
TNTC PATIENT PACKET

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WELCOME

As medical director of the Thyroid Treatment Center, I would like to welcome you to our center. I sincerely hope to make your procedure a very pleasant experience for you. The mission of the TNTC is preservation of normal thyroid function while treating benign symptomatic thyroid nodules using the most advanced minimally invasive treatments available.

Every day new thyroid nodules are discovered by their physicians, family, friends, and even their hairdressers! Some people have symptoms related to the size of the nodules, which directs them to seek medical consultation. Others have no symptoms but learn about these nodules after undergoing radiologic testing for different reasons. The proper evaluation of these nodules is very routine. Much of the evaluation is predicated on the size of the nodule. Once nodules measure about 15 mm, we generally recommend an ultrasound guided biopsy. If there are some concerning features seen on ultrasound, a biopsy can be performed even if the size criteria are not met. Additionally, an enlarging nodule should be sampled under ultrasound guidance. Very small nodules under 6 mm do not require a biopsy under most conditions.

The presence of a nodule does not alter thyroid function. If a patient is hypothyroid, they should be thoroughly evaluated by their primary physician or an endocrinologist. Hypothyroidism is not caused by nodules. Occasionally, some nodules are autonomous and do not respond to the hormonal regulatory system that keeps the thyroid hormone levels in a normal range. These over-functioning nodules cause symptoms of fatigue, insomnia, and heat intolerance. Frank hyperthyroid symptoms include nervousness that makes people tremulous and shaky. Additionally, these patients feel hot and have a racing heart. Long term heart disease is a common consequence of this disorder. If this condition exists, these patients need an endocrinologist who will prescribe medications to regulate and suppress the thyroid function down to normal levels. Once properly regulated, further therapies can be considered.

Most thyroid nodules are benign. The most readily available modality for evaluating these is ultrasound.

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The test is easily performed without any concern for radiation exposure. The physician performed exam is much better than reviewing stationary images saved from prior examinations. The neck ultrasound study is easily repeated with no potential harm to the patient. There are several features in benign nodules that we like to identify to consider a lesion low risk of malignancy. When some of these features are absent, the nodule would be considered indeterminate, or potentially at risk for malignancy. These nodules will be tested using a needle biopsy to help the physician guide therapy. Not all nodules have favorable ultrasound characteristics, although they may prove benign on biopsy. Additionally, a small percentage of nodules can have favorable findings on ultrasound yet can be found to have papillary thyroid cancer. It is for these reasons that routine surveillance ultrasound is initiated once a nodule grows to about 15 mm in largest dimension.

The treatment of these thyroid nodules varies depending on the nature of the nodules as well as the symptoms produced. Any malignancy will need to be removed if it is over 15 mm. Some smaller malignancies are now being followed without surgery. These are followed utilizing strict criteria and under research-based protocols. This mode of therapy in avoiding surgery and monitoring the patient has been very successful.

Small nodules tend not to create symptoms, whereas large nodules can create many problems such as difficulty with breathing when lying flat, difficulty with swallowing solid food (pills), and even a chronic cough. Nodules with compression symptoms can be removed with surgery. If they are not cancer and not suspicious for the possibility of cancer, then a minimally invasive, ultrasound guided therapy is very effective applying energy directly into the nodule. This treatment applies energy directly to heat it up to the point of tissue death. Once the tissue is devitalized, the body walls off and slowly reabsorbs the treated tissue. This method leaves the adjacent normal tissue unharmed and thus preserves the thyroid function. Unfortunately, surgery removes the entire side (lobe) due to safety concerns. This unavoidably removes the abnormal and normal tissue on the entire side. Approximately 60-75% of these patients will require thyroid hormone supplementation. Surgeons have been performing this treatment routinely for over 100 years.

