to perform urologic procedures on pediatric patients. Indeed, subspecialty certification is not intended to imply that hospital or emergency room coverage of pediatric patients be denied by general urologists on that basis alone or that institutions require that pediatric urologic patients be treated only by urologists with subspecialty certification in pediatric urology.

Q: Should I be concerned that with the implementation of subspecialty certification in female pelvic medicine and reconstructive surgery, my current practice in the area of female pelvic medicine may become limited?

A: Diplomates of the American Board of Urology with a general certificate in urology are certified to be trained in all areas of urology, including those for which subspecialty certificates are available. This all-inclusive policy is also endorsed by the American Board of Medical Specialties in reference to all subspecialty certificates offered by ABMS member boards.

Subspecialty certification in Female Pelvic Medicine and Reconstructive Surgery, currently one of only two subspecialty certifications offered by the American Board of Urology, signifies that the Diplomate who is so certified has done special training in female pelvic medicine and reconstructive surgery and has successfully met all requirements for subspecialty certification. A urologist certified by the American Board of Urology who holds a general urology certificate is trained, qualified, and certified to perform female pelvic medicine and reconstructive surgery procedures. Indeed, subspecialty certification is not intended to imply that hospital or emergency room coverage of female pelvic medicine and reconstructive surgery patients be denied by general urologists on that basis alone or that institutions require that female pelvic medicine and reconstructive surgery patients be treated only by urologists with subspecialty certification in Female Pelvic Medicine and Reconstructive Surgery.

Q: We have a urology group that is telling us they 'cannot' treat testicular torsion in children. We know for a fact that all urologists are trained to manage and treat testicular torsion in children, and the treatment is not difficult. Does the Board have a position on the treatment of testicular torsion in children or any guidance to help us manage this pediatric emergency when the patients appear in our Emergency Department?

A: Again, as stated above, ABU certified urologists are certified to be trained in all areas of urology, including those for which subspecialty certificates are available. Just as the intent of the ABU implementing subspecialty certification was not to restrict practice in so called subspecialty areas by urologists who do not hold a subspecialty certificate, the Board does not support the practice of urologists on call deferring routine pediatric care to subspecialty certified colleagues in order to avoid call cases.

While the ABU is hesitant to second guess a practitioner's comfort level with regards to the treatment of certain urologic issues, there are certain conditions that are considered core to urologic training. In some of the inquiries to the board relating to this issue, patients have possibly been exposed to delays in diagnosis or treatment. These instances are of concern to the Board, as they raise questions about professionalism and ethics that surround these circumstances.

Q: My partner received a letter from the ABU Recertification Committee questioning his use of the code for urine creatinine testing; specifically protein to creatinine ratio. What is the board's position on the use of this urologic test?

A: The American Board of Urology requires the submission of a practice log from all applicants for certification (both initial and subspecialty), recertification, and maintenance of certification. The review of these logs examines the breadth, volume, and patterns of practice which reveals outliers in the use of certain codes; that is, the program identifies those practitioners whose usage far exceeds that of their peers. When these outliers are identified, the ABU committees reviewing logs send letters of inquiry requesting more information on the applicant's practice pattern and an explanation of indications for usage. We are aware that the technology of diagnostic medical testing provides multiple results as part of diagnostic panels; however, in some cases, there appear to be tests reported as part of a panel which are billed separately in addition to the base cost of the panel. When office testing is done, documentation of the indications for the test, the result, and the therapeutic value/plan for the patient is necessary. The practice of ordering and billing for a test, only because the result is part of a panel, is not considered proper administration of urologic care. In the matter of urine protein to creatinine ratio testing, the recently revised NKF KDOQI guidelines clearly elucidate the proper use of this test.

Q: I am a Diplomate in Maintenance of Certification (MOC) and I just completed my required Practice Assessment Protocol (PAP). I only scored an 80%. I am not satisfied with this assessment. What does the ABU do with this information and score?

