

# Thyroid Surgeries (Thyroidectomy & Lobectomy)



INDEPENDENT CARE HEALTH PLAN

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## Medical Coverage Policy

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## Related Medical/Pharmacy Coverage Policies

Molecular Markers in Fine Needle Aspirates of Thyroid Nodules Medical Coverage Policy HUM-1161-00

## Related Documents

Please refer to [CMS website](#) for the most current applicable National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA)/CMS Online Manual System/Transmittals.

There are no NCD and LCDs for Thyroid Surgeries.

## Description

The thyroid is a butterfly-shaped gland in the front of the neck just below the larynx (voice box). The thyroid makes specific hormones that are secreted into the blood and then carried to other tissues in the body. Thyroid hormones help the body use energy, stay warm and keep organs working properly. The term thyroid nodule refers to an abnormal growth of cells that form a lump within the thyroid gland. Although

many thyroid nodules are benign (noncancerous), a small proportion of thyroid nodules may be malignant (cancerous).

### **Evaluation**

Once a nodule is discovered, further evaluation is necessary to learn if the rest of the thyroid is healthy or whether the entire thyroid gland has been affected by a more general condition (eg, hyperthyroidism, hypothyroidism) or cancer. During a physical examination, the physician will assess for enlargement of the entire gland and whether single or multiple nodules are present. Initial laboratory tests may include measurement of thyroid hormone (thyroxine or T4) and thyroid-stimulating hormone (TSH) in the blood to determine how the thyroid is functioning. Since it is not always possible to determine whether a thyroid nodule is cancerous by physical examination and blood tests alone, the evaluation of the thyroid nodules will often include specialized tests. Some of these tests include, but are not limited to:

**Thyroid ultrasound** uses high frequency sound waves to obtain a picture of the thyroid. This test can determine characteristics or precise size of a nodule and identify nodules too small to be felt during a physical examination. Ultrasound can also be used to accurately guide a needle directly into a nodule when a fine needle biopsy is warranted. Once the initial evaluation is completed, thyroid ultrasound can be used to monitor thyroid nodules that do not require surgery to determine if they are growing or shrinking over time.

**Fine needle aspiration biopsy (FNA or FNAB)** is a procedure where a thin needle is inserted into the nodule to withdraw cells for examination. Ordinarily, samples will be taken from various parts of the nodule to provide the best chance of finding cancerous cells, if they are present. The cells are then examined under a microscope by a pathologist. The report of a thyroid fine needle biopsy will usually indicate that the nodule is in one of six categories according to the [Bethesda Classification System](#).<sup>44</sup>

Laboratory examination of cells in thyroid nodules acquired through FNA has been proposed to assist in exploring the possibility of thyroid cancer. These tests are used to detect molecular markers associated with thyroid cancer and are performed when cytopathology cannot determine if the nodule is malignant or benign.

### **Surgical Treatment**

Thyroid nodules found to be benign by initial FNA or too small to biopsy are monitored closely via physical exam and repeated ultrasound or FNA. Surgery may still be recommended even for a nodule that is benign if it causes compression symptoms or other worrisome features to develop.

Thyroid nodules that are malignant, or that are highly suspicious of cancer, typically require surgery. The extent of the surgery performed depends on many variables; some include cancer type, size and location of nodule(s), symptoms, individual's age and/or preference. Thyroid surgeries include, but are not limited to:

- **Lobectomy (or hemi-thyroidectomy)** – Procedure where one lobe (one half) of the thyroid is removed
- **Thyroidectomy (total or near-total)** – Procedure where all or most of the thyroid tissue is removed

### **Coverage Determination**

*iCare follows the CMS requirement that only allows coverage and payment for services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member except as specifically allowed by Medicare.*

*In interpreting or supplementing the criteria above and in order to determine medical necessity consistently, iCare may consider the criteria contained in the following:*

**Thyroid lobectomy or thyroidectomy** will be considered medically reasonable and necessary when all the following requirements are met:

- Diffuse enlargement of the thyroid gland; **OR**
- Nodule(s) causing compressive symptoms (eg, choking, dysphagia, dyspnea, hoarseness); **OR**
- Nodule(s) measuring greater than or equal to 4 cm; **OR**
- Nodule(s) measuring less than 4 cm with suspicious pattern identified on ultrasound;

**AND any of the following:**

- Documented contraindication to radioactive iodine therapy; **OR**
- FNA results of indeterminate or malignant ([Bethesda III, IV, V or VI](#)); **OR**
- Results of molecular testing demonstrate suspicious pattern; **OR**
- Prior surgery of nodule(s) demonstrated malignancy and further removal is required based on pathology

*The use of the criteria in this Medicare Advantage Medical Coverage Policy provides clinical benefits highly likely to outweigh any clinical harms. Services that do not meet the criteria above are not medically necessary and thus do not provide a clinical benefit. Medically unnecessary services carry risks of adverse outcomes and may interfere with the pursuit of other treatments which have demonstrated efficacy.*

### Coverage Limitations

[US Government Publishing Office. Electronic code of federal regulations: part 411 – 42 CFR § 411.15 - Particular services excluded from coverage](#)

### Coding Information

Any codes listed on this policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and/or reimbursement for a service or procedure.

CPT® Code(s)	Description	Comments
60210	Partial thyroid lobectomy, unilateral; with or without isthmusectomy	

60212	Partial thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy	
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	
60225	Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy	
60240	Thyroidectomy, total or complete	
60252	Thyroidectomy, total or subtotal for malignancy; with limited neck dissection	
60254	Thyroidectomy, total or subtotal for malignancy; with radical neck dissection	
60260	Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid	
60270	Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach	
60271	Thyroidectomy, including substernal thyroid; cervical approach	
<b>CPT® Category III Code(s)</b>	<b>Description</b>	<b>Comments</b>
No code(s) identified		
<b>HCPCS Code(s)</b>	<b>Description</b>	<b>Comments</b>
C7555	Thyroidectomy, total or complete with parathyroid autotransplantation	

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**Appendix**

**Appendix A**

**Bethesda Classification System<sup>44</sup>**

<p><b>Nondiagnostic or inadequate</b> (<i>Bethesda I</i>)</p>	<p>This result indicates that not enough cells were obtained to make a diagnosis. These nodules may require re-evaluation with second FNA or may need to be removed surgically.</p>
<p><b>Benign</b> (<i>Bethesda II</i>)</p>	<p>These nodules do not usually need to be removed surgically unless they are causing compressive symptoms (eg, choking, dysphagia, dyspnea, hoarseness). These enlargements may be considered goiters, cysts, follicular adenomas, Hurthle cell adenomas or Hashimoto’s thyroiditis.</p>
<p><b>Indeterminate</b> (<i>Bethesda III, IV, or V</i>)</p>	<p>Atypia (or follicular lesion) of undetermined significance (<i>Bethesda III</i>) has features that cannot be placed in one of the other diagnostic categories. Diagnoses in this category rarely are malignant, so repeat FNA is commonly recommended.</p>
	<p>Follicular neoplasm or suspicious for follicular neoplasm (<i>Bethesda IV</i>) can be either benign or malignant. This category often prompts surgeons to perform a lobectomy.</p>
	<p>Suspicious for malignancy (<i>Bethesda V</i>) has a higher chance of being malignant, as the term explains. A near-total thyroidectomy or lobectomy may be performed for FNA results in this grouping.</p>
<p><b>Malignant</b> (<i>Bethesda VI</i>)</p>	<p>These nodules either have cancerous cells or have a high suspicion for malignancy. After consultation with an endocrinologist or surgeon, this type will often require surgical removal. There are different types of malignancies; papillary cancer of the thyroid is the most common in this category. Others include follicular carcinomas, transformed Hurthle cell adenomas, medullary carcinomas, anaplastic carcinomas or metastatic carcinomas.</p>

**Change Summary**

- 01/01/2024 New Policy.
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