If a biopsy raises a concern for the possibility of cancer, then surgery is recommended to allow for proper analysis of the tissue by pathologist. The surgery should be performed by a surgeon very familiar with thyroid operations, and who performs them regularly. The definition of a high-volume thyroid surgeon is currently established at 25 operations annually.

The Thyroid Nodule Treatment Center is available to navigate the numerous diagnostic and therapeutic options with you. Patients with normal thyroid function can present immediately to review treatment options regarding symptomatic thyroid nodules or nodules which they can see and feel because the

nodules are so large. The most innovative therapy may be available to you. The immediate and long-term results with thyroid radiofrequency ablation are excellent. The overall satisfaction of this therapy has been uniformly high.

Sincerely,

Dr. Richard J. Harding

INVOICE

Name:

DOB:

DOS:

Diagnosis:

Provider: Thyroid Nodule Treatment Center Tax ID: 85-0986673

Dr. Richard J Harding, Endocrine Surgeon

Procedure Invoice:

Comprehensive Neck Ultrasound	76536	\$ 350
Cervical Plexus Block	64999	\$1100
Ultrasound Guidance for Radiofrequency procedures	76940	\$ 250
Radiofrequency Ablation Thyroid Nodule(s)	60699	\$6860
OR Charges (includes generator, ultrasound machine, water cooled RFA catheter probe, OR medications, sterile supplies)	C1889	\$1800

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Miscellaneous Surgical Supply

A4649

TOTAL

\$10,360

Thyroid Nodule Treatment Center,

Medical Director: Richard J Harding MD FACS

PRE-OP INSTRUCTIONS: Thyroid RFA and CellFX nsPFA

5-7 Days Before Your Procedure

Blood Thinners & Supplements

Discontinue the following medications or supplements as they may increase bleeding or interfere with anesthesia:

- Aspirin or aspirin-containing products (e.g. Alka-Seltzer, BC powder, unless otherwise advised by your physician).
- Baby Aspirin 81mg needs to be stopped 1 day prior to procedure
- Coumadin, Plavix or other blood-thinning agents.
- Supplements, herbal remedies, and vitamins (e.g. Vitamin E, Omega 3, Fish Oil, Flax
- Seed Oil, Garlic Pills, Black Cohosh, Ginseng, Ginkgo, Fen-phen, Saw Pimento, St. John's Wort, etc.)

Day of Procedure

Medications

- Mild anxiety medications are recommended and can be prescribed for you to take 15 minutes before the procedure. If requested, prescription will be sent to your pharmacy of choice at least one day in advance of your procedure for you to bring with you.
- Bring Ibuprofen or Tylenol with you to take after the procedure, if needed.

General

- Do not wear jewelry or makeup on day of procedure
- Wear loose cotton clothing. Shirt must have an open collar/neck line. Wear an old shirt as there is a possibility that the orange sterile prep used prior to the procedure could stain clothing.

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- Wear or bring a pair of loose shorts with you as there will be grounding pads placed on your skin above the knee cap.
- Bring a hair tie (non-metallic) to eliminate any hair from touching your neck.
- Ice packs are very helpful after the procedure for minimizing discomfort.
- Be prepared to stay in our office for an hour after the procedure for observation.
- Pre-op pictures of the neck will be taken prior to the procedure unless refused by the patient.

*If you have any questions, please call our office at (602) 889-2924 and ask for the medical assistant.

PATIENT INFORMED CONSENT

Operation or procedure and alternatives:

I, _____, authorize Dr. Richard Harding, and assistants of his choosing to perform the procedure: Radiofrequency Ablation of thyroid nodule(s) (Left) (Right). I understand the reason for the procedure is to treat large benign nodules in order to shrink the size of nodule(s), destroy nodule function, and decrease symptoms.

Alternatives include:

1. Thyroid surgery which has potential complications of nerve injury, hoarseness, scar on neck, loss of thyroid function, hypocalcemia, anesthesia, hospital admission.
2. To not undergo procedure listed which will not improve symptoms or condition, and the disease may progress.

