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
Accident Fund Insurance Co. of America

MFDR Tracking Number
M4-25-0380-01

Carrier's Austin Representative
Box Number 6

DWC Date Received
October 16, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 16, 2024 – August 18, 2024	99082-51-59	$0.00	$0.00
	99199-51-59	$0.00	$0.00
	90792-51-59	$4,381.77	$0.00
	96116-51-59	$0.00	$0.00
	96121-51-59	$0.00	$0.00
	96132-51-59	$5,292.52	$0.00
	96133-51-59	$0.00	$0.00
	96136-51-59	$0.00	$0.00
	96137-51-59	$0.00	$0.00
	Total	$9,674.29	$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: $4,381.77

96132-51-59:

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. I was asked to determine all or part of the following issues: 1. Impairment rating, 2. Maximum medical improvement date, 3. Ability of the employee to return to work, 4. Extent of the employee's compensable injury, 5. Whether the employee's disability is a direct result of the work injury, 6. Other similar issues. Neuropsychiatric testing interpretation, report preparation, as well as a review of medical records were accomplished.

This process involved approximately 15 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 July 14, 2024, July 15, 2024, July 16, 2024, July 29, 2024, July 30, 2024, July 31, 2024, August 9, 2024, August 10, 2024, August 11, 2024, August 16, 2024, August 17, 2024, and August 18, 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.

Amount Due: $5,292.52."

Amount in Dispute: $9,674.29

Respondent's Position

"CPT 90792: This charge was paid at the fee scheduled rate for 1 unit. Medically Unlikely Edits (MUE) limit units for this CPT code to one; the billing received from the provider for 12 units is not supported by documentation. Payment issued is accurate to the fee schedule.

CPT 96132: This charge was paid at the fee scheduled rate for 1 unit. Medically Unlikely Edits (MUE) limit units for this CPT code to one; the billing received from the provider for 21 units is not supported by the code definition. Payment issued is accurate to the fee schedule."

Response Submitted by: Stone, Loughlin, Swanson

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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. What services are to be 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?

4. Is Dr. Brylowski entitled to additional reimbursement for procedure code 96132?

5. What amount of additional reimbursement is Dr. Brylowski entitled to for the services in dispute?

Findings

1. Dr. Brylowski submitted this medical fee dispute resolution (MFDR) request 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

   The only procedure codes that Dr. Brylowski is seeking additional reimbursement for are 90792-51-59 and 96132-51-59, for which he is seeking additional reimbursement in the amount of $9,674.29. Therefore, DWC finds that these are the only two procedure codes in dispute and the only codes to be considered in this MFDR review.

2. 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."

   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 procedure code 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 the service of procedure code 90792 as defined. DWC will review this code for additional reimbursement.

4. Dr. Brylowski is seeking additional 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."

   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 finds the requestor billed 21 units of CPT code 96132-51-29. A review of the documentation does not support that the services defined above, billed under procedure code 96132-51-59, were performed as billed.

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.

5. In accordance with 28 TAC §134.203, to determine the MAR, 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 dates of service after March 9, 2024, is 33.2875.
    - Per the submitted medical bills, the service was rendered in zip code 78746 which is in Medicare locality 04412 31, "Austin."

      <u>CPT code 90792:</u>

    - The Medicare participating amount for CPT code 90792 is $195.53.
    - The MAR is calculated as follows: (67.81/33.2875) x $195.53 = $398.31.
    - Dr. Brylowski billed 12 units for this service, however the requestor submitted no evidence that multiple assessments as defined were performed.
    - The total MAR for one unit of procedure code 90792 is $398.31.
    - A review of the explanation of benefits documents submitted finds that the insurance carrier previously allowed reimbursement in the amount of $398.31 for one unit of procedure code 90792 on the disputed date of service. Therefore, no additional reimbursement is recommended.

DWC finds that the maximum allowable reimbursement for the services in dispute is $398.31. Per explanation of benefits submitted, the insurance carrier paid $398.31 for the disputed procedure code 90792-51-59. 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 reimbursement for the disputed services in the amount of $0.00.

Authorized Signature

		November 20, 2024
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.