TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Andrew Brylowski, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-24-0492-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
October 30, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 6 – 10, 2023	Designated Doctor Examination 99456-W5-WP	$950.00	$150.00
	99199-51-59	$594.99	$0.00
	90792-51-59	$3,788.83	$378.83
	96116-51-59	$179.73	$0.00
	96121-51-59	$1,468.90	$0.00
	96132-51-59	$1,004.80	$251.19
	96133-51-59	$4,026.33	$0.00
	96136-51-59	$82.68	$82.68
	96137-51-59	$1,689.03	$0.00
	Total	$13,785.29	$862.70

Requestor's Position

I administered psychiatric-neuropsychiatric measures to the claimant for the following reasons: From DSM IV: Use of DSM-IV in Forensic Settings page xxiii … a clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a 'mental disorder,' 'mental disability,' 'mental disease,' or 'mental defect.' In determining whether an individual meets a specified legal standard … additional information is usually required beyond that contained in the DSM-IV diagnosis. … And specifically in this case, reference to anxiety and stress in the initial treatment documents …

"… If impairment due to disfigurement does exist, it is usually manifested by change in behavior, such as withdrawal from social contacts, in which case it would be evaluated in accordance with the criterion the guides Chapter of mental and behavioral conditions …

"Since this referral is for additional examination and testing involving a commissioner ordered Designated Doctor Examination, per TAC §127.10 – General procedures for Designated Doctor Examinations: (c) The designated doctor shall perform additional testing when necessary to resolve the issue in question …"

Amount in Dispute: $13,785.29

Respondent's Position

"… Texas Mutual requested MMI/IR be addressed on the upper extremities only. There was no mention of any mental health assessments that needed to be done. Additionally, payment for the MMI/IR portion was made on 10/27/23."

Response Submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §127.10, effective November 4, 2018, 43 TexReg 7149 sets out the procedures for designated doctor examinations.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

4. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 225 – Line 1 – Incorrect modifier for a DD to bill.
- 225 – Need clarification as to why the DD would do these exams on the date of an MMI IR exam
- 225 – Line 2 – Need clarification on how many pages and what type of documentation this was.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- CAC-18 – Exact duplicate claim/service
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
- 878 – Appeal (request for reconsideration) previously processed. Refer to Rule 133.250(H)
- 891 – No additional payment after reconsideration
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- 224 – Duplicate charge.
- 877 – Bill previously processed. Refer to rule 133.250 regarding request for reconsideration and submit with original EOB and corrected bill.
- CAC-131 – Claim specific negotiated discount.
- DC3 – Additional reimbursement allowed after reconsideration.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. Is Andrew Brylowski, M.D. entitled to additional reimbursement for the examination to determine maximum medical improvement and impairment rating?

2. Is Dr. Brylowski entitled to reimbursement for procedure code 99199-51-59?

3. Is Texas Mutual Insurance Company's denial based on the performance of mental health assessments supported?

4. Is Texas Mutual Insurance Company's denial based on billing or submission errors supported?

5. Is Dr. Brylowski entitled to reimbursement for testing services?

6. What is the total reimbursement amount recommended for the services in dispute?

Findings

1. Dr. Brylowski submitted a request for medical fee dispute resolution in accordance with 28 TAC §133.307. The request included $950.00 for a designated doctor examination to determine maximum medical improvement and impairment rating billed with code 99456-W5-WP.

   Per submitted explanation of benefits dated October 27, 2023, Texas Mutual Insurance Company paid $800.00 for this service.

   According to 28 TAC §§134.250(3)(C) and 134.240(1)(B), the designated doctor is required to bill an examination to determine maximum medical improvement (MMI) using CPT code 99456 with modifier "W5."

   The submitted documentation supports that Dr. Brylowski performed an evaluation of MMI as ordered by the DWC. 28 TAC §134.250(3)(C) states that the maximum allowable reimbursement (MAR) for this examination is $350.00.

   When a designated doctor calculates an impairment rating, 28 TAC §§134.250(4)(A) and 134.240(1)(A) require the doctor to bill using CPT code 99456 with modifier "W5." When the examining doctor also performs the testing for impairment rating of musculoskeletal body areas, 28 TAC §134.250(4)(C)(iii) requires the examining doctor to add modifier "WP."

   Review of the submitted documentation finds that Dr. Brylowski performed impairment rating evaluations of the hand, elbow, and wrist with range of motion testing. 28 TAC §134.250(4)(C) states, "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

   (i) Musculoskeletal body areas are defined as follows:
   (I) spine and pelvis;
   (II) upper extremities and hands; and
   (III) lower extremities (including feet)."

