



# The NT Examiner

Sponsored by the Nuchal Translucency Quality Review Program 

Winter 2008

"Welcome to the Winter 2008 edition of the NT Examiner. Inside you will find NTQR's perspectives on nasal bone assessment and on physician credentialing as well as other news."

Steven L. Warsof, MD

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## Top Tip: Establishing a Practice Administrators Account to Pay Registration and Participation fees.

A Practice Administrator may establish and fund a Registration and Training account by clicking the green **Register Now** button below the phrase **Are you a Practice Administrator?** on the NTQR home page. The Practice Administrator enters a promo code of their choosing that corresponds to the account. When sonologists or sonographers in the practice log in to NTQR they may use the promo code to pay fees. The amount paid is subtracted from the amount in the Practice Administrator Account (PAA) and the Practice Administrator is notified of the transaction and remaining balance. If you need additional information or assistance please E-mail [ntqrsupport@ntqr.org](mailto:ntqrsupport@ntqr.org).

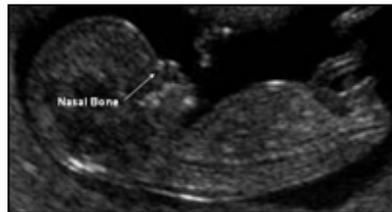
## Announcement: Nasal Bone Program

The Maternal Fetal Medicine Foundation Nuchal Translucency Quality Review Program will offer an educational program in nasal bone imaging to participants credentialed by NTQR in nuchal translucency. The educational program will consist of documentation of didactic education in nasal bone and submission and review of five images. We believe this education is adequate to submit nasal bone images as part of a risk assessment program.

## Publication of Nasal Bone Commentary

The Maternal Fetal Medicine Foundation Nuchal Translucency Oversight Committee is pleased to announce the publication of a comprehensive commentary on nasal bone assessment and its role in assessment of aneuploidy. Readers are urged to review

Rosen, Todd MD; D'Alton, Mary E. MD; Platt, Lawrence D. MD; Wapner, Ronald MD; for the Maternal Fetal Medicine Foundation Nuchal Translucency Oversight Committee. First-Trimester Ultrasound Assessment of the Nasal Bone to Screen for Aneuploidy. *Obstetrics & Gynecology* 2007;110:399-404.



## Nasal Bone Interpretation

By Ronald Wapner, MD  
Professor of OB/GYN  
Columbia University

NTQR and others are now credentialing individuals to perform first trimester nasal bone (NB) determination for use in routine Down syndrome (DS) screening. This marker, in the hands of skilled operators with considerable experience in determining NB absence or presence, has the potential to substantially improve screening performance. But the interpretation of the NB result is not straightforward.

Firstly, the marker is correlated with CRL and NT; the proportion of both DS and unaffected pregnancies having absent NB decreases with increasing CRL and increases with NT (Cicero et al, *Ultrasound Obstet Gynecol* 2004;23:218-223). This precludes the use of a single likelihood ratio (LR) to increase the DS risk, calculated from an NT or a combined test, for absent NB, and one to reduce risk for present NB. As a guide, the absent & present LRs are: CRL=64 mm & NT>1.6 MoM, 26 & 0.37; CRL=64 mm & NT>1.6 MoM, 12 & 0.29; CRL>64 mm & NT>1.6 MoM, 72 & 0.43; CRL>64 mm & NT>1.6 MoM, 35 & 0.33 (Cuckle, *DSNews* 2005[2]).

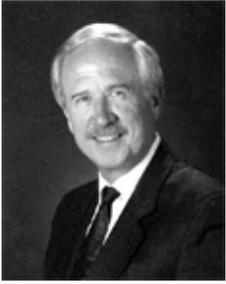
Secondly, unlike continuous variables such as NT, there is no satisfactory way of providing external quality control for NB. It is relatively simple to establish whether an individual operator can identify the NB landmarks. But, since absent NB is a relatively rare event, the frequency with which the operator misclassifies absent NB as present or vice versa can't easily be found.

This consideration suggests a cautious approach to interpretation for the inexperienced operator. In women with high DS risk based on NT or a combined test, when there is absent NB it is reasonable to use an LR to increase the risk, since there is no great penalty for misclassification. Similarly, in women with intermediate or borderline risks (see Cicero et al, *Am J Obstet Gynecol* 2006;195(1):1-3); and even in women with low risks, some would consider NB absence alone to be sufficient indication for invasive testing. However, in women with high DS risk who apparently have NB presence, it may be imprudent to use an LR to reduce the risk, at least not if this would make the final result negative.