A: The PAP is a web-based, self-evaluation process designed to assist the Diplomate in keeping abreast of current treatment guidelines. The PAP involves self-review of a small number of sequential cases in a specific area, a comparison of the Diplomate's evaluation and management of these cases to accepted practice guidelines, and the successful response to a series of questions relating to the appropriate clinical guidelines.

The "score" of 80% is not regarded as a score, as in the percentage of correct responses. The AUA has developed guidelines for practice and where possible, PAP's are based on those guidelines. The questions regarding the treatment of patients seek to have the practitioner reflect on his/her management as it complies with the guidelines. We recognize that guidelines are exactly that, and that they do not represent absolutes in the management of all patients or patient situations. Therefore, if a Diplomate is 80% guideline compliant, it suggests that the management of one of the five patients evaluated in the PAP was not absolutely as the guidelines would suggest. The reflective process then seeks to ascertain why that patient was treated differently; there is no implication that the patient was treated incorrectly. ■

Important Notice Regarding 2014 Recertification Application Mailing

In the past, the ABU office has mailed all Diplomates eligible for recertification an application packet in a 9x12 manila envelope. The envelope contained all application materials necessary to apply for recertification: the application form, a current handbook, log materials, etc. This was both costly and wasteful, given that Diplomates have three opportunities to recertify and many choose to delay the application process and therefore do not "use" the first or second application mailing. Additionally, if a Diplomate has relocated and not updated his/her mailing address with the board office, those application packets were undeliverable and were returned to the ABU.

Beginning in December 2013, the ABU office will invite all potential Recertification Diplomates into the recertification process by a single letter in a business sized (#10) envelope only. The letter will contain all instructions, deadlines, and information necessary to enter recertification in 2014, including how to print the required application materials from the ABU website. The letter to first time recertification applicants and final year recertification applicants will continue to be sent via certified mail to allow the ABU office to track receipt. Diplomates will continue to receive notification for three years until they complete their required recertification or notify the ABU office otherwise. This change will significantly reduce printing and mailing costs and the waste of unused application materials. Diplomates with certificate expirations of 2015, 2016, or 2017 and those who have contacted the board office regarding voluntary recertification can expect to receive a recertification mailing in a single, #10 ABU envelope in early December 2013. ■

