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**
City of Fort Worth

**MFDR Tracking Number**
M4-25-1114-01

**Carrier's Austin Representative**
Box Number 04

**DWC Date Received**
January 27, 2025

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| December 20, 2024 – January 8, 2025 | 99082 | $642.00 | $0.00 |
| | 99199 | $627.00 | $0.00 |
| | 96116 | $188.52 | $0.00 |
| | 96121 | $153.60 | $0.00 |
| | **Total** | $1,611.12 | $0.00 |

## Requestor's Position

"**99082-51-59:** Physician unusual travel CPT code 99082 is billed at $2 per mile.
Amount: $642.00

"**99199-51-59:** This code was used for record organization, tagging, sorting, linking of specific record to report, and having the record available in the cloud for immediate viewing by stakeholder(s).
Amount: $627.00

"**96116-51-59, 96121-51-59:** 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."

**Amount in Dispute:** $1,611.12

## Respondent's Position

"The City stands by its denial of the EOB and no additional payment is owed. The provider billed 99082 for return to work on line 2 when they should be billing 99456. CPT code 99199 is not a reimbursable expense."

**Response Submitted by:** Ricky D. Green, PLLC

## 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 §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

Denial Reasons

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

- 10 - THE BILLED SERVICE REQUIRES THE USE OF A MODIFIER CODE.
- 292 - THIS PROCEDURE CODE IS ONLY REIMBURSED WHEN BILLED WITH THE APPROPRIATE INITIAL BASE CODE.
- 305 - THIS PROCEDURE, MATERIAL, SERVICE DOES NOT NORMALLY WARRANT A CHARGE.
- 107 - CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM.
- 4 - THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- N572 - THIS PROCEDURE IS NOT PAYABLE UNLESS APPROPRIATE NON-PAYABLE REPORTING CODES AND ASSOCIATED MODIFIERS ARE SUBMITTED.
- N702 - DECISION BASED ON REVIEW OF PREVIOUSLY ADJUDICATED CLAIMS OR FOR CLAIMS IN PROCESS FOR THE SAME/SIMILAR TYPE OF SERVICES.
- N600 - ADJUSTED BASED ON THE APPLICABLE FEE SCHEDULE FOR THE REGION IN WHICH THE SERVICE WAS RENDERED.

Issues

1. What are the applicable rules for review of this dispute?

2. Is Andrew Brylowski, M.D. entitled to reimbursement for procedure code 99082?

3. Is Dr. Brylowski entitled to reimbursement for procedure code 99199?

4. Is Dr. Brylowski entitled to reimbursement for procedure codes 96116 and 96121?

Findings

1. The services in dispute are considered professional medical services. DWC will review these services for reimbursement in accordance with relevant rules and statutes.

   Reimbursement policies for professional services is 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 $642.00 for procedure code 99082. This procedure code is defined as "Unusual travel (e.g., transportation and escort of patient). This code is adjunct to basic services rendered. The physician reports this code to indicate unusual travel for the purpose of transportation or accompanying the patient."

   CMS Internet Only Manual 100-04, Chapter 12, Section 80.3 states, "Unusual Travel (CPT Code 99082) (Rev. 1, 10-01-03) B3-15026 In general, travel has been incorporated in the MPFSDB individual fees and is thus not separately payable. A/B MACs (B) must pay separately for unusual travel (CPT code 99082) only when the physician submits documentation to demonstrate that the travel was very unusual."

DWC found no documentation to support that very unusual travel was performed. No reimbursement is recommended for this service.

3. Dr. Brylowski is seeking $627.00 for procedure code 99199. This procedure code is defined as "Unlisted special service, procedure, or report. A service, procedure or report that is above and beyond the usual for a condition."

   The insurance carrier denied this service, in part, with denial code 97, stating, "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   In his position statement, Dr. Brylowski stated, "This code was used for record organization, tagging, sorting, linking of specific record to report, and having the record available in the cloud for immediate viewing by stakeholder(s)."

   DWC finds that Dr. Brylowski failed to demonstrate how this service was "above and beyond the usual" for the conditions in question. No reimbursement can be recommended for this service.

4. Dr. Brylowski is seeking $188.52 for procedure code 96116 and $153.60 for procedure code 96121, which were billed for dates of service December 20, 2024, through January 8, 2025. On the same disputed dates of service and medical bill, Dr. Brylowski charged for procedure code 90792. Procedure code 90792 received reimbursement and is not in dispute.

   Disputed procedure code 96121 is a timed add-on code 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 appended modifier 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 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 procedure code 96121 is an add-on code for timed procedure code 96116, no reimbursement can be recommended for CPT code 96121.

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**

| Signature | Medical Fee Dispute Resolution Officer | March 6, 2025<br>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.