Codify
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# Internal Medicine Coding Alert

## Experts Explain Whether You Can Report Suture Removal

**Hint: Modifier 52 won't cure all of your coding woes**

Your suture-removal services can be payable, but you have to know the rules before you bill.

Specific codes for suture removal are rare, and insurers often bundle the procedure into the other services, so coding suture removal can make even the most seasoned internal medicine coder groan. Learn the basic coding options and the stitching scenarios that apply to your suture-removal claims.

**Option 1: Honor the original procedure's global; use no separate code**

**Scenario:** A patient had a laceration repair eight days ago for a 3-cm cut on her scalp. The original procedural code, 12002 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; 2.6 cm to 7.5 cm), already includes the suture removal.

Laceration repair codes (12001-13153) that would require a suture removal have a 10-day global period. So if the patient returns within that global period, you can't report the suture removal separately because it's already a part of the global service.

Other procedures that involve suture removal include major surgeries, which carry a 90-day global, so for any other occasion, you wouldn't typically consider reporting the suture removal separate from the primary procedure.

**Tip:** You can't report it to your payer, but 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason[s] related to the original procedure) is valid for suture removal and is good for tracking.

Although it has zero reimbursement, you can use 99024 to keep track of visits for utilization purposes to show that the patient did present for a follow-up visit within the surgical period.

**Option 2: Report 15850 or 15851**

Another common coding snag is when staff members try to report 15850-15851 for simple suture removals that don't involve anesthesia.

CPT reserves codes 15850 (Removal of sutures under anesthesia [other than local], same surgeon) and 15851 (Removal of sutures under anesthesia [other than local], other surgeon) for patients who go under general anesthesia for suture removal. General internists would not use these codes, but specialists who offer more surgical services may consider using them.

**Example:** A physician used sutures to treat a patient's wound, but skin has grown over the sutures, requiring a complex suture removal.

**Common mistake:** Don't consider a modifier to stretch these codes to cover non-anesthesia suture removals. Some people will put modifier 52 (Reduced services) on 15850 or 15851. "This doesn't work because the anesthesia is the main component of the code--either you're doing it under general anesthesia or you're not performing the work described by the code," says **Barbara J. Cobuzzi, CPC, CPC-H, CPC-P, CHCC,** president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J.

Because internists would not use general anesthesia to remove sutures, you should never report the 15850-15851 series--with or without modifier 52--for your suture removal services.

**Option 3: Incorporate into the appropriate E/M**

**Scenario:** If the original physician removes the patient's sutures after the global period of the original procedure, you can incorporate the suture removal into your E/M visit. This coding scenario also applies when the internist who removes the sutures is not the original operating physician.

"Because there is not a CPT code for a simple suture removal, when we remove any sutures in the doctor's office or in our urgent care, we use the appropriate level of E/M based on the entire service provided to the patient at that visit," says **Ronda Scalise,** medical biller at Premier Medical Group Inc. in West Virginia.

**Example:** A 60-year-old patient gets a large cut on his hand while on an out-of-state vacation and must visit the local emergency department for suturing. The emergency doctor reports 12044 (Layer closure of wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm), but the patient returns to his home state the next day, and the original physician cannot perform the suture removal.

"Removal of sutures by other than the operating surgeon may be coded as a level of E/M service if the suture removal is the only postoperative service performed," according to the Spring 1992 CPT Assistant.

**How:** The patient's hometown physician should report a low-level E/M depending on the medical necessity for the suture removal. This office visit would most likely not warrant a higher E/M because the history, exam and medical decision-making are minimal for suture removal. However, documentation supporting the suture removal and the proper level of E/M service should accompany
the claim.

**Pitfalls: The Problem With Modifiers 54 and 55**

When one physician places sutures and you remove them, you may be tempted to use modifier 55 (Postoperative management only). The modifier is not correct in this situation.

**How it works:** CPT 2006 recommends modifier 55 to identify the postoperative management when a different physician performs the surgical procedure.

It may sound like the perfect answer to a situation in which an emergency physician applies the sutures and the patient's internist removes them, but this method is difficult for carriers to track. Why? If you append modifier 55 to the original procedural code, the emergency physician has to use modifier 54 (Surgical care only) on the same code.

**Example:** A patient was injured in a car crash, and the emergency physician does a complex laceration closure onthe patient's face and arm.

The physician reports 13132 (Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm) for two wounds on the forehead and cheeks, and 13121 (Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm) for arm lacerations. The doctor then tells the patient to follow up with her personal physician at your practice.

The doctor performing the emergency surgery could use modifier 54 on these codes because he's only doing the surgical care, but in reality, most physicians would not do so. Because it would be very difficult to coordinate laceration repair coding with an emergency department physician, using modifiers 54 and 55 for this type of situation is unrealistic.

**Bottom line:** You can't disagree with the official commentary from the AMA, which clearly indicates that a suture removal should be incorporated into the E/M.

**Tip:** When you remove a patient's sutures, you can link the visit to ICD-9 code V58.3 (Attention to surgical dressings and sutures).