Consent, Coding & Reporting Neck Ultrasound Procedures

Thyroid Ultrasound and FNAB Course
May 2016
Information is based on national CMS guidelines
Check with local carriers for specific guidelines
Coding and reimbursement vary tremendously by geography and by insurance carrier
All medical coding must be supported by documentation and medical necessity
Ultrasound Codes

- 76536 – Diagnostic ultrasound of neck soft tissues, including the use of Doppler
- 76942 – Use of ultrasound for needle guidance
- 10022 – Ultrasound guided FNA
- 10021 – Non-US-guided FNA
- 88172* – Cytology adequacy assessment
- 88177* – Repeat adequacy assessment

*Requires MODERATELY COMPLEX CLIA LICENSE
-26 covers the physician’s work and practice overhead

- TC covers the equipment, technician and supplies

If procedure billed w/o these modifiers, it is considered “global” billing
  • most common for office-based procedures
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<th>Procedure Code</th>
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<td>99213/4/5</td>
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### 2016 National Medicare Allowable & WRVU

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*Global code

Expected Combination

- 76942 and 10022
  - 76942 Ultrasound guidance
  - 10022 Biopsy with US

- Use in combination for all ultrasound guided FNA procedures
These modifiers indicate locations and are typically coded subsequent to any payment specific modifiers such as -59. Please check with commercial carriers for their guidelines regarding modifiers.
-59 Modifier

- Indicates that a procedure is separate and significant from another procedure performed that day.
- Used for procedures that are not usually reported together or represent expected combinations.
- Used for multiple nodules as well as diagnostic US same day as USG-FNA.
- Not used with E/M codes.
Patient comes for planned US-FNA of a Right Thyroid Nodule

- 10022-RT
- 76942

No documentation to support a significant and separate E/M

-59 modifier should not be needed for this combination when one nodule is biopsied under US guidance
-25 Modifier

- Applied to an E/M code to signify that a significant, separate and identifiable procedure was required on the same day as the E/M service.
- The E/M documentation could stand alone, with or without the procedure documentation.
Visit and Procedure

- **Visit Codes (Eval & Management – E/M)**
  - 99211 – 99215 Return Visit
  - 99201 – 99205 New Patient
  - 99241 – 99245 Consult
    
    - Note: Medicare has eliminated consult codes, all first visits are therefore “New” for Medicare

- **Modify the visit code with -25 to explain a separate & identifiable procedure is being done**
Consult and USG-FNA

- Patient with a nodule comes in for consult (not Medicare patient)
  - 99244-25 (comprehensive consult w/ 25 modifier indicating you are doing an additional procedure to the E/M code)
  - 76942 (US guidance for needle placement)
  - 10022 (FNA done under US guidance)
    - In some regions, modify w/ -RT or –LT to designate side. Medicare recognizes –RT/-LT, but not all commercial carriers allow them.
    - -59 modifier should not be needed
Diagnostic Ultrasound & FNA

- 76536 code is used for diagnostic ultrasound – may be repeated by clinician even if recently done by outside facility
- 76942 is “modified” with a 59 to state that a separate procedure was performed in addition to the 76536 procedure (or vice-versa – may vary geographically)
- 10022 is used (as always w/ 76942) w/ RT or LT
- If done as part of return visit, then coded:
  - 9921x-25
  - 76536
  - 76942-59
  - 10022-LT
Effective 1/1/2016 Medicare will not reimburse for both codes reported on the same date of service. NCCI stated, “Evaluation of an anatomic region and guidance for needle placement procedure in that anatomic region by the same radiologic modality at the same patient encounter are not separately reportable services. Providers should not bypass this edit with modifiers unless two procedures are performed on different anatomic regions.”

Both codes can only be reported **one** time per date of service regardless of the number of nodules viewed or aspirated.

Per CMS’ Medicare Unlikely Edits (MUEs) https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

Watch commercial contractors for this change as well! Most of the time they follow Medicare.
Modify the 10022 code to show that there was a separate nodule that was biopsied.

- 9921x-25
- 76942
- 10022-LT
- 10022-RT (-59)

Check with payers to see if -59 needed when LT/RT modifiers are used.

