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
Travelers Casualty Ins. Co. of America

MFDR Tracking Number
M4-23-1192-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
January 25, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 26, 2022	99199-59	$354.00	$0.00
	90792-59	$3,286.54	$0.00
	96116-59	$174.47	$0.00
	96121-59	$1,453.20	$0.00
	96133-59	$2,625.84	$0.00
	96137-59	$742.90	$0.00
	Total	$8,636.95	$0.00

Requestor's Position

"Physical and neuro-behavioral examination along with diagnostic interview and additional testing that was forensically medically necessary for this examination such as neuropsychiatric testing and measures, blood work, imaging studies, etc. History and diagnostic interview along with a review of medical records and collateral information that was available was done … Neuropsychiatric testing interpretation, report preparation, as well as a review of medical records were accomplished. This process involved approximately 11 hours of staff and physician time. Neuropsychiatric testing administration and interpretation, report preparation, review of medical records, literature search, AMA guides 4th edition, MD Guidelines, ODG, DSM 5, and other specialty guideline search as necessary were accomplished on May 25, 2022, May 26, 2022, May 27, 2022, Jun 3, 2022, June 4, 2022, June 5, 2022, June 10, 2022, June 11, 2022, June 12, 2022, and June 13, 2022. This process involved approximately 26 hours of physician time. Total hours for

evaluation, forensic measure ordering, interpretation, and integration, neuropsychiatric testing supervision, scoring, and interpretation, urine drug evaluation and interpretation, literature and guideline search and integration with report integration of this information in addition to the routine designated doctor issues was approximately 26 hours."

Amount in Dispute: $8,636.95

Respondent's Position

"The Provider's Request for Medical Fee Dispute Resolution involves reimbursement for a neuropsychological testing referral from the Designated Doctor. To be clear, the Provider was not appointed as the Designated Doctor in this claim but was referred to for testing by the appointed Designated Doctor.

"As to CPT code 99199 … This unlisted code is documented on the HCFA-1500 as 'Vol Rec Org', however, the Provider does not submit any documentation of what this billing represents. Without documentation to support the billing of this unlisted code, the Provider is not entitled to reimbursement.

"As to CPT code 90792 … The Provider billed 10 units for this CPT code … the documentation submitted indicates that only one evaluation was performed on 05-26-2022, not ten. As the documentation supports one unit of this CPT code, which the Carrier has reimbursed, the Provider is not entitled to additional reimbursement.

"As to CPT code 96116 … This CPT code is inclusive to CPT code 90792 when billed on the same date. Per the Medicare edits, the use of the -59 modifier is not allowed to override this inclusive relationship. The Provider is not entitled to separate reimbursement for this included service.

"As to CPT code 96121 … This code is for additional units of the neurobehavioral status exam. As the exam itself is inclusive to CPT code 90792, the additional units are also inclusive. The Provider is not entitled to separate reimbursement for this included service.

"As to CPT code 96133 … The Provider bill 21 units for this CPT code on the single date of service, corresponding to 21 hours of testing that day … on page 21 of the Provider's report, it indicates he administered the neuropsychological testing. On page 13 of the Provider's report, it indicates has had face-to-face time with the Claimant from 9:13 to 10:40 AM, equaling one hour and 27 minutes, including the neurobehavioral status exam and this testing. Given that the CPT code also includes reviewing the results and drafting the report, the Carrier reimbursed the Provider at the full Medicare edit allowed of 7 units. The Provider has not submitted documentation to substantiate additional time or dates of service.

"As to CPT code 96137 … The Provider billed another 21 units for this CPT code on the single date of service, corresponding to 10.5 hours of additional testing that day, on top of the original 30 minutes of testing reflected in the base CPT code 96136 also billed for that date of service … on page 21 of the Provider's report, it indicates has had face-to-face time with the Claimant from 9:13 to 10:40 AM, equaling one hour and 27 minutes, including the neurobehavioral status exam, this testing, and the neuropsychological testing above. Given that the CPT code also includes

reviewing the results and drafting the report, the Carrier reimbursed the Provider for 11 units reflecting the 11 individual psychological tests the report indicates were conducted. The Provider has not submitted documentation to substantiate additional time or dates of service."