Second trimester nasal bone length (NBL) is a weaker DS marker than first trimester NB but, as a continuous variable, it has the advantage of external quality control. Moreover, combining it with the measurement of pre-nasal oedema yields results comparable with NB (Maymon et al, *Prenat Diagn* 2005;25(10)).

Ron Wapner & Howard Cuckle, Columbia University Medical Center

## Providing First Trimester Risk Assessment in a Variety of Practice Locations



Richard Depp, MD  
President, MFM Foundation  
Member, NT Oversight Committee



Beryl Benaceraf, MD  
Radiologist Member  
Member, NT Oversight Committee

Most NT measurements are currently provided by MFM subspecialty consultant groups, but there are definite prominent exceptions. We have received increasing number of questions from radiologists as well as their sonographers / sonographers. The following are questions sent to us; the text has been shortened and edited. Similar principles will apply across a variety of circumstances including a large practice group of MFM consultants with multiple practice sites.

### A Radiology Model

**QUESTION:** *It seems that NT assessment is more geared to high risk, high volume OB practices. I am trying to define a different model: one where the OBs collect the bloods (assuming they are not required to use central lab); refer the patients to us - just for the NT Ultrasound; and then discuss the results / risks with the patients.*

*Do you have any / many general radiology groups in the program? I may need to contact one to see exactly how they do it.*

**RESPONSE:** Your multi-site operation can be perfect situation to offer NT screening. As a Radiologist too, my two partners (perinatologists) and I have a referral practice much like yours where we offer ultrasound and nothing else. Many of the OB practices around us have elected to send their patients to us for NT measurement only.

The process is relatively simple once you and your referring OBs create and learn a mutually acceptable system process. The OBs either collect the blood in house or the sonologist (radiologist or MFM) after performing the scan, can send the patients with the linked completed lab slip in-hand to a nearby commercial or university blood lab that is part of the NT network. It can work perfectly with planning.

Ultimately the risk (NT and lab analyte) for Down syndrome is calculated by the commercial lab (Genzyme, NTD Quest, LabCorp, etc) which in turn transmits the "risk" results directly to the referring MD. The referring obstetrician then counsels the patient about the reported risks for Down syndrome and possible need for further diagnostic testing such as CVS.

### Components of First Trimester Risk Assessment

**QUESTION:** *What is involved in the first trimester Down syndrome screening process? We do not collect any bloods and are not linked to a path lab. The website seems to imply that is a requirement that the sonologist be linked to an analyte lab. We cannot supply any biochemical data.*

**RESPONSE:** The process is reasonably straight-forward. Depending on the circumstances some steps may be accomplished by the referring Obstetrician, some by the NT sonologist (MFM or Radiologist) and some by either the referring OB or the Radiologist / MFM sonologist. (see Table). Blood is commonly collected at central lab collection sites and occasionally in the OB's office.

#### The role of the sonologist (Radiologist or MFM) is to

1. Perform the NT determination and crown-rump length;
2. Fill out a appropriate NT and clinical entries on the lab slip for the appropriate university or commercial analyte lab. The lab slip entries should include the following:
  - a. *Appropriate NT and CRL measurements;*
  - b. *NTQR credential number for the responsible sonologist **and** for the sonographer / technologist.*
  - c. *Required clinical information*

CLINICAL ROLE	REFERRING OBSTET.	SONOLOGIST	
		RADIOLOGY	MFM
1. Counsels re screen options	Yes	Few	Yes
2. Refers out for Counseling	Many	Not apply	Rare
3. Refers out for NT / Nasal Bone	Almost all	Not apply	Not Apply
4. NT determination	Not apply	Yes, if credentialed	Yes, if credentialed
5. Completes Lab Slip - (NT data, NTQR Number, and historical info)	Not practical for patient or OB (2nd contact)	Yes to minimize steps by patient & OB	Yes to minimize steps by patient & OB

6. Collects blood (PAPP-A & hCG (free beta or total) on scan day.	Only If lab work not referred out	No - sends Pt. to Lab with Lab slip	No - sends Pt to Lab with Lab slip
7. Reports NT / NB to OBs	Not apply	Yes, after lag	Yes, after lag
8. Discusses Risk with patient	Yes or MFM	Less likely	Yes on OB request

## Efficiency and Cost Issues Arising Out of Participation in the NTQR Program

**QUESTION:** *We are very busy. I am not too sure about sending each case to the NTQR program. Doesn't this process (entry of both NTQR numbers and the NT & clinical data on lab slips) add a lot of time? We work at a very rapid pace and I am not sure how much time this would take. In addition there are participation fees for NTQR.*

**RESPONSE:** It is important to develop an acceptable process to respond efficiently to one of two common blood collection approaches and come to consensus on who should enter the required data (NTQR numbers, NT and CRL measurements and historical data) on the lab slip that is either carried by the patient or sent to the analyte laboratory.

