



## CONSULTATIONS - QUESTIONS AND ANSWERS

- 1. The physician has admitted the patient to a palliative care unit in the hospital or nursing facility. Can the palliative care physician, responsible for the care of the patients in that unit, bill for a consultation?**

The admitting physician is not requesting the advice, opinion, suggestions etc. from the palliative care physician. The palliative care physician can bill for a new or subsequent patient visit code as appropriate. The Centers for Medicare & Medicaid Services (CMS) has published information on consultation services. You can find this information in the Internet-Only Manual (IOM) 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.10. Please see the reference below:

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

- 2. The patient's attending physician suggested a patient make an appointment with a specialist. The attending physician and the specialist have not had any contact, either verbal or written, concerning this patient's care. The specialist will send a written report to the attending physician. Is this a consultation?**

No. The attending physician is not requesting the advice, opinion, suggestion etc. from the specialist. The specialist does not have any documentation indicating a request from the attending physician. While it is good medical practice for the specialist to share his/her findings with the attending physician for continuity of care, this does not make the service a consultation. The specialist should bill an initial or subsequent care visit as appropriate.

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- 3. What is Medicare's definition of a specific problem?**

As the term relates to consultation services, "specific problem" should address the medical reason for the request for advice. The CMS IOM 100-04, Chapter 12, Section 30.6.10 states a consultation service is distinguished from other evaluation and management visits because it is provided by a physician or qualified Non-Physician Practitioner (NPP) whose opinion or advice regarding evaluation and management of a specific problem is requested by another physician or appropriate source.

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

- 4. Can a physician bill a consultation for preoperative clearance when the patient does not have a diagnosis other than needing clearance for surgery?**

As stated in CMS IOM 100-04 *Claims Processing*, Chapter 12, Section 30.6.10, Section G: Preoperative consultations are payable for new or established patients performed by



any physician or qualified non-physician practitioner (NPP) at the request of the surgeon, as long as all of the requirements for performing and reporting consultation codes are met and the service is medically necessary and not routine screening.

If the services provided are clearance for surgery, then the physician must document the findings of the evaluation and management examination in the patient's medical record. As directed by CMS, Carriers pay for a reasonable and medically necessary consultation. According to Pub 100-4, Ch. 12, Section 30.6.10 indicates the surgeon must request opinion or advice of the physician regarding evaluation and/or management of a specific problem. In the scenario outlined in the question above, bill the diagnosis for the reason for the request, or the reason for the surgical procedure. Bill the appropriate office consultation codes (CPT 99241-99245) or initial inpatient consultation codes (CPT 99251-99255.) The reason for the consultation must be evident in the consulting physician's written report and in the request from the referring physician. REFERENCE: *Consultations*; IOM Pub 100-4, Ch. 12, Section 30.6.10

**5. Does a consulting provider need to have written documentation requesting the consultation in order to qualify the visit as a consultation?**

Yes. The request for advice and/or opinion may be written, verbal or in shared medical records. A written request is a letter or e-mail from the requesting physician to the performing physician. A verbal request is a conversation between the physicians or the office staff. Both offices must document this verbal conversation in the patient's medical records. Shared medical records include both facility and medical group records. There must be a mechanism to determine the request and the nature of that request. A notation of "have Dr. Smith see the patient" or "have cardiology see the patient" is not sufficient. A written report shall be furnished to the requesting physician or qualified NPP. In shared medical records, the consultation report is a separate document communicated to the requesting physician or qualified NPP.

**6. Can physicians and nurse practitioners combine documentation to bill a higher level of service for a consultation?**

No. According to the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Pub. 100-4, Chapter 12, Section 30.6.10, a consultation shall not be performed as a split/shared evaluation and management visit. If the service is shared or split between the practitioners, it is an initial or subsequent care visit as appropriate.

**7. Does the statement "transfer of complete care" from the National Coverage Provision (NCP) policy PHYS-006, Consultations, mean transfer of complete care of a specific problem (e.g. eye disease)?**

Per 30.6.10 B, a transfer of care occurs when a physician or qualified NPP requests that another physician or qualified NPP take over the responsibility for managing the patient's **complete care for a condition** and does not expect to continue treating or caring for the patient for that condition. When this transfer is arranged, the requesting physician or qualified NPP is not asking for an opinion or advice to personally treat this patient and is not expecting to continue treating the patient for the condition. The receiving physician or qualified NPP shall document this transfer of the patient's care in the patient's medical record or plan of care. In a transfer of care, the receiving physician or qualified NPP



would report the appropriate new or established patient visit code according to the place of service and level of service performed, and shall not report a consultation service.

