



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Andrew Brylowski, M.D.

**Respondent Name**

Service American Indemnity Co.

**MFDR Tracking Number**

M4-25-0933-01

**Carrier's Austin Representative**

Box Number 60

**DWC Date Received**

December 16, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 17, 2024 – November 3, 2024	96116	\$188.52	\$0.00
	96121	\$1,843.20	\$0.00
	96137	\$772.35	\$0.00
<b>Total</b>		<b>\$2,804.07</b>	<b>\$0.00</b>

### Requestor's Position

**"AND 28 TAC §42.15 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: \$2,031.72**

**96116: \$188.52**

**96121: \$1,843.20**

**"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. 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 interpretation, report preparation, as well as a review of medical records, were accomplished on October 16, 2024, October 17, 2024, October 18, 2024, October 25, 2024, October 26, 2024, October 27, 2024, October 28, 2024, November 1, 2024, November 2, 2024, and November 3, 2024. This process involved approximately 20 hours of physician time. Total hours of physician time for evaluation, testing administration, testing supervision, testing scoring, testing interpretation, medical record integration, collateral information integration, literature review, urine drug testing and interpretation and integration of this information into report format was approximately 25 hours.

**Amount due: \$772.35"**

**Total Amount in Dispute: \$2,804.07**

### **Respondent's Position**

"DOS 10/17/2024 CPT 96116 billed amount 188.52 previously denied as a component to CPT 90792. This CPT is not separately payable when billed on the same DOS as another comprehensive code. We stand on previous denial.

"DOS 10/17/2024 CPT 96121 billed amount \$1,843.20 previously denied as this add on code was billed without the associated parent code. We stand on the previous denial.

"DOS 10/17/2024 CPT 96137 billed amount \$1,621.62 previously processed for payment with the professional fee schedule amount \$849.27 no additional payment due as we stand on the previous payment."

**Response submitted by:** Mitchell International

### **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

- 236 - THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NCCI OR WORKERS COMPENSATION STATE REGULATIONS /FEE SCHEDULE REQUIREMENTS.
- 435 - PER NCCI EDITS, THE VALUE OF TIDS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
- 446 - THIS ADD-ON CODE HAS BEEN DENIED AS THE PRINCIPAL PROCEDURE WAS NOT BILLED.
- B15 - THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED
- G15 - PRICING IS CALCULATED BASED ON THE MEDICAL PROFESSIONAL FEE SCHEDULE VALUE.
- J18 - THE ALLOWANCE FOR THE LINE HAS BEEN ADJUSTED TO A SINGLE UNIT PER THE POLICIES AND GWDELINES ESTABLISHED FOR THE BILATERAL INDICATOR.
- 59 - PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
- P12 – WORKERS’ COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- W3 – BILL IS A RECONSIDERATION OR APPEAL.

#### Issues

1. What are the applicable rules for reviewing the testing services in this dispute?
2. Is Dr. Brylowski entitled to reimbursement for procedure codes 96116 and 96121?
3. Is Dr. Brylowski entitled to reimbursement for the procedure code 96137?
4. Is Dr. Brylowski entitled to additional reimbursement for the disputed date of service?

#### Findings

1. 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."

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 "28 TAC §42.15." 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 ..."

2. 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. On the same date and medical bill, Dr. Brylowski billed 12 units of procedure code 90792-51-59.

[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. The insurance company has already paid for CPT code 90792; thus, it is uncontested.

3. Dr. Brylowski is seeking additional reimbursement for procedure code 96137, which is a timed add-on code to procedure code 96136, billed on the same disputed date and medical bill together.

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."

Dr. Brylowski billed for 21 units of procedure code 96137. A review of the medical report submitted does not list the start and end time to support the number of hours billed for add-on timed procedure code 96137; therefore, Dr. Brylowski is not entitled to additional reimbursement for this code as defined.

4. Dr. Brylowski is seeking additional reimbursement in the total amount of \$2,804.07 for the services in dispute. For reasons outlined in findings number two and three above, DWC finds that Dr. Brylowski is not entitled to additional reimbursement for CPT codes 96121, 96116, and 96137 rendered October 17, 2024, through November 3, 2024.

### 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 in the amount of \$0.00 for the services in dispute

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

February 25, 2025

\_\_\_\_\_  
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).