The system's sonologists and referring OBs should agree on a practical means (fewest steps by the patient and referring OB) to assure reliable entry of the limited but required clinical and historical data in the designated spaces on the lab slip.

In our (BB) case, the patient carries the completed lab slip to the commercial lab in the building next to us to have the blood collected after we enter the required information on the lab slip. The referring OBs will need to make separate arrangements for the blood work with the relevant university or commercial laboratory (NTD, Genzyme, LabCorp, Quest etc). This will allow you to send the patients directly to the blood collection sites for the labs with their completed NT measurement in hand - minimizing any fuss with either the patient returning to the OB's office or the referring OB need to retrieve files etc.

Fortunately most of the laboratories now provide lab slips with designated response locations for the required information including the NTQR number for the sonographer as well as the supervising sonologist which can be entered upon completion of the NT determination.

The NTQR participation fees fund the data monitoring activities that are essential for maintaining accuracy. In addition NTQR provides customer service, and patient and participant education.

## NTQR Credentialing - Practical Issues in LARGE Practice Groups

**QUESTION:** *It seems the NTQR program is mostly geared towards large referral centers (OB or MFM), where there is a stable group of physicians and techs, the bloods are taken, results are discussed with the patients, and the entire operation is closely controlled in one or perhaps two locations.*

*I am part of a big group, with 70 radiologists, 15 offices and ~100 technologists. Our physicians and some of the techs rotate daily between different offices. I have a number of questions for the NTQR Program.*

*How do the Credentialing Guidelines apply to a large radiology group?*

*We have had requests from community OBs to offer NT determinations, but have not been able to help them. I don't want to get involved unless we can become credentialed. Due to the size and complexity of our group, it doesn't seem feasible to get everyone credentialed*

*After reviewing the NTQR website, I am a little confused as to how the guidelines apply to a radiology group such as mine. I can see how it would apply to an OB/Radiology group where there is one office, and a constant group of docs and techs. My questions are:*

- 1. I see that the doc and tech needs to be certified, does the office also need to be certified? For example, if I am certified and 1 tech is certified, can we provide coverage at 15 offices if the tech goes to a different one each day, or is it limited to a "primary" office. The website seems to only have a "primary" office listed for the certified practices.*
- 2. Would it be possible to just get one physician credentialed and have at least one credentialed tech at each site; all the images would be read real-time over our PACS system by a NTQR credentialed physician who may be in a different office across town while the patient is still in the office; reports would go out under that physician's name. That way we could offer the service at all our offices. With time, the credentialed physician can train and supervise the techs at the various offices,*

## RESPONSE:

The NTQR program does **credential** sonographers and sonologists, but does not "credential" offices / ultrasound labs. An individual, once credentialed can work at multiple sites / offices. We request site information for administrative purposes to be able to link sonographers and sonologists.

As you know, the reading sonologist(s) should be credentialed, have a realistic supervisory role over credentialed sonographers and both should practice within a framework of quality review. The NTQR can provide quarterly quality review reports for all your sonographers and sonologists if they enter a sufficient number of cases annually; pay the annual sonologist fee and enter the NTQR numbers for both the sonologist and sonographers / technologists.

I (BB) urge you (and some of your sonographers) to become credentialed as I think it will work very well for you. Our group has all 11 of our sonographers and all 3 MDs credentialed so we don't have to worry about which sonographer or MD is available to perform the test when patients come in!

We suggest that your group make an effort to NTQR credential:

1. a small cadre of radiologists - probably more than one - especially those with interest in ultrasound- to cover each other for vacations / overlapping responsibilities etc.
2. a larger number of sonographers - probably at least 2 at each site because they too need to be credentialed and would have similar vacation / overlapping responsibility issues.