(Please note: PHYS-006 is only available to Illinois, Michigan, Minnesota, and Wisconsin providers.)

- 8. If the statement "transfer of complete care" from the National Coverage Provision (NCP) policy PHYS-006, Consultations, mean transfer of complete care of a specific problem (e.g. eye disease), does that mean that the initial visit of all cases that are referred to, for example an ophthalmologist, would be a consultation?**

No. The referral of a problem for management, or "transfer of care," is different from a consultation. A provider may choose to refer a patient to another appropriate provider therefore, transferring complete care for evaluation and ongoing treatment of a specific problem. A transfer of care occurs when a physician or qualified NPP requests that another physician or qualified NPP take over the responsibility for managing the patient's complete care for the condition or problem; does not expect to continue treating or caring for the patient for that condition and is referring the patient to a physician who is better prepared to manage that particular issue or problem.

At that time, the receiving provider must accurately bill the correct level of a new or subsequent patient visit. In a consultation, the requesting provider is looking for the consulting provider's professional opinion to determine the best course of treatment for the requesting provider's patient. The requesting provider will order a consultation, document the need for the consultation, and expect a written report from the consultant. Only under those circumstances, with documentation supporting the three components of a consultation per IOM 100-4 Chapter 12, Section 30.6.10 would the initial visit be a consultation.

(Please note: PHYS-006 is only available to Illinois, Michigan, Minnesota, and Wisconsin providers.)

- 9. Is only one consultation code per provider/specialty allowed per patient, per hospitalization? In the case of a trauma patient who is hospitalized for an extended period of time, is it appropriate (for a provider who bills an initial consultation then does not follow the patient, but is consulted again at a later date) to bill a subsequent initial consultation?**

The Inpatient Consultation may be reported only **once** per consultant per patient per facility admission. Report any follow-up care using the Subsequent Hospital Care codes. Effective January 1, 2006, the follow-up Inpatient Consultation codes (99261-99263) are deleted. In the nursing facility setting, following the initial consultation service, report the Subsequent Nursing Facility (NF) Care codes (new CPT codes 99307-99310.) Effective January 1, 2006, CPT codes 99311-99313 were deleted and not valid for Subsequent NF visits. In addition, effective January 1, 2006, the Confirmatory Consultation codes (99271-99275) were deleted. Please remember, Medicare views physician in the same group with the same specialty as the same person.



**10. Where in Medicare policy or in the CMS Internet-Only Manual is the definition of "appropriate source"?**

Upon further research, there is no definition of "appropriate source" in the manual or policy. Any Medicare eligible provider acting within his/her scope of practice and involved in the care and treatment of patients within that scope, is an appropriate source in seeking advice from a specialist or expert in the care and treatment of the patient.

**11. In regard to consultations, is a copy of the consulting physician's note sent to the requesting physician, sufficient documentation to satisfy the consultation criteria that states "a written report from consulting physician to the referring physician?"**

After a consultation is completed, provision of a copy of the consulting physician's note to the referring physician can satisfy the Medicare requirement of a written report from the consulting physician to the referring physician. The consulting physician's note however, must contain the referring physician's name, and evidence that the referring physician requested both the consultation and the consulting physician's opinion. The report must also contain the advice and/or opinion concerning the patient's condition. A telephone communication, alone, from the consulting physician will **not** satisfy the requirement. There must be a **written** report from the consultant. (In addition, all the additional criteria for a consultation that have been set forth in IOM 100-4 Chapter 12, Section 30.6.10, must be met.)

**12. What are the requirements for consultations in a hospital setting?**

The Centers for Medicare & Medicaid Services (CMS) Medicare Claims Processing Manual (Publication 100-4), Chapter 12, Section 30.6.10 (F) states: Documentation for Consultations: A written request for a consultation from an appropriate source and the need for a consultation must be documented in the patient's medical record. The initial request may be a verbal interaction between the requesting physician and the consulting physician; however, the verbal conversation shall be documented in the patient's medical record, indicating a request for a consultation service was made by the requesting physician or qualified NPP.

