Coding for Postoperative Removal of Sutures or Staples

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For the Current Procedural Terminology (CPT®) 2023 code set, coding changes were made to allow for reporting of postoperative suture and/or staple removal, when appropriate. Code 15850 was deleted, and code 15851 was revised. In addition, two new add-on codes (15853, 15854) were established. This article provides an overview of the intent and use of these new codes.

Integumentary System

Other Procedures

?(15850 has been deleted. To report, use 15851) ?

s15851 Removal of sutures **or** staples requiring anesthesia (ie, general anesthesia, moderate sedation)

?(Do not report 15851 for suture and/or staple removal to re-open a wound prior to performing another procedure through the same incision)?

#??**15853** Removal of sutures **or** staples not requiring anesthesia (List separately in addition to E/M code)

?(Use 15853 in conjunction with 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350)?

?(Do not report 15853 in conjunction with 15854)?

#??**15854** Removal of sutures **and** staples not requiring anesthesia (List separately in addition to E/M code)

?(Use 15854 in conjunction with 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350)?

?(Do not report 15854 in conjunction with 15853)?

Removal of Sutures or Staples with Anesthesia

Stakeholder societies found unusual reporting of code 15851 during review of coding practices for reporting suture and/or staple removal for procedure codes with a 0-day global period. Code 15851 previously described removal of sutures or staples under anesthesia (other than local). The intent of this code was for reporting a facility-based procedure, but more than 80% of the Medicare claims were office-based. In response to possible coding confusion, code 15851 was revised to describe suture or staple removal specifically “requiring anesthesia (ie, general anesthesia, moderate sedation)” (eg, removal of sutures on the face of an infant). Code 15851 should not be reported for suture or staple removal requiring local anesthesia. In addition, code 15850 (suture removal “same” surgeon) was deleted, with a parenthetical note added to indicate that code 15851 should be reported. This change was made because it was determined that returning a patient to the operating room for a procedure, even within a global period, is separately reportable by any

surgeon, regardless of whether it is the same surgeon or a different surgeon who performed the index procedure.

Removal of Sutures or Staples Without Anesthesia

There was also a need to have codes to report practice expenses related to suture or staple removal for postoperative evaluation and management (E/M) visits after 0-day- global period procedures. For 2023, two new add-on codes (15853, 15854) were established for reporting suture and/or staple removal in conjunction with an E/M visit. These codes may be reported with an appropriate E/M service for any procedure that has a 0-day global period, and possibly for codes with XXX global period assignment if sutures or staples were placed. These new add-on codes do not have physician work relative value units (RVUs) assigned to them because they are practice expense (PE)-only (ie, clinical staff time, disposable supplies, use of equipment). Prior to 2023, there was no PE-only reimbursement code to report suture or staple removal at an E/M visit after a procedure with a 0-day or XXX global period assignment. Because codes 15853 and 15854 are add-on codes to be reported with an E/M code, no modifier should be appended to the E/M code.

Clinical Example (15851)

A 3-year-old male, who is status post-repair of multiple lacerations, now undergoes suture removal while under general anesthesia.

Description of Procedure (15851)

Cleanse area surrounding the wound(s) with normal saline or soak if crusting inhibits access to sutures. Remove sutures. Observe the wound line(s) for separation during the procedure. Obtain hemostasis with pressure as needed. Apply adhesive strips as needed.

Clinical Example (15853)

A 60-year-old male, who is status post-hernia repair of a 3- to 10-cm defect, undergoes removal of sutures during a separately reportable office or other

outpatient evaluation and management service. [**Note:** This is an add-on code. Consider only the work associated with removal of the sutures.]

Description of Procedure (15853)

Clean the area surrounding the wound(s) with normal saline or soak if crusting inhibits access to sutures/staples. Remove the sutures or staples. Observe the wound line(s) for separation during the procedure. Obtain hemostasis with pressure as needed. Apply adhesive strips and sterile dressings as needed.

Clinical Example (15854)

A 60-year-old male, who is status post-hernia repair of a 3- to 10-cm defect, undergoes removal of sutures and staples during a separately reportable office or other outpatient evaluation and management service. [**Note:** This is an add-on code. Consider only the work associated with removal of the sutures and staples.]

Description of Procedure (15854)

Clean the area surrounding the wound(s) with normal saline or soak if crusting inhibits access to sutures/staples. Remove the sutures and staples. Observe the wound line(s) for separation during the procedure. Obtain hemostasis with pressure as needed. Apply adhesive strips and sterile dressings as needed.