## NICHD Spina Bifida Trial

**We would like to bring to your attention the fact that a major NICHD clinical trial of prenatal versus postnatal repair of spina bifida is still**

recruiting study participants. Already in its fourth year, the Management of Myelomeningocele Study (MOMS) needs about 70 more patients achieve the sample size of 200. In order to finish this trial in a reasonable amount of time, it is essential that as many patients as possible are referred to the study for evaluation.

NTQR physicians and sonographers can play an important role in helping to identify eligible subjects for this study. I encourage all of you to be cognizant of this trial and to publicize it to members of our profession. You also may know of patients who can be referred to the study. It is critically important to complete this research and to determine whether prenatal or postnatal surgery is the best procedure for mother and baby.

Following is an overview of the trial. For more information on the MOMS trial, please call 1-866-ASK MOMS, or go to the [www.spinabifidamoms.com](http://www.spinabifidamoms.com) website.

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## Quality Monitoring Report



By Ronald Wapner,  
MD  
Professor of OB/GYN  
Columbia University

Quality Monitoring is an important part of the NTQR program. This assures that accurate risk assessment is provided to all of our patients. There are two approaches to accomplish this. In one, a group of experts periodically review submitted NT images and the quality of each image is evaluated. In the other approach, the measurements of each provider are compared to a referent curve and those with measurements outside the expected norm are identified. The NTQR program has chosen the later approach (epidemiologic monitoring) for a number of reasons. First, studies have shown very poor concordance when individual images are reviewed by various examiners. Secondly, collecting and submitting these images is an additional burden on busy practitioners. Thirdly, review of a limited number of images collected for review may not be representative of the daily work of any provider. And finally, it is the comparison of measurements to those used for clinical care that truly reflects the performance of risk prediction.

Epidemiologic monitoring requires the comparison of clinical measurements to an acceptable referent curve. Since in the United States, most NT measurements are submitted to commercial or university laboratories which combine these values with biochemical data, the NTQR monitoring referent should be the same as that used for these clinical calculations. While there are slight differences in the curves between the labs offering risk calculations, the majority of them use a variant of data collected in Great Britain (London and/or Leeds). These curves are the same as those used in the United States as part of the BUN trial but have slightly larger NTs for each CRL than the curve used in FASTER.

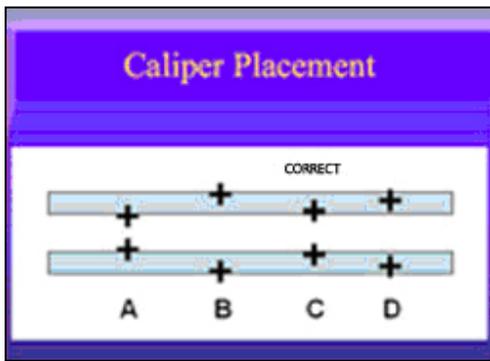
There are multiple ways to compare each provider's measurements to the referent. NTQR plots the measurements on the referent curve, calculates each provider's mean NTs and standard deviation for each CRL and quantifies their deviation from the expected values. We also determine the percent less than the 5th and over the 95th percentile, the number above and below the median, and the slope of the curve.

Choosing which individuals are to be notified that their measurements significantly deviate from the expected curve is a difficult decision. NTQR uses each practitioner's median as our primary determinant (expected to be 1.0 MOM). Centers or practitioners whose overall median is within 10% of this (0.9 MOM - 1.1MOM) are considered to be within compliance. If the submitted values are outside the expected range, further analysis is performed to confirm that this deviation is statistically significant. To do this the standard deviation of your measurements is calculated and used to determine significance. For example, centers with values 15% higher than expected (1.15 MOM) with a small standard deviation are more likely to be significantly different than a center with a similar deviation but a larger SD. Sample size may also play a role. For example, a center submitting 100 measurements with a median NT of 1.15 and a standard deviation of 0.1 and a center with a 20% deviation (MOM 1.2) having a similar SD of 0.1 but submitting only 36 measurements would both be borderline elevated.

We have intentionally made the quality monitoring criteria somewhat stringent with the intent of identifying issues relatively early in any center's experience. A report that is "outside the expected range" could occur for a number of reasons which could include a systematic imaging and measuring error or a machine that is not correctly calibrated. Alternatively, it could be related to a unique aspect of a center's population (eg a large number of patients referred for elevated NTs), a small sample size, or just chance. Accordingly, when a center is noted to have their results outside the expected range they should review all of the possibilities and attempt to improve those requiring remediation. It would be anticipated that centers that do this should have values within range at the next review.