The reason for the consultation service shall be documented by the consultant (physician or qualified NPP) in the patient's medical record and included in the requesting physician or qualified NPP's plan of care. The consultation service request may be written on a physician order form by the requestor in a shared medical record. The performing provider must furnish a written report to the requesting physician or qualified NPP.

In an emergency department or an inpatient or outpatient setting in which the medical record is shared between the referring physician or qualified NPP and the consultant, the request may be documented as part of a plan written in the requesting physician or qualified NPP's progress note. An order in the medical record may consist of an appropriate entry in the common medical record.

REFERENCE: IOM Pub. 100-4, Chapter 12, Section 30.6.10.



**13. Clarification from CMS regarding Consultation documentation: must there be documentation by both the referring physician and the consultation in the patient's medical record?**

- A request for a consultation from an appropriate source and the need for consultation (i.e. the reason for a consultation service) must be documented by the consultant in the patient's medical record and included in the requesting physician or qualified NPP's plan of care in the patient's medical record; and
- After the consultation is provided, the consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician. REFERENCE: IOM Pub 100-4, Chapter 12, Section 30.6.10 (A)

**14. What if the receiving physician does not accept the transfer of care?**

**Example: A primary care physician sends a patient to an endocrinologist due to uncontrolled diabetes and asks the endocrinologist to assume the care of the diabetes. The endocrinologist evaluates the patient, sends back his report and recommendations, but also sends the patient back to his primary care physician and does not formally accept the transfer of the patient's care.**

Because the intent of the request is not for advice or opinion, the endocrinologist has a new or subsequent patient visit code as appropriate. A physician can determine those patients they will and will not accept. However, the intent of the visit and not the outcome determine whether a service is a consultation.

**15. When a facility performs a self-audit and identifies concerns, can they just go forward with doing consultations according to the guidelines?**

We encourage you to perform a self-audit on billing consultation services. If you identify errors, please use the voluntary refund form on our Website to refund any incorrect payment amounts and then make any changes in your billing from that point on.

**16. Twelve general internists work in the same medical group practice. General Internist A performs a pre-operative consultation for advice and opinion regarding management of hypertension in the pre-operative, intra-operative, and postoperative period. This pre-operative consultation service may occur one week prior to admission for the surgery (i.e., as an outpatient) or on the day of admission to surgery (i.e., as an inpatient). Does that fact matter? At two o'clock in the morning on the day immediately following the surgery, the patient has an apparent stroke. The surgeon (who is the attending or admitting physician) requests the advice and opinion of General Internist again. General internist A is home asleep. As such, General Internist B receives the consultation request. Can General Internist B submit his postoperative services as a consultation? I know only one physician per inpatient stay can submit a consultation but since these services were performed by different doctors, does that matter?**



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**In addition, if the pre-operative consultation took place in the outpatient setting (so that there was only one inpatient consultation performed on this patient), does that make a difference? Assume the criteria for a consultation are met but since General Internist B is covering for General Internist A, does that negate a consultation code as an option?**

**Does it matter if the pre-operative consultation occurred in the outpatient or inpatient setting?**

**Does it matter that Internist B was taking call for Internist A?**

**Does it matter that Dr. A had no intention of following the patient in the hospital and only returned to see patient at the surgeon's request?**

The first determination to make in these situations is whether your physician has a consultation. A consultation is visit performed at the request of another physician asking for advice and/or opinion. If the surgeon is asking General Internist A his/her opinion on the patient's candidacy for surgery based on the hypertension, this can be a consultation. This is a pre-operative consultation. This also means that General Internist A cannot perform a post-operative consultation - the global period assigned to the surgery procedure code whether 0, 10 or 90 days. Since General Internist A and General Internist B are in the same group with the same specialty, General Internist B cannot bill a consultation service either during this time frame, but instead would have a subsequent care visit code. The situation above goes with the statement that you cannot perform a post-operative consultation if you have performed a pre-operative consultation and the guideline applies to members of the same group with the same specialty.

