



# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**

Andrew Brylowski, M.D.

**Respondent Name**

Mitsui Sumitomo Insurance Co. of America

**MFDR Tracking Number**

M4-25-0105-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

September 16, 2024

## Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 7, 2023 – December 1, 2023	99456-RE	\$0.00	\$0.00
	99082-51-59	\$0.00	\$0.00
	99199-51-59	\$0.00	\$0.00
	90792-51-59	\$4,648.72	\$348.09
	96116-51-59	\$00.00	\$0.00
	96121-51-59	\$0.00	\$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
<b>Total</b>		\$4,648.72	\$348.09

## 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 in Dispute:** \$4,648.72

## **Respondent's Position**

The Austin carrier representative for Mitsui Sumitomo Insurance Co. of America is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on September 24, 2024. Per 28 Texas Administrative Code §133.307 (d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the 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 \(TAC\), 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.

### Adjustment Reasons

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

- RAI - Medical Unlikely Edit: DOS exceeds MUE value.
- P13 – Payment reduced/denied based on state WC regs/policies.
- ZZ – Timely Filing rule reviewed and suppressed
- 51 – Multiple Procedure
- 59 – Distinct Procedural Service

### Issues

1. What are the services considered in this review?
2. What are the applicable rules for review of the testing services in this dispute?
3. Is Dr. Brylowski entitled to additional reimbursement for procedure code 90792?

### Findings

1. Dr. Brylowski submitted this dispute in accordance with 28 TAC §133.307 for the procedure codes listed above in the Summary of Findings table. The only code he is seeking additional reimbursement for is CPT code 90792 in the additional amount of \$4,648.72. For all other CPT codes listed, he is seeking \$0.00 additional reimbursement. Therefore, this is the only procedure code that will be considered in this review.
2. The procedure code in question is considered a professional medical service. DWC will review the service of CPT code 90792 for additional 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 additional 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.”

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.”

DWC finds that the insurance carrier paid a reduced amount of \$31.64 for CPT code 90792 rendered on the disputed date of service. A review of the submitted documentation supports the performance of this service as defined. Therefore, the disputed service will be reviewed and adjudicated for additional reimbursement.

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 Fee = MAR.

- The DWC conversion factor for 2023 is 67.81.
- The Medicare conversion factor for 2023 for the date of service in question is 33.8872.
- Per the submitted medical bills, the service was rendered in zip code 77581 which is Medicare locality 0441209, "Brazoria."
- The Medicare participating amount for CPT code 90792 in this locality on the disputed date of service is \$198.49.
- The MAR is calculated as follows:  $(67.81/33.8872) \times \$198.49 = \$379.73$
- Dr. Brylowski billed 12 units for CPT code 90792, however provided no evidence that multiple assessments as defined were performed.
- The total MAR for CPT code 90792 at one unit is \$379.73.
- The insurance carrier paid \$31.64.
- Additional reimbursement in the amount of \$348.09 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 additional reimbursement in the amount of \$348.09 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 service. It is ordered that Mitsui Sumitomo Insurance Co. of America must remit to Andrew Brylowski, M.D. \$348.09 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

December 19, 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).