General Principles for the Safe Performance, Training, and Adoption of Ablation Techniques for Benign Thyroid nodules: An ATA® Statement

Considerations for Training and Practical Implementation

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Training

- Appropriate medical specialty training: Otolaryngology – Head and Neck Surgery, Interventional Radiology, General Surgery with focused practice in Endocrine Surgery, Endocrinology

- Preclinical training:
  - Participation in thermal ablation education and training course(s)
  - Performance of thermal ablation on phantom models prior to direct patient care

- Initial ablations on patients should be guided by a proctor with experience in thermal ablation

- Practitioners should keep a record of cases, outcomes and complications for self-audit purposes

Learning Curve

- Proceduralists should have prior proficiency in thyroid ultrasonography (US) and US guided fine needle aspiration (FNA)

- Studies of RFA learning curves involved proceduralists who were already proficient at US and US FNA
  - Clinical efficacy ~ 30 cases
  - Consolidation phase (continued improvement) 30-60 cases
  - Proficiency > 60 cases

- Ideal nodule selection during early cases:
  - Moderate size (<20-30 ml)
  - Non-vascular
  - Favorable location (e.g. anterior positioning)

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Practical Considerations in Program Development

- Consider the questions in the following table:

TABLE 5. ORGANIZATIONAL CONSIDERATIONS WHEN IMPLEMENTING A NEW THERMAL ABLATION PROGRAM

Operation step	Considerations
Initial patient consultation	Within the multidisciplinary team, who are the best physicians to perform the ablative procedure? Will it be the main responsibility of one specialty? Does it make sense for specialties to partner together? If a partnership, who provides the consult? How will physicians wishing to perform ablation get appropriate training? What are the credentialing requirements (if any) of the institution?
Location: Where should the procedure be performed?	What facility resources are available at your institution? (outpatient setting, ambulatory surgery center, IR suite, operating room) Need to consider the ease of preauthorization for each location (i.e., preauthorization for an outpatient setting is generally easier than for the operating room) The chosen location will also have implications for anesthetic options
Billing	Currently, there is no dedicated CPT code for RFA or MWA CPT code 0673T is a category III code specifically for laser ablation of thyroid nodules using the Elesta System (should not be used for RFA or MWA) Although recognition of the procedure and reimbursement by third-party payers is increasing, there is still no guarantee of reimbursement and there is high geographic and regional variability Thorough discussion and planning with your finance department is necessary to ensure smooth operations. Do you want cash pay only? If you choose to bill insurers, will you do an appeal? How many times will you appeal? If the appeal fails, will the patient be responsible for payment? If so, how much will they be responsible for?

CPT, Current Procedural Terminology; IR, interventional radiology; MWA, microwave ablation.

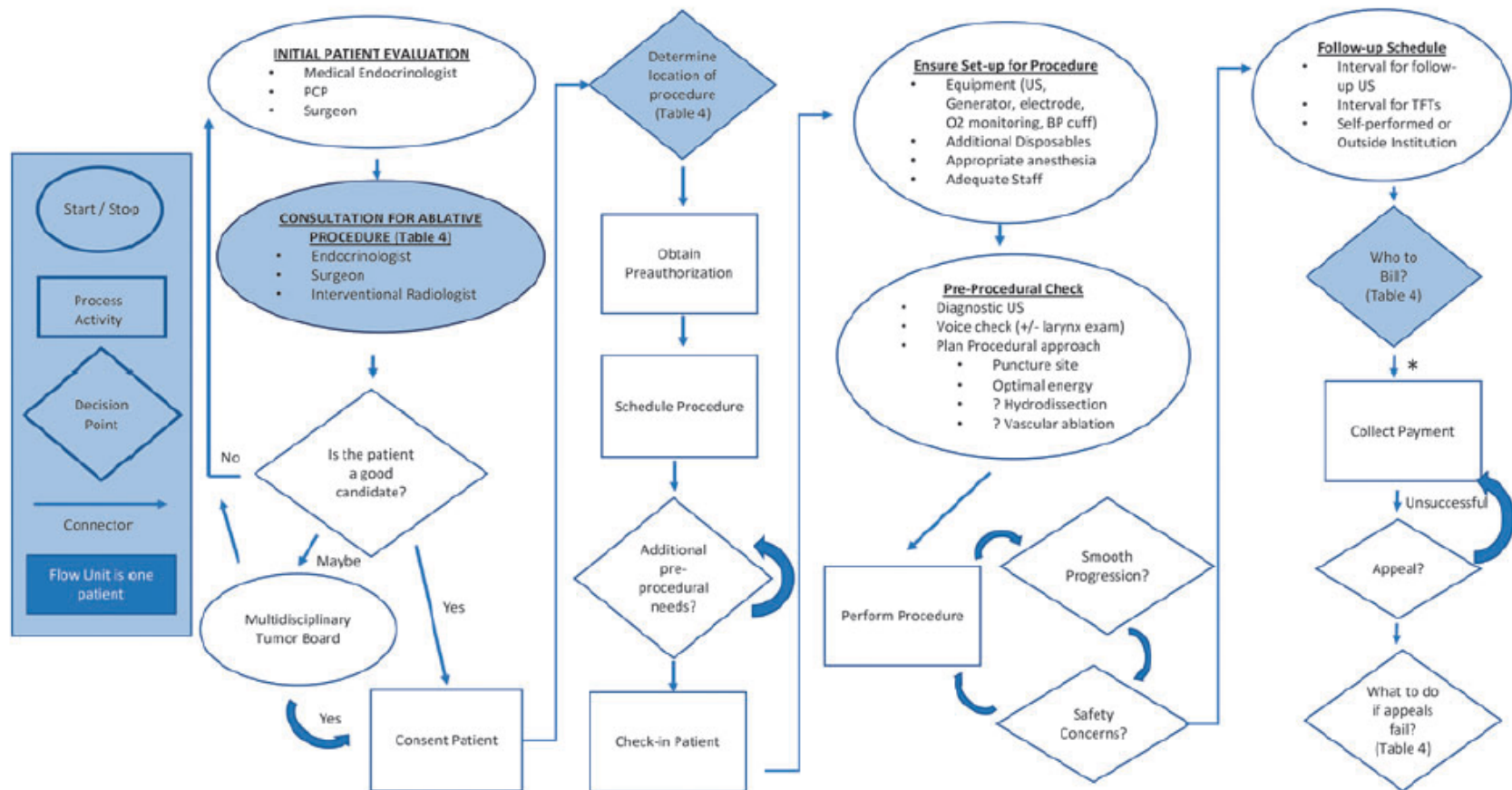- It may be helpful to develop an operational flow chart (see following slide for example)

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FIG. 3. Operations and process flow chart for implementing a new TA program. A sample flow chart of the operations and processes involved in implementing a new TA clinical program is shown. To ensure safe implementation, the various points in the flow chart should all be addressed. Additional considerations of highlighted points are summarized in Table 5. *The process of billing, payment, and appeal is also a pre-procedural consideration and may occur before performance of the ablation procedure. BP, blood pressure; PCP, primary care physician; TA, thermal ablation; TFT, thyroid function tests; US, ultrasound.