

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Andrew Brylowski, M.D.

**Respondent Name**

Zurich American Insurance Co.

**MFDR Tracking Number**

M4-24-1917-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

May 1, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 2, 2023 – November 20, 2023	Designated Doctor Examination 99456-W5-WP	\$300.00	\$300.00
	99199-51-59	\$0.00	\$0.00
	90792-51-59	\$0.00	\$0.00
	96116-51-59	\$179.73	\$0.00
	96121-51-59	\$1,468.94	\$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
<b>Total</b>		<b>\$3,463.68</b>	<b>\$300.00</b>

### 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.'

"1 unit for Upper Extremity: \$350

1 unit for Lower Extremity: \$300

2 units for Mental and Behavioral=\$300

1 units for Skin= \$150

1 unit for Ear, Nose & Throat= \$150

**"Total Amount Due: \$300**

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.' A complete neurobehavioral status exam was performed ..., therefore, Dr. Brylowski can use both codes 96116 & 96121 together.

**"96116 Total Amount Due: \$179.73**

**96121 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. A history and diagnostic interview along with a review of medical records and collateral information that was available was done. Neuropsychiatric testing interpretation, report preparation, as well as a review of medical records were accomplished.

"This process involved approximately 14 hours of staff and physician time. Neuropsychiatric testing interpretation, report preparation, as well as a review of medical records were accomplished on October 31, 2023, November 1, 2023, November 2, 2023, November 3, 2023, November 6, 2023, November 7, 2023, November 8, 2023, November 13, 2023, November 14, 2023, November 17, 2023, November 18, 2023, November 19, 2023, and November 20, 2023. This process involved approximately 23 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 27 hours."

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

### **Respondent's Position**

The Austin carrier representative for Zurich American Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on May 7, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

## 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 out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed prior to June 1, 2024.

### Denial Reasons

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

- TXP12 – Workers' compensation jurisdictional fee schedule adjustment.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 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.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 2008 – Additional payment made on appeal/reconsideration.
- 292 – This procedure code is only reimbursed when billed with the appropriate initial base code.
- 86 – Service performed was distinct or independent from other services performed on the same day.
- 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 (90000-999999) has been disallowed.
- TX96 – Non-covered charge(s).
- TX97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 6590 – Reviewed per applicable State Fee Schedule guidelines.
- 6766 – Specialty Bill Audit/Expert Code Review involving the application of code auditing rules and edits based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, and coding

guidelines developed by na

- 97 – Charge Included in another Charge or Service
- TX193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- TXB20 – Payment adjusted because procedure/service was partially or fully furnished by another provider.

### 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 \$300.00 for a designated doctor examination requested by the insurance carrier to determine maximum medical improvement and impairment rating. He is also seeking \$3,163.68 for testing procedures. These are the services reviewed in this dispute.

2. A designated doctor examination was billed using procedure codes 99456-W5-WP representing an evaluation to determine maximum medical improvement and impairment rating. 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.
- TX97 – 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 code in question is a division-specific service reimbursed in accordance with 28 TAC §134.250 and is not subject to Medicare fee guidelines or the National Correct Coding Initiative and Medically Unlikely Edits. It is 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 upper and lower extremities. 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; 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.

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement			\$350.00
IR: Bilateral Shoulders (ROM)	Musculoskeletal System	Upper Extremities	\$300.00
IR: Bilateral Knees (ROM)		Lower Extremities	\$150.00
IR: Mental and Behavioral	Mental & Behavioral	Mental & Behavioral	\$150.00
IR: Contusions and Abrasions	Skin	Body Structures	\$150.00
IR: Ear/Nose/Throat Conditions	Ear, Nose, Throat, Related	Body Structures	\$150.00
<b>Total MMI</b>			<b>\$350.00</b>
<b>Total IR</b>			<b>\$900.00</b>
<b>Total Exam</b>			<b>\$1,250.00</b>

The total allowable reimbursement for the designated doctor examination is \$1,250.00. Per explanation of benefits dated February 28, 2024, the insurance carrier paid \$950.00. Dr. Brylowski is seeking \$300.00. 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 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 Zurich American 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

July 10, 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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).