TDI Division of Workers' Compensation
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Amended Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Andrew Brylowski, M.D.

Respondent Name
Old Republic Insurance Company

MFDR Tracking Number
M4-24-2020-02

Carrier's Austin Representative
Box Number 44

DWC Date Received
May 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 7, 2023 – December 14, 2023	Designated Doctor Examination 99456-W5-WP	$950.00	$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	$146.89	$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	$0.00	$0.00
	Total	$1,276.62	$300.00

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.'

"1-unitMMI Uper Extremity: **$350** 1-unit IR Upper Extremity: **$300**
"2-units Behavioral & Mental Ch. 14 & Ch. 4= $150+$150=**$300** **"Total Amount Due:$950"**

"**96116-51-59 & 96121-51-59:** Dr. Brylowski performed a complete neurobehavioral status examination, therefore, he can bill both codes together. 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: $146.89**

"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 8 hours of staff and physician time. Neuropsychiatric testing interpretation, report preparation, as well as a review of medical records were accomplished on December 6, 2023, December 7, 2023, December 8, 2023, December 13, 2023, and December 24, 2023. This process involved approximately 5 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 12 hours."

Amount in Dispute: $1,276.62

Respondent's Position

"The provider believes additional reimbursement should be awarded for an examination and testing. The provider billed $5,635.52 for the services rendered and the Respondent overpaid $4,358.78. The provider believes more reimbursement should be paid. However, the fee guidelines do not support additional reimbursement.

"The bill in question was processed per the Texas Fee Guidelines. The initial bill was processed and an allowance was recommended. Respondent is now requesting reimbursement for the payments issued on CPTs 99199, 96132, 96133, 96136, & 96137. These are time-based codes and the Requestor is not documenting time per billed code in the documentation. The Requestor is required to document how much time each time-based code took to complete. As this was not done, reimbursement should not have been allowed. Requestor was only entitled to the $650.00 for CPT 99456 and reimbursement for CPT 90792 which was paid $757.68."

Response Submitted by: White-Espey, PLLC

Findings and Decision

Authority

By Official Order Number 8468 dated January 12, 2024, the undersigned has been delegated authority by the Commissioner to **amend** fee dispute decisions.

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

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, TexReg 4839 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating for the dates of service in question.

Denial Reasons

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

- 292 – This procedure code is only reimbursed when billed with the appropriate initial base code.
- 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.
- 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
- 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.

Issues

1. What services are considered in this dispute?

2. Are Old Republic Insurance Company's denials of payment for the designated doctor examination supported?

3. Is Andrew Brylowski, M.D. entitled to reimbursement for procedure code 99456-W5-WP?

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?

Findings

1. Dr. Brylowski is seeking additional reimbursement for a designated doctor examination and

related testing. He is seeking $0.00 for procedure codes . Therefore, this service will not be considered in this dispute.

The requestor is seeking $950.00 for a designated doctor examination to determine maximum medical improvement and impairment rating. He is also seeking $326.62 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.
   - 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 examination were not supported, Dr. Brylowski is entitled to reimbursement for this service.

   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. Brylowsk performed impairment rating evaluations of the knee and ankle 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 indicates that Dr. Brylowsk also performed impairment rating evaluations of peripheral nerve injuries and mental and behavioral 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	[redacted]		$350.00
IR: Knee and Ankle (ROM)	Musculoskeletal System	Lower Extremities	$300.00
IR: Peripheral Nerve Injuries	Nervous System	Body Systems	$150.00
IR: Mental/Behavioral Disorders	Mental and Behavioral	Mental and Behavioral	$150.00

Total MMI	[redacted]	**$350.00**
Total IR		**$600.00**
Total Exam		**$950.00**

The total allowable reimbursement for the designated doctor examination is $950.00. The insurance carrier made a payment in the amount of $650.00. A balance of $300 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 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.

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).

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.

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 Old Republic Insurance Company 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 3, 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.