Do not use modifier -50 (bilateral procedure) for US-FNA coding.
Visit and 2 separate left nodules biopsied after doing diagnostic US

- 9921x-25
- 76536
- 76942-59 (only use 76942 once)
- 10022-LT
- 10022-LT-59

Be clear in your notes that after review of the diagnostic US, there are two separate and significant nodules on the left which need FNA.

As of 1/1/16, MCR does not allow 76536 and 76942 on same day.
FNA Cytology Adequacy

88172  Cytopathology, evaluation of FNA; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site

88177  Cytopathology, evaluation of FNA; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (list separately in addition to code for primary procedure- [88172]). Use when repeat immediate evaluation is required on subsequent cytologic material from the same site following determination that the prior sample was not adequate.

**88173 is for the pathologist’s report ONLY**
Bilateral FNA w/ Adequacy

- 9924x-25 (consult code, non-MCR)
- 76942
- 10022-RT
- 88172-RT
- 10022-LT-59
- 88172-LT-59

Use only one unit for each of these codes per site, regardless of # FNA passes / slides reviewed
Follow-up ultrasound study

- This is not a commonly used code in thyroid practice
- Best example would be a patient who returns later in the day after FNA of a cyst with neck pain and increased mass size
- Would need to repeat US to determine if hemorrhage into cyst occurred
All coding must be supported by documentation and medical necessity.

If multiple nodules are selected for FNA, the exact site of each nodule, highlighting that it is a separate significant lesion, should be documented.
Ultrasound, soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), real time with image documentation

Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation

**Images must be saved to patient’s medical record for 76536 and 76942 and a complete interpretation and report should be found in the medical record with appropriate signatures of the interpreting physician.**
Geographical and Insurance Carriers Differ!

- It cannot be over-emphasized that coding and reimbursement varies by geographic region and by insurance carrier.
- It is important to discuss with your coding/billing expert the procedures and “try” different combinations to see what is the best for your area and the patient’s insurance.
- Speak to other providers in your area to see what works.
Ultrasound Reports
This “9mm left inferior nodule” should remind us all why we’re here!
Order Description: US THYROID/SOFT T ISSUE NECK

Date of exam: September 3, 2009

Indication: Possible thyroid enlargement

Findings: Ultrasound the thyroid gland was performed. One of two cysts are identified in the right lobe of the thyroid gland. The largest is in the mid pole and measures up to 0.3 cm. The smaller one is located more inferiorly. The right lobe otherwise appears unremarkable, measures 4.9 x 1.4 1.6 cm. There are several cysts and hypodensities in the left lobe of the liver. The largest is in the lower pole and has a complex appearance with some blood flow. It measures up to 1.2 cm. The left lobe overall measures 5.8 x 1.3 x 1.3 cm.

Impression: There are multiple nonspecific hypodensities and small cystic nodules in the thyroid gland. Their appearance is nonspecific. Most prominent one is in the lower pole of the left lobe the thyroid gland. This does appear complex.
ULTRASOUND EVALUATION OF THE THYROID GLAND:
There is a heterogeneous isotope uptake noted with several small nodular lesions noted scattered throughout the thyroid gland, the largest measuring 6 mm in the upper pole of the right lobe of the thyroid. Otherwise no other solid or cystic masses are noted. No other abnormalities are identified. The right lobe of the thyroid measures 3.8 x 1.2 x 1.5 cm. The left lobe measures 3.3 x 0.9 x 1.2 cm.

THYROID ULTRASOUND:
Thyroid gland is mildly enlarged. There are multiple bilateral solid nodules. Nodules are mostly well defined and of varying echogenicity. All are similar in appearance. Nodules range in size from 5 mm to 13 mm.

IMPRESSION:
(1) Multiple bilateral solid thyroid nodules. None distinguishes itself as being any different than any of the others and there is no dominant nodule. I recommend correlation with a nuclear medicine thyroid scan as most thyroid cancers are cold by nuclear medicine. If any cold nodule is determined to be present on nuclear medicine study, then we will direct biopsy to that area.
Thyroid ultrasound

The rectum measures 5.2 x 1.6 x 1.5 cm while the left lobe measured 5.1 x 1.7 x 1.5 cm. Isthmus is 3 mm in thickness. Findings suggest minimal thyromegaly. The right lobe demonstrates 1 x 0.5 cm solid nodule while the left lobe demonstrates 8 x 3 mm cyst.