NTQR has now reviewed 2 cycles of results. An important finding from this review is that nearly 90% of centers that had values outside the expected range in the first review continued to do so in the next evaluation. Similarly, those within range remained so. This suggests that active intervention is required to standardize NT measurements. The next step in the development of the NTQR program is to assist centers whose values remain outside the expected range in identifying and remediating systematic errors. The next issue of the newsletter should give more details on this program.

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## Criteria for Nuchal Translucency (NT) Measurements

By Steven L. Warsof, MD  
 EDITOR-IN-CHIEF, The NT Examiner  
 Prof. OB/GYN, Eastern Virginia Medical School  
 Director, Center for Advanced Fetal Therapy

This is the final installment in a series of articles for the NT Examiner to clarify the nine criteria established by the Nuchal Translucency Quality Review (NTQR) Program for NT measurements. It is the goal of the NTQR to standardize the NT measurement. It is critical for First Trimester Risk Assessment that the NT measurement be done uniformly, correctly, and precisely. The NT measurement is unique in diagnostic obstetrical ultrasound as fractions of mm's can make significant differences in individual risk assessment for Down Syndrome, patient's decisions for diagnostic testing, and the overall effectiveness of any Down Syndrome screening program.

Nuchal Translucency measurements must be between 10 3/7 weeks and 13 6/7 weeks gestation. This is equivalent to a CRL measurement between 38-84 mm. In this window of time CRL accuracy for gestational dating is 3-5 days. The CRL measurement must be included with NT measurement as the NT measurement is converted into multiples of the mean (MOM) for the CRL. The measured CRL is not the actual anatomic CRL but rather the longest straight line measurement of the fetus while its head is maintained in the neutral position. Unlike the NT measurement in which the longest of three good measurements is used, the CRL uses the average from 3 good measurements. NT measurements can be obtained either transabdominally or endovaginally. Criteria 1-5 have been printed in earlier editions of the NT examiner. We will conclude with criteria 6-9.

### Criteria 6-9. Caliper Placement and Actual Measurements.

- 6. When taking an NT measurement always use the + calipers and not x or other caliper markers. This allows for the most precise measurement of the NT.**
- 7. The horizontal crossbars of the calipers must be placed on the inner borders of the nuchal membranes with none of the horizontal crossbars protruding into the NT space. This is referred to as an "inner to inner" measurement.**
- 8. The actual NT measurement is made with a vertical line connecting the 2 calipers. The measurement should always be perpendicular to the long axis of the fetus. Avoid membrane shadows.**
- 9. In each case, obtain 3 good images, but use the longest of the 3 values. Do not use the average of the 3 best measurements as is done with CRL measurements.**

## NTQR Advocates for Credentialed Sonologist / Sonographer Teams



By Jean Lea Spitz, MPH,  
 RDMS  
 NTQR Program Director

The Nuchal Translucency Quality Review program is a strong advocate for credentialed sonologist, credentialed sonographer partnerships in practices providing first trimester risk assessment. Having both the sonographer and the physician credentialed benefits all. Sonographers want the level of support that credentialed supervising physicians can provide; physicians need the medicolegal validation and the education on counseling, image interpretation, and skills that the credentialing process can provide; patients deserve a fully qualified team.

NTQR is a strong advocate for sonographers' skills and abilities. The critical issue for NTQR is quality first trimester risk assessment. Patient care needs to be foremost in any discussion. In first trimester risk assessment adequate patient care is achieved by a partnership of minimally a sonographer and a sonologist and perhaps others including genetic counselors, MFM's, etc. The referring and supervising physicians have the responsibility for the counseling and assessment process. That includes supervising the sonographer, validating the measurement, counseling the patient, and referring for additional testing as needed.

Sonographers are best served by working with physicians who can be a "second eye" in validating or obtaining the images, who will recognize the criteria and importance of sonographic skill, and who can counsel patients before and after the measurement, or when the results come in. I have found that most sonographers want that level of supervision and partnership, a physician who is fully engaged and ready to step in as needed. The medical practice regulations that are associated with the nuchal translucency CPT code require supervision by a physician.

### The NTQR is a consensus governed organization.

The position of the NTQR is that every patient deserves a credentialed sonographer / sonologist team providing optimum patient care. The issue of patient

access to credentialed sonographer / sonologist teams may be addressed in several ways. The NTQR provides web-based education and credentialing available to all. There are alternative methods of risk assessment that do not require nuchal translucency and these can be used when credentialed sonographers and sonologists are not available. Risk assessment is a complicated process and the team approach works best for patients. The recommendations of the ACOG Practice Bulletin #77, Screening for Fetal Chromosomal Abnormalities are best met with a credentialed team. NTQR is committed to this practice model.

