Medtronic

Thyroid and
parathyroid procedures

Commonly Billed Codes

Effective January 1, 2025

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ICD-10-PCS[1] procedure codes

Hospitals use ICD-10-PCS procedure codes for inpatient services.

Parathyroid procedures	**0GBR0ZX**	Excision of parathyroid gland, open approach, diagnostic
	0GBR0ZZ	Excision of parathyroid gland, open approach
	0GBR4ZZ	Excision of parathyroid gland, percutaneous endoscopic approach
	0GTR0ZZ	Resection of parathyroid gland, open approach
	0GTR4ZZ	Resection of parathyroid gland, percutaneous endoscopic approach
Thyroid procedures	**0GBG0ZX**	Excision of left thyroid gland lobe, open approach, diagnostic
	0GBH0ZX	Excision of right thyroid gland lobe, open approach, diagnostic
	0GBG0ZZ	Excision of left thyroid gland lobe, open approach
	0GBH0ZZ	Excision of right thyroid gland lobe, open approach
	0GBG3ZZ	Excision of left thyroid gland lobe, percutaneous approach
	0GBH3ZZ	Excision of right thyroid gland lobe, percutaneous approach
	0GBG4ZZ	Excision of left thyroid gland lobe, percutaneous endoscopic approach
	0GBH4ZZ	Excision of right thyroid gland lobe, percutaneous endoscopic approach
	0GTG0ZZ	Resection of left thyroid gland lobe, open approach
	0GTH0ZZ	Resection of right thyroid gland lobe, open approach
	0GTG4ZZ	Resection of left thyroid gland lobe, percutaneous endoscopic approach
	0GTH4ZZ	Resection of right thyroid gland lobe, percutaneous endoscopic approach
	0GTKoZZ	Resection of thyroid gland, open approach
	0GTK4ZZ	Resection of thyroid gland, percutaneous endoscopic approach

HCPCS II Device Codes[2]

These codes are used by the entity that purchased and supplied the medical device, DME, drug, or supply to the patient. Medicare provides C-codes for hospital use in billing Medicare for medical devices in the outpatient setting. Although other payers may also accept C-codes, regular HCPCS II device codes are generally used for billing non-Medicare payers. ASCs, however, usually should not assign or report HCPCS II device codes for devices on claims sent to Medicare. Medicare generally does not make a separate payment for devices in the ASC. Instead, payment is "packaged" into the payment for the ASC procedure. ASCs are specifically instructed not to bill HCPCS II device codes to Medicare for devices that are packaged.[3]

Device or product	HCPCS	Description / commentv
PTeye™ System[4]	N/A[5]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.

Coding and payment – Effective January 1, 2025

CPT™* procedure codes

Physicians use CPT codes for all services. Under Medicare's Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each CPT code is assigned a point value, known as the relative value unit (RVU), which is then converted to a flat payment amount.

Hospitals use CPT codes for outpatient services. Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to an APC. Each APC has a relative weight that is then converted to a flat payment amount. Multiple APCs can sometimes be assigned for each encounter, depending on the number of procedures coded and whether any of the procedure codes map to a Comprehensive APC (C-APC). A CPT procedure code assigned to C-APC is considered a primary service, and all other procedures and services coded on the bill are considered adjunctive to delivery of the primary service. This results in a single APC payment and a single beneficiary copayment for the entire outpatient encounter, based solely on the primary service. Separate payment is not made for any of the other adjunctive services. Instead, the payment level for the C-APC is calculated to include the costs of the other adjunctive services, which are packaged into the payment for the primary service. When more than one primary service is coded for the same outpatient encounter, the codes are ranked according to a fixed hierarchy. The C-APC is then assigned according to the highest ranked code. In some special circumstances, the combination of two primary services leads to a "complexity adjustment" in which the entire encounter is re-mapped to another higher-level APC. As shown on the tables below, the procedures that are subject to C-APCs are identified by status indicator J1.

