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Requirements for Billing Peripheral Blood Smears vs. Clinical Consultation Charges

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

A key difference between these CPT® codes is that unlike a peripheral blood smear, a consultation charge is only billed if a request is received from the attending physician in reference to a previously resulted, significantly abnormal test result. The request must be documented as such in the medical record and can be made verbally, electronically, or written, but it must be documented in the report. Standing orders are not accepted.

Peripheral Blood Smear Review (CPT 85060):
This code applies to a pathologist interpretation of an atypical, abnormal, or otherwise suspect peripheral blood smear. This service cannot be billed under clinical pathology consultation codes 80503-80506. If a peripheral blood smear is evaluated as part of a larger clinical consultation service, the applicable consult code could be reported.

Pathologists evaluate peripheral blood smears in response to:

1. Patient's attending physician asks for an interpretation of the smear.
2. Technologist notices an anomaly and asks for an interpretation of the smear.
3. Blood count instrument flag or abnormal parameter is observed during screening of a manual smear, and the pathologist must intervene to evaluate it.

A written report must be documented in the patient's record to support the charge of 85060. The report must demonstrate exercise of medical judgement ("agree with technologist" or "reviewed" is not a valid interpretation for billing support purposes).

The national coverage limitation by Medicare and Tricare is still in effect: The code 85060 may be billed to the program, program beneficiary, or a secondary insurer *if and only if* the place of service is 21 (patient was registered as an inpatient of a hospital at the time the blood was drawn). For any other service location, the charge must be written off. *Substitution of another CPT code like 80503 to get around this policy would be subject to challenge as a false claim.*

Billing Clinical Consultations (CPT 80503-80506):
It is inappropriate to report 80503-80506 for a service that is more accurately described by another, more specific CPT code (like 85060). There are 4 parts to the coverage criteria required by Medicare that must be met to support billing charges 80503-80506.

1. Must be specifically requested in writing by the patient's attending physician. These charges cannot be met by a standing order, they must be requested per patient. The written request must be recorded in the medical record (a phone request, electronic request, etc. can be accepted as long as it is documented specifically in the medical record).

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2. Must relate to an abnormal test result that requires medical judgement by a physician. The referenced test must already be resulted and shown to lie outside the clinically significant normal or expected range.
3. Must result in a written narrative report that is included in the patient's chart. It is important to note the review of the pathologist must be documented as a "consultation" and not as an "interpretation" or "review." The entry cannot simply say "agree with tech" or "elevated test result." Note: If code selection is based on time, this must also be included in the report.
4. Must require the exercise of medical judgement by a pathologist, rather than a lab scientist, technologist, or technician. The report must express a medical opinion and demonstrate the exercise of medical judgement. Again, the entry cannot simply say "agree with tech" or "elevated test result."

Example verbiage which supports billing a consultation:
A request for consultation was received from Dr (name) on (date) to review (abnormal test result) along with (EMR/other medical history reviewed).

The rules for billing 85060 and consultation charges have not changed; this document is intended to help clarify the correct billing codes for the work being done.

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