Patient Initials _____

Risks: This authorization is given with the understanding that any operation or procedure involves some risks and hazards. Some of the significant risks of this particular procedure are: pain, injury to thyroid, injury to surrounding structures, recurrent laryngeal nerve injury with temporary or permanent hoarseness, need for ongoing medical treatment of disease, bruising, complicate further surgery, failure to treat undiagnosed cancer, failure to improve existing symptoms, temporary pain at injection site during administration, prolonged numbness and tingling, accidental vascular injection, tumor regrowth,

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burn caused by the overheated electrodes, local bleeding at site of the ablation, nodule rupture. **Any compromise in airway concerns may warrant a transfer to the hospital for further therapy.**

I also understand that the more common risk of any procedure include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reaction, and pneumonia. **These risks are serious and possibly fatal.**

Patient Initials _____

Anesthesia: the administration of anesthesia also involves serious risks, most importantly a rare risk of reaction to medication causing death. This medication can cause nausea, drowsiness, and dizziness. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services.

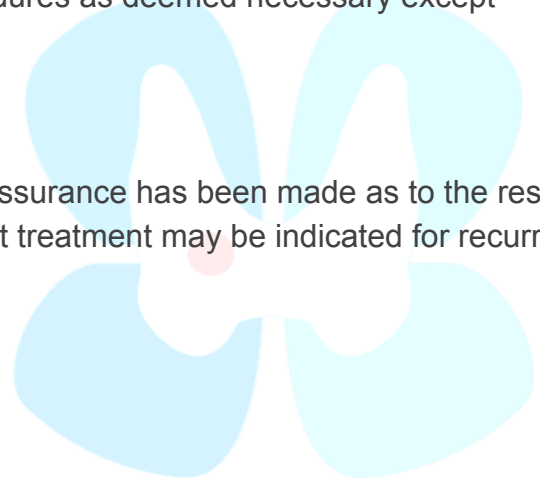
Patient Initials _____

Additional procedure: if Dr. Harding discovers an unsuspected condition at the time of the procedure such as bleeding, I authorize him to perform such other procedures as deemed necessary except _____.

Patient Initials _____

Results not guaranteed: I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition. Repeat treatment may be indicated for recurrent growth of some nodules.

Patient Initials _____



Patient consent: I have read and fully understand this consent form. I understand I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form. I have no further questions.

Patient Initials _____

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR ANY QUESTIONS CONCERNING THEM, ASK DR RICHARD HARDING BEFORE SIGNING THIS FORM.

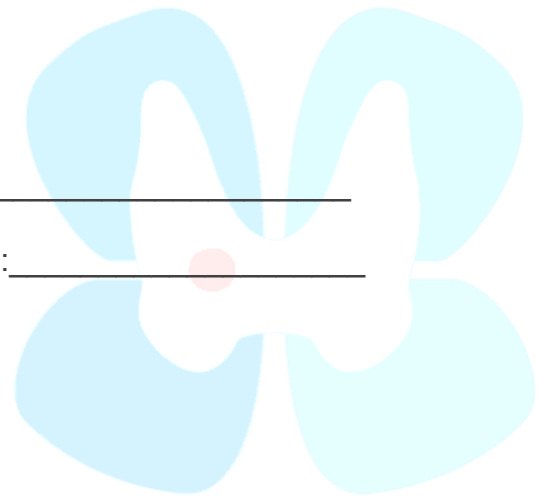
DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM

Patient name: _____

Patient signature: _____ DOB: _____

Today's date: _____

Witness: _____



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Physician declaration: I have explained the contents of this document to the patient and have answered all the patient's questions; to the best of my knowledge, the patient has been adequately informed. The patient has been consented.