ASCs use CPT codes for their services. Medicare payment for procedures performed in an ambulatory surgery center is based on Medicare's ambulatory patient classification (APC) methodology for hospital outpatient payment. However, Comprehensive APCs (C-APCs) are used only for hospital outpatient services and are not applied to procedures performed in ASCs. Each CPT code designated as a covered procedure in an ASC is assigned a comparable weight as under the hospital outpatient APC system. This is then converted to a flat payment amount using a conversion factor unique to ASCs. Multiple procedures can be paid for each claim. Certain ancillary services, such as imaging, are also covered when they are integral to covered surgical procedures, although they may not be separately payable. In general, there is no separate payment for devices; their payment is packaged into the payment for the procedure.

CPT™* procedure codes - *continued*

Procedure	CPT code and description[6]	Physician				Hospital Outpatient				Ambulatory Surgery	
		Total Non-Facility RVUs[7.8]	Total Facility RVUs[7.9]	Non-facility Rate[7.8]	Facility Rate[10]	APC[11]	Status Indicator[12]	Relative Weight[11]	Payment[11.13]	Payment Indicator[11.14]	Payment[11.15]
Thyroid procedures	**60212** Partial thyroid lobectomy. unilateral; with contralateral subtotal lobectomy. including isthmusectomy	N/A	31.03	N/A	$1,004	5361	J1	65.43	$5,834	G2	$2,860
	60225 Total thyroid lobectomy. unilateral; with contralateral subtotal lobectomy. including isthmusectomy	N/A	28.41	N/A	$919	5361	J1	65.43	$5,834	G2	$2,860
	60240 Thyroidectomy. total or complete	N/A	27.70	N/A	$896	5361	J1	65.43	$5,834	G2	$2,860
	60252 Thyroidectomy. total or subtotal for malignancy; with limited neck dissection	N/A	39.73	N/A	$1,286	5165	J1	66.34	$5,916	Not included on ASC list of covered procedures	
	60254 Thyroidectomy. total or subtotal for malignancy; with radical neck dissection	N/A	50.13	N/A	$1,622	Inpatient Only				Not included on ASC list of covered procedures	
	60260 Thyroidectomy. removal of all remaining thyroid tissue following previous removal of a portion of thyroid	N/A	32.8	N/A	$1,061	5165	J1	66.34	$5,916	G2	$2,917
	60270 Thyroidectomy. including substernal thyroid; sternal split or transthoracic approach	N/A	40.95	N/A	$1,325	Inpatient Only				Not included on ASC list of covered procedures	
	60271 Thyroidectomy. including substernal thyroid; cervical approach	N/A	31.83	N/A	$1,030	5165	J1	66.34	$5,916	Not included on ASC list of covered procedures	
Parathyroid procedures	**60500** Parathyroidectomy or exploration of parathyroid(s)	N/A	29.33	N/A	$949	5165	J1	66.34	$5,916	G2	$2,917
	60502 Parathyroidectomy or exploration of parathyroid(s); re-exploration	N/A	39.39	N/A	$1,275	5165	J1	66.34	$5,916	Not included on ASC list of covered procedures	
	60505 Parathyroidectomy or exploration of parathyroid(s); with mediastinal exploration. sternal split or transthoracic approach	N/A	42.03	N/A	$1,360	Inpatient Only				Not included on ASC list of covered procedures	

Hospital Inpatient Coding and Payment – Effective October 1, 2024 - September 30, 2025

MS-DRG Assignments

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 760 diagnosis-related groups, based on the ICD-10-CM codes assigned to the diagnoses and ICD-10-PCS codes assigned to the procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. The MS-DRGs shown are those typically assigned to the following scenarios.

Procedure	MSDRG[16]	MS-DRG title[16,17]	Relative weight[16]	Medicare national average[18]
Thyroid and parathyroid procedures[19]	**625**	Thyroid, Parathyroid and Thyroglossal Procedures W MCC	2.8671	$20,405
	626	Thyroid, Parathyroid and Thyroglossal Procedures W CC	1.5093	$10,742
	627	Thyroid, Parathyroid and Thyroglossal Procedures W/O CC/MCC	1.2669	$9,017

1. Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). https://www.cdc.gov/nchs/icd/icd-10-cm/files.html. Accessed November 18, 2024.
2. Healthcare Common Procedure Coding System (HCPCS) Level II codes, including device C-codes, are maintained by the Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update. Accessed November 18, 2024.
3. ASCs should report all charges incurred. However, only charges for non-packaged items should be billed as separate line items. Because of a Medicare requirement to pay the lesser of the ASC rate or the line-item charge, breaking these packaged charges out onto their own lines can result in incorrect payment to the ASC. Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 14–Ambulatory Surgical Centers, Section 40. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c14.pdf. Accessed November 18, 2024.
4. PTeye™ system is trademark of a Medtronic company.
5. N/A indicates that CMS and other payers do not have a need for these items to be individually identified, although the associated charges must still be reported. When hospitals use a device or supply that does not have a HCPCS II code, they should report the charges in the general revenue code for the item, typically revenue code 270 for Medical-Surgical Supplies.
6. CPT copyright 2024 American Medical Association. All rights reserved. CPT™* is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
7. Centers for Medicare & Medicaid Services Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2025; CMS-1807-F. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f. Accessed November 18, 2024. The total RVU as shown here is the sum of three components: physician work RVU, practice expense RVU, and malpractice RVU.
8. "N/A" shown in Physician Office setting indicates that Medicare has not developed RVUs in the office setting because the service is typically performed in a facility (e.g. in a hospital). However, if the local contractor determines that it will cover the service in the office, then it is paid using the facility RVUs at the facility rate.
9. The RVUs shown are for the physician's services and payment is made to the physician. However, there are different RVUs and payments depending on the setting in which the physician rendered the service. "Facility" includes physician services rendered in hospitals, ASCs, and SNFs. Physician RVUs and payments are generally lower in the "Facility" setting because the facility is incurring the cost of some of the supplies and other materials. Physician RVUs and payments are generally higher in the "Physician Office" setting because the physician incurs all costs there.
10. Medicare national average payment is determined by multiplying the sum of the three RVUs by the conversion factor. The conversion factor for CY 2025 is $32.3465. Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments; CMS- 1807-F. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f. Accessed November 26, 2024.
11. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc. Accessed November 26, 2024.
12. Status Indicator (SI) shows how a code is handled for payment purposes: J1 = paid under a comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; N = packaged service, no separate payment; T = Significant procedure subject to multiple procedure discounting.
13. Medicare national average payment rate is determined by multiplying the APC weight by the conversion factor. The final conversion factor for 2025 is $89.169 as published in CMS-1809-fc. The conversion factor of 89.169 assumes that hospitals meet reporting requirements of the Hospital Outpatient Quality Data Reporting Program.https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc. Accessed November 26, 2024.
14. The Payment Indicator shows how a code is handled for payment purposes: A2 = Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight. G2 = surgical procedure, non-office-based, payment based on hospital outpatient rate adjusted for ASC. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost. N1 = Packaged service/item; no separate payment made.

15. Medicare national average payment is determined by multiplying the relative weight by the ASC conversion factor. The 2025 ASC conversion factor is $54.895. The conversion factor of $54.895 assumes the ASC meets quality reporting requirements. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices/cms-1809-fc. Accessed November 26, 2024. Payment is adjusted by the wage index for each ASC's specific geographic locality, so payment will vary from the stated national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
16. Medicare Program; Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation; Corrections. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page#data. Posted October 3, 2024.
17. W MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs W MCC have at least one major secondary complication or comorbidity. Similarly, W CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs W CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs W/O CC/MCC have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions are acquired in the hospital during the stay.
18. Payment is based on the average standardized amount of $7,117.02. Medicare Program; Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation; Corrections. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page#data. Posted October 3, 2024. The payment rate shown is the standardized amount for facilities with a wage index greater than one. The average standard amounts shown also assume facilities receive the full quality update. The payment will also be adjusted by the Wage Index for specific geographic locality. Therefore, payment for a specific hospital will vary from the stated Medicare national average payment levels shown. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
19. Only open thyroid biopsies group to DRGs 625-627. Percutaneous and percutaneous endoscopic biopsies are not designated as significant operating room procedures for the purpose of DRG assignment. If they are the only procedures performed, the case groups to a medical DRG based on the principal diagnosis code.

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