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
Texas Mutual Insurance Company

MFDR Tracking Number
M4-24-1156-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
January 24, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 23, 2023 – April 12, 2023	99082-59	$0.00	$0.00
	99199-59	$974.00	$0.00
	90792-59	$3,409.52	$0.00
	96116-59	$0.00	$0.00
	96121-59	$1,468.94	$0.00
	96132-59	$2,260.77	$0.00
	96133-59	$4,026.29	$0.00
	96136-59	$0.00	$0.00
	96137-59	$1,610.79	$0.00
	Total	$13,750.31	$0.00

Requestor's Position

"**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 the necessity arises, you are allowed to claim more than one unit of 90792 in a year indicating the medical necessity of the evaluation. The following ICD-10-CM codes: (redacted), support medical necessity and provide coverage for CPT/HCPCS codes: 90792, 96121, 96132, 96133, & 96137.

"**96131-59:** 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.

"**96132-59, 9613359, 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 …

"This process involved approximately 10 hours of staff and physician time. Neuropsychiatric testing administration nd 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 March 22, 2023, March 23, 2023, March 24, 2023, March 28, 2023, March 29, 2023, April 1, 2023, April 2, 2023, April 6, 2023, April 7, 2023, April 10, 2023, April 11, 2023, and April 12, 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: $13,750.31

Respondent's Position

"Texas Mutual denied CPT code 99199 as review of medical records is a part of the examination process. We denied CPT code 96121-59 due to not being able to confirm the amount of time spent with the injured worker during the exam. 96121 is a timed add on code that is billed per hour and the health care provider is billing for 10 hours spent. Additionally, CPT code 96132 is also a timed code to be billed for the first hour of neuropsychological testing and the health care provider is billing for 10 hours. CPT code 96133-59 was billed for 21 units and is also a timed code for each additional hour of neuropsychological 96137-59 was billed for 21 units and again Texas Mutual is unable to determine time spent with the injured worker during the examination."

Response Submitted by: Texas Mutual Insurance Company

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 or denied the payment for the disputed services with the following claim adjustment codes:

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 641 – The Medically Unlikely Edits (MUE) from CMS has been applied to this procedure code.
- 750 – The service billed does not qualify as a medical service nor has medical necessity of the non-medical service provided been established
- 790 – This charge was reimbursed in accordance with the Texas Medical Fee Guideline.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- Notes: "225, 892: Documentation is not consistent with CPT code 90791 in reference to CPT/AMA guidelines."
- DC4 – No additional reimbursement allowed after reconsideration.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-18 – Exact duplicate claim/service
- 224 – Duplicate charge.
- DC7 – Duplicate appeal. Network contract applied by WorkWell, TX Network.
- Notes: "225, 892: Documentation is not consistent with CPT code 90791 in reference to CPT/AMA guidelines. Documentation does not support timed treatment billed."

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 99199?

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

5. Is Dr. Brylowski entitled to reimbursement for procedure code 96121?

6. Is Dr. Brylowski entitled to additional reimbursement for procedure codes 96132, 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 99082-59, 96116-59, 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 $974.00 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)."

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

4. 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 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. Per explanation of benefits dated May 19, 2023, the insurance carrier paid this amount in full. No additional reimbursement is recommended.

5. 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. Because disputed procedure code 96121 is an add-on code for timed procedure code 96116, no reimbursement can be recommended for CPT code 96121.

6. 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.

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."

The insurance carrier paid $251.19 for procedure code 96132 and $0.00 for procedure code 96133. The insurance carrier paid $0.00 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, 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

		May 2, 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.