Physician signature: _____ Today's date: _____

DYSPHAGIA HANDICAP INDEX (DHI)

Patient Name _____ DOB _____



Today's Date _____

		Never	Sometimes	Always	
1P	I cough when I drink liquids.				
2P	I cough when I eat solid food.				
3P	My mouth is dry.				Date of Procedure:
4P	I need to drink fluids to wash food down.				
5P	I've lost weight because of my swallowing problem.				
1F	I avoid some foods because of my swallowing problem.				Initial size of nodule: _____ mL
2F	I have changed the way I swallow to make it easier to eat.				
1E	I'm embarrassed to eat in public.				
3F	It takes me longer to eat a meal than it used to.				1 month: _____ mL
4F	I eat smaller meals more often due to my swallowing problem.				VRR: _____
6P	I have to swallow again before food will go down.				
2E	I feel depressed because I can't eat what I want.				3 months: _____ mL
3E	I don't enjoy eating as much as I used to.				VRR: _____
5F	I don't socialize as much due to my swallowing problem.				
6F	I avoid eating because of my swallowing problem.				6 months: _____ mL
7F	I eat less because of my swallowing problem.				VRR: _____
4E	I am nervous because of my swallowing problem.				
5E	I feel handicapped because of my swallowing problem.				
6E	I get angry at myself because of my swallowing problem.				
7P	I choke when I take my medication				
7E	I'm afraid that I'll choke and stop breathing because of my swallowing problem.				
8F	I must eat another way (e.g., feeding tube) because of my swallowing problem.				
9F	I've changed my diet due to my swallowing problem.				
8P	I feel a strangling sensation when I swallow.				
9P	I cough up food after I swallow.				

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2

3

4

5

6

Normal

Moderate Problem

Severe Problem

Please circle the number that matches the severity of your swallowing difficulty (1 = no difficulty at all; 4 = somewhat of a problem; 7 = the worst problem you could have)

Place a check in the box that describes your swallowing difficulty

Total

P (Physical)

F (Functional)

E (Emotional)

Values are given as mean \pm SD

Normal, n - 35; Mild n - 65; Moderate, n - 93; Severe, n - 20

Table 4 Subscales by self-perceived dysphagia severity for dysphagia group

Subscale	Normal	Mild	Moderate	Severe
Total	7.89 \pm 7.75	15.69 \pm 9.77	34.86 \pm 16.01	63.20 \pm 23.38
Physical	4.74 \pm 3.66	8.68 \pm 3.80	13.85 \pm 5.55	21.50 \pm 7.70
Functional	2.34 \pm 4.27	4.58 \pm 5.28	13.68 \pm 8.51	24.00 \pm 10.68
Emotional	0.80 \pm 2.53	2.43 \pm 2.90	7.33 \pm 5.74	17.70 \pm 8.37

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Toxic nodule	Non-toxic nodule
RIGHT	LEFT

85-0986673

PATIENT FINANCIAL RESPONSIBILITY FORM

The treatment at the Thyroid Nodule Treatment Center, LLC. (TNTC) involves the use of highly technical equipment. These procedures which provide excellent results are currently not coded in standard AMA procedures recognized by insurance companies or Medicare. Therefore, the formation of a separate company is necessary to provide patients with the interventional services they desire to avoid surgery and preserve the thyroid gland function. This company is an “out of network” provider and does not bill your insurance company, nor does it submit for authorization to these companies. We will assist our patients with this effort if they desire. Most insurance companies are now reimbursing the patients for this service, but at variable amounts.

The services provided at TNTC do not include the initial patient evaluation and procedures performed during this evaluation. These services provided by Dr. Richard Harding and his staff are charged through the routine insurance companies as an “in network” provider. The patient is responsible for this service through the contract with Arizona Advanced Surgeons, LLC. (84-3016310)

The successful RFA of the thyroid gland on the day of treatment requires the following services:

- Comprehensive Neck Thyroid Ultrasound
- Cervical Plexus Block
- Ultrasound Guidance for Radiofrequency Procedure
- Radiofrequency of the Thyroid Nodule

Other therapies which may be necessary include Ultrasound guided drainage of thyroid cyst. This incurs extra time and expense which can increase the complexity of the procedure. These procedures may be performed and billed through ordinary insurance routes although they are performed on the day of the RFA procedure.