   28 TAC §134.250(4)(C)(ii) defines the fees for the calculation of an impairment rating for musculoskeletal body areas and states that the MAR for assignment of impairment of the first musculoskeletal body area, in this case, the upper extremity, performed with range of motion is $300.00.

   Dr. Brylowski also performed impairment rating evaluations of the skin and mental and behavioral function. 28 TAC §134.250(4)(D)(i) states, "Non-musculoskeletal body areas are defined as follows:

   (I) body systems;
   (II) body structures (including skin); and
   (III) mental and behavioral disorders."

28 TAC §134.250(4)(D)(v) states that the MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each. Therefore, the total allowable reimbursement for the assignment of impairment rating of the skin and mental and behavioral function is $300.00.

The total allowable reimbursement for the examination to determine MMI and impairment rating is $950.00. Per the explanation of benefits dated October 27, 2023, the insurance carrier paid $800.00. An additional $150.00 is recommended.

2. Dr. Brylowski is seeking $594.99 for procedure code 99199-51-59. This procedure code is defined as "Unlisted special service, procedure, or report. A service, procedure or report that is above and beyond the usual for a condition." The insurance carrier denied this service, in part, with denial code CAC-97, stating, "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   In his position statement, Dr. Brylowski stated, "This code was used for record organization, tagging, sorting, linking of specific record to report, and having the record available in the cloud for immediate viewing by stakeholder(s)."

   28 TAC §134.250(1) states, "The total maximum allowable reimbursement (MAR) for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

   (A) the examination;
   (B) consultation with the injured employee;
   (C) review of the records and films;
   (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and
   (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title."

   Because the services described by Dr. Brylowski represented by the code in question are included in the MAR for an examination of MMI and impairment rating, no reimbursement can be recommended.

3. The request for medical fee dispute resolution included the reimbursement of testing for mental and behavioral impairment.

   The insurance carrier denied the services, in part, with denial code 225, stating, "The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information." Additional notes on this code stated, "Need clarification as to why the DD would do these exams on the date of an MMI IR exam." In its response, the insurance carrier stated, "Texas Mutual requested MMI/IR be addressed on the upper extremities only. There was no mention of any mental health assessments that needed to be done."

28 TAC §127.10(b) states, "Before examining an injured employee, the designated doctor shall review the injured employee's medical records, including any analysis of the injured employee's medical condition, functional abilities and return to work opportunities provided by the insurance carrier and treating doctor in accordance with subsection (a) of this section, and any materials submitted to the doctor by the division. The designated doctor shall also review the injured employee's medical condition and history as provided by the injured employee, any medical records provided by the injured employee, and shall perform a complete physical examination of the injured employee. The designated doctor shall give the medical records reviewed the weight the designated doctor determines to be appropriate."

28 TAC §127.10(c) states, in relevant part, "The designated doctor shall perform additional testing when necessary to resolve the issue in question. … Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title"

Per the documentation available Dr. Brylowski performed additional testing in accordance with 28 TAC §127.10. The DWC finds that the insurance carrier's denial based on the performance of mental health assessments is not supported.

4. Texas Mutual Insurance Company also denied the testing services, in part, based on billing or submission errors. A review of the submitted documentation finds no evidence of errors in billing or submission. The DWC finds that this denial reason is not supported.

5. Because the insurance carrier failed to support its denial of the designated doctor's testing services, the DWC will review these services for reimbursement.

   Reimbursement for professional services is found in 28 TAC §134.203, which states, in relevant part: "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Dr. Brylowski is seeking reimbursement for procedure code 90792, which is defined as "Psychiatric diagnostic evaluation with medical services: An assessment by a psychiatrist of a person's mental health status conducted through an interview, exam, or nonverbal methods. It includes additional medical services such as pharmacy or other diagnostic evaluation." This is a timed code to include up to a total of one hour and 30 minutes. The submitted documentation indicates that an examination as defined by this code began at 9:42 AM and ended at 11:06 AM.

Dr. Brylowski is also seeking reimbursement for procedure code 96116, which is defined as "Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgment, [e.g., acquired knowledge, attention, language, memory, planning, and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour. Behavioral exam with interpretation and report. Usually involves clinical assessment of skills in acquired knowledge, attention, memory, visual spatial abilities, language, or planning. The physician or psychologist evaluates aspects of thinking, reasoning, and judgment to evaluate a patient's neurocognitive abilities. These codes apply to each hour of examination time and must include face-to-face time with the patient and time spent interpreting test results and preparing a report. Report 96116 for the initial hour and 96121 for each additional hour." Dr. Brylowski appended modifiers 51 and 59 for this code.