IMPRESSION: Minimal thyroid enlargement. 1 cm solid nodule in the right lobe. 8 mm cyst in the left lobe.

Thank You,
# Thyroid Ultrasound

**Name:** [Redacted]  
**Date test:** 8/26/2008  
**Indication:** h/o medullary thyroid CA

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<tr>
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<td>III</td>
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<tr>
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<tr>
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**Comment recommendations:**

H/O medullary CA s/p thyroidectomy 04/10/08. Inflammatory lymphadenopathies left IIb and left III regions. Reexamine in four months.
HX - HYPERTHYROIDISM

THYROID ULTRASOUND
Right thyroid lobe measures 3.9 cm in greatest length and left thyroid lobe 3.5 cm in greatest length. Heterogeneous tissue pattern is seen in both thyroid lobes and there is a solitary nodule in left lower thyroid lobe. This nodule measures 9 mm in greatest diameter and has some hypervascular markings. No additional nodularities are seen in right thyroid lobe.

IMPRESSION
Heterogeneous tissue pattern in the thyroid lobes with questionable nodule in lower aspect of left thyroid lobe. This solitary pulmonary nodule has a differential diagnosis of carcinoma, adenoma, thyroiditis or hemorrhage. Tissue sampling may be warranted as clinically indicated.
THYROID ULTRASOUND

INDICATION: Goiter.

FINDINGS: Real-time imaging performed.

Right lobe is 1.62 x 1.6 x 4.9 cm. Echogenicity is inhomogeneous and has areas that appear that of a bag of marbles, c/w early Hashimoto. No increased vascularity. No nodules.

Left lobe is 1.76 x 1.6 x 4.45 cm. Echogenicity is inhomogeneous. There are areas that appear to be lumpy-bumpy, c/w early Hashimoto. No nodules. No increased vascularity.

Isthmus is 0.45 cm.

IMPRESSION: Inhomogeneous goiter c/w early Hashimoto. No nodules.
## Thyroid Gland

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</table>

## Lymph Nodes

- Right lobe enlarged and numerous hypoechoic nodule noted
THYROID ULTRASOUND

NAME: 
SS#: 
DOE.

INDICATION: Right thyroid complex cyst. Previous FNA biopsy "Benign." Prior ethanol ablation.

PROCEDURE: Using physician-performed, real time ultrasound limited to the thyroid gland and the anterior neck, longitudinal and transverse images were obtained.

The right thyroid lobe measures 69.0 x 16.0 x 21.4 mm.
The left thyroid lobe measures 58.0 x 13.8 x 19.6 mm.
The isthmus is 3.8 mm in greatest depth.

Overall, the thyroid is prominent with a homogeneous echotexture.

In the right mid to lower lobe is a nodule that measures 26.4 x 14.7 x 19.2 mm. This nodule is solid with some cystic degeneration, hypoechoic, and heterogeneous. This nodule has a smooth border. No calcifications are seen. Grade 3 Doppler flow is seen.

In the left mid to lower lobe is a colloid nodule that measures 3.6 x 2.5 x 2.5 mm. This nodule is solid, hypoechoic, and heterogeneous. This nodule has a smooth border. No calcifications are seen. Grade 1 Doppler flow is seen.

IMPRESSION:
1. Prominent thyroid gland with a homogeneous echotexture.
2. Dominant right mid to lower lobe nodule measuring 2.6 cm in greatest dimension.
3. No significant cervical lymphadenopathy is seen.
4. When compared to the previous study of 12/06/2010, the right mid lobe nodule is no longer seen.
5. Recommend follow-up ultrasound in 2 to 3 years.

J. Woody Sistrunk, MD
Commonly asked question:
How many images must be taken for a complete thyroid US exam

- There is no absolute number of images required for documentation
- ECNU does not require a set number of images
- AIUM does require the 13 routine images or a cine loop for review of the entire gland
- ECNU requires these 13 images for the 5 Nodule Cases
- As a minimum it is imperative to have images of both lobes in the transverse and longitudinal views
- Nodules should be shown in two views.
- If you could review the images one year from now and create a meaningful report, you probably have a sufficient number of images.
A complete report must contain:

- Identification data
- Indication
- Explanation of the Procedure
- Thyroid Size (measurements)
- Thyroid parenchyma description
- Description of pathology
- Impression
- Recommendations
The right thyroid lobe measures 70.9 x 26.0 x 21.8 mm.
The left thyroid lobe measures 65.6 x 26.8 x 23.3 mm.
Overall, the thyroid gland is symmetrically enlarged, diffusely heterogeneous and hypervascular.
In the lower right isthmus is a nodule that measures 19.6 x 13.8 x 20.0 mm. This nodule is solid with some cystic degeneration, hyperechoic, and heterogeneous. This nodule has a smooth border. A halo surrounds this nodule. No calcifications are seen. Grade 2 Doppler flow is seen.
In the right mid neck (Level III) is a node that measures 17.4 x 4.8 x 12.6 mm. A central hilar line is seen. No intra-nodal Doppler flow is seen.

Remember, Doppler Grades (Arabic #'s 1-4) **DO NOT** Apply to Lymph Nodes nor parathyroid glands.
3. Correlation with pending thyroid antibodies and I123 uptake is planned.
THYROID ULTRASOUND (FNA)

NAME: [Redacted]  DATE: 02/07/2012
SSN: [Redacted]  DOB: [Redacted]

INDICATION: Hyperthyroidism. Thyroid nodule.

PROCEDURE: Using physician-performed, real time ultrasound limited to the thyroid gland and the anterior neck, longitudinal and transverse images were obtained.

The right thyroid lobe measures 76.9 x 26.0 x 21.8 mm.
The left thyroid lobe measures 65.6 x 26.8 x 23.3 mm.
The isthmus is 8.1 mm in greatest depth.
Overall, the thyroid gland is symmetrically enlarged, diffusely heterogeneous and hypervascular.
In the lower right isthmus is a nodule that measures 19.6 x 13.8 x 20.6 mm. This nodule is solid with some cystic degeneration, hyperechoic, and heterogeneous. This nodule has a smooth border. A halo surrounds this nodule. No calcifications are seen. Grade 2 Doppler flow is seen.
No discrete nodules are seen in the left lobe.
In the right mid neck (Level III) is a node that measures 17.4 x 4.8 x 12.6 mm. A central hilar line is seen. No intra-nodal Doppler flow is seen.
After reviewing the diagnostic thyroid ultrasound images, the decision was then made to proceed with ultrasound guided fine needle aspiration.
Written and verbal consent was obtained from the patient to proceed with fine needle aspiration of this lower right isthmus nodule. A procedural pause was observed. Using aseptic technique, under ultrasound guidance, fine needle aspiration was accomplished. Aftercare instructions were given to patient.
COMPLICATIONS: None. ESTIMATED BLOOD LOSS: Minimal.

IMPRESSION:
1. Symmetrically enlarged, diffusely heterogeneous, hypervascular goiter, compatible with the clinical history of Graves' disease/ hyperthyroidism.
2. Solitary lower right isthmus nodule measuring 2.0 cm in greatest dimension. FNA biopsy accomplished.

J. Woody Sistrunk, MD
Demographics

- Facility where study performed / Physician name
- Patient name and other identifier
  - Date of birth
- Requesting/Primary Physician
- Name of examination
  - Thyroid US; USG-FNA; Parathyroid US; Endocrine Neck US (i.e., post-op)
- Date of Exam
Indication for exam

- Thyroid Nodule
- Multinodular goiter
- Goiter
- Palpable neck mass
- Hashimoto’s thyroiditis
- Hyperthyroidism
- Thyroid nodule / cyst seen on other imaging
- Hyperparathyroidism
- Thyroid Cancer – preoperative lymph node study
- Detect recurrent disease in cancer patients
- High risk patients for occult malignancy
- Localize lesion for FNA biopsy
Right papillary thyroid cancer, s/p total thyroidectomy and subsequent I131 therapy.

Adding any necessary descriptors such as
- “1.9 cm Right tall cell variant papillary thyroid cancer, s/p total thyroidectomy and subsequent I131 therapy. T1b, N0, M0– (STAGE 1)”
- “Right thyroid nodule found on CT angiogram.”
- “History of Papillary thyroid cancer in sister.”
“Using physician performed, real-time ultrasound limited to the thyroid gland and anterior neck, longitudinal and transverse images were obtained of both lobes and isthmus.”

