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 Indemnity Co.

MFDR Tracking Number
M4-24-1740-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
April 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 24, 2023 – August 22, 2023	99082-51-59	$0.00	$0.00
	99199-51-59	$0.00	$0.00
	90792-51-59	$4,092.67	$0.00
	96116-51-59	$0.00	$0.00
	96121-51-59	$0.00	$0.00
	96132-51	$2,738.89	$0.00
	96133-51	$2,659.93	$0.00
	96136-51-59	$0.00	$0.00
	96137-51-59	$744.28	$0.00
	Total	$10,235.77	$0.00

Requestor's Position

"**90792-51**: 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 …

"**Total Amount Due: $4,092.67**

"**96132-51-59, 96133-51, 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. A history and diagnostic interview along with a review of medical records and collateral information that was available was done …

"This process involved approximately 21 hours of staff and physician time. Neuropsychiatric testing administration and interpretation, report preparation, review of medical records, literature search, AMA guides 4th edition, MD Guidelines, ODG, DSM 5, and other specialty guideline search as necessary as well as discussion of the case with primary assigned DDE were accomplished on July 22, 2023, July 23, 2023, July 24, 2023, July 30, 2023, July 31, 2023, August 3, 2023, August 4, 2023, August 6, 2023, August 7, 2023, August 8, 2023, August 9, 2023, August 18, 2023, and August 22, 2023. This process involved approximately 23 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 29 hours.

"**96132 Total Amount Due: $2,738.89** **96133 Total Amount Due: $2,659.93**
"**96137 Total Amount Due: $744.28**"

Amount in Dispute: $10,235.77

Respondent's Position

"The Provider contends they are entitled to additional reimbursement for multiple CPT codes related to the testing and evaluation. As to CPT code 90792 …, the Provider contends they are entitled to additional reimbursement. The Provider billed 12 units for this CPT code. The Medicare edits limit reimbursement for this code to 1 unit per day under the Medicare Unlikely Edits. The Carrier reimbursed the maximum Medicare allowable units …

"As to CPT code 96132 … the Provider contends they are entitled to additional reimbursement. The Provider billed 12 units for this CPT code. The Medicare edits limit reimbursement for this code to 1 unit per day under the Medicare Unlikely Edits. The Carrier reimbursed the maximum Medicare allowable units …

"As to CPT code 96133 …, the Provider contends they are entitled to additional reimbursement. The Provider billed 12 units for this CPT code. The Provider billed 21 units for this CPT code on the single date of service, corresponding to 21 hours of testing. The Medicare edits limit reimbursement for this code to 7 units per day under the Medicare Unlikely Edits. The Carrier reimbursed the Provider at the full Medicare edit allowed of 7 units. The Provider has not submitted documentation to substantiate additional time or dates of service …

"As to CPT code 96137 …, the Provider contends they are entitled to additional reimbursement. The Provider billed another 21 units for this CPT code on the single date of service, corresponding to 21 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 again limit reimbursement for this code to 7 unit per day under the Medicare Unlikely Edits. The Carrier reimbursed the Provider at the full Medicare edit allowed of 7 units. The Provider has not submitted documentation to substantiate additional time or dates of service."

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 services.

Denial Reasons

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

- 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.
- 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.
- 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.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 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 services are considered in this dispute?

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

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

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

Findings

1. Dr. Brylowski is seeking additional reimbursement for testing related to a designated doctor examination.

   He is seeking $0.00 for procedure codes 99082, 99199, 96116, 96121, and 96136. Therefore, these services will not be considered in this dispute.

   Dr. Brylowski is seeking an additional payment of $10,235.77 for procedure codes 90792, 96132, 96133, and 96137. These services are considered in this dispute.

2. Reimbursement policies for professional services are 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 additional 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 12 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 76102 which is in Medicare locality 0441228.

   The Medicare participating amount for CPT code 90792 is $196.48. The MAR is calculated as follows:

   - (64.83/33.8872) x $196.48 = $375.89

   The total MAR for procedure code 90792 is $375.89. Per explanation of benefits dated August 18, 2023, this amount was paid in full. No additional reimbursement is recommended for this service.

4. Dr. Brylowski is also 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 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 the timed procedure codes in question. Per explanation of benefits dated August 18, 2023, the insurance carrier paid $248.99 for procedure code 96132; $1,329.93 for procedure code 96133; and $827.42 for procedure code 96137.

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 these services.

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

Signature	Medical Fee Dispute Resolution Officer	June 14, 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, 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.