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85060 vs. Clinical Consultation Charges (80503, 80504, 80505, 80506)

Peripheral smear interpretations and clinical consultations are two separate services. If an encounter qualifies as 85060, no clinical consultation charge would be billed for that encounter.

The most obvious difference between these CPT® codes is that a consultation charge is only billed if a request is received by the attending physician in reference to significantly abnormal test results, and the request must be documented as such in the medical record. This request can be made verbally, electronically, or written, but it must be documented. Standing orders are not accepted.

The requirements for billing consultation charges are as stringent as they were with the now deleted codes 80500 and 80502, in that (per AMA) they must:

1. be specifically requested in writing by the patient's attending physician;
2. relate to an abnormal test result that requires medical judgement by a physician (M.D. or D.O.);
3. result in a written narrative report that's posted to the patient's chart; and
4. require the exercise of medical judgment by a pathologist, rather than a laboratory scientist, technologist or technician.

What to look for:

85060	80503 (or other consult code)
Initial peripheral blood smear interpretation is requested from clinician.	Peripheral blood smear with abnormal result is sent to pathologist for consult, with review of other pieces of patient medical history.
Report does not include documentation of a requested consult from a previously interpreted peripheral blood smear.	A request is received and documented on the report to review the peripheral blood smear as a result of abnormal test results.
Interpretation does not include review of any additional medical information (ie, EMR)	Other pieces of medical record are also reviewed; for example, anything in the EMR, previous blood smear interpretations, etc.

Should you have any questions, please contact your APS Practice Manager.

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