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
Standard Fire Insurance Co.

MFDR Tracking Number
M4-24-1151-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
January 22, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 27, 2023 – February 15, 2023	99082-59	$180.00	$0.00
	99199-59	$258.00	$0.00
	90792-59	$3,420.36	$0.00
	96116-59	$179.73	$0.00
	96121-59	$0.00	$0.00
	96132-59	$0.00	$0.00
	96133-59	$2,726.36	$0.00
	96136-59	$0.00	$0.00
	96137-59	$888.12	$0.00
	Total	$7,652.57	$0.00

Requestor's Position

"**99082-59:** Physician unusual travel CPT code 99082 is billed at $2 per mile … He traveled a total of 90 miles roundtrip.

"**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:** 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 …

"**96116-59:** 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.

"**96133-59, 96137-59:**
"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. A history and diagnostic interview along with a review of medical records and collateral information that was available was done … History and physical and neuropsychiatric diagnostic interview as well as neuropsychiatric testing administration were accomplished.

"This process involved approximately 7 hours of staff and physician time. Neuropsychiatric testing administration and interpretation, report preparation, review of medical records, literature search, AMA guides 4th edition, MDGuidelines, ODG, DSM 5, and other specialty guideline search as necessary were accomplished on January 26, 2023, January 27, 2023, January 28, 2023, January 29, 2023, February 4, 2023, February 5, 2023, February 8, 2023, February 9, 2023, February 12, 2023, February 13, 2023, February 14, 2023, and February 15, 2023. This process involved approximately 21 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: $7,652.57

Respondent's Position

"For CPT code 99082 (travel), this code is not separately reimbursable under the Medicare edits when the place of service code is an office (11).

"For CPT code 99199 (report preparation), this code is not separately reimbursable under the Medicare edits as it is included in the reimbursement for the individual tests, specifically CPT codes 90792, 96132, 96133, 96136 and 96137.

"For CPT code 97092 (interview and examination), the Medically Unlikely Edits (MUE) limit this CPT code to one unit unless appropriately documented. The Carrier reimbursed one unit as only one examination is documented.

"For CPT code 96116 (psychological testing), reimbursement for tis code is included in the reimbursement for CPT code 90792.

"As to CPT code 96133 (neuropsychological testing, per hour), the Provider billed 21 units for this CPT code, corresponding to 21 hours of testing that day. The Medicare edits limit reimbursement for this code to 7 units per day under the Medicare Unlikely Edits. The Provider has not submitted documentation to substantiate additional time for this code. As the Medicare edits allow only 7 units of this CPT code per day, which the Carrier has reimbursed, the Provider is not entitled to additional reimbursement.

"As to CPT code 96137 (psychologist administered psychological testing, additional 30 minutes), the Provider billed another 21 units for this CPT code, 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. The Medicare edits limit reimbursement for this code to 11 units per day under the Medicare Unlikely Edits. The Provider has not submitted documentation to substantiate additional time or dates of service. As the Carrier has reimbursed for the maximum allowed testing, the Provider is not entitled to additional reimbursement."

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 §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.
- 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 number 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 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.
- 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 code.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 947 – Upheld. No additional allowance has been recommended.
- 1001 – Based on the corrected billed and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 863 – Reimbursement is based on the applicable reimbursement fee schedule.
- 2008 – Additional payment made on appeal/reconsideration.
- 5449 – Review of the submitted documentation does not substantiate the service billed.
- 50 – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.
- 5758 – The service/procedure is not reimbursable under workers' compensation law.
- 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 are the services considered in this report?
2. What are the applicable rules for review of this dispute?
3. Is Andrew Brylowski, M.D. entitled to reimbursement for procedure code 99082?
4. Is Dr. Brylowski entitled to reimbursement for procedure code 99199?
5. Is Dr. Brylowski 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 96133 and 96137?

Findings

1. Dr. Brylowski submitted this dispute in accordance with 28 TAC §133.307 for the following procedure codes:

    - 99082-59
    - 99199-59
    - 90792-59
    - 96116-59
    - 96121-59
    - 96132-59
    - 96133-59
    - 96136-59
    - 96137-59

    He is seeking $0.00 for procedure codes 96121-59, 96132-59, and 96136-59. Therefore, these procedures will not be considered in this dispute. The remaining codes will be reviewed in accordance with applicable statutes and rules.

2. The services in dispute are considered professional medical services. 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 …"

3. Dr. Brylowski is seeking $180.00 for procedure code 99082. This procedure code is defined as "Unusual travel (eg, transportation and escort of patient). This code is adjunct to basic services rendered. The physician reports this code to indicate unusual travel for the purpose of transportation or accompanying the patient."

   The insurance carrier denied this service, in part, with denial code 97, stating, "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   CMS Internet Only Manual 100-04, Chapter 12, Section 80.3 states, "Unusual Travel (CPT Code 99082) (Rev. 1, 10-01-03) B3-15026 In general, travel has been incorporated in the MPFSDB individual fees and is thus not separately payable. A/B MACs (B) must pay separately for unusual travel (CPT code 99082) only when the physician submits documentation to demonstrate that the travel was very unusual."

   DWC found no documentation to support that very unusual travel was performed. No reimbursement is recommended for this service.

4. Dr. Brylowski is seeking $258.00 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 97, stating, "Payment adjusted because 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)."

   DWC finds that Dr. Brylowski failed to demonstrate how this service was "above and beyond the usual" for the conditions in question. No reimbursement can be recommended for this service.

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."

DWC finds that the submitted documentation supports this service as defined. Dr. Brylowski billed 10 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 75702 which is in Medicare locality 0440299.

The Medicare participating amount for CPT code 90792 is $192.60. The MAR is calculated as follows: (64.83/33.8872) x $192.60 = $368.47.

The total MAR for procedure code 90792 is $368.47. Per explanation of benefits dated March 3, 2023, the insurance carrier paid this amount in full. No additional reimbursement is recommended.

6. Disputed procedure code 96121 is a timed add-on code 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 modifier 59.

   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. Disputed procedure code 96133 is a timed add-on code 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 96137 is a timed add-on code 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."

   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."

Procedure code 96133 is an add-on code to procedure code 96132. The insurance carrier paid $1,299.97 for procedure code 96133. Procedure code 96137 is an add-on code to procedure code 96136. The insurance carrier paid $800.91 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 reimbursement for the disputed services.

Authorized Signature

		April 26, 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.