OR FOR CANCER:

“Using physician performed, real time ultrasound limited to the thyroid bed and anterior neck, including nodes (Levels I, II, III, IV, V, and VI), longitudinal and transverse images were obtained.”

Leave OFF the brand name of the machine and the mHz of the probe—This is not relevant to the report.
Body of Report

- Description…e.g.: “personally performed in real-time with a linear probe in both transverse and longitudinal planes”
- Size of each lobe in three dimensions
  - Length x AP x Transverse (standard, or specify if any other order used)
  - AP measurement of isthmus
- Echotexture of thyroid parenchyma
- Size, location, number and characteristics of nodules and cysts
- Comment on vascularity of gland and abnormalities
- Abnormalities of adjacent soft tissues
Potential limitations of study should be noted

Comparison to other studies

Impression is very important

- Precise diagnosis preferred
- Differential diagnosis when appropriate
- Recommendations for follow-up ultrasound or for additional studies (I-123 or FNA, etc)
Measurements should include:

- longitudinal/sagittal
- transverse measurement
- depth (AP-ANTERIOR to POSTERIOR) of each lobe and isthmus
- LONGITUDINAL X DEPTH(AP) X WIDTH(TRV).
  - ECNU convention
  - Best to specify order at some point in report
  - “All measurements are expressed as: longitudinal x AP x transverse, unless otherwise specified.”
AIUM/ACR Guidelines

- Archived Images necessary for exam
  - Transverse: Sup, Mid, Inf each lobe
  - Longitudinal: Med, Mid, Lat each lobe
  - Isthmus: Trans view w/ AP measurement

  (Video clips are acceptable for AIUM)

- Abnormalities: three dimensions
  - Requires at least two images (TRV and SAG)
  - At least one Doppler image (per abnormality)
  - Annotate images with orientation/location
Description of the overall gland

- Overall, the thyroid gland is enlarged and asymmetric with a prominent right lobe. The gland has a hypoechoic and heterogeneous echotexture.
- Overall, the thyroid gland is enlarged and asymmetric with a prominent left lobe. The gland has a homogeneous echotexture with increased vascularity.
Nodules are:

- NOT LESIONS
- NOT MASSES
- NOT GROWTHS
- NOT HYPODENSITIES
- NOT POLYPS
- NOT GOITERS
- NOT AREAS
- NOT NODULARITIES
- NOT NODULATIONS
THREE MAJOR DESCRIPTORS:
- SOLID, CYSTIC, or complex
- HYPOECHOIC, HYPERECHOIC OR ISOECHOIC
- HOMOGENEOUS OR HETEROGENEOUS

These are good ROOTS to expand upon, but other modifiers can also be added.

Borders: Smooth, distinct, irregular, infiltrative, vague, ill defined, halo characteristics…

Calcifications: micro, coarse, peripheral, punctate

Taller than wide
- **Note**– Arabic Numbers, Not Roman Numerals
- Doppler is always capitalized
  - Grade 1 (Absent) No Doppler flow is seen.
  - Grade 2 (Peripheral) Doppler flow is seen.
  - Grade 3 (Penetrating) Doppler flow is seen.
  - Grade 4 (Intense) Doppler flow is seen.
All thyroid / cervical ultrasound studies should comment on nodes.
AIUM guidelines now require a brief examination of the lateral neck for the presence of nodes.
Describe nodes by: size (3D), shape, echogenicity, hilar line, calcification and cystic degeneration.
Consider using this outline for impression and recommendations.

- Impressions:
  - Bullet # 1 - GLAND OVERVIEW (Summation statement.)
  - Bullet# 2 - Pathology seen.
  - Bullet#3 –Comment on nodes.
  - Bullet#4- Comparison to previous if applicable.

- Recommendations:
  - Timing for followup study
  - FNA needed
  - Lab or other imaging suggested
“A follow-up ultrasound in 6-12 months is recommended in keeping with the 2009 American Thyroid Association Guidelines.”

