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
City of Dallas

MFDR Tracking Number
M4-25-0337-01

Carrier's Austin Representative
Box Number 53

DWC Date Received
October 10, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 25, 2024 – July 25, 2024	99199-51-59	$0.00	$0.00
	90792-51-59	$4,371.39	$0.00
	96116-51-59	$0.00	$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
	Total	$4,371.39	$0.00

Requestor's Position

"**90792-51**: ...

"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

"**Total Amount Due: $4,371.39**

"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 … Neuropsychiatric testing interpretation, report preparation, as well as a review of medical records were accomplished.

"This process involved approximately 12 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 or about June 24, 2024, June 25, 2024, June 26, 2024, June 30, 2024, July 5, 2024, July 6, 2024, July 7, 2024, July 15, 2024, July 16, 2024, July 17, 2024, July 21, 2024, July 22, 2024, July 23, 2024, July 24, 2024, and July 25, 2024. This process involved approximately 22 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."

Amount in Dispute: $4,371.39

Respondent's Position

"We are in receipt of the Medical Dispute Resolution concerning claimant … from Andrew Brylowski for dates of service 6/5/2024-7/25/2024. Our records indicate original bill processed per fee guidelines. Additional payment is not warranted for CPT code 90792.

"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 this code."

Response Submitted by: Injury Management Organization, Inc.

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.

Denial Reasons

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

- 222 – Charge exceeds Fee Schedule allowance
- 267 – Reimbursement of this procedure is limited to once per date of service.
- ANSI119 – 119-Benefit maximum for this time period or occurrence has been reached.
- ANSI151 – 151-Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
- ANSIP12 – P12-Workers' compensation jurisdictional fee schedule adjustment.
- RARCN435 – N435-Exceeds number/frequency approved/allowed within time period without support documentation.
- Notes: "This procedure on this date was previously reviewed
- 18 – Exact duplicate claim/service.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- Notes: "An allowance was previously recommended on bill …"

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

Findings

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

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

    Dr. Brylowski is seeking $4,371.39 for procedure code 90792. This procedure will be reviewed in this dispute.

    He is seeking $0.00 for the remaining procedure codes. Therefore, these codes will not be reviewed in this dispute.

2. The procedure code in question is considered a professional medical service. DWC will review this 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 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. Per explanation of benefits dated August 2, 2024, the insurance carrier paid $397.05 for the procedure code in question.

   Procedure code 90792 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."

   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 75234 which is in Medicare locality 0441211, "Dallas."

   The Medicare participating amount for CPT code 90792 is $194.91. The MAR is calculated as follows: (67.81/33.2875) x $194.91 = $397.05. Dr. Brylowski billed 12 units for this service, however this is not a time-based procedure, and he provided no evidence that multiple assessments as defined were performed. The total MAR for procedure code at one unit is 90792 is $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 $0.00 reimbursement for the disputed services.

Authorized Signature

		January 28, 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.