TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Andrew Brylowski, M.D.

Respondent Name
American Guarantee & Liability Insurance

MFDR Tracking Number
M4-25-0118-01

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
February 22, 2024 – March 13, 2024	99456-W8-RE	$500.00	$0.00
	99199-51-59	$0.00	$0.00
	90792-51-59	$3,973.70	$0.00
	96116-51-59	$188.52	$0.00
	96121-51-59	$1,536.00	$0.00
	96132-51-59	$2,631.00	$0.00
	96133-51-59	$4,192.02	$0.00
	96136-51-59	$85.27	$0.00
	96137-51-59	$1,621.62	$0.00
	Total	$14,728.13	$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: $3,973.70"

Amount in Dispute: $14,728.13

Respondent's Position

"Upon receipt of the MDR requested, the bill was sent for reconsideration. A payment of $11,145.08 for dos 02/22/2024 – 03/13/2024 was issued on 10/07/2024. Attached is a copy of the EOR..."

Response Submitted by: ESIS

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

- 1 -Charge exceeds Fee Schedule allowance (222)
- 2 -Reimbursement of this procedure is limited to once per date of service. (267)
- 119 - Benefit maximum for this time period or occurrence has been reached. (ANSI119)
- 151 - Payment adjusted because the payer deems the information submitted does not support this many services.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 7 – Rush Bill (E328)
- 8 – A technical Bill Review (TBR) has been performed. (ETBR)
- N435 - Exceeds number/frequency approved /allowed within time period without support documentation. (RARCN435)
- Notes/Messages: 1& 2 - Resubmit bill with appropriate ICD-10 diagnosis codes: … invalid; 3 - Diagnosis was invalid for the date(s) of service reported.

Issues

1. Have the services in dispute received payment after the request for medical fee dispute resolution (MFDR)?

2. What are the services considered in this review?

3. What are the applicable rules for reviewing the testing services in this dispute?

4. Is Dr. Brylowski entitled to additional reimbursement for the procedure code 90792?

Findings

1. A review of the submitted documents finds that this request for MFDR was received in accordance with 28 TAC §133.307 by DWC on September 16, 2024. DWC later received an explanation of benefits (EOB) document dated September 30, 2024, and a corresponding check dated October 7, 2024, in the amount of $11,145.08. DWC finds that payment for the

services in dispute was made after the request for MFDR.

The EOB dated September 30, 2024, allowed reimbursement per line item as follows:

Procedure Code	Charge	Allowed reimbursement
99456-RE-W8	$500.00	$500.00
99199-51	$2,208.00	$0.00 (this code is not in dispute)
90792-51	$3,973.70	$397.05
96116-51	$188.52	$188.52
96121-51	$1,536.00	$1,536.00
96132-51	$2,631.00	$2,628.00
96133-51	$4,192.02	$4,189.29
96136-51	$85.27	$85.27
96137-51	$1,621.62	$1,621.20

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

   - 99456-W8-RE
   - 99199-51-59
   - 90792-51-59
   - 96116-51-59
   - 96121-51-59
   - 96132-51-59
   - 96133-51-59
   - 96136-51-59
   - 96137-51-59

   As shown in finding number one, as of the date of this review, the procedure codes in dispute have all received payment in full according to the fee schedule, except for code 90792-51, which received a reduced payment. Therefore, DWC finds that the only procedure code to be considered in this MFDR review is 90792-51.

3. The procedure code in question is considered a professional medical service. DWC will review the service 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 or reduce 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's 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 …"

4. 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 were provided in addition to the diagnostic evaluation. Interviews and communication with family members or other sources are included in these codes."

   The submitted documentation supports the performance of this service as defined. DWC finds that this procedure code, 90792, has received a reduced payment as of the date of this review. DWC will review the disputed procedure code 90792 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 Amount.

   - The DWC conversion factor for 2024 is 67.81.
   - The Medicare conversion factor for 2024 for the date of service in question is 32.7442.
   - Per the submitted medical bills, the service was rendered in zip code 75234 which is in Medicare locality 0441211, "Dallas."

   The Medicare participating amount for CPT code 90792 is $191.73. The MAR is calculated as follows: (67.81/32.7442) x $191.73 = $397.05. Dr. Brylowski billed 10 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 $397.05.

A review of the submitted EOB dated September 30, 2024, finds that the insurance carrier allowed payment in the amount of $397.05. No additional reimbursement 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 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 additional reimbursement for the disputed services in the amount of $0.00.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 22, 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.