Internal Medicine Coding Alert

Back to the Basics: 5 FAQs to Help You Accurately Code Suture Removals

Knowing the right answer could mean $35 in deserved payment

If you code for an internist and don't know how to report suture removals, you could soon find yourself in a bind. Review the following FAQs to get the lowdown on everything from E/M codes to modifiers to S0630.

Avoid Anesthesia Suture Codes

Question #1: Established patients frequently present to the office so our internist can remove sutures that an emergency department (ED) physician put in. Which CPT code can we use for this procedure?

Answer: Unfortunately, CPT doesn't offer a specific suture-removal code that applies to IM offices. The reason is that both CPT and Medicare consider suture removal a part of a minor surgical procedure's global package.

When a physician removes sutures while the patient is under anesthesia, you could report either 15850 (Removal of sutures under anesthesia [other than local], same surgeon) or 15851 (Removal of sutures under anesthesia [other than local], other surgeon). The catch: Internists rarely use anesthesia to remove sutures.

Best bet: You should report a low-level E/M (for example, 99212, Office or other outpatient visit for the evaluation and management of an established patient ... Physicians typically spend 10 minutes face-to-face with the patient and/or family), says **Lisa Barnes, CPC**, a coder with Fayetteville Diagnostic Clinic, an Arkansas multi-specialty practice that includes internists.

Depending on location, Medicare pays about $35 for 99212. If your internist wants to bill suture removal at a higher E/M service level, be sure to double-check the documentation.

How to Code Separate Problems

Generally, the medical documentation for suture removal supports only a low-level code like 99212. But if the removal is part of a visit for another problem, the suture removal is included in the E/M visit for the separate problem.

Example: A patient comes in to discuss changing his heart and blood pressure medication, have his blood pressure checked, and for a suture removal. If the physician appropriately documents the visit, you may be able to report 99213 or 99214.

Don't Count on Surgeons to Use -54

Question #2: Should we attach any modifiers to the E/M code?

Answer: No, says **Kathy Pride, CPC, CCS-P**, a coding consultant for QuadraMed in Port St. Lucie, Fla.

"If you are going to use the modifier for postoperative management of a procedure, the CPT guidelines state that you should use the same code as for the physician performing the procedure and you should append modifier -55 (Postoperative management only)," Pride says. "The physician performing the procedure should append modifier -54 (Surgical care only) to the procedure code"

For example, an emergency-department physician repairs a patient's minor laceration, and bills 12001-54 (Simple repair

of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; 2.5 cm or less).

Attaching modifier -54 informs the carrier that the ED physician performed only the repair. When the patient goes to your internist for suture removal, you'd report 12001-55.

"Generally, the performing physician who appends modifier -54 receives 85 percent of the reimbursement, and the physician providing the postoperative care and appending modifier -55 receives 15 percent of the reimbursement," Pride says.

Pitfall: Most physicians who perform the laceration repair do not attach modifier -54 because they assume that the patient will return for suture removal, Pride says. Not applying the modifier means the physician is billing the global procedure, so the payer will reimburse him for both the surgery and post-op care.

Payer Denied E/M? Try This

Question #3: When should we report S0630?

Answer: When the patient has a private carrier, such as Blue Cross Blue Shield, you may be able to report suture removal with S0630 (Removal of sutures by a physician other than the physician who originally closed the wound) as long as the insurer recognizes the code.

Double-check: Check with your insurer before submitting this code. If the carrier doesn't accept it, your best bet is an E/M code. Typically, Blue Cross Blue Shield and Medicaid pay for S0630 and other S codes, but Medicare does not.

Question #4: What's the appropriate ICD-9 code for sutures? Should we also specify the location?

Answer: For the primary diagnosis, you should list V58.3 (Encounter for other and unspecified procedures and aftercare; attention to surgical dressings and sutures). As the secondary diagnosis, be sure you use an ICD-9 code that specifies the laceration's site.

For instance, if a patient presents to have sutures removed from a cut on his ear, you would assign 872.0x (Open wound of ear; external ear, without mention of complication), coding experts say.

Global Package Includes Suture Removals

Question #5: My internist closed a 5-cm simple laceration on a patient's face. Six days later the patient returned for suture removal. Can we bill for the suture removal separately?

Answer: No, laceration code 12013 (Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm) has a 10-day global package, which includes one related E/M service and postoperative care, according to CPT guidelines.

This means that 12013 covers any suture-removal services your internist provides within those 10 days.