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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Don't Let Suture Removal Coding Get You In a Stitch

See why using a 52 modifier on 15850 and 15851 is not a valid option

Reporting suture removal procedures is tricky--especially since specific codes for this service are few and far between. Learn the basic coding options and the stitching scenarios that apply.

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

Scenario: This method is for situations where the patient's original procedure has a global period that covers a suture removal by the same physician.

Example: Suppose a patient underwent a laceration repair eight days ago for a 5cm cut on her scalp. The original procedural code, 12032 (Layer closure of wounds of scalp, axillae, trunk and/or extremities [excluding 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," points out **Linda S. Templeton, CPC**, coding consultant for **The Rybar Group, Inc**. in Fenton, MI. So if the patient comes in 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, Templeton explains. "So for any other occasion, you wouldn't typically come across a scenario where you would 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 covering suture removal and is good for tracking. Although it has a zero charge, you can use 99024 to keep track of visits for risk management purposes to show that the patient did present for a follow-up visit within the surgical period, Templeton says.

Option 2: Report 15850 or 15851.

Scenario: CPT reserves codes 15850 and 18581 for patients who go under general anesthesia for suture removal.

Example: A patient received sutures for a serious wound, and skin has grown over the sutures, requiring a complex suture removal.

A suture removal under general anesthesia is one of the rare cases in which you can report a separate CPT code. Two valid CPT codes exist that involve no other surgeries but the suture removal: 15850 (Removal of sutures under anesthesia [other than local], same surgeon) and 15851 (Removal of sutures under anesthesia [other than local], other surgeon).

Common mistake: If you're looking for a modifier to stretch these codes to cover non-anesthesia suture removals, you're out of luck. Many people will try to put a 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 doing the code," explains **Barbara J. Cobuzzi, CPC, CPC-H, CHBME**, president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, NJ.

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Option 3: Incorporate into the appropriate E/M.

Scenario: This coding method works if the original surgeon removes the sutures after the global. It also applies when the doctor removing the sutures is not the original operating physician.

Example: Suppose a Medicare patient gets a large cut on his hand while on an out-of-state vacation and must visit the local ER for stitches. The ED doctor reports 12044 (Layer of closure of wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm), but the patient is returning to his home state the next day and can't have the sutures removed by the same physician.

"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," says the Spring 1992 issue of the American Medical Association's CPT Assistant.

How: "The patient's primary care physician should report a low-level E/M, such as 99212, for removing the sutures," Templeton recommends. This office visit would most likely not warrant a higher E/M because history, exam and medical decision-making are minimal for suture removals. However, documentation reporting the suture removal and supporting the proper level of E/M service should accompany the claim, Templeton says.

Another way: In complex cases, such as multiple lacerations, you may be able to reflect your suture removal in a prolonged service E/M, such as 99212 +99354, points out **Eric Sandhusen**, director of reimbursement, HIPAA and fiscal compliance for the **Columbia University Department of Surgery** in New York, NY. But this procedure must add on at least another 40 minutes to the E/M.

Option 4: Report 46754.

Scenario: Use this anatomically specific code only for removing sutures from the anal canal.

Example: A patient who has undergone a hemorrhoid procedure or a fistula repair and must have a Thiersch wire removed from his or her anal canal.

You would report 46754 (Removal of Thiersch wire or suture, anal canal) as its own procedure.

Fact: Other than 15850 and 15851, this code is the only other code where CPT will let you report a suture removal under a procedural code by itself.

Pitfalls: The Problem With Modifiers 54 and 55

When a different physician removes sutures than the one who placed them, you may be tempted to use a modifier 55 (Postoperative management only). The modifier isn't necessarily incorrect, but tread with caution: It may get you into some coding quagmires if you're not careful.

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

It may sound like the perfect answer to a situation where an ED physician applies the sutures and the patient's primary care physician in your office removes them--but this method is difficult for carriers to track. Why? If you append modifier 55 to the original procedural code, then the ED physician has to use modifier 54 (Surgical care only) on the same code (see the Medicare Carriers Manual 4281).

Example: A patient had an out-of-town car accident, and the ED physician does a complex laceration closure on the patient's face and arms.

The physician reports 13132 (Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6-7.5 cm) for 2 wounds on the forehead and cheeks, 13121 (Repair, complex, scalp, arms, and/or legs; 2.6 to 7.5 cm)

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and 13122 (...2.6cm to 7.5 cm) for lacerations on an arm. The doctor then tells the patient to follow up with her primary care physician. The doctor performing the ER surgery can use modifier 54 on these codes since he's only doing the surgical care, but the primary care physician should use modifier 55 on the same codes for the suture removal.

And you need to get the physicians to form an agreement on the coding and transfer of care, Cobuzzi emphasizes. If this is too difficult to coordinate, the primary care physician can choose to report the appropriate E/M codes instead.

Best bet: "I would only recommend using modifier 55 if you're on sufficiently congenial terms with the ED physician to be sure that he will use modifier 54, Sandhusen says. And be sure to use the date you first see the patient as the "from date" and the end of the global period for the "end date," he adds.

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," Sandhusen remarks.

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