- 17. A group of interventional radiologists along with a physician assistant would like to begin seeing patients prior to an interventional procedure. The physician assistant would conduct the history and physical and the interventional radiologist would then see the patient to describe the procedure and answer any questions the patient might have. The procedure, if necessary, is performed on a later date. The ordering physician has provided a written request for this visit. The interventional radiologist will provide a written report back to the ordering physician. Can we bill a consultation for this visit? If not, is there an appropriate charge for this encounter**

A shared/split visit cannot be billed as a consultation. In your example, the physician assistant provides both the history and Exam during the service.

In addition, even if your physician performed the service exclusively, the intent of the request as described above does not appear to be seeking your physician's advice or opinion on how the request physician should treat the patient. This instead sounds like a referral from the physician to your interventional radiologist for a service.

Please look at the documentation of what your radiologist provides to the patient and compare that to the documentation guidelines for a Evaluation and Management service. If your physician and non-physician practitioner together are performing the components of an E&M, then an initial or subsequent care visit is appropriate. If not, see if there



another appropriate code. If not, then the time spent is part of the reimbursement for the radiology service.

- 18. A surgeon sees a patient at the request of another physician and determines surgery is warranted. Can the surgeon bill the visit as a consultation, or is he/she assuming responsibility for management of the patient's care for that condition and needs to bill new patient visit?**

The determination as to whether a service is a consultation is made prior to the service, not afterward. You can have three different situations.

1. The originating physician requests advice or opinion from your surgeon. The advice or opinion is on their continuing treatment of the patient. This could be a consultation.
2. The originating physician may determine that your surgeon is the best choice for the patient's care. This is a transfer of care, not a consultation. An initial or subsequent care visit code is appropriate.
3. The originating physician requests your surgeon's advice or opinion and that advice or opinion is that your surgeon should continue treatment of the patient's condition. This is a consultation followed by treatment.

In looking to determine whether the service is a consultation, please look at the intent of the service and your physician's understanding of that intent. If your surgeon understands the intent is for him/her to treat the patient, this is not a consultation. If your physician's understanding of the intent is to provide his/her advice or opinion, then the service could be a consultation. The performance of the surgery is the outcome of the visit and does not determine whether your service is a consultation or an initial subsequent visit.

- 19. Patient is sent to an orthopaedic surgeon to look at a shoulder problem. Patient examined and an MRI is ordered. When the patient leaves the office the only thing that has happened is history, exam and a diagnostic test has been ordered and the outcome is unknown at this time, so the surgeon has no idea if treatment will be required until the diagnostic test is completed. Letter sent back to originating physician stating that MRI has been ordered for further evaluation. Is this seen as a consultation?**

A consultation is a request for advice, opinion, suggestions, recommendation, etc from one physician to another. If the documentation supports a request for advice and/or opinion, then the fact that the orthopedic surgeon ordered an MRI does not preclude billing a consultation services.

The outcome of the situations does not determine whether a service is a consultation, but the intent of the request and the performing physician's understanding of the intent of the request.

- 20. If a consultation is requested (appropriately) of a cardiologist and after offering their "opinion and advice" the consultant decides that he should follow the patient (either in visits or with a procedure) can he without waiting for the "requesting physician" to say thank you for your Opinion &**



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**Advice and I agree with you that you, Dr. Consultant, should continue to see/treat this person. Can the consultant schedule the follow up or procedure before there is a conversation or correspondence signifying the transfer of care? In other words, can the consultant say my opinion and advice is that I treat this patient?**

When determining whether the cardiologist has a consultation, please look to the intent of the request. The cardiologist should document his/her understanding of the intent. If the cardiologist understands the request to be for advice and/or opinion, then you can have a consultation and in the situation you describe, this would be followed by treatment. However, if the cardiologist understands the request is for him/her to treat the patient's heart condition, then the service is not a consultation. The outcome of the visit, in this case, treatment, does not determine whether the service is or is not a consultation, but it is the intent of the original request.