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## **MFM Foundation Guidelines NTQR Credentialing for Physicians**

By the Members of the NT Oversight Committee

### **Preamble:**

The Maternal Fetal Medicine Foundation recommends nuchal translucency (NT) credentialing for all physician sonologists and sonographers involved in first trimester Down Syndrome risk assessment. The Maternal Fetal Medicine Foundation is committed to NT credentialing of both members of the team, not just the person who scans, to establish a team approach and to meet the recommendations of the ACOG Practice Bulletin Number 77 titled *Screening for Fetal Chromosomal Anomalies*. Ongoing quality monitoring of both sonographers and supervising sonologists helps insure that patients receive the most accurate first trimester risk assessment possible.

### **MFM Foundation Guidelines for Physician Credentialing**

Credentialing for physician participants in the NTQR program requires didactic education, successful completion of a written examination, and evidence of image proficiency.

In many practices sonographers perform the technical acquisition of the NT image. The supervising physician performs the medical management and decision-making including program development, patient counseling, verification of measurement accuracy, and explanation of results and diagnostic options. In recognition of these different roles the NTQR program has outlined the educational and image proficiency requirements for physicians.

#### **1. Didactic Evaluation**

a) All supervising physicians must take a didactic course and pass a written examination that demonstrates their ability to perform and supervise first trimester Down Syndrome risk assessment. Successful completion of the exam will require didactic knowledge of the principals of first trimester risk assessment as well as confirmation of the ability of the examinee to identify appropriately performed NT images

#### **2. Image Submission**

a) If in practice a physician will be independently acquiring images for NT risk assessment, then the physician must obtain the images submitted for credentialing.

b) If in practice the physician does not perform image acquisition then:

(1) Images sent in for credentialing review must be acquired under direct supervision of the physician.

(a) This requires that the physician be present in the room during the complete acquisition of the images and personally supervise the acquisition and selection of the submitted images.

(b) Submitted images must not have been previously used for credentialing by any one else.

c) When submitting images for review, physicians must attest that the acquisition of the images meet the NTQR criteria listed above.

The MFM Foundation is a 501(c)(3) non-profit entity. This practice bulletin was developed by the Nuchal Translucency Oversight Committee of the MFM Foundation. The information is designed to aid practitioners in making decisions about appropriate maternal fetal care. These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

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## **Nuchal Translucency Reimbursement White Paper**

### **Nuchal translucency components:**

1. Fetal viability Assessment
2. Crown-rump length determination
3. Nuchal Translucency measurement.

**New CPT codes** for a Nuchal Translucency issued - January 1, 2007.

**76813** is the nuchal translucency for a single or first gestation pregnancy.

- o Can be either transabdominal or transvaginal approach.
- o Total RVUs are 3.43; the professional component RVUs are 1.56.

**76814** is the CPT code for each additional gestation.

- o Total RVUs are 2.29; the professional components RVUs are 1.31.

### **For comparison:**

- 76801 - the total RVUs are 3.51; the professional component RVUs are 1.31.
- 76802 - the total RVUs are 1.92; the professional component RVUs are 1.11.

A 76801 can be billed with a 76813/14 - if there is an appropriate indication for its use.

**Example:** Size/dates discrepancy, bleeding.

*Billing examples:* 76801 and 76813-59

- Modifier 59 is used to show the 76813 as a distinct and independent service from the 76801. (See modifier in CPT book for clarification.)

- An E&M is not indicated for this testing unless there is a specific consultation requested or if an abnormality is found and the referring physician requests a consultation.
- The Nuchal Translucency ultrasound must be performed by a sonographer and/or physician that has been specifically trained and credentialed to perform the service. Credentialing can be done through the NTQR program ([www.ntqr.org](http://www.ntqr.org))

17 December 2007

## Join NTQR and Get Credentialed

The Nuchal Translucency Quality Review Program (NTQR) is an American based effort seeking to establish a NT quality control system and help formalize set standards. NTQR offers a unique opportunity to learn about the proper techniques and theories involved in obtaining accurate and reproducible NT measurements from the 11-14 week ultrasound scan and first trimester risk assessment for Down Syndrome, while also offering a method to evaluate and track provider proficiency through ongoing NT quality monitoring reports.

