TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
Andrew Brylowski, M.D.

**Respondent Name**
Benchmark Insurance Co.

**MFDR Tracking Number**
M4-24-1711-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
April 9, 2024

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| June 28, 2023 – July 15, 2023 | 99456-W5-WP | $300.00 | $300.00 |
| | 99456-W8-RTW | $0.00 | $0.00 |
| | 99199-51-59 | $0.00 | $0.00 |
| | 90792-51-AF | $0.00 | $0.00 |
| | 96116-51 | $179.73 | $0.00 |
| | 96121-51 | $1,468.94 | $0.00 |
| | 96132-51-59 | $0.00 | $0.00 |
| | 96133-51-59 | $0.00 | $0.00 |
| | 96136-51-59 | $0.00 | $0.00 |
| | 96137-51-59 | $1,515.01 | $0.00 |
| | **Total** | $3,463.68 | $300.00 |

## Requestor's Position

Initial Statement: "**99456-W5-WP:** TAC §134.250(4)(C)(iii) states, 'If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP.' Reimbursement shall be 100 percent of the total MAR.'

"**Total Amount Due: $300**

"**96116-51-59:** 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.' Dr. Brylowski performed a complete neurobehavioral status examination, therefore, he can bill both codes together.
"**Total Amount Due: $179.73**

"**96121-51-59:** 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.' Dr Brylowski performed a complete neurobehavioral status examination; therefore, he can bill both codes together.

"**Total Amount Due: $1,468.94**

"**96137-51-59:** 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... History and diagnostic interview along with a review of medical records and collateral information that was available was done …

"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 June 27, 2023, June 28, 2023, June 29, 2023, July 7, 2023, July 8, 2023, July 9, 2023, July 12, 2023, July 13, 2023, July 14, 2023, and July 15, 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.

"**Total Amount Due: $1,515.01**"

Subsequent Statement: "You are referring to clinical examination not to forensic examinations. This would not apply to a forensic examination … Clinical examination means that the person's subjective report is taken at face value.

"Forensic examination means that the person subjective reporting has to be corroborated and alternative explanations have to be ruled out so that there is objective data is either a positive or negative direction supporting or not supporting subjective complaints."

**Amount in Dispute:** $3,463.68

## Respondent's Position

"… 96116 bundles with 90792 and 96121 was not billed with the correct base code. The provider is billing MMI/IR for 2 body areas (concussion & spine) which pays $800.00 … 90792 isn't payable

because it was billed with 99456 so if 90792 isn't payable (meaning they shouldn't have billed it to begin with because it's not payable with 99456) then 96116 isn't payable either."

**Response Submitted by:** Downs & Stanford, P.C.

## 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 services.

3. 28 TAC §134.235, effective July 7, 2016, 41 TexReg 4839, sets out the fee guidelines for examinations to determine the ability to return to work on the date of service in question.

4. 28 TAC §134.250, effective July 7, 2016, 41 TexReg 4839, sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed on the date of service in question.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 86 – Service performed was distinct or independent from the other services performed on the same day.
- P12 – Workers 'compensation jurisdictional fee schedule adjustment.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- 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.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has been adjudicated.
- 292 – This procedure code is only reimbursed when billed with the appropriate initial base code.
- 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
- N702 – Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.

- 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.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2008 – Additional payment made on appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- MA46 Alert: The new information was considered but additional payment will not be issued.

Issues

1. What services are considered in this dispute?

2. Is Dr. Brylowski entitled to additional reimbursement for the examination to determine maximum medical improvement and impairment rating?

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

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

5. Is Dr. Brylowski entitled to additional reimbursement for procedure code 96137?

Findings

1. Dr. Brylowski submitted a request for medical fee dispute resolution in accordance with 28 TAC §133.307. He is seeking additional reimbursement for a designated doctor examination and related testing provided from June 28, 2023, through July 15, 2023. Dr. Brylowski is seeking $0.00 for procedure codes 99456-W8, 99199, 90792, 96132, 96133, and 96136. Therefore, these services will not be considered in this dispute.

   DWC will consider the remaining services represented by procedure codes 99456-WP-W5, 96116, 96121, and 96137.

2. This request for medical fee dispute resolution included an additional $300.00 for a designated doctor examination to determine maximum medical improvement (MMI) and impairment rating.

   The submitted documentation supports the claim that Dr. Brylowski performed an evaluation of MMI 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 cervical, thoracic, and lumbar spine with range of motion testing. 28 TAC §134.250(4)(C) states, "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are defined as follows:
(I) spine and pelvis;
(II) upper extremities and hands; and
(III) lower extremities (including feet)."

28 TAC §134.250(4)(C)(ii) defines the fees for the calculation of an impairment rating for musculoskeletal body areas and states that the MAR for assignment of impairment of the first musculoskeletal body area, in this case, the spine, performed with range of motion is $300.00.

Dr. Brylowski also performed impairment rating evaluations of a concussion, the skin, and mental and behavioral function. 28 TAC §134.250(4)(D)(i) states, "Non-musculoskeletal body areas are defined as follows:

(I) body systems;
(II) body structures (including skin); and
(III) mental and behavioral disorders."

28 TAC §134.250(4)(D)(v) states that the MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each. Therefore, the total allowable reimbursement for the assignment of impairment rating of non-musculoskeletal body areas is $450.00.

The total allowable reimbursement for the examination to determine MMI and impairment rating is $1,100.00. Per the explanation of benefits dated September 20, 2023, the insurance carrier paid $800.00. An additional $300.00 is recommended.

3. According to the submitted records, Dr. Brylowski performed additional testing and incorporated that testing into the designated doctor examination report.

   28 TAC §134.250(4)(D) states, "Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR."

   Examinations to determine the ability to return to work are subject to 28 TAC §134.235 which states, in relevant part, "Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

   The testing services in dispute are professional services subject to the fee guidelines 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."

4. Dr. Brylowski is 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." Dr. Brylowski appended modifiers 51 for this 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."

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. Procedure code 96121 is an add-on code for timed procedure code 96116.

The requestor has failed to demonstrate its reasoning for why the disputed fees should be paid; how the Labor Code and DWC rules, including fee guidelines, impact the disputed fee issues; and how the submitted documentation supports the request for each disputed fee issue in accordance with 28 TAC §133.307(c)(2)(N). No reimbursement can be recommended for these services.

5. Dr. Brylowski is also seeking additional reimbursement for procedure code 96137, which is a timed add-on code for 96136 that 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 documentation provided does not list the start and end times to support the number of hours billed for add-on timed procedure code 96137. Per explanation of benefits dated July 20, 2023, the insurance carrier paid $76.28 for this service.

The requestor has failed to demonstrate its reasoning why the disputed fees should be paid; how the Labor Code and DWC rules, including fee guidelines, impact the disputed fee issues; and how the submitted documentation supports the request for each disputed fee issue in accordance with 28 TAC §133.307(c)(2)(N). No additional reimbursement can be recommended for this service.

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 additional reimbursement of $300.00 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 Benchmark Insurance Co. must remit to Andrew Brylowski, M.D. $300.00 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 | June 18, 2024<br>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.