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
M4-24-2620-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
July 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 10, 2024 – February 4, 2024	99082-51-59	$0.00	$0.00
	99199-51-59	$0.00	$0.00
	90792-51-59	$4,371.07	$0.00
	96116-51-59	$188.52	$0.00
	96121-51-59	$1,843.20	$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	$6,402.79	$0.00

Requestor's Position

"**90792-51**: Please note that 2 (TWO) HCFA CMS 1500 invoices are attached in combined format for the correct billing of multiple CPT codes necessary for the COMPREHENSIVE FORENSIC INDEPENDENT MEDICAL EXAMINATION from a neuropsychiatric point of view.

"Please note that 2 Texas Administrative Code rules (TAC) apply:
"TAC §127.10 - General procedures for Designated Doctor Examinations:

"(c) The designated doctor shall perform additional testing when necessary to resolve the issue in

question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure).
"AND TAC §41.104 also applies. (4) Billing by report--The billing procedure to be used by a health care provider when:
"(A) no procedural definition and/or dollar value is established in the board's fee guidelines for the treatment or service rendered; or
"(B) when the provider determines that the procedural definition and/or dollar value established in the fee guidelines does not adequately describe the treatment or service rendered. (See §42.145 of this title (relating to Billing.)

"Please note there is no procedural definition established in the fee (Medicare) guidelines for a COMPREHENSIVE FORENSIC INDEPENDENT MEDICAL EXAMINATION

"**Amount Due: $4,371.07**

"**96116-51-59, 96121-51-59**:
"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 15 hours of staff and physician time. Neuropsychiatric testing administration and interpretation, report preparation, review of medical records, literature search, AMA guides 4th edition, MDGuidelines, ODG, DSM 5, and other specialty guideline search as necessary were accomplished on January 9, 2024, January 10, 2024, January 11, 2024, January 12, 2024, January 18, 2024, January 19, 2024, January 20, 2024, January 26, 2024, January 27, 2024, January 31, 2024, February 1, 2024, February 2, 2024, February 3, 2024, and February 4, 2024. This process involved approximately 25 hours of physician time. Total hours for evaluation, forensic measure ordering, interpretation, and integration, neuropsychiatric testing supervision, scoring, and interpretation, urine drug evaluation and interpretation, literature and guideline search and integration with report integration of this information in addition to the routine designated doctor issues was approximately 29 hours.

"**96116 Amount Due: $188.52** **96121 Amount Due: $1,843.20**"

Amount in Dispute: $6,402.79

Respondent's Position

"To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services of CPT code 90792-51-59 in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 - Guidelines for Medical Services, Charges and Payments. CPT code 96116-51-59 denied for being included in the comprehensive code 90792. Since 96121 is an add on code for 96116, it too is denied. No payment will be made for CPT codes 96116 and 96121."

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), Section 41 sets out the procedures for administration of workers' compensation claims with dates of injury prior to January 1, 1991.

2. 28 TAC §127.10, effective April 30, 2023, 48 TexReg 2123, sets out the procedures for designated doctor examinations.

3. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

4. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

5. 28 TAC §134.250, effective July 7, 2016, 41 TexReg 4839, sets out the fee guidelines for examinations to determine maximum medical improvement with dates of service prior to June 1, 2024.

Denial Reasons

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

- CAC-B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
- 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.
- CAC-236 – This billing code is not compatible with another billing code provided on the same day according to NCCI or workers' compensation state regulations/fee schedule requirements.

- G15 – Pricing is calculated based on the medical professional fee schedule value.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 435 – Per NCCI Edits, the value of this procedure is included in the value of the comprehensive procedure.
- 446 – This add-on code has been denied as the principal procedure was not billed.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

1. What are the services considered in this dispute?

2. What are the applicable rules for review of the testing services in this dispute?

3. Is Andrew Brylowski, M.D. entitled to additional reimbursement for procedure code 90792?

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

Findings

1. Dr. Brylowski submitted this dispute in accordance with 28 TAC §133.307 for the following procedure codes:

   - 99082-51-59
   - 99199-51-59
   - 90792-51-59
   - 96116-51-59
   - 96121-51-59
   - 96132-51-59
   - 96133-51-59
   - 96136-51-59
   - 96137-51-59

   He is seeking $0.00 for procedure codes 99082, 99199, 96132, 96133, 96136, and 96137. Therefore, these procedures will not be considered in this dispute.