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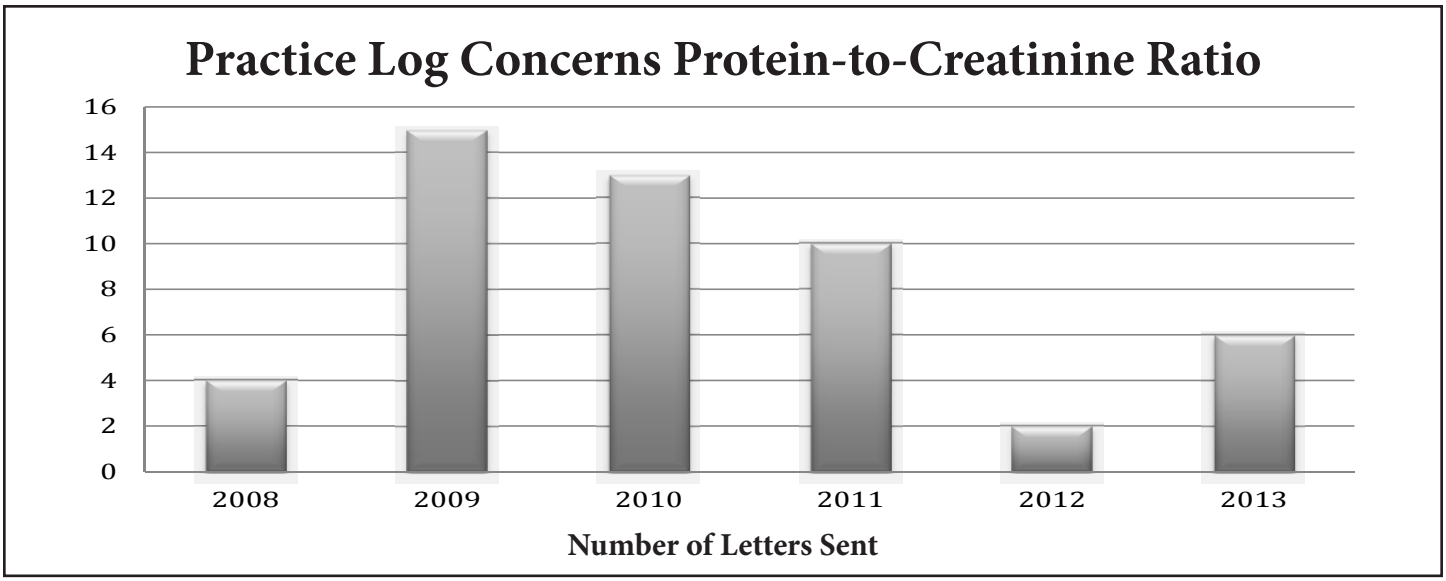
offenders at the highest level of utilization. The concern on the part of the ABU was how this test was being utilized and if its use translated into improved patient care. While this test is an important screening tool in high risk patients, benefit can only be realized when an abnormal test prompts appropriate referral. Candidates who could not demonstrate how the test results changed management or in whom the test was used seemingly indiscriminately were either warned to avoid this practice or were invited for a face-to-face interview. The Figure shows the number of letters of inquiry sent to diplomates regarding CPT code 82570 from 2008 to 2013, revealing a peak in 2009 and a rapid drop off in frequency thereafter until 2013 when it rose again. Not coincidentally, the 2009 ABU Report cautioned diplomates to refrain from billing for procedures that may not pass the scrutiny of medical necessity, but that may be readily available as part of a panel for which medical necessity can be demonstrated. Presumably as diplomates became aware of the oversight of billing practices afforded by the practice logs, they discontinued this practice.

To be sure, the ABU is not in the business of policing for fraudulent billing practices, as that falls under the purview of the Centers for Medicare and Medicaid Services (CMS). However, the practice of maximizing revenue through creative or duplicitous billing or by performing unnecessary procedures reflects a facet of unprofessionalism that will not be tolerated by the ABU, whose charge is to protect the public. Declining reimbursement and greater time spent on non-revenue generating activities has led to mounting pressure on physicians to develop creative ways to maintain their income through entrepreneurial activities. On a plot of revenue generated versus time spent, physicians rapidly reach a plateau where their incomes cannot be effectively increased by working harder and seeing more patients. These conflicting demands on physicians have the potential to compromise their integrity. The goal of incorporating practice logs into the ABU Program of MOC is to identify and inform diplomates who are practicing outside the norm for their peers, and hopefully to educate them about potentially unnecessary, harmful or unsupported medical practices, thereby improving patient care. ■

1. http://surveygizmolibrary.s3.amazonaws.com/library/236612/ProposedStandardsfortheABMSProgramforMOC.pdf
2. http://www.kidney.org/professionals/kdoqi/pdf/ckd_evaluation_classification_stratification.pdf



The Pearson Professional Center Test Experience for ABU Diplomates

Pearson Professional Centers are fully ADA compliant test locations designed to provide a secure, consistent, and comfortable testing experience, with keyed lockers for storing personal items, laminated boards and markers for note-taking, individual work stations for privacy and distraction-free testing, and proctors to address questions or concerns during testing.

Upon arrival at your selected test center, Diplomates will check in with a Pearson test administrator who will require two forms of identification, one of which must bear your photograph. A digital signature, photo, and fingerprint/palm vein scan will be taken and the information is securely encrypted along with an individual's examination data once the exam is completed. Diplomates will be directed to place

all belongings, including purses, bags, writing implements, watches, cell phones, and any other devices into a locker as no personal items are permitted in the testing room. Lockers are keyed and Diplomates retain the key until the conclusion of the examination.

