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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Test Your Suture Removal Savvy With 5 Expert Q&A's

There's no specific suture removal code, but that doesn't mean you can't bill for the service

If you're not reporting your physician's suture removals in certain tricky cases, you're probabaly denying your office legitimate reimbursement.

See if you need to remove any unnecessary binds from your suture coding practices by studying these frequently asked suturecoding questions:

Remove Sutures With an E/M

Question #1: Established patients frequently present to the office so our physician 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 physician 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:** Physicians 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 ...), says **Lisa Barnes, CPC**, a coder with **Fayetteville Diagnostic Clinic**, an Arkansas multispecialty practice. This would be a problem-focused visit, notes **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME**, president of **Cash Flow Solutions, Inc.** in Brick, NJ.

Medicare pays approximately $35 for 99212. If your physician wants to bill suture removal at a higher E/M services level, be sure to double-check the documentation.

Add Suture Removal Into Separate Problem E/M

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.

Consider Care and Management Modifiers -54 and -55

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, FL.

"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), which has a 10-day global package.

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

"Generally, the performing physician who appends modifier -54 receives 80 percent of the reimbursement, and the physician providing the postoperative care and appending modifier -55 receives 10 percent of the reimbursement," Pride says. (The remaining 10 percent is for pre-operative care, reported with modifier -56 [Preoperative management only].)

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.

Try S0630 Instead Of E/M

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 and a different physician than the one who put in the sutures removes them.

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 some Medicaid programs 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.

Check Global Period Before Billing Suture Removal

Question #5: My physician 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 physician provides within those 10 days.