RECOMMENDATION 14

(a) It is recommended that all benign thyroid nodules be followed with serial US examinations 6–18 months after the initial FNA. If nodule size is stable (i.e., no more than a 50% change in volume or <20% increase in at least two nodule dimensions in solid nodules or in the solid portion of mixed cystic–solid nodules), the interval before the next follow-up clinical examination or US may be longer, e.g., every 3–5 years. Recommendation rating: C
Including a mapping image with ultrasound findings is an option that many find useful.
STEP 1: Comprehensive Certification Examination (CCE)

STEP 2: Validation of Competency Process (VCP) – Validation of the competency in the performance and interpretation of diagnostic US and US-Guided FNA

- Perform at least 100 studies (70 US, 30 FNA) and submit 15 examinations and reports

For more information: https://www.aace.com/college/ECNU
ECNU Validation Process Criteria for Reports/Images

- AIUM/ACR guidelines are followed
- Specific details suggested reflecting the high-quality thyroid ultrasound performed by the clinician
  - Nodule characteristics to include
    - Echogenicity, vascularity (Doppler grade 1-4), margins (irregular, smooth, halo, invasion)
    - Calcifications (presence or absence), comet tails, posterior enhancement/attenuation
    - Cysts (simple, complex, mural component)
ECNU Validation Process Criteria for Reports/Images

- Description of surrounding lymph nodes
  - Compartment I-VI
  - 3 dimensions (L x AP x T –or specify if other)
  - Short to Long (S:L) axis (short is AP, long can be width in TRV or length in SAG)
  - Echogenicity and vascular pattern
  - Absence/presence of hilar line, calcifications and cystic necrosis

- Parathyroid
  - Location
  - Measurement (L x AP x T – or specify if other)
  - Echogenicity and vascularity (? Polar artery)
Thyroid Ultrasound and Biopsy Report

Patient:

Date of examination:

Indication: Ultrasound guidance for fine needle aspiration biopsy

Referring physician:

Real-time imaging was performed in two planes. INSERT DESCRIPTION

Following informed consent a procedural pause was held to confirm patient identity and site of biopsy. After sterile preparation, fine needle aspiration guidance was performed using direct ultrasound guidance to confirm accurate needle placement. Three aspirations were made using 27 gauge needles. Samples were submitted for cytology. The patient tolerated the procedure well without complication. After care instructions were provided.

Impression: Uncomplicated fine needle aspiration biopsy of thyroid nodule under ultrasound guidance.
Thyroid Ultrasound Report

Patient:
Date of examination:
Indication: History of total thyroidectomy for Stage _____
___________cancer (date)
Referring physician:

Real-time imaging was performed in two planes. Comprehensive evaluation of the medial and lateral neck compartments was carried out. The thyroid is surgically absent. There are no abnormal masses within the thyroid beds. No abnormal lymph nodes are identified.

Impression: Negative comprehensive neck ultrasound with no evidence of recurrent thyroid cancer. A repeat ultrasound should be performed in ___ months.

(Note: All measurements are reported as transverse x AP x longitudinal unless otherwise indicated.)
Thyroid Ultrasound Report
Patient: K. S.
Date of examination: July 25, 2012
Referring physician: Dr. C. G.
Real-time imaging was performed in two planes. Comprehensive evaluation of the medial and lateral neck compartments was carried out. The thyroid is surgically absent. There are no abnormal masses within the thyroid beds. Once again, a prominent lymph node is identified in the left neck compartment III, deep to the SCM muscle. This measures 1.02 x 0.52 x 1.25 centimeters. (L:S = 1.96) This has enlarged from the prior study performed one year ago at which time it measured 0.6 x 0.3 x 1.1 centimeters. The internal echotexture is heterogeneous, and there is variable posterior enhancement suggestive of cystic necrosis. No other abnormal lymph nodes are identified. There several small nodes with normal morphology identified superior to the index node.
Impression: Comprehensive neck ultrasound demonstrating interval enlargement of a left lateral lymph node previously identified. There is an abnormal internal echotexture. Fine needle aspiration biopsy will be performed of the node with samples submitted for cytology and thyroglobulin analysis.
(Note: All measurements are reported as transverse x AP x longitudinal unless otherwise indicated.)
Elements of Informed Consent
Fine needle aspiration Biopsy

• Confirm that patient informed of potential complications
  • Risk is Small
  • Potential Complications
    • Bruising, Bleeding, Infection
    • Nerve Injury (PEI) and Damage to Neck Tissue
    • Vagal reaction (fainting)
  • Possibility of an Inadequate Sample being obtained
  • Possibility of a False Diagnosis exists
• Read and understood
  • Questions have been answered
  • Agree to proceed.