Please feel free to ask further questions for clarification prior to your procedure so that there are no misunderstandings of the services provided and how they will be charged.

Patient Name: _____ **Date:** _____

AUTHORIZATION LETTER FOR RADIOFREQUENCY ABLATION OF THE THYROID GLAND

The management of thyroid nodules has changed dramatically in the last twenty years worldwide. With the introduction of fine needle biopsy over 40 years ago, we can characterize nodules as either benign, indeterminate, and potentially malignant with an in-office biopsy. A symptomatic nodule determined to be benign now can be treated with multiple options.

Of course, the most definitive option is surgery, which has the advantage of eliminating the entire nodule completely. The **downside of surgery**, however, is that the entire thyroid lobe is removed, including functional thyroid tissue, thus predisposing to hypothyroidism and a **lifetime of medication**. The hospital charges alone for this procedure are approximately \$30,000-\$40,000. This does not include the additional surgeon's, anesthesiologist's, and pathologist's charges. Long term costs for management of permanent hypothyroidism is also not factored in these charges. Although surgical risks for thyroidectomy are low, complications are frequent enough to increase the morbidity to the patient and create considerable cost for management and therapy. Most of the thyroid surgery in the United States is performed by low volume surgeons, who have a higher complication rate compared to high volume surgeons. Fortunately, nonoperative approaches are now available for which the complication rate for is easily one tenth or less than for open surgery.^{1,2}

Thyroid radiofrequency ablation (RFA) was introduced in Korea in 2002 and has become the most common mode of managing benign thyroid nodules throughout Asia, Europe, and the United Kingdom for the past decade. This treatment modality has become so common that entire sets of guidelines have been established and even updated. An International Multidisciplinary Consensus Statement of the Head and Neck Society states that radiofrequency ablation should now be recognized as the first modality of treatment if available.³

Radiofrequency Ablation of soft tissue received U.S. FDA clearance in late 2018 and has been slowly introduced to the endocrine, surgical, and head and neck community of physicians. This intervention requires a water-cooled RF probe which can be specifically directed to the vascular margins of the target nodule. The water-cooled RF probe focused energy safely and effectively destroys the abnormal tissue and vascular supply. The equipment is expensive, and the length of the procedure takes much longer than laser thermal ablation. With the laser treatment, a laser fiber is introduced in the middle of the nodule and the heat dissipates radially.

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*The studies comparing the two treatments document the **superiority of RFA** over laser in terms of better outcomes. The nodules decrease more in volume with RFA and the requirement for secondary procedures is only 5% as compared to 10% seen with laser. This superiority of RFA has been documented in multiple studies including the 12-month Randomized (LARA II Study) Trial.⁴*

The significant difference in the procedure regarding skill required, time of the procedure, cost of the equipment, and effectiveness of therapy, makes applying the Category III CPT code assigned for Laser ablation of thyroid nodules inappropriate. **RFA thyroid nodules are equivalent to interventions performed by an interventional radiologist for RF Ablation of liver and renal tumors.**

These procedures require image guided complete thermal ablation of solid tumors in other complex areas of the body. The procedure codes for these procedures are

- 47382 which has a work RVU assignment of 14.9, and
- 50592 which has a work RVU of 6.55.

Hospital charges for these procedures range from \$45,000 to \$25,000 respectively.

The indications for thyroid RFA are the same as for thyroid surgery. Visual deformity and compressive symptoms (such as foreign body sensation, pressure, dysphagia, hoarseness, and choking sensation) are relieved within weeks of RFA as the ablated nodule shrinks in volume.

