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
American Zurich Insurance Co.

MFDR Tracking Number
M4-24-0496-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 30, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 1, 2023 – May 8, 2023	Designated Doctor Examination 99456-WP-51	$0.00	$0.00
	99199-59	$2,776.00	$0.00
	90792-59	$757.68	$378.83
	96116-59	$179.73	$0.00
	96121-59	$757.80	$0.00
	96132-59	$502.40	$0.00
	96133-59	$1,917.30	$0.00
	96136-59	$82.68	$0.00
	96137-59	$757.76	$0.00
	Total	$7,731.35	$378.83

Requestor's Position

"Neuropsychiatric testing interpretation, report preparation, as well as a review of medical records were accomplished on April 30, 2023, May 1, 2023, May 2, 2023, May 7, 2023, and May 8, 2023. This process involved approximately 5 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 with comparison to previous testing and integration of this information into report format was approximately 12 hours."

Amount in Dispute: $7,731.35

Respondent's Position

"The Respondent notes that Dr. Brylowski, MD rendered non-musculoskeletal testing for a claim whose injuries are musculoskeletal by nature. On 3/27/2023 a Presiding Officer ordered a Designated Doctor Exam and instructed the Requestor to address MMI and IR for the compensable conditions ... Specifically, the PO indicated 'another' neuropsychiatric evaluation should not be necessary for this request as there were no compensable psychiatric to consider."

Response Submitted by: CorVel

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 April 30, 2023, 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 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 reduced the payment for the disputed services with the following claim adjustment codes:

- 234 – This procedure is not paid for separately.
- ORC – See Additional Information
- Notes: "PER PRESIDING OFFICER'S SPECIAL INSTRUCTIONS LISTED IN SECTION V OF THE HRG-04-TM-04 FORM, ANOTHER NEUROPSYCHIATRIC EVAL IS NOT NECESSARY FOR THIS EXAM AS THERE ARE NO COMPENSABLE PSYCHIATRIC CONDITIONS TO CONSIDER FOR PURPOSE OF MMI & IR."
- 97 – Charge Included in another Charge or Service
- R09 – CCI; CPT Manual and CMS coding manual instructions
- Notes: "Per rule 134.250(1) an MMI/IR exam includes all time spent on the exam/evaluation; consultation w/IW, review of records, narrative preparation, testing, calculation tables, figures, worksheets and addendums"
- 236: "This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements."

- Notes: "DUPLICATE RECONSIDERATION REQUEST: CORRECTED CLAIM ALREADY PROCESSEDON EOR# 7754550-3.15"
- Notes: "Per rule 134.240, only a Designated Doctor can bill with modifiers W5-W9. HCP continues to bill incorrectly. While the previous comment indicated incorrectly that this is not a DD exam, it is a DDE. Physician needs to bill per rule.
- 4 – Procedure code inconsistent with modifier used.
- 18 – Duplicate Claim/Service
- R1 - Duplicate Billing

Issues

1. What services are considered in this dispute?

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

3. Is American Zurich Insurance Co.'s denial based on the medical necessity of mental health assessments supported?

4. What rules apply to a review of payment for the testing services in question?

5. Is Andrew Brylowski, M.D. entitled to reimbursement for procedure code 90792?

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

7. Is Dr. Brylowski entitled to additional reimbursement for procedure codes 96132, 96133, 96136, and 96137?

Findings

1. Dr. Brylowski is seeking additional reimbursement for a designated doctor examination and related testing. He is seeking $0.00 for the examination to determine maximum medical improvement and impairment rating. Therefore, this service will not be considered in this dispute.

   Dr. Brylowski is seeking $2,776.00 for records processing related to the examination. He is also seeking $4,955.35 for testing. These are the services reviewed in this dispute.

2. Dr. Brylowski is seeking $2,776.00 for procedure code 99199-59. 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 97, stating, "Charge Included in another Charge or Service."

   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 insurance carrier denied payment, in part, stating, "PER PRESIDING OFFICER'S SPECIAL INSTRUCTIONS LISTED IN SECTION V OF THE HRG-04-TM-04 FORM, ANOTHER NEUROPSYCHIATRIC EVAL IS NOT NECESSARY FOR THIS EXAM AS THERE ARE NO COMPENSABLE PSYCHIATRIC CONDITIONS TO CONSIDER FOR PURPOSE OF MMI & IR."

   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. (1) The designated doctor must also review the injured employee's medical condition, history, and any medical records the injured employee provides and must perform a complete physical examination of the injured employee. (2) 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 must perform additional testing when necessary to resolve the issue in question … (2) Payment for additional testing or referrals that the designated doctor has determined are necessary under this subsection must not be denied prospectively or retrospectively, regardless of any potential disagreements about medical necessity, extent of injury, or compensability."

   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 medical necessity of mental health assessments is not supported and denial of payment for this reason is not supported.

4. Because the insurance carrier failed to support its denial of payment for the testing services in question, the DWC will review these services for reimbursement in accordance with relevant rules and statutes.

   Reimbursement policies 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."

Reimbursement fee guidelines for professional services are addressed in 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 …

(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 …"

5. 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 … 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."

   The DWC finds that the submitted documentation supports this service as defined. Dr. Brylowski billed two units for this service, however provided no evidence that multiple assessments as defined were performed. The requestor is therefore entitled to reimbursement for one unit of CPT code 90792.

   To determine the maximum allowable reimbursement (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 for procedure code 90792 is $378.83. This amount is recommended.

6. 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." Disputed procedure code 96121 is a timed add-on code for procedure code 96116. Dr. Brylowski appended modifier 59 for each 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 CPT code 96116. Because disputed procedure code 96121 is an add-on code for timed procedure code 96116, no reimbursement can be recommended for CPT code 96121.

7. 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 does not support the claim that the services described above were documented within the billed dates of service. Reimbursement for these codes is not 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.

DWC finds the requestor has established that an additional reimbursement of $378.83 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that American Zurich Insurance Co. must remit to Andrew Brylowski, M.D. $378.83 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 25, 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, 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.