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
Dallas Area Rapid Transit

MFDR Tracking Number
M4-24-1890-01

Carrier's Austin Representative
Box Number 53

DWC Date Received
April 25, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 31, 2023 – November 14, 2023	Designated Doctor Examination 99456-W5-WP	$1,100.00	$1,100.00
	Designated Doctor Examination 99456-W8-RE	$500.00	$500.00
	99199-51-59	$0.00	$0.00
	90792-51-59	$0.00	$0.00
	96116-51-59	$179.73	$0.00
	96121-51-59	$1,615.79	$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	$4,910.53	$1,600.00

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: $1,100**

"**99456-W8-RE:** (k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC Examinations. 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 MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

"**Total Amount Due: $500**

"**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.'

"**96116 Total Amount Due: $179.73** **96121 Total Amount Due: $1,615.79**

"**96137-51-59:**
Physical and neuro-behavioral examination along with additional testing that was medically necessary for this examination such as functional capacity examination, neuropsychiatric testing/measures, blood work, imaging studies, etc. and examination were accomplished along with a review of medical records that were available …

"This process involved approximately 12 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 were accomplished on October 30, 2023, October 31, 2023, November 1, 2023, November 2, 2023, November 6, 2023, November 7, 2023, November 8, 2023, November 11, 2023, November 12, 2023, November 13, 2023, and November 14, 2023. this process involved approximately 21 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"

Amount in Dispute: $4,910.53

Respondent's Position

"They complete psych evaluations and bill with time-based codes and then don't document the time spent to complete each exam. For example….they are billing 21 hours of testing for code 96133 (which was paid in full on this bill and should not have been). Another example on the bill is code 96121. They are billing for 11 hours of evaluation time but they never documented the time it took to complete the exam. They are also billing 99199, which also should not have been

paid as we do not pay for 'Vol Rec Org' which is printed on the bill next to the code. The provider has already been overpaid in this case due to lack of documentation, so they are not owed any additional at this time."

Response Submitted by: Hoffman Kelley, LLP

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 out the fee guidelines for examinations to determine ability to return to work.

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.

Denial Reasons

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

- 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 already been adjudicated.
- N702 – Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
- 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.
- 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.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- N600 – Adjusted based on the applicable fee schedule for the region in which the

service was rendered.

- 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.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1003 – In response to your appeal of our previous re-evaluation, no significant additional documentation or information regarding this claim has been received. Our position remains unchanged on the same questions that were previously posed by the provider. Therefore, no additional allowance is recommended.
- 247 – A payment or denial has already been recommended for this service.
- 18 – Exact duplicate claim/service.
- N111 – No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.

Issues

1. What are the services considered in this dispute?

2. Are Dallas Area Rapid Transit's denials of payment for the designated doctor examination supported?

3. Is Andrew Brylowski, M.D. entitled to reimbursement for the designated doctor examination?

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

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

6. Is Dr. Brylowski entitled to reimbursement for procedure code 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, 90792, 96132, 96133, and 96136. Therefore, these services will not be considered in this dispute.

   The requestor is seeking $1,100.00 for a designated doctor examination requested by the insurance carrier to determine maximum medical improvement and impairment rating. He is seeking $500.00 for a designated doctor examination requested by the insurance carrier to determine the injured employee's ability to return to work. He is also seeking $3,310.53 for testing procedures. These are the services reviewed in this dispute.

2. A designated doctor examination was billed using procedure codes 99456-W5-WP and 99456-W8-RE, representing an evaluation to determine maximum medical improvement, impairment rating, and ability to return to work. This examination was requested by the insurance carrier and ordered by DWC.

   The insurance carrier denied payment for the following reasons:

- 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 already been adjudicated.

The procedure codes in question are division-specific services reimbursed in accordance with 28 TAC §§134.235 and 134.250 and are not subject to Medicare fee guidelines or the National Correct Coding Initiative and Medically Unlikely Edits. They are not included in the other services performed with this designated doctor examination. Therefore, DWC finds that these denial reasons are not supported.

3. Because the insurance carrier's denials of payment for the designated doctor examinations were not supported, Dr. Brylowski is entitled to reimbursement for these services.

   The submitted documentation supports that Dr. Brylowski performed an evaluation of maximum medical improvement (MMI) as ordered by 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 lumbar spine and hip 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 MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.

   The submitted documentation indicates that Dr. Brylowski also performed impairment rating evaluations of mental and behavioral conditions; cranial nerves; contusions and abrasions; and ear, nose, and throat conditions. 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 submitted documentation indicates that Dr. Brylowski performed an examination to determine the ability to return to work. According to 28 TAC §134.235, the MAR for this examination is $500.00.

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Lumbar Spine (ROM)	Musculoskeletal System	Spine and Pelvis	$300.00
IR: Hip (ROM)		Lower Extremities	$150.00
IR: Mental and Behavioral	Mental & Behavioral	Mental & Behavioral	$150.00
IR: Cranial Nerves	Nervous System	Body Systems	$150.00
IR: Contusions and Abrasions	Skin	Body Structures	$150.00
IR: Ear/Nose/Throat Conditions	Ear, Nose, Throat, Related	Body Structures	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$1,050.00**
Total Return to Work			**$500.00**
Total Exam			**$1,900.00**

The total allowable reimbursement for the designated doctor examination is $1,900.00. Dr. Brylowski is seeking $1,600.00. This amount is 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 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.

6. 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.

   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 this disputed fee issue in accordance with 28 TAC §133.307(c)(2)(N). No additional reimbursement can is 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 $1,600.00 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 Dallas Area Rapid Transit must remit to Andrew Brylowski, M.D. $1,600.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 24, 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.