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 Co.

MFDR Tracking Number
M4-25-0126-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
September 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 1, 2024 – May 31, 2024	99082-51-59	$0.00	$0.00
	99199-51-59	$0.00	$0.00
	90792-51-59	$5,259.83	$0.00
	96116-51-59	$191.41	$0.00
	96121-51-59	$1,860.48	$0.00
	96132-51-59	$3,197.98	$129.29
	96133-51-59	$4,230.03	$0.00
	96136-51-59	$86.00	$40.94
	96137-51-59	$1,629.18	$0.00
	Total	$16,862.91	$170.23

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: $5,259.83

96116-51-59, 96121-51-59, 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. History and diagnostic interview along with a review of medical records and collateral information that was available was done …

This process involved approximately 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 April 29, 2024, April 30, 2024, May 1, 2024, May 2, 2024, May 9, 2024, May 10, 2024, May 11, 2024, May 23, 2024, May 24, 2024, May 25, 2024, May 29, 2024, and May 30, 2024, and May 31, 2024. This process involved approximately 24 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 28 hours.

96116 Amount Due: $191.41
96121 Amount Due: $1,860.48
96132 Amount Due: $3,197.98
96133 Amount Due: $4,230.03
96136 Amount Due: $86
96137 Amount Due: $1,629.18"

Amount in Dispute: $16,862.91

Respondent's Position

"Texas Mutual has reimbursed the provider for one unit of 90792, additional units are not supported. In review of codes 96116 and 96121 these codes should not be reported with psychiatric diagnostic examination, 90791 or 90792 per Medicare NCCI Manual, Chapter XI, Section M,1. CPT Codes 96132, 96133, 96136, and 96137 were denied as the documentation provided does not give start and stop times for the timed codes …

"Texas Mutual has elected to reprocess the following disputed services in accordance with the appropriate Medical Fee Guidelines as defined per Texas Administrative Code Rule 134 – Guidelines for Medical Services, Charges and Payments. Texas Mutual will allowing [*sic*] reimbursement for CPT code 96132 for the first hour and CPT code 96136 for the initial 30 minutes."

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.

Adjustment Reasons

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

- Notes: "DOCUMENTATION DOES NOT SUPPORT SEPARATE DIAGNOSTIC

EVALUATIONS CONDUCTED WITH THE PATIENT AND OTHER INFORMANTS (FAMILY)."

- Notes: "DOCUMENTATION DOES NOT SUPPORT FULL TIMED CODES BILLED."
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-151 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 298 – Only one is allowed per date of service.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code description/instructions.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration.
- W3 & 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 45 - CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- DC3 - ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.
- 920 – REIMBURSEMENT IS BEING ALLOWED BASED ON A DIPSUTE.

Issues

1. What are the services to be considered in this dispute?
2. Have the services in dispute received payment after the request for medical fee dispute resolution (MFDR)?
3. What are the applicable rules for reviewing the testing services in this dispute?
4. Is Dr. Brylowski entitled to additional reimbursement for procedure code 90792?
5. Is Dr. Brylowski entitled to reimbursement for procedure codes 96116 and 96121?
6. Is Dr. Brylowski entitled to reimbursement for procedure codes 96132, 96133, 96136 and 96137?
7. 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:

    - 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

According to the DWC060 Medical Fee Dispute Resolution (MFDR) Request form submitted, procedure codes 99082 and 99199 identify a disputed amount of $0.00. Therefore, these two procedure codes will not be considered in this review. All other disputed procedure codes listed above will be addressed in this review.

2. A review of the explanation of benefits (EOB) documents submitted finds that prior to the MFDR request, only procedure code 90792 had received reimbursement in a reduced amount of $388.33.

   Per submitted EOB dated October 10, 2024, the insurance carrier allowed a reduced reimbursement for procedure codes 96132 and 96136 in the amounts of $126.90 and $41.20, respectively.

   DWC finds that the insurance carrier allowed reimbursement for procedure codes 96132 and 96136 after the request for MFDR was received by DWC.

3. The procedure codes in question are considered professional medical services. DWC will review the 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 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 in the amount of $5,259.83 for procedure code 90792-51-59 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 to determine if additional reimbursement is due.

5. 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 conflict 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.

6. 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 supports that the services described above for procedure codes 96132 and 96136 were performed by the requestor for tests administered, scored, evaluated, and interpreted within the billed dates of service. As established in finding number two of this review, these procedure codes have received a reduced reimbursement as

of the date of this review. DWC will review these codes for additional reimbursement.

The report does not list the start and end time to support the number of hours billed for add-on timed procedure codes 96133 and 96137; therefore, Dr. Brylowski is not entitled to additional reimbursement for these codes as defined.

7. To determine the maximum allowable reimbursement (MAR) the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Medicare Payment Amount = MAR

    - The DWC conversion factor for 2024 is 67.81.
    - The Medicare conversion factor in 2024 for the date of service in question is $33.2875.
    - Per the submitted medical bills, the service was rendered in zip code 75702, Medicare locality 04412-99, "Rest of Texas."

    The Medicare participating amount for CPT code 90792 is $190.63. Using the formula above, the MAR is $388.33. Dr. Brylowski billed 14 units for this service, however provided no evidence that multiple assessments as defined were performed. The total MAR for procedure code 90792 at one unit is $388.33. Per the EOB submitted, the insurance carrier paid $388.33 for disputed procedure code 90792. No additional reimbursement is recommended.

    The Medicare participating amount for CPT code 96132 is $125.76. Using the formula above, the MAR is $256.19. Dr. Brylowski billed for 12 units. No evidence was provided to support the billed units within the dates of service in dispute. The total MAR for procedure code 96132 at one unit is $256.19. Per EOB submitted, the insurance carrier paid $126.90. Additional reimbursement is recommended.

    The Medicare participating amount for CPT code 96136 is $40.32. Using the formula above, the MAR is $82.14. Dr. Brylowski billed for one unit. The total MAR for procedure code 96136 at one unit is $82.14. Per EOB submitted, the insurance carrier paid $41.20. Additional reimbursement is recommended.

    DWC finds that the total allowed amount for the services in question is $726.66. Per the explanation of benefits documents submitted, the insurance carrier previously paid a total amount of $556.43. Therefore, additional reimbursement in the amount of $170.23 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 $170.23 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 Texas Mutual Insurance Co. must remit to Andrew Brylowski, M.D. $170.23 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 7, 2025
Signature	Medical Fee Dispute Resolution Officer	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.