Medicare's CCI manual Chapter XI, Section M.1 states, "Neurobehavioral status exam (CPT codes 96116 and 96121) shall not be reported when a mini-mental status examination is performed. CPT codes 96116 and 96121 shall not be reported with psychiatric diagnostic examinations (CPT codes 90791 or 90792). CPT codes 96116 and 96121 may be reported with other psychiatric services or E&M services only if a complete neurobehavioral status exam is performed. If a mini-mental status examination is performed by a physician, it is included in the E&M service."

The DWC reviewed Medicare's CCI edits for this procedure code and found that an edit exists between procedure code 90792 and 96116, with procedure code 90792 as the primary code. No modifier is allowed to override this edit. Therefore, reimbursement cannot be recommended for this code. Because disputed procedure code 96121 is an add-on code for timed procedure code 96116, no reimbursement can be recommended for this code.

Dr. Brylowski is seeking reimbursement for procedure code 96132, which is defined as "Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour. The physician or other qualified health care professional evaluates and interprets the results of psychological or neuropsychological testing … Neuropsychological testing consists of a series of tests in thinking, reasoning, judgment, and memory to evaluate the patient's neurocognitive abilities. Report 96132 for the first hour of evaluation/ interpretation and 96133 for each additional hour thereafter. Codes within this range describe the evaluation component, including combining data from different sources, interpreting test results and clinical data, decision-making, and providing a plan of treatment and report, as well as providing interactive feedback with the patient and family members or caregivers. These codes apply to each hour of evaluation and must include face-to-face time with the patient, as well as the time spent integrating and interpreting data; however, the actual test administration and scoring services are not reported by these codes." Disputed procedure code 96133 is a timed add-on code for procedure code 96132.

Dr. Brylowski is also seeking reimbursement for procedure code 96136, which is defined as, "Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes. A physician, other qualified health care professional, or technician administers and scores two or more psychological or neuropsychological tests by any method … neuropsychological testing consists of a series of tests in thinking, reasoning, judgment, and memory to evaluate the patient's neurocognitive abilities. Report 96136 for the initial 30 minutes of time by a physician or other qualified health care professional and 96137 for each additional 30 minutes." Disputed procedure code 96137 is a timed add-on code for procedure code 96136.

Medicare's CCI manual Chapter XI, Section M.2 states, "The psychiatric diagnostic interview examination (CPT codes 90791, 90792), psychological/neuropsychological testing (CPT codes 96136-96146), and psychological/ neuropsychological evaluation services (CPT codes 96130-96133) must be distinct services if reported on the same date of service. CPT Professional instructions permit physicians to integrate other sources of clinical data into the report that is generated for CPT codes 96130-96133. Since the procedures described by CPT codes 96130-96139 are timed procedures, providers/suppliers shall not report time for duplicating information (collection or interpretation) included in the psychiatric diagnostic interview examination and/or psychological/neuropsychological evaluation services or test administration and scoring."

A review of the documentation provided supports that the services described above for procedure codes 96132 and 96136 were performed by the requestor for one test administered, scored, evaluated, and interpreted within the billed dates of service. The DWC will review these codes for reimbursement.

The report does not list the start and end time to support the number of hours billed for add-on timed procedure codes 96133 and 96137; therefore, reimbursement cannot be recommended for these codes.

6. The payment of the services in question is subject to 28 TAC §134.203(c), which states, in relevant part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

    (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

    (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

To determine the MAR, the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Amount.

- The DWC conversion factor for 2023 is 64.83.
- The Medicare conversion factor for 2023 is 33.8872.
- Per the submitted medical bills, the service was rendered in zip code 75234 which is in Medicare locality 0441211, "Dallas."

The Medicare participating amount for CPT code 90792 is $198.02. The MAR is calculated as follows: (64.83/33.8872) x $198.02 = $378.83. Dr. Brylowski billed for 10 units. No evidence was provided to support the billed units. The total MAR for procedure code 90792 at one unit is $378.83. This amount is recommended.

The Medicare participating amount for CPT code 96132 is $131.30. The MAR is calculated as follows: (64.83/33.8872) x $131.30 = $251.19. Dr. Brylowski billed for four units. No evidence was provided to support the billed units within the dates of service in dispute. The total MAR for procedure code 96132 at one unit is $251.19. This amount is recommended.

The Medicare participating amount for CPT code 96136 is $43.22. The MAR is calculated as follows: (64.83/33.8872) x $43.22 = $82.68. Dr. Brylowski billed for one unit. The total MAR for procedure code 96136 at one unit is $82.68. This amount is recommended.

The DWC finds that the total allowed amount for the services in question is $862.70. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requestor has established that additional reimbursement of $862.70 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Texas Mutual Insurance Company must remit to Andrew Brylowski, M.D. $862.70 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 16, 2024
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1 (d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.