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
M4-24-1768-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
April 15, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 30, 2023 – September 17, 2023	Designated Doctor Examination 99456-W6-RE	$0.00	$0.00
	Specialist Report Incorporated 99456-SP	$50.00	$0.00
	99199-51-59	$1,643.00	$0.00
	90792-51-59	$3,409.52	$0.00
	96116-51-59	$179.73	$0.00
	96121-51-59	$1,468.94	$0.00
	96132-51-59	$2,511.96	$0.00
	96133-51-59	$4,026.29	$0.00
	96136-51-59	$82.68	$0.00
	96137-51-59	$1,591.29	$0.00
	Total	$14,963.41	$0.00

Requestor's Position

"**99199-51-59:** 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).

"**Total Amount Due: $1,643**

"**90792-51-59:** 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 …

"**Total Amount Due: $3,409.52**

"**96116-51-59, 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 with [the injured employee], therefore he can use both codes together.

"**96116 Total Amount Due: $179.73** **96121 Total Amount Due: $1,468.94**

"**96132-51-59, 96133-51-59, 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, electrodiagnostic 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 interpretation, report preparation, as well as a review of medical records were accomplished on August 29, 2023, August 30, 2023, August 31, 2023, September 1, 2023, September 2, 2023, September 6, 2023, September 10, 2023, September 11, 2023, September 15, 2023, September 16, 2023, and September 17, 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, MRI examination, neuropsychiatric measures and EMG studies and interpretation and integration of this information into report format was approximately 26 hours.

"**96132 Total Amount Due: $2,511.96** **96133 Total Amount Due: $4,026.29**
"**96136 Total Amount Due: $82.68** **96137 Total Amount Due: $1,591.29**"

Amount in Dispute: $14,963.41

Respondent's Position

"Texas Mutual denied CPT code 99199 as review of medical records is inclusive to the examination process. Texas Mutual paid 1 unit for code 90792, however the remaining 9 units were denied as the documentation does not support additional units. Texas Mutual denied the following timed codes 96136, 96137, 96116, 96121, 96132, and 96133 as the documentation provided does not give start and stop times for the timed codes. On page 8 of the DWC-60 packet the provider gives approximate times, however no where in the documentation are specific start and stop times. Texas Mutual is unable to determine time spent with the injured worker during the examination. Refer to rule 134.203(b) states 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. Refer to the Medicare National Correct Coding Initiative Policy Manual (NCCI) manual found at www.cms.gov, Chapter XI, Evaluation and Management Services, CPT Codes 90000 – 99999, Section M, 2, states, 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. In addition, 96116 and 96121 shall not be reported with psychiatric diagnostic examinations, 90791 or 90792 per Medicare NCCI Manual, Chapter XI, Section M,1.

"Texas Mutual has elected to reprocess the disputed services for code 99456-SP-51-59 in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 …"

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 (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 §134.235, effective July 7, 2016, 41 TexReg 4839 sets forth the fee guidelines for examinations to determine the extent of a compensable injury.

Denial Reasons

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

- Notes: Please submit documentation to support the full time of treatment billed. Documentation does not support units billed.
- 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.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 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.
- CAC-18 – Exact duplicate claim/service
- 224 – Duplicate charge.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 891 – No additional payment after reconsideration

Issues

1. What services are considered in this dispute?
2. Is Andrew Brylowski, M.D. entitled to reimbursement for incorporating a specialist's report?
3. Is Dr. Brylowski entitled to reimbursement for procedure code 99199?
4. What rules apply to a review of payment for the testing services in question?
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 96132, 96133, 96136, and 96137?

Findings

1. Dr. Brylowski is seeking additional reimbursement for a designated doctor examination and related testing. He is seeking $0.00 for the examination to determine the extent of the compensable injury. Therefore, this service will not be considered in this dispute.

   The requestor is seeking $50.00 for incorporating a specialist's report into the documented findings. He is seeking $1,643.00 for records processing related to the examination. He is also seeking $13,270.41 for testing procedures. These are the services reviewed in this dispute.

2. The requestor is seeking $50.00 for incorporating a specialist's report into the documented findings using procedure code 99456-SP-51-59. Per explanation of benefits dated May 1, 2024, the insurance carrier paid this amount in full. No additional reimbursement is recommended for this service.

3. Dr. Brylowski is seeking $1,643.00 for procedure code 99199-51-59. 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 750, stating, "The service billed does not qualify as a medical service nor has medical necessity of the non-medical service provided been established."

   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 §134.235 states, in relevant part, "When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier "RE." In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports."

   Because the services described by Dr. Brylowski represented by the code in question are included in the MAR for an examination to determine the extent of the compensable injury, no reimbursement can be recommended.

4. DWC will review the disputed testing services in accordance with the applicable fee guidelines for professional medical services 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. The 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.

5. Dr. Brylowski is seeking additional reimbursement in the amount of $3,409.52 for a total of 10 units for procedure code 90792, which is defined as a "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. Per explanation of benefits dated October 11, 2023, the insurance carrier reimbursed this amount in full. DWC finds that Dr. Brylowski is not entitled to additional reimbursement for this code.

6. Dr. Brylowski is also seeking reimbursement for procedure code 96116 and 96121.

   Procedure code 96116 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." Disputed procedure code 96121 is a timed add-on code for procedure code 96116. Dr. Brylowski appended modifiers 51 and 59 for each 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. 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. Dr. Brylowski is seeking reimbursement for procedure code 96132, 96133, 96136, and 96137.

   Procedure code 96132 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.

Procedure code 96136 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." Disputed procedure code 96137 is a timed add-on code for procedure code 96136.

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 submitted documentation does not indicate the start and end times to support the number of hours billed for these services. 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 additional reimbursement is 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 21, 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.