

## Consultations

Medicare has specific guidelines on what is and what is not a consultation. Wisconsin Physicians Service (WPS) Medicare is responsible for correct payment of claims. The Comprehensive Error Rate Testing (CERT) program shows an increase in payment errors on consultations from 29 to 37. The WPS Medicare Medical Review (MR) Department is looking at data on consultation services.

The *Common Procedure Terminology (CPT)* book defines a consultation as a “type of service provided by a physician whose opinion or advice regarding an evaluation and/or management of a specific problem is requested by another physician or appropriate source.”

This definition shows that the requesting physician (physician or non-physician practitioner) is asking another physician who has more expertise or knowledge of a particular area for his/her opinion on the treatment needs of the patient. The requesting physician anticipates continuing to treat the patient condition. The documentation includes the request for the consultation from the originating physician, the need for the consultation, and a written report back to the referring physician.

A consultation is different from a referral or transfer of care. When the originating physician determines another office or specialty is better equipped to treat the patient’s condition, this is a referral or transfer of care. The originating physician is not asking for advice or an opinion; he or she is referring the patient to the second physician for treatment. The originating physician does not anticipate continuing to treat this condition. In this case, the performing physician bills the services using a new or established patient code as appropriate.

A referral may also have a written request, and the performing physician may respond to the originating physician as a courtesy. However, Medicare will look for documentation to support the request for advice or opinion and will look for the intent of the originating physician.

Documentation must support the use of the consultation procedure codes. The documentation includes the request for the consultation from the originating physician, the need for the consultation, and a written report back to the referring physician. In addition, the documentation must meet the requirements for Evaluation and Management (E/M) services.

There are three applicable situations.

- The originating physician is unsure of how to treat the problem. The originating physician requests someone with expertise in the patient’s condition (the performing physician) to look at the patient and provide his/her advice and opinion on treatment. The originating physician then treats the patient’s condition. In this case, the performing provider may bill a Consultation.
- The originating physician knows the patient has a problem and he/she is not the best choice to treat the problem. The originating physician asks the expert (performing physician) to treat the patient’s condition. The performing provider does not provide a Consultation since he/she assumes responsibility for the problem. He/she has a new or established patient visit.
- The originating physician asks the expert their advice or opinion on treating the patient. Once the originating physician hears that advice, he/she determines the expert is the better choice to treat the patient’s condition. In this case, the expert provides a Consultation followed by treatment.

The performing physician may initiate diagnostic tests to determine the patient's condition. This does not preclude billing a Consultation.

We are asking the provider community to perform a self-audit on their internal processes for submitting consultation services. Documentation must support the use of the consultation code billed and the medical necessity of the service. Our Webpage [http://www.wpsmedicare.com/part\\_b/education/consult\\_resources.shtml](http://www.wpsmedicare.com/part_b/education/consult_resources.shtml) provides resources WPS Medicare has available for your use in performing the self-audit.