   Dr. Brylowski is seeking $6,402.79 for procedure codes 90792, 96116, and 96121. These procedures will be reviewed in this dispute.

2. The procedure codes in question are considered professional medical services. DWC will review these services for reimbursement in accordance with relevant rules.

   Dr. Brylowski indicated that reimbursement should be evaluated based on rules found in "TAC §127.10" and "TAC §41.104."

   While he referenced an older version of Chapter 127, Section 10, DWC finds that this rule in effect for the dates of service in question states in Subsection (c), in relevant part, "Additional testing and referrals. The designated doctor must perform additional testing when necessary

to resolve the issue in question. The designated doctor must also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question, and the designated doctor is not qualified to fully resolve it.

(1) Any additional testing or referrals required for the evaluation are not subject to preauthorization requirements.

(2) Payment for additional testing or referrals that the designated doctor has determined are necessary under this subsection must not be denied prospectively or retrospectively, regardless of any potential disagreements about medical necessity, extent of injury, or compensability.

(3) Any additional testing or referrals required for the evaluation are subject to the requirements of §180.24 of this title (relating to Financial Disclosure).

(4) Any additional testing or referrals required for the evaluation of an injured employee under a certified workers' compensation network under Insurance Code Chapter 1305 or a political subdivision under Labor Code §504.053(b):

(A) are not required to use a provider in the same network as the injured employee; and

(B) are not subject to the network or out-of-network restrictions in Insurance Code §1305.101 (relating to Providing or Arranging for Health Care).

DWC reviewed the explanations of benefits submitted and found that the insurance carrier did not deny payment based on medical necessity, preauthorization requirements, extent of injury, compensability, or network status. Therefore, this rule is not applicable to the dispute in question.

Dr. Brylowski also referenced "TAC §41.104." He did not provide the title number for referenced rule TAC §41.104, therefore, DWC performed a search for this rule within Title 28 as it is the administrative authority for general and workers' compensation insurance. Section 104 was not found in Chapter 41 that was in effect on the date of service in question. However, the language quoted in Dr. Brylowski's position statement is found in 28 TAC §42.145. It is important to note that the Texas Administrative Code, Title 28, Chapters 41 through 69 are applicable only to claims with dates of injury prior to January 1, 1991. Therefore, they do not pertain to the claim that is the subject of this dispute.

Dr. Brylowski further states that "there is no procedural definition established in the fee (Medicare) guidelines for a COMPREHENSIVE FORENSIC INDEPENDENT MEDICAL EXAMINATION." The documentation submitted to DWC fails to demonstrate how the services in question are substantively different from the defined services as billed. For this reason, DWC must review the services in question based on the fee guidelines that are applicable to those services.

Reimbursement policies for professional services are 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."

Reimbursement fee guidelines for professional services are addressed in 28 TAC §134.203(c), which states in relevant part: "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. 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 …"

3. Dr. Brylowski is seeking reimbursement for procedure code 90792, which is defined as "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."

   DWC finds that the submitted documentation supports the performance of this service as defined. The requestor is therefore entitled to reimbursement for CPT code 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 2024 is 67.81.
   - The Medicare conversion factor for dates of service before March 9, 2024, is 32.7442.
   - Per the submitted medical bills, the service was rendered in zip code 78746 which is in Medicare locality 0441231, "Austin."

   The Medicare participating amount for CPT code 90792 is $192.34. The MAR is calculated as follows: (67.81/32.7442) x $192.34 = $398.32. Dr. Brylowski billed 12 units for this service, however provided no evidence that multiple assessments as defined were performed. The total MAR for procedure code at one unit is 90792 is $398.32. Per explanation of benefits dated March 15, 2024, the insurance carrier paid $397.37. No additional reimbursement is

recommended for this service.

4. Dr. Brylowski is seeking reimbursement for procedure code 96116 which 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."

   Dr. Brylowski billed one unit of procedure code 96116 with appended modifiers 51 and 59. He also billed 12 units of timed add-on code 96121 with modifiers 51 and 59.

   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 timed 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 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	September 25, 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.