### Two ways to join NTQR and get credentialed!

#### 1. On Line

1. Go to [www.ntqr.org](http://www.ntqr.org)
2. Register
3. On your computer, watch the same lectures given at NTQR's land-based courses. (This doesn't have to be done in one sitting)
4. Take the same on-line test as land-based course participants
5. Submit 10 slides for quality review
6. Get credentialed

#### 2. Plan to attend one of these upcoming NTQR land-based courses:

1. Register and attend a 2008 Planned Land-Based Courses (see below)
2. Take the on line exam.
3. Submit 10 slides for quality review
4. Get credentialed

#### World Class CME

##### Maternal Fetal Imaging 2008

Nuchal Translucency Credentialing and Advances in OB-GYN Ultrasound  
The Westin Riverwalk  
San Antonio, Texas  
Jan 20 - 22, 2008

<http://worldclasscme.com/conferences.php?id=26&PHPSESSID=253186705ada1dfe2c3a70e57a2e3c64>

#### 28th Annual Meeting

##### The Pregnancy Meeting™

Nuchal Translucency Credentialing Course  
Dallas Hyatt Regency at Reunion  
Dallas, Texas  
Jan 28 - Feb 2, 2008

<http://www.smfm.org/index.cfm?zone=calendar&nav=meeting>

#### 2008 American Institute of Ultrasound in Medicine Annual Conference

First-Trimester Screening: Nuchal Translucency  
Credentialing and More  
San Diego Marriott Hotel and Marina  
San Diego, California  
Mar 12-15, 2008

<http://www.aium.org/cmeActivities/events/ann2008/intro.asp>

#### Fetal and Women's OB/GYN Ultrasound Conference

Nuchal Translucency Education and Quality Monitoring Program  
Hyatt Regency Scottsdale Resort and Spa at Gainey Ranch  
Scottsdale, Arizona  
Mar 28-30, 2008

<http://meetingpro.info/plaza/registrants/FWOBGYNS08/FWOBGYNS08.htm>

#### 39th Annual OB/GYN Spring Symposium

Nuchal Translucency Quality Review (NTQR) Program  
Doubletree Guest Suites Hotel  
Charleston, South Carolina  
Mar 31-Apr 2, 2008

<http://www2.edserv.musc.edu/cme/programs/upcoming.lasso>

#### ACOG Annual Clinical Meeting

Special Course on Nuchal Translucency Credentialing (MFMF)  
New Orleans Morial Convention Center  
New Orleans, Louisiana  
May 3-8, 2008

<http://www.acog.org/acm/>

#### The Leading Edge in Diagnostic Ultrasound Annual Conference

Fetal NT Credentialing Course  
The Borgata Hotel Casino & Spa  
Atlantic City, New Jersey  
May 20-23, 2008

<http://www.jefferson.edu/jurei/conference/>

#### IAME 12th Annual Fetal and Women's Ultrasound

Nuchal Translucency Credentialing Course  
Dallas/Addison Marriott  
Dallas, Texas  
May 30-June 1, 2008

<http://www.iame.com/courses/fetal0508/fetal.html>

#### IAME 9th Annual Obstetric Ultrasound in the High Risk Patient

Nuchal Translucency Education and Quality Monitoring Program  
The Venetian Resort Hotel  
Las Vegas, Nevada  
Oct 17-19, 2008