Once in the testing room, a proctor will assist with placement at a workstation and ensure that the ABU Recertification examination (ABU-RE) is ready to begin. Testing sessions are audio and video recorded for security. If a Diplomate needs assistance or wishes to leave the testing room at any point during the examination, he/she may do so by raising a hand to indicate to a proctor that assistance is needed. The clock on the computer continues to count down during all unscheduled breaks within the four-hour period allotted for the ABU-RE. Each time a Diplomate re-enters the testing room after a departure, another palm scan is performed to verify identity.

Following the conclusion of the examination, the Diplomate is free to depart after being signed out by a Pearson test administrator. Results of the examination are mailed to Diplomates at their preferred mailing address approximately four weeks following the examination. For more information on the Pearson testing or to view helpful videos regarding the Pearson test experience, go to http://media.pearsonvue.com/videos/security.html and http://www.pearsonvue.com/ppc/. ■

ABU Statement on Irregular Examination Behavior

The American Board of Urology is committed to maintaining the integrity of its examinations. These tests are a critical basis of the decision making process for urology board certification, recertification, and maintenance of certification. Irregular behavior threatens the integrity of the ABU certification process. Irregular behavior is a defined as any action by applicants, examinees, potential applicants, or others that subverts or attempts to subvert the examination process. Examples of irregular behavior include (but are not limited to):

- Falsifying information
- Giving, receiving or obtaining unauthorized assistance during the exam.
- Altering or misrepresenting scores
- Behaving in a disruptive or unprofessional manner at a testing site
- Theft of examination materials
- Unauthorized reproduction, by any means, and/or dissemination of examination content or other copyrighted materials
- Posting or discussing content on any website, or asking others to do so

If the Board is made aware of irregular behavior on the part of an individual participating in an ABU examination process, the Board will review the information and determine if there is sufficient evidence of irregular behavior. The individual in question is required to cooperate during that review/investigation with ABU officials. Consequences for irregular behavior may include but are not limited to a warning, censure, deferral from the certification process, suspension, or revocation of a current ABU certificate. ■

Advertising Board Certification in the Era of Subspecialty Certification

With the implementation of subspecialty certification in Pediatric Urology in 2008 and subspecialty certification in Female Pelvic Medicine and Reconstructive Surgery in 2013, the ABU office has received inquiries from Diplomates requesting guidance on advertising their practices in general urology or in an area of urology without a subspecialty certification. Prior to 1995, certificates issued by the American Board of Urology bore the terminology, *Board certified in Adult and Pediatric Urology*. Since that time, ABU certificates indicate that the individual whose name appears on the certificate has met all requirements and passed all examinations required for certification or recertification and is certified as a Diplomate of the American Board of Urology or is declared a Recertified Diplomate of the American Board of Urology. Subspecialty certificates reflect the fact that the individual so certified is certified in General Urology with subspecialty certification in their respective subspecialty field. Therefore, it is most appropriate for those Diplomates in general urology practice or whose practice focuses in an area of urology for which there is no subspecialty certification to advertise on letterhead or other forms of practice communication that they are Diplomates of the American Board of Urology certified in the specialty of urology. If a Diplomate or his/her practice has questions about such matters, he/she should feel free to submit inquiries or samples of letterhead and advertisement to the ABU office for review and recommendations. ■

ABU Maintenance of Certification (MOC)

1239 ABU Diplomates were required to complete Level 1 or Level 2 of Maintenance of Certification (MOC) in 2012. The majority of these Diplomates successfully met all requirements; those Diplomates who were non-compliant received letters informing them that they were being given an additional ninety days in which to complete all necessary requirements to avoid revocation of their ABU certification.

