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 & Surety Co.

MFDR Tracking Number
M4-24-0696-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
November 21, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 26, 2023 – February 5, 2023	Designated Doctor Examination 99456-W5-WP	$600.00	$150.00
	Designated Doctor Examination 99456-W8-RE	$0.00	$0.00
	99199-51-59	$2,386.00	$0.00
	90792-51-59	$3,410.00	$0.00
	96116-51-59	$179.73	$0.00
	96121-51-59	$1,468.90	$0.00
	96132-51-59	$753.62	$0.00
	96133-51-59	$4,026.33	$0.00
	96136-51-59	$0.00	$0.00
	96137-51-59	$849.95	$0.00
	Total	$13,674.53	$150.00

Requestor's Position

"**99456-W5-WP:** … TAC §134.250(3)(C) states, 'The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT code 99456. Reimbursement shall be $350.' **(Total=$350)**

"RULE §134.204 (ii) The MAR for musculoskeletal body areas shall be as follows … (-a-) $300 for the first musculoskeletal body area; **(1 unit-Spine for ROM=$300)**

"28 TAC §134.250(4)(D)(i) and (ii) state: non-musculoskeletal body areas are defined as follows: body systems; body structures (including skin); and o[sic] mental and behavioral disorders …

"**2 units-Mental & Behavioral-Chapter 4 &14 used =$300**
"**1 unit – Skin-Chapter 13= $150**
"**1 unit – ENT-Chapter 9= $150**

"**Total due: $600** …

"**99199-59:** 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).

90792-59: If 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:**
"**96121-51:** 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."

"**96132-51, 96133-51, 96137-51**
"This process involved approximately 14 hours of staff and physician time. Neuropsychiatric testing interpretation, report preparation, as well as a review of medical records were accomplished on January 24, 2023, January 25, 2023, January 26, 2023, January 27, 2023, February 1, 2023, February 2, 2023, February 3, 2023, February 4, 2023, and February 5, 2023. This process involved approximately 22 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 27 hours."

Amount in Dispute: $13,674.53

Respondent's Position

"The Carrier reimbursed a total of $4,043.89 as reflected in the attached Explanations of Reimbursement … 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 the amount of $3,897.02 in accordance with the Texas Workers' Compensation Act and adopted Rules of the Division of Workers' Compensation. This brings total reimbursement for the disputed services to $7,940.91 … The Carrier would note that CPT codes 99199, 96116, and 96121 are not reimbursable under the NCCI coding edits. Further, only one unit of CPT code 96123 is reimbursable as this is an initial base code with additional units billed under CPT code 96133."

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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 2008 – Additional payment made on appeal/reconsideration.
- 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.
- 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.
- 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
- 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.
- 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.
- 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.
- 292 – This procedure code is only reimbursed when billed with the appropriate initial base code.

Issues

1. What services are considered in this dispute?

2. Is Andrew Brylowski, M.D. entitled to additional reimbursement for procedure code 99456-WP?

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

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

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

6. Is Dr. Brylowski entitled to additional reimbursement for procedure code 96132?

Findings

1. Dr. Brylowski is seeking additional reimbursement for a designated doctor examination and related testing provided from January 26, 2023, through February 5, 2023. Per explanations of benefits dated March 3, 2023; July 24, 2023; and December 5, 2023, the insurance carrier reimbursed procedure codes 99456-RE, 96133, and 96136 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.

Per explanations of benefits dated March 3, 2023, and December 5, 2023, the insurance carrier reimbursed procedure code 96137 in part. Dr. Brylowski revised his request and is seeking $0.00 for these codes. Therefore, this service will not be considered in this dispute.

The DWC will consider the remaining services represented by procedure codes 99456-W5-WP, 99199, 90792, 96116, 96121, and 96132.

2. Dr. Brylowski is seeking an additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

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

   Review of the submitted documentation finds that Dr. Brylowski performed impairment rating evaluations of the spine with range of motion testing; mental, emotional, and behavioral conditions; concussion; contusions, abrasions, and lacerations; and conditions related to the ears.

   28 TAC §134.250(4)(C)(ii) defines the fees for the calculation of an impairment rating for musculoskeletal body areas. The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is $300.00.

   28 TAC §134.250(4)(D) defines the fees for the calculation of an impairment rating for non-musculoskeletal body areas. The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]	[redacted]	$350.00
IR: Cervical Spine (ROM)	Musculoskeletal System	Spine and Pelvis	$300.00
IR: Lumbar Spine (ROM)			
IR: Mental, Emotional, Behavioral	Mental & Behavioral	Mental & Behavioral	$150.00
IR: Concussion	Nervous System	Body Systems	$150.00
IR: Contusions, Abrasions, Lacerations	Skin	Body Structures	$150.00
IR: Ear Conditions	Ear, Nose, Throat, Related	Body Structures	$150.00
Total MMI	[redacted]	[redacted]	**$350.00**
Total IR			**$900.00**
Total Exam			**$1,250.00**

   The total allowable reimbursement for the examination in question is $1,250.00. The insurance carrier paid $1,100.00. An additional reimbursement of $150.00 is recommended.

3. Dr. Brylowski is seeking $2,386.00 for procedure code 99199. 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.

4. 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.

Dr. Brylowski is seeking additional reimbursement in the amount of $3,410.00 for 10 units of 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. The requestor is therefore entitled to one unit of 90792.

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.

5. 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 ... 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.

6. Dr. Brylowski is seeking an 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."

   The insurance carrier paid $251.19 for procedure code 96132 billed with four units. The report does not indicate the start and end times to support the number of units billed for this service. Therefore, Dr. Brylowski is not entitled to additional reimbursement for this code.

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.

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 $150.00 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 Travelers Casualty & Surety Co. must remit to Andrew Brylowski, M.D. $150.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 15, 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.