Eli's Rehab Report

Reader Question: You Can Bill Suture Removal Sometimes

Question: Our physiatrist saw a patient in rehab following knee surgery and removed the patient's sutures. I know this would be part of the global period if we had performed the surgery, but because we did not, can we bill for the suture removal?

Ohio Subscriber

Answer: Assuming that you removed the sutures in the office, you should report the procedure with the appropriate office visit code (99201-99205, New patient; 99211-99215, Established patient).

In your case, the suture removal was a small part of what was probably a comprehensive rehab visit. But if the patient came to your practice strictly so you could remove her sutures, you should report the diagnosis code V58.3 (Encounter for other and unspecified procedures and aftercare; attention to surgical dressings and sutures) because no other problems existed.

Do not report 15850 (Removal of sutures under anesthesia [other than local], same surgeon) or 15851 (Removal of sutures under anesthesia [other than local], other surgeon) because these codes clearly indicate that you administered general anesthesia, which requires a trip to the operating room.

Reporting these codes in the office, even with modifier -52 to indicate reduced services, represents a difference in the expected site of service and will probably result in a denial for this reason. Regardless of whether a payer reimburses this way, CPT intends these codes for postsurgical procedures requiring general anesthesia and not simple in-office suture removals.