Suture Removal

May 1, 2014

Question:

We had a patient come into our office to have their sutures removed from a facial laceration repaired by someone else. The patient was hurt while on vacation and couldn’t have the sutures removed while away. The problem is the patient is still in the global period from the repair performed by another physician. How can I report this work? Or is it not billable since the patient came into our office during the other physician’s global period?

Answer:

Billing for suture removal depends on several factors. Technically, suture removal is included in the intermediate and complex repair codes (but not in the simple repair codes so you can always bill for suture removal). Ideally, the physician who placed the sutures would have reported the intermediate or complex repair code with modifier 54 (surgical care only) so you would report the same surgical CPT code with modifier 55 (postoperative management only). But we know this rarely happens!

There isn’t a CPT code for suture removal in the office setting. There are codes to report removal of sutures under anesthesia (other than local) for either the same surgeon (CPT 15850) or other surgeon (15851). Therefore, your work is captured through whatever Evaluation and Management (e/m) code you will report.

Remember to document appropriately to support the e/m code reported. The three key components for an e/m service are history, exam and medical decision making. A new patient e/m code requires 3 of 3 key components meet the same level and an
established patient e/m code requires 2 of 3 key components meet the same level. *See CPT Evaluation and Management Services Guidelines for official rules and guidelines for reporting office and other outpatient services.

ICD-9-CM = V58.32 Encounter for removal of sutures with code for the injury.

ICD-10-CM = Z48.02 Encounter for removal of sutures with code for the injury.