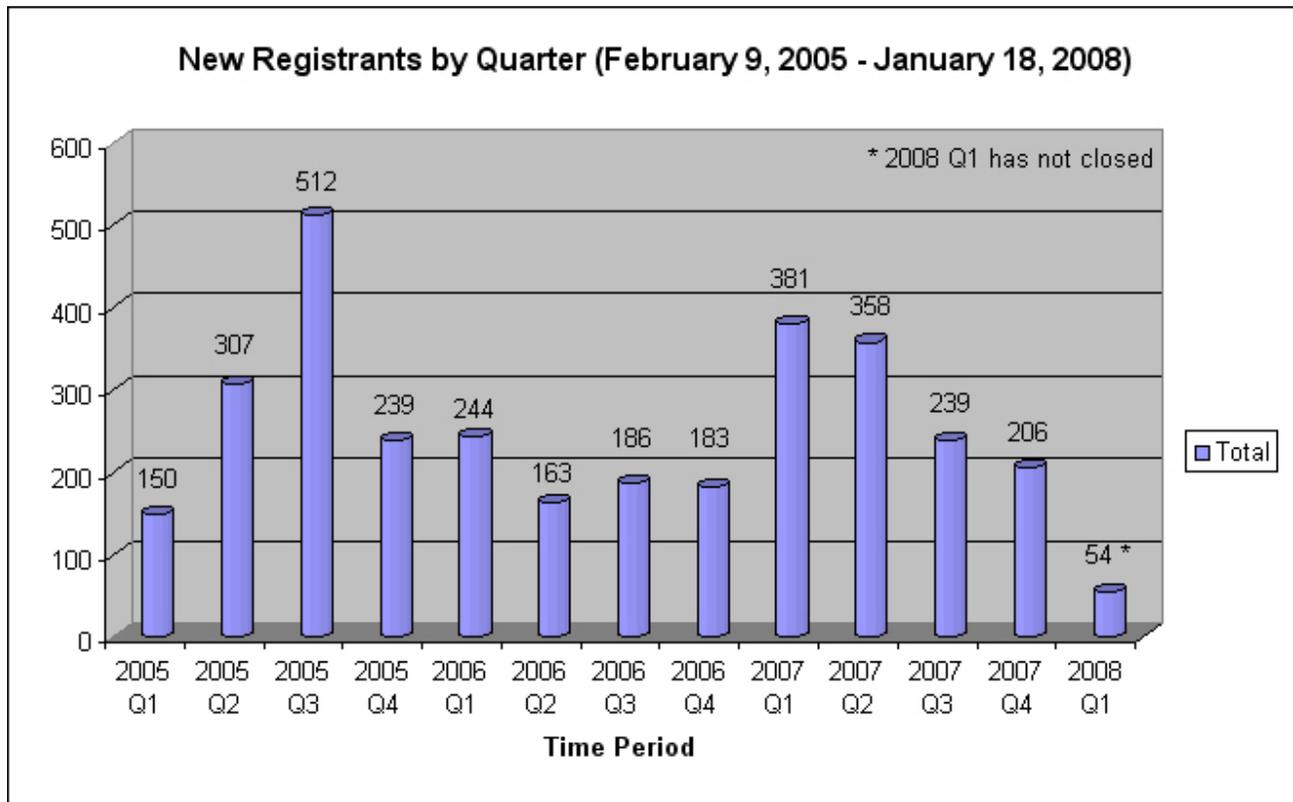
<http://www.iame.com/courses/hirisk1008/hirisk.html>

#### IAME National Conference on OB-GYN Ultrasound

Nuchal Translucency Credentialing Course  
Chicago Marriott Downtown  
Chicago, Illinois  
Dec 5-7, 2008

<http://www.iame.com/courses/ob1208/ob.html>

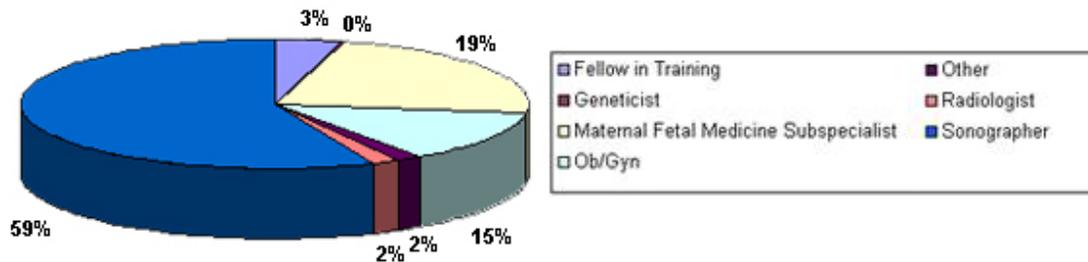
**NTQR Program Fast Facts**



**Program Statistics**

- 3,222 providers of NT measurements have registered with the Nuchal Translucency Quality Review Program
- 2,097 providers have been credentialed through NTQR
- Over 12,775 NT images have been reviewed by NTQR's Expert Reviewers
- Twelve laboratories currently participate with the NTQR Program. To view the list of our partner laboratories, go to [www.NTQR.org](http://www.NTQR.org)

**Registrants by Primary Clinical Role**





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**LETTERS AND OTHER INQUIRIES**

Send letters to the editor and all other inquiries to the NT Examiner newsletter,  
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Washington, DC 20024, or send e-mail to [NTEditor@ntqr.org](mailto:NTEditor@ntqr.org).

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