**21. I need clarification regarding radiation oncology physicians billing consultations in an outpatient hospital setting. Can radiation oncologists bill consultation services?**

A provider office determines whether a service is a consultation based on the intent of the request. If the intent of the request is for advice, opinion, recommendations, suggestions, etc., then the service may be a consultation. If however, the request is for the performing provider to take over a portion of the patient's care, then the service is not a consultation. Each service is specific to the patient and the circumstances surrounding that patient's care. Medicare guidelines do not generally result in an "always" and "never." If your office always bills a consultation, then we would suggest performing a self-audit to determine if there are changes necessary. A radiation oncologist may bill an appropriate consultation service just as any other physician.

**22. If a physician orders diagnostic tests, does this mean the physician does not have a consultation?**

A physician performing an appropriately documented consultation may order diagnostic tests to assist in providing the advice or opinion back to the originating physicians. The ordering of diagnostic tests does not mean the service is not a consultation. The documentation of the intent of the request determines whether a service is a consultation.

**23. If we provide a service to a new patient in the hospital, don't we have to submit a consultation code since we did not admit the patient?**

If another physician asks for your advice, opinion, recommendation, suggestion etc, and the service meets the additional requirements of a consultation service, then you can bill a consultation. If your service is not for advice or opinion, but instead the originating physician wants you to treat a portion of the patient's condition, you would bill a subsequent care visit. You would not bill the initial inpatient codes since you are not admitting the patient.



- 24. Our physician was called to the hospital to give an admitted patient a second opinion. The claim denied as the service being partially or fully furnished by another provider. Should there be a modifier appended to the evaluation and management or do we send in an appeal with the consultation report?**

If the service was a request for a second opinion from the patient, you do not have a consultation service. You are providing your advice and/or opinion to the patient, not to another physician and should submit a subsequent inpatient hospital visit code. If another physician from your same group with the same specialty provided a consultation service to the patient during this hospital admission, this could be the reason for the denial. Medicare only allows one consultation, per patient, per physician, per facility admission. Medicare views physicians in the same group with the same specialty as the same person. Medicare does not have any modifier to address these situations as they are not consultation services, but instead subsequent hospital care codes.

- 25. A confirmatory consultation or second opinion may be initiated by the patient or third party insurance payers who require another opinion before approving a medical treatment or surgical procedure. Is a confirmatory consultation billed as a consultation or a visit?**

The confirmatory consultation codes are no longer available. A patient initiated request for a second opinion is an initial or subsequent visit code depending on whether the physician has had any face-to-face contact with the patient within the previous three years. Billing a consultation is only appropriate when the service meets the Medicare guidelines for consultation services. Medicare does not pay for mandated requests such as by a third-party insurance payer. Modifier 32 identifies these situations.

- 26. Can a specialist report a consultation service in which the patient is actively being seen in the outpatient setting for a chronic pulmonary condition and is now admitted to the hospital for a complication of this chronic pulmonary condition as well as other problems? The attending physician is an internist. The pulmonary specialist, who sees the patient in the hospital, is not the same pulmonary specialist that is actively treating the patient in the outpatient setting, but is part of that specialty group. The pulmonologist treating the patient in the hospital setting wants to bill a consultation as there is an order and the problem is a complication of the chronic pulmonary condition.**

The decision to bill a consultation or a subsequent hospital visit depends on the nature of the request. If the request by the internist indicates he/she wants the pulmonologist to treat the patient's pulmonary condition, then the service is not a consultation. The internist is not asking for advice or opinion, they are asking the pulmonologist to treat. If the internist is asking for the advice or opinion of the pulmonologist so that the internist can continue treating the patient, this could be a consultation. The requirements are the same whether the patient has a new problem or a complication of an existing problem. The fact that there is an order or request for the pulmonologist to see the patient does not determine whether the service is a consultation. It goes back to the understanding of the intent of the service.



**27. Must a shared medical record have the request for a consultation documented in the note or can the information be contained in the orders?**

The physician must notate in his/her note in the shared medical record, that he/she is requesting the advice and/or opinion of another doctor on the patient's condition. The performing physician must have documentation to support the request for advice and/or opinion and the service must meet the consultation requirements.

**28. If the hospitalist is asked by a surgeon to see a patient for multiple medical problems, evaluates the patient, provides a recommendation for their problems and then also indicates he will follow the patient, would this meet the requirements for a consultation service?**

You would need to look at the documentation to determine the intent of the request from the surgeon. If the intent is for advice and/or opinion, then the service may be considered a consultation as long as all requirements are met. If the surgeon is not asking for advice and /or opinion, but is instead requesting the hospitalist to manage the patient's condition, this is not a consultation. The outcome of the visit, whether the hospitalist continues to follow the patient, is not the determining factor.

