Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Get Suture Removal Pay Without Using a Procedure Code

4 coding tips you should implement

You can correctly report suture removal if you choose your code based on which practitioner placed the sutures, and how your payer views this service.

No CPT code exists for suture removal. You should therefore code the procedure based on the following four expert guidelines:

1. Use a Post-Op Code When the Physician Performs Global

You shouldn't separately bill suture removal when you also place the sutures. Laceration repair codes contain 10 days of related postoperative care, says **Imelda Y. Lee, RHIA,** coding specialist at the **University of Texas Health Science Center**'s pediatrics department in San Antonio. So the repair code's global package includes suture removal.

Example: Your physician places sutures to close a 3-cm simple laceration on a 10-year-old boy's upper arm. Eight days later, the boy presents for suture removal. You should use a different CPT code for the suture removal than you reported when the physician placed the sutures. On day one, when the physician repaired the laceration, you reported 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) linked to 880.03 (Open wound of shoulder and upper arm; without mention of complication; upper arm).

Don't be tempted to reuse 12002 for the suture removal. Code 12002 includes the suture removal postoperative care. But you still want to record your work.

Better way: To track the follow-up care without triggering a payment, you should use the post-op follow-up visit code 99024 (Post-op follow-up visit, normally included in the surgical package ...) with V58.3 (Attention to surgical dressings and sutures). The code tells the insurer that you performed suture removal as part of the laceration's global surgical package.

Rule: You should report 99024 for suture removal when the physician who removes the stitches:

1. also performed the suture removal, or
2. is in the same group practice as the physician who placed the sutures.

2. Bill E/M for Different Physician Placement, Removal

However, you should bill suture removal when you or another physician in your group didn't place the stitches. But reporting the procedure is tricky.

No CPT code exists for suture removal because the laceration repair code includes both the placement and the removal, Lee says. "The physician group that placed the sutures is supposed to see the patient postoperatively." But a physician will often perform only the placement.

Modifier -55 Unlocks Suture Removal Pay

Scenario: A woman presents at her physician's office for suture removal. An emergency department (ED) physician had

placed the sutures to close the woman's intermediate 2.4-cm forehead gash (12051, Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less), but the woman had not wanted to wait in the ED to have the sutures removed. In this case, the ED physician would ideally append modifier -54 (Surgical care only) to his suture placement code. A patient usually won't return to the ED for suture removal, Lee says. "Appending modifier -54 to the laceration code (12051) would indicate that the physician is not overseeing the postoperative care."

If the ED physician uses modifier -54, the postoperative care could remain unclaimed. "The physician who removes the sutures could then receive partial payment for suture removal," Lee says. In this case, you would append modifier -55 (Postoperative management only) to the laceration code (12051) to indicate that you are billing the postoperative care only.

Reality: The original physician will most likely not append modifier -54 to the laceration code. "He will probably bill for the whole 10-day global package," Lee says. So if you report the suture removal with the laceration code (12051), the insurer will deny the procedure as duplicative.

E/M Is a Realistic Alternative

Tip: You can avoid double-dipping for the repair if you instead code an E/M service for the suture removal.

In the ED scenario, you should use the appropriate office visit code (99201-99215, Office or other outpatient visit for the evaluation and management of a new or established patient ...) to report the physician's suture removal.

Link the E/M service with V58.3 (Encounter for other and unspecified procedures and after-care; attention to surgical dressings and sutures [removal of sutures]) as the primary suture removal diagnosis and 873.42 (Other open wound of head; face, without mention of complication; forehead) as the secondary diagnosis, Lee says. "You may use these codes because the physician who removed the sutures never took part in placing the sutures."

3. Try S0630 for E/M Rejections

Because some insurers deny an office visit with V58.3, you may have to resort to alternative coding for suture removal.

For these payers, you should try using a HCPCS code. Blue Cross Blue Shield created "S" codes to report drugs, services and supplies for which no national code exists. One of the S codes describes suture removal: S0630 (Removal of sutures by a physician other than the physician who originally closed the wound).

You may use S0630 for Blue Cross Blue Shield. "We started billing S0630 to Blue Cross Blue Shield, and they have paid," says **April Mariniello,** billing specialist at the eight-pediatrician **North Raleigh Pediatric Group** in Raleigh, N.C.

Some Medicaid programs, such as Colorado Medicaid, may also recognize S0630. To improve your suture removal reimbursement, make sure to track payment when you report E/M codes with V58.3.

Here's how: Run a system report of your E/M code with V58.3 use. For insurers that denied your E/M service, try billing S0630 and track the results, Mariniello says.

Be careful: Treat S0630 the same as billing 99201-99215 for suture removal. "Only use S0630 when a [physician] removes sutures that a [provider] not in your practice placed," Mariniello says. You'll usually encounter this scenario when an ED physician or urgent-care clinic physician placed the sutures.

4. Submit 92211 for Nurse Removal

But how should you code when a nurse removes sutures that a physician outside your practice placed? "Often, a nurse will perform straightforward suture removal," says **Richard Tuck, MD, FAAP,** pediatrician at **Prime Care of Southeastern Ohio** in Zainesville.

Method: Report 99211 with V58.3. "Make sure the nurse documents an interval history and E/M," Tuck says.

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