Internal Medicine Coding Alert

Reader Question: Report Appropriate E/M for Suture Removal by Another Physician

Question: We recently had a patient coming into our practice to meet our family physician for removal of sutures. The patient got the sutures from another physician when he was rushed to the emergency department after a fall that he sustained about a week back. Since our clinician is his family physician, the patient decided to meet him for the removal of the sutures. How do we code the visit?

Colorado Subscriber

Answer: Under general circumstances, if your family physician was removing sutures that he had himself previously placed, you cannot claim separately for the suture removal, as it will be part of the global service that resulted in placement of the sutures. The code for suturing a wound (see 12001-13160) typically has a 10-day global period, and payment received for the placement of the sutures will include suture removal within that period, so no separate payment for the removal can usually be claimed.

However, in this instance, since your family physician is removing sutures that another physician placed, you can claim for the service provided by your clinician. To do so, you will use an appropriate E/M code. In this case, since the patient is already established with your physician, you will choose to report an appropriate level of established patient, outpatient E/M code (e.g. 99212) for the visit to your practice.

Caution: If the physician in the emergency room was also a family physician from the same group practice as your physician and both physicians bill under a group provider number, the patient's insurance may consider the situation no different than if one physician had provided both services. In that case, the payer may consider the visit for removal to not be separately payable.

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