1464 Diplomates are currently enrolled in the 2013 MOC classes (Levels 1, 2, and 3) and are working towards the completion of requirements, including online applications, verification of medical licensure, completion of a PAP of their choice, peer review and documentation of 90 hours of urology focused CME for Level 2 Diplomates, and completion of one Patient Safety Module for Level 3 Diplomates. As was true in prior years, the majority of ABU Diplomates have complied with the requirements and deadlines and are expected to complete their respective MOC components and maintain their ABU certification. Trustees of the American Board of Urology will review the files of any non-compliant Diplomates at their board meeting in February 2014.

MOC PRODUCT/TOOLS UPDATE

Patient Safety Modules Launched for Level 3

The Patient Safety modules recently implemented for Level 3 MOC are designed to improve patient care in a variety of clinical environments. Each of the ten modules will provide Diplomates with the skills and knowledge necessary to ensure optimal patient care. Topics range

MOC Entry Timeline

CERTIFICATION PROCESS

Certification Exam Year	Certificate Expires	Year for Level 1 (year 2)	Year for Level 2 (year 4)	Year for Level 3 (year 6)	Year for Level 4 (years 7, 8, or 9)
2007	2017	2009	2011	2013	2014-2016
2008	2018	2010	2012	2014	2015-2017
2009	2019	2011	2013	2015	2016-2018
2010	2020	2012	2014	2016	2017-2019
2011	2021	2013	2015	2017	2018-2020
2012	2022	2014	2016	2018	2019-2021
2013	2023	2015	2017	2019	2020-2022
2014	2024	2016	2018	2020	2021-2023
2015	2025	2017	2019	2021	2022-2024
2016	2026	2018	2020	2022	2023-2025
2017	2027	2019	2021	2023	2024-2026

RECERTIFICATION PROCESS

Current Certificate Expires	Recertification Exam Years	Year for Level 1 (year 2)	Year for Level 2 (year 4)	Year for Level 3 (year 6)	Year for Level 4 (years 7, 8, or 9)
2008	2007	2010	2012	2014	2014-2016
2009	2007-2008	2011	2013	2015	2015-2017
2010	2007-2009	2012	2014	2016	2016-2018
2011	2008-2010	2013	2015	2017	2017-2019
2012	2009-2011	2014	2016	2018	2018-2020
2013	2010-2012	2015	2017	2019	2019-2021
2014	2011-2013	2016	2018	2020	2020-2022
2015	2012-2014	2017	2019	2021	2021-2023
2016	2013-2015	2018	2020	2022	2022-2024
2017	2014-2016	2019	2021	2023	2023-2025
2018	2015-2017	2020	2022	2024	2024-2026
2019	2016-2018	2021	2023	2025	2026-2028

from disruptive behavior, fatigue, and sexual misconduct to informed consent, patient handoff, and relationship with industry, offering Diplomates a variety of subject areas in which to assess knowledge and ensure appropriate care. The Trustees of the ABU are exploring options for expanding access to patient safety education that will meet both ABMS MOC mandates and provide opportunities for Diplomates to earn continuing medical education credits.

Practice Assessment Protocols (PAP)

- A new PAP on the Evaluation and Management of Male Patients with Non-Obstructive Azoospermia has been written and launched for all levels of 2013 MOC.
- The PAPs on PSA, Ureteral Calculi, and Renal Mass have all been updated in accordance with the latest AUA Guidelines.

Ethics Modules Update

The ABU Trustees are continuing their work on exploring and developing professionalism and ethics modules for use by Diplomates in Level 3 of MOC, with a target date of 2014 for implementation. Information and updates on the status of these modules will be communicated to MOC Level 3 Diplomates in the spring of 2014.

