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
AIU Insurance Co.

MFDR Tracking Number
M4-24-1825-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 18, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 21, 2023 – October 8, 2023	Designated Doctor Examination 99456-W5-WP	$150.00	$150.00
	99199-51-59	$0.00	$0.00
	90792-51-59	$3,409.52	$0.00
	96116-51-59	$0.00	$0.00
	96121-51-59	$0.00	$0.00
	96132-51-59	$2,260.77	$0.00
	96133-51-59	$3,834.56	$0.00
	96136-51-59	$0.00	$0.00
	96137-51-59	$1,515.01	$0.00
	Total	$11,169.86	$150.00

Requestor's Position

"**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: $150**

"**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: $3,409.52**

"**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, 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 12 hours of staff and physician time. Neuropsychiatric testing interpretation, report preparation, as well as a review of medical records were accomplished on September 20, 2023, September 21, 2023, September 22, 2023, September 29, 2023, September 30, 2023, October 1, 2023, October 5, 2023, October 6, 2023, October 7, 2023, and October 8, 2023. This process involved approximately 26 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 28 hours.

"**96132 Total Amount Due: $2,260.77** **96133 Total Amount Due: $3,834.56**
"**96137 Total Amount Due: $1,515.01**"

Amount in Dispute: $11,169.86

Respondent's Position

"For an exam that appears to be based solely on the issues of MMI and the impairment rating and should be based solely upon the compensable injury … the provider billed $15,014.24 for an exam that would normally be billed at between $500 and $650.

"The provider conceded that the carrier had already paid him $3729.33 … The reimbursement rate for the MMI portion of the exam is $350. The impairment rating portion of the exam is reimbursed at $150 for each body area unless there is a full physical evaluation with range of motion in which case, the reimbursement is $300. Accordingly, it is the carrier's position that the reimbursement should have been either $500 which is based upon $350 for the MMI portion of the exam plus $150 for the impairment rating portion of the exam or $650 if in fact, range of motion was done …

"It is the carrier's position that it has already overpaid the provider but it agrees with the denials and reductions in the EORs."

Response Submitted by: Flahive, Ogden & Latson

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 §134.250, effective July 7, 2016, 41 TexReg 4839 sets forth the fee guidelines for examinations to determine

Denial Reasons

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

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 5141 – Bill has been reviewed by a nurse or under the direction of a nurse.
- 5346 – Please specify time spent on billed procedure for further review.
- 250 – The attachement/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 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.
- 1126 – This reconsideration reflects corrected charge amounts
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 2008 – Additional payment made on appeal/reconsideration
- 5191 – This amount has been determined to have been paid in excess of the correct allowance; therefore, an overpayment request is being issued.
- 5420 – The procedure was reviewed according the submitted report. Please note number of units were changed according to the performed Service/Time/Qty.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P13 – Payment reduced or denied based on Workers' Compensation jurisdictional regulations or payment policies.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.

Issues

1. What services are considered in this dispute?

2. Is Andrew Brylowski, M.D. 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 code 90792?

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

Findings

1. Dr. Brylowski is seeking additional reimbursement for a designated doctor examination and related testing. He is seeking $0.00 for procedure codes 99199, 96116, 96121, and 96136. Therefore, these services will not be considered in this dispute.
   The requestor is seeking $150.00 for the examination to determine maximum medical improvement and impairment rating. He is also seeking $11,019.86 for testing procedures. These are the services reviewed in this dispute.

2. The submitted documentation supports that Dr. Brylowski performed an evaluation of maximum medical improvement 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 (redacted) with range of motion testing. 28 TAC §134.250(4)(C)(ii) defines the fees for the calculation of an impairment rating for musculoskeletal body areas. The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is $300.00.
   The submitted documentation also supports that Dr. Brylowski performed impairment rating evaluations of mental and behavioral conditions; contusions, abrasions, and lacerations; and (redacted). 28 TAC §134.250(4)(D) defines the fees for the calculation of an impairment rating for non-musculoskeletal body areas. The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.
   The total allowable reimbursement for the services in question is $1,100.00. Per explanation of benefits dated October 23, 2023, the insurance carrier paid $800.00. Dr. Brylowski is seeking an additional $150.00. This amount is recommended.

3. The testing services in question are considered professional medical services. DWC will therefore 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.

4. 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 23,

2023, the insurance carrier reimbursed this amount in full. The requestor has failed to demonstrate its reasoning why the disputed additional 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 this disputed fee issue in accordance with 28 TAC §133.307(c)(2)(N). DWC finds that Dr. Brylowski is not entitled to additional reimbursement for this code.

5. Dr. Brylowski is seeking additional reimbursement for procedure code 96132 and 96133. 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.

   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 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 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). The insurance carrier paid $519.20. 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 established that additional reimbursement of $150.00 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 AIU Insurance Co. must remit to Andrew Brylowski, M.D. $150.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		July 10, 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.