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
Charter Oak Fire Insurance Co.

MFDR Tracking Number
M4-24-0340-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
October 11, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 12, 2023 – May 26, 2023	Designated Doctor Examination 99456-W6-RE-51	$500.00	$0.00
	99199-51	$1,666.00	$0.00
	90792-51	$3,409.52	$0.00
	96116-51	$179.73	$0.00
	96121-51	$1,468.94	$0.00
	96132-51	$2,260.77	$0.00
	96133-51	$2,684.18	$0.00
	96136-51	$0.00	$0.00
	96137-51	$753.21	$0.00
	Total	$12,922.35	$0.00

Requestor's Position

"**99456-W6-RE-51 Extent:** 28 TAC §134.204(k) states 'the following shall apply to Return to Work (RTW)and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE'. In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection(i) of this section and shall include Division-required reports. This was denied by the insurance company.

"**99199-51**: 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).

"**90792-51**: According to Medicare, you can only claim for one unit of 90792 in a year. But, if the necessity arises, you are allowed to claim more than one unit of 90792 in a year indicating the medical necessity of the evaluation …

"**96116-51**: A complete Neurobehavioral Status Examination was performed. Based on the NCCI 2022 Coding Policy Manual: "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 …

"This process involved approximately 12 hours of staff and physician time. Neuropsychiatric testing interpretation, report preparation, as well as a review of medical records were accomplished on May 11, 2023, May 12, 2023, May 13, 2023, May 14, 2023, May 19, 2023, May 20, 2023, May 21, 2023, May 24, 2023, May 25, 2023, and May 26, 2023. This process involved approximately 20 hours of physician time. Total hours of physician time for evaluation, testing administration, testing supervision, testing scoring, testing interpretation, medical record integration, collateral information integration, literature review, urine drug testing and interpretation and integration of this information into report format was approximately 26 hours."

Amount in Dispute: $12,922.35

Respondent's Position

"The Carrier has reviewed the documentation and determined the Provider is entitled to supplemental reimbursement for the disputed services. Supplemental reimbursement for these services is being issued in accordance with the Texas Workers' Compensation Act and adopted Rules of the Division of Workers' Compensation."

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.

3. 28 TAC §134.250 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:

- 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.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
- 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.
- 3247 – 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. 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.
- 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.
- 5526 – Please provide correct CPT codes for all services rendered.
- 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.
- 292 – This procedure code is only reimbursed when billed with the appropriate initial base code.
- 947 – Upheld. No additional allowance has been recommended.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 18 – Exact duplicate claim/service.
- 247 – A payment or denial has already been recommended for this service.
- DUPL – These services have already been considered for reimbursement.

Issues

1. What services are considered in this dispute?

2. Is Andrew Brylowski, M.D. entitled to reimbursement for procedure code 99199-51-59?

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

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

5. Is Dr. Brylowski entitled to additional reimbursement for procedure codes 96132 and 96133?

Findings

1. Dr. Brylowski is seeking additional reimbursement for a designated doctor examination and related testing provided from May 12, 2023, through May 26, 2023. Per explanations of benefits dated June 6, 2023, and November 7, 2023, the insurance carrier reimbursed procedure codes 99456, 96136, and 96137 in full. Dr. Brylowski revised his request and is seeking $0.00 for these codes. Therefore, these services will not be considered in this dispute.

   The DWC will consider the remaining services represented by procedure codes 99199, 90792, 96116, 96121, 96132, and 96133.

2. Dr. Brylowski is seeking $1,666.00 for procedure code 99199-51. 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. 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. The 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.

Dr. Brylowski is seeking additional 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 … 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.

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.

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

The total MAR procedure code 90792 is $378.83. The insurance carrier reimbursed this amount in full. The DWC finds that Dr. Brylowski is not entitled to additional reimbursement

for this code.

4. Dr. Brylowski is also seeking additional 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 ... 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.

5. Dr. Brylowski is seeking additional 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.

   The insurance carrier paid $251.19 for procedure code 96132 and $1,342.11 for procedure code 96133. The report does not indicate the start and end times to support the number of hours billed for these services. Therefore, 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 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 15, 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.