Response Submitted by: Travelers

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) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

Denial Reasons

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

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
- 3243 – The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely Edits amount for the amount of times this procedure can be billed on a date of service. Since the allowance for the procedure is to be determined by report an allowance has not been paid.
- 3247 – The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely Edits amount for the amount of times this procedure can be billed on a date of service. The correct use of a modifier to report the same code on a separate line permits an additional unit of service to be allowed. Since the modifier has not been used correctly, an additional unit cannot be paid.
- 5526 – Please provide correct CPT codes for all services rendered.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 3244 – The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely Edits amount for the number of times this procedure can be billed on a date of service. An allowance has not been paid.
- 86 – Service performed was distinct or independent from other services performed on

the same day.

- 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation, and management services procedure (90000-99999) has been disallowed.
- 292 – This procedure code is only reimbursed when billed with the appropriate initial base

Issues

1. Is Andrew Brylowski, M.D. entitled to reimbursement for procedure code 99199?

2. Is Dr. Brylowski entitled to additional reimbursement for procedure code 90792?

3. Is Dr. Brylowski entitled to reimbursement for procedure codes 96116 and 96121?

4. Is Dr. Brylowski entitled to additional reimbursement for procedure codes 96133 and 96137?

Findings

1. Dr. Brylowski is seeking additional reimbursement for designated doctor referred testing provided May 26, 2022. Dr. Brylowski is seeking reimbursement, in part, for procedure code 99199, defined as an "Unlisted special service, procedure or report." On the submitted HCFA/CMS 1500 form, Dr. Brylowski labeled the service as "Vol Rec Org." The DWC finds that the documentation was insufficient to support reimbursement for this code.

2. Dr. Brylowski is seeking additional reimbursement in the amount of $3,286.54 for 10 units of procedure code 90792, which is defined as a "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 … A psychiatric diagnostic evaluation is performed, which includes the assessment of the patient's psychosocial history, current mental status, review, and ordering of diagnostic studies followed by appropriate treatment recommendations. In 90792, additional medical services such as physical examination and prescription of pharmaceuticals are provided in addition to the diagnostic evaluation. Interviews and communication with family members or other sources are included in these codes." Dr. Brylowski billed 10 units, however provided no evidence that multiple assessments as defined were performed. The requestor is therefore entitled to one unit of 90792.

   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 …

(c) 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 ...

(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 2022 is 62.46.
- The Medicare conversion factor for 2022 is 34.6062.
- Per the submitted medical bills, the service was rendered in zip code 75234 which is in Medicare locality 0441211.

The Medicare participating amount for CPT code 90792 is $202.32. The MAR is calculated as follows:

- (62.46/34.6062) x $202.32 = $365.16

The total MAR procedure code 90792 is $365.16. The insurance carrier reimbursed this amount in full. The DWC finds that Dr. Brylowski is not entitled to additional reimbursement for this code.

3. Dr. Brylowski is also seeking reimbursement for procedure code 96116, which is defined as a "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 ... Report 96116 for the initial hour and 96121 for each additional hour."

   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, Dr. Brylowski is not entitled to reimbursement for 96116. Because disputed procedure code 96121 is an add-on code for timed procedure code 96116, Dr. Brylowski is not entitled to reimbursement for 96121.

4. Dr. Brylowski is seeking an additional reimbursement for procedure code 96133, which is defined as a "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; each additional hour (List separately in addition to code for primary procedure)."

   Dr. Brylowski is also seeking an additional reimbursement for procedure code 96137, which is defined as a "Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)."

   Procedure code 96133 is an add-on code to procedure code 96132. The insurance carrier paid $1,312.92 for procedure code 96133. Procedure code 96137 is an add-on code to procedure code 96136. The insurance carrier paid $817.19 for procedure code 96137. The report does not indicate the start and end times to support the number of hours billed for these services. Therefore, the DWC finds that Dr. Brylowski is not entitled to additional reimbursement for these codes.

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.

DWC finds the requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 21, 2024 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.