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
Liberty Insurance Corp.

MFDR Tracking Number
M4-25-0099-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
September 13, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 6, 2023 – December 31, 2023	99456-W8-RE	$500.00	$500.00
	99456-W7	$250.00	$250.00
	99456-W6	$125.00	$125.00
	99199-51-59	$0.00	$0.00
	99082-51-59	$0.00	$0.00
	90792-51-59	$4,680.36	$396.85
	96116-51-59	$185.01	$0.00
	96121-51-59	$1,784.28	$0.00
	96132-51-59	$3,059.88	$0.00
	96133-51-59	$4,645.92	$0.00
	96136-51-59	$83.42	$0.00
	96137-51-59	$1,840.80	$0.00
	Total	$17,154.67	$1,271.85

Requestor's Position

"**99456-W8-RE:** 28 TAC §134.204(k) states '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. This was denied by the insurance company.

Amount Due: $500

"**99456-W7, 99456-W6:**
TAC 134.204 (C)(2) When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection:
(A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section;
(B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section;
(C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.

"**99456 W7 Disability= $250** **99456 W6 Extent of Injury= $125**

"**90792-59:**
… Please note that 2 Texas Administrative Code rules (TAC) apply:
TAC §127.10 - General procedures for Designated Doctor Examinations: 1-59:

"(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: $4,680.36**

"**96116-51-59, 96121-51, 96132-51-59, 96133-51-59, 96136 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 15 hours of staff and physician time. Neuropsychiatric testing interpretation, report preparation, as well as a review of medical records were accomplished on December 5, 2023, December 6, 2023, December 7, 2023, December 8, 2023, December 11, 2023, December 12, 2023, December 13, 2023, December 19, 2023, December 20, 2023, December 26, 2023, December 27, 2023, December 29, 2023, December 30, 2023, and December 31, 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.

"**96116 Amount Due: $185.01**
96121 Amount Due: $1,784.28
96132 Amount Due: $3,059.88
96133 Amount Due: $4,645.92
96136 Amount Due: $83.42
96137 Amount Due: $1,840.80

"**Total Amount Due: $17,154.67**

… Liberty Mutual also paid interest before paying the actual bill amount paid of $509.96 received on 8/9/2024."

Amount in Dispute: $17,154.67

Respondent's Position

The Austin carrier representative for Liberty Insurance Corp. is Downs Stanford, PC. The representative was notified of this medical fee dispute on September 17, 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. TLC §408.004 provides the authority to perform required medical examinations.
2. 28 Texas Administrative Code (TAC) §126.5 sets out the procedures for requesting a required medical examination.
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 §134.235, effective July 7, 2016, 41 TexReg 4839 sets out the fee guidelines for examinations to determine the extent of injury, ability to return to work, and disability for 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:

- 5884 – Provider is not within the Liberty Health Care Network (HCN for this customer. Insurance Code 1305.004 (b) and Labor Code 401.011.
- 5917 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. What are the services considered in this dispute?

2. Is the insurance carrier's denial based on network status and preauthorization supported?

3. Is Dr. Brylowski entitled to reimbursement for examinations to determine the extent of injury, ability to return to work, and disability?

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

5. Is Dr. Brylowski entitled to reimbursement for procedure code 90792?

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

7. Is Dr. Brylowski entitled to reimbursement for procedure codes 96132, 96133, 96136, and 96137?

8. What is the total reimbursement amount recommended for the services in dispute?

Findings

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

- 99456-W8-RE
- 99456-W7
- 99456-W6
- 99199-51-59

- 99082-51-59
- 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 99199-51-59 and 99082-51-59. Therefore, this procedure will not be considered in this dispute.

Dr. Brylowski is seeking $17,154.67 for the remaining procedure codes. These procedures will be reviewed in this dispute.

2. The insurance carrier denied payment for the services in question stating that the "provider is not within the Liberty Health Care Network," and "pre-authorization was required, but not requested for this service."

   Per 28 TAC §126.5(a), "A doctor who has contracted with or is employed by an authorized workers' compensation health care network established under Insurance Code Chapter 1305, (network doctor) may not perform a required medical examination, as those terms are used under the Texas Workers' Compensation Act (the Act), for an employee receiving medical care through the same network. It is the responsibility of the requesting party to ensure the doctor selected does not have a disqualifying association." Therefore, the insurance carrier's denial based on network status is not appropriate for the services in question.

   Per 28 TAC §126.5(b) "The Division may authorize a required medical examination (RME) for any reason set forth in the Act, Texas Labor Code §408.004, §408.0041, or §408.151 at the request of the insurance carrier (carrier). The request shall be made in the form and manner prescribed by the Division. A carrier is not entitled to take action with respect to benefits based on, and the Division shall not consider, a report of an RME doctor that was not approved or obtained in accordance with this section." The submitted documentation indicates that DWC authorized the examination in question. Therefore, the insurance carrier's denial based on preauthorization is not supported.

3. At the request of the insurance carrier and on the order of DWC, Dr. Brylowski performed an examination to determine the extent of the compensable injury, if disability is related to the compensable injury, and the injured employee's ability to return to work.

   28 TAC §134.235 states, in relevant part, "The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations … the reimbursement shall be $500 in accordance with §134.240 of this title 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."

   Dr. Brylowski is seeking $500.00 for the examination to determine the injured employee's

ability to return to work. This amount is recommended.

Dr. Brylowski is seeking $250.00 for the examination to determine whether the injured employee's disability was related to the compensable injury. This amount is recommended.

Dr. Brylowski is seeking $125.00 for the examination to determine the extent of the compensable injury. This amount is recommended.

4. 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."

   DWC finds that 28 TAC §127.10 is a rule that is specific to designated doctor examinations. The examination in question is a required medical examination, with Dr. Brylowski requested by the insurance carrier. Because Dr. Brylowski was not acting as a designated doctor selected by DWC, this rule does not apply to the services 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 …"

5. 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 maximum allowable reimbursement (MAR) for procedure code 90792, 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 2024 for the date of service in question is 33.2875.
   - Per the submitted medical bills, the service was rendered in zip code 77581 which is in Medicare locality 0440209, "Brazoria."

   The Medicare participating amount for CPT code 90792 is $194.81. The MAR is calculated as follows: (67.81/33.2875) x $194.81 = $396.85. 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 $396.85. This amount is recommended.

6. 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 248 units 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.

7. Dr. Brylowski is seeking reimbursement for procedure code 96132, which 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 reimbursement for procedure code 96136, which 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." Disputed procedure code 96137 is a timed add-on code for procedure code 96136.

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."

A review of the documentation provided does not support billing for the services defined above were performed within the billed dates of service.

The requestor has failed to demonstrate its reasoning for why this disputed fee should be paid; how the relevant Labor Code and DWC rules, including fee guidelines, impact the disputed fee issues; and how the submitted documentation supports the request for the disputed fee issue in accordance with 28 TAC §133.307(c)(2)(N). No additional reimbursement is recommended for this service.

8. DWC finds that the total allowable reimbursement for the services in question is $1,271.85. This amount is recommended.

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 reimbursement of $1,271.85 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Liberty Insurance Corp. must remit to Andrew Brylowski, M.D. $1,271.85 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	January 23, 2025 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.