Additionally, RFA thyroid has completely changed the management of autonomous thyroid nodules. No longer is costly radioactive iodine exposure necessary. Radioactive iodine not only destroys the specific lesion, but also the adjacent healthy thyroid tissue, more often rendering the recipient hypothyroid. The surgical option of thyroid lobectomy requires removal of healthy thyroid tissue around the toxic nodule. **With RFA thyroid nodules, only the abnormal tissue is treated**, thus allowing for prompt restoration of normal thyroid function.

With the success of RFA in treatment of autonomous thyroid nodules, those of us in the Thyroidology community envision a change in the upcoming guidelines to consider RFA thyroid as the first line of therapy for this disease process.

Each of the following, recent references refer to decades of articles of successful RFA well recognized and accepted in World literature. Where noted, the full article can be downloaded from the Thyroid Nodule Treatment Center website.

Research

1. Kandil, E., Omar, M., Aboueisha, M., Attia, A. S., Ali, K. M., Abu Alhuda, R. F., Issa, P. P., Wolfe, S., Omari, S., Buti, Y., Abozaid, O., Toraih, E., Shama, M. A., Lee, G., Tufano, R. P., & Russell, J. O. (2022). *Efficacy and Safety of Radiofrequency Ablation of Thyroid Nodules: A Multi-institutional Prospective Cohort Study*. *Annals of surgery*, 276(4), 589–596. <https://doi.org/10.1097/SLA.0000000000005594> [Download from TNTC](#):
2. Hussain I, Zulfiqar F, Li X, Ahmad S, Aljammal J. *Safety and Efficacy of Radiofrequency Ablation of Thyroid Nodules-Expanding Treatment Options in the United States*. *J Endocr Soc*. 2021;5(8):bvab110. Published 2021 Jun 10. doi:10.1210/endo/bvab110 [Download from TNTC](#)
3. Orloff LA, Noel JE, Stack BC Jr, et al. *Radiofrequency ablation and related ultrasound-guided ablation technologies for treatment of benign and malignant thyroid disease: An international multidisciplinary consensus statement of the American Head and Neck Society Endocrine Surgery Section with the Asia Pacific Society of Thyroid Surgery, Associazione Medici Endocrinologi, British Association of Endocrine and Thyroid Surgeons, European Thyroid Association, Italian Society of Endocrine Surgery Units, Korean Society of Thyroid Radiology, Latin American Thyroid Society, and Thyroid Nodules Therapies Association*. *Head Neck*. 2022;44(3):633-660. doi:10.1002/hed.26960 [Download from TNTC](#)
4. Cesareo R, Manfrini S, Pasqualini V, et al. *Laser Ablation Versus Radiofrequency Ablation for Thyroid Nodules: 12-Month Results of a Randomized Trial (LARA II Study)*. *J Clin Endocrinol Metab*. 2021;106(6):1692-1701. doi:10.1210/clinem/dgab102 [Download from TNTC](#)
5. Zielske, Dr., Broek, RE. Radiofrequency ablation, cryoablation, irreversible electroporation, and other ablation procedures. *Interventional Radiology Coding Reference; Radiofrequency Ablation, Cryoablation, Irreversible Electroporation, and Other Ablation Procedures*. *Dr. Z's Medical Coding Series: Interventional Radiology Coding Reference*. 20th ed. Brentwood, TN:ZHealth Publishing; 2023: 549-559. <https://www.zhealthpublishing.com/coding-products/books-and-ebooks/interventional-radiology-coding-reference-2023>
6. L. Yan, X.Y. Li, Y. Li and Y. Luo. *Ultrasound-Guided Radiofrequency Ablation versus Thyroidectomy for the Treatment of Benign Thyroid Nodules in Elderly Patients: A Propensity Matched Cohort Study*. *American Journal of Neuroradiology* June 2023, 44 (6) 693-699; DOI: <https://doi.org/10.3174/ajnr.A7890>. [Download from TNTC](#)