MOC Requirements

Requirements	Level 1 (year 2)	Level 2 (year 4)	Level 3 (year 6)	Level 4 (years 7, 8, or 9)
Complete application online	yes	supplemental application	supplemental application	supplemental application
ABU office verify licensure	yes	yes	yes	yes
ABU office complete peer review		yes		yes
Candidate: Complete online Practice Assessment Protocol	yes	yes	yes	yes
Candidate: Submit documentation of 90 hours of CME		yes		yes
* Candidate: Complete Patient Safety Module (*implemented in 2013)			yes	
* Candidate: Complete Ethics Module (*proposed implementation in 2014)			yes	
Candidate: Submit 6 month electronic practice log				yes
Candidate: Computer-based closed-book exam				yes

NEW POLICY ON MOC EXAMINATION ATTEMPTS

In order to maintain consistency with other ABU examinations, the Trustees have increased the number of examination attempts for MOC Diplomates from two years to three years; therefore, MOC Diplomates may apply for their final level of MOC, which includes the cognitive exam, in year 7, 8, or 9 of their MOC cycle.

Diplomates who are eligible to enter Level 4 of MOC in 2014 will receive a letter in December 2013 informing them of the required deadlines if they wish to complete Level 4 requirements early. As always, entering the examination process on the first opportunity (year 7) does not change the Diplomate's MOC cycle; that is, the Diplomate's certificate is still valid through 2017 in this case and the next cycle of MOC will not begin until two years following that original expiration date (2019 in this scenario). Likewise, entering in year 8 or 9 does not impact the expiration of the certificate or the timeframe in which one enters the next MOC cycle. ■

Dr. Abraham T.K. Cockett, former ABU Trustee

By Stephen Y. Nakada, MD & Ronald Rabinowitz, MD

Dr. Abraham Cockett was born September 4, 1928 and raised in Hawaii, one of twelve children. As a thirteen year-old boy he was an eyewitness to the Japanese attack that launched the United States into World War II. He was an outstanding student at the Kamehameha School as well as an outstanding athlete. He attended Brigham Young University on a basketball scholarship and he met his wife Willia in college and they were married in 1951, during Dr. Cockett's first year in medical school.

In 1954, he obtained his M.D. from the University of Utah, College of Medicine, and that year he interned and spent a year in general surgery at the VA Hospital in Los Angeles. He completed his urology residency at UCLA School of Medicine in 1960, and he was awarded the McCarthy Prize Essay on renal lymphatics and the grand prize for the scientific exhibit on renal revascularization at the 1959 Western Section Meeting of the AUA. Following his residency, Dr. Cockett spent two years as a captain in the United States Air Force where he was Chief of Experimental Surgery at the School of Aerospace Medicine in Texas. There, he carried our research on urolithiasis in space.

In 1969, Abe was recruited to the University of Rochester to become the Professor and Chair of the Division of Urology, and under his leadership the Division achieved Department status in 1983. He would remain the Department Chairman for over 20 years, until 1995. During that time he trained more than 50 residents, 8 former research fellows, and secured research grants of $2.5 million ranging from renal physiology, decompression sickness, renal transplantation, male factor infertility, bladder cancer, and BPH. Dr. Cockett served as President of the Society for the Study of Male Reproduction and he obtained one of the first HM-3 lithotriptors in 1986 for Strong Memorial Hospital in Rochester, New York. He was a consummate academician, with over 400 publications to his credit.

In addition to being a Trustee of the American Board of Urology, Dr. Cockett served as Treasurer and President of the Northeastern Section of the AUA, and Secretary and President of the American Urological Association. His extensive world travels led to his theme for "bridging the world" through international collaboration in urology. This indeed was a concept well ahead of its time. Dr. Cockett also was instrumental in the development of publication the AUA Today, which is now known as AUA News. On the personal side, Dr. Cockett was great tennis player as well as an avid boatsman. He was competitive, but always the ultimate sportsman and gentleman. After retirement in 1999, he and Willia lived in Park City, Utah, while they built their dream home in Waianae, Hawaii.

Dr. Cockett passed away August 16, 2011 after a lengthy battle with Alzheimer's disease. Dr. Cockett and his wife, Willia had three children, Shannon, Catherine Cockett, and John. They were also blessed with five grandchildren and one great grandchild. ■

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