**29. If a patient calls to make an appointment with the specialist (at the request of their primary care physician) for he/she to render their opinion/advice about a specific problem, can the visit with the specialist be billed as a consultation.**

**Does the appointment with the specialist have to be arranged between the primary care physician's office and the specialist's office?**

A consultation is distinguished from a visit based on the request from the originating provider; the intent of the request is a request for advice and/or opinion and a written report back to the originating physician. There has to be contact between the two offices so that both offices are aware of the intent of the request. You can access more information on this subject in the Power Point presentation we have available on our Website or in the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) 100-04, Claims processing, Chapter 12, Section 30.6.10.

You can also access a mediasite presentation on consultations on our Website <http://www.wpsmedicare.com> choose your contract, accept the CPT License agreement and then go to Education and Computer Based Training.

**30. With an appropriate request from a surgeon, a patient presents to their primary care physician office for medical clearance prior to surgery. The patient has no medical indications/chronic conditions that would interfere with or affect the outcome of the surgery. Is this a consultation?**

You want to look at the documentation showing the intent of the surgeon's request. If the request is for your advice and/or opinion, the service may be a consultation. If the request is not for advice or opinion, the service is not a consultation. The intent of the request will determine whether you bill a consultation or a visit code. The service must be medically necessary and not routine screening.



- 31. A patient is sent to radiation oncology for a consultation related to either cancer or some other diagnosis. That patient is seen by the radiation oncologist for therapy of the specific diagnosis only. The radiation oncologist does not, by definition, receive the patient to manage the other issues that can be associated with that patient. The physician asking for the consultation would still manage those conditions. Example: A patient who may be receiving concurrent chemotherapy as directed by the medical oncologist. Can this be a consultation?**

A provider office determines whether a service is a consultation based on the intent of the request. If the intent of the request is for advice, opinion, recommendations, suggestions, etc., then the service may be a consultation. If however, the request is for the performing provider to take over a portion of the patient's care, then the service is not a consultation. Each service is specific to the patient and the circumstances surrounding that patient's care. Medicare guidelines do not generally result in an "always" and "never." If your office always bills a consultation, then we would suggest performing a self-audit to determine if there are changes necessary.

- 32. We are a urology office. A primary care physician sends patients to us for any number of urological problems. Are most of our patients going to be new patients rather than consultations? The urologists will see the patient and immediately begin treatment, medications, schedule cystoscopy, etc. In these instances, is care being transferred to the urologist?**

A consultation is distinguished from a new or subsequent patient visit by the intent of the request from the primary care physician. If the primary care physician is asking for your physician's advice, opinion, suggestion, recommendation, etc. on their continued treatment of the patient, the service could be a consultation. If the intent of the request is for your office to treat the patient's urological problems, then the service is not a consultation. If the primary care physician is asking for your advice or opinion and that advice is for your office to treat the patient, you could have a consultation followed by treatment. The determination of whether a service is a consultation is based on whether the primary care physician is asking for advice or opinion or if they want your office to treat the patient's problem. The outcome of the visits (whether you begin treatment) does not determine whether a service is or is not a consultation.

You can access the CMS IOM, 100-04. Claims Processing, Chapter 12, Section 30.6.10 for more information. This shows the requirements along with several examples of a consultation. The intent of the request is the determining factor.

- 33. If a surgeon is consulted and the diagnosis is already established, but the surgeon has to make sure the diagnosis is correct, would they still be allowed to bill a consultation? For example, a physician consults with the surgeon for appendicitis or a hernia.**

The determination of whether the surgeon may bill a consultation service or should instead bill an initial or subsequent care visit depends on the intent of the original request. If the physician sends the patient to the surgeon asking the surgeon to treat the



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patient's appendicitis or hernia, this is not a consultation. The physician is not asking for advice or opinion.

If the physician sends the patient asking for the surgeon's advice and/or opinion on how the physician should treat the patient's condition, this may be a consultation. The documentation of the request determines the intent and the surgeon understands of the request, whether for treatment or advice and/or opinion.