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
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-25-1303-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
February 11, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 21, 2024 – December 1, 2024	Designated Doctor Examination 99456-W5-WP	$192.00	$0.00
	99199	$4,308.00	$0.00
	96132	$5,287.19	$0.00
	96133	$2,396.79	$0.00
	Total	$12,183.98	$0.00

Requestor's Position

"**99456-W5-WP:** TAC §134.250(4)(C)(iii) states, 'if the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP.' Reimbursement shall be 100 percent of the total MAR.'
"**Amount: $192.00**

"**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: $4,308.00**

"**96132 51-59, 96133 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 10 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 August 29, 2023, August 30, 2023, August 31, 2023, September 1 2023, September 2, 2023, September 6, 2023, September 10, 2023, September 11, 2023, September 15, 2023, September 16, 2023, and September 17, 2023. This process involved approximately 10 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 26 hours.
"**Amount: $7,681.15**"

Amount in Dispute: $12,183.98

Respondent's Position

"Texas Mutual reimbursed for the MMI/IR exam as follows: $449 base + $385 for upper extremity (thumb/elbow) + $192 for CTS/Nerve + $192 for mental + $192 for skin lacerations and $642.00 for extent of injury. Texas Mutual denied 1 unit of the MMI/IR exam as a 5th body area was not identified in the documentation.

"Texas Mutual upholds its denial for CPT codes 99199-51-59, 96132-51-59, 96136, and 96137 as these are not supported in the documentation."

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. TLC §408.004 provides the authority to perform required medical examinations.
2. 28 Texas Administrative Code (TAC) §126.5 sets out the procedures for requesting a required medical examination.

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 §134.235, effective July 7, 2016, 41 TexReg 4839 sets out the fee guidelines for examinations to determine the extent of injury, ability to return to work, and disability for dates of service prior to June 1, 2024.

6. 28 TAC §134.240, effective July 7, 2016, 41 TexReg 4839 sets out the fee guidelines for designated doctor examinations for dates of service prior to June 1, 2024.

7. 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.

Denial Reasons

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

- 892 – 5 units billed, per DWC rule 134.240, 4 units reimbursed per the body areas/systems rated. 4 units allowed; 1 unit denied. 892,225 – Documentation not consistent with 21 hours for exam/testing.
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- G15 – Pricing is calculated based on the medical professional fee schedule value.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

1. Is Andrew Brylowski, M.D. entitled to reimbursement for examination to determine maximum medical improvement and impairment rating?

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

3. Is Dr. Brylowski entitled to reimbursement for procedure codes 96132 and 96133?

Findings

1. Dr. Brylowski is seeking reimbursement, in part, for a designated doctor examination to determine maximum medical improvement and impairment rating. The insurance carrier reduced payment for these services stating, "5 UNITS BILLED, PER DWC RULE 134.240, 4 UNITS REIMBURSED PER THE BODY AREAS/SYSTEMS RATED. 4 UNITS ALLOWED; 1 UNIT DENIED."

   Per 28 TAC §134.240(d)(3), "MMI. MMI evaluations will be reimbursed at $449 adjusted per

§134.210(b)(4), and the designated doctor must apply the additional modifier 'W5.'" DWC finds that no adjustments apply to the date of service in question.

28 TAC §134.240(d)(4) states, in relevant part, "IR. For IR examinations, the designated doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. The designated doctor must apply the additional modifier 'W5.' Indicate the number of body areas rated in the units column of the billing form.

(A) For musculoskeletal body areas, the designated doctor may bill for a maximum of three body areas.
    (i) Musculoskeletal body areas are:
        (I) spine and pelvis;
        (II) upper extremities and hands; and
        (III) lower extremities (including feet).
    (ii) For musculoskeletal body areas:
        (I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4); and
        (II) the reimbursement for each additional musculoskeletal body area is $192 adjusted per §134.210(b)(4).
(B) For non-musculoskeletal body areas, the designated doctor must bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area examined.
    (i) Non-musculoskeletal body areas are defined as follows:
        (I) body systems;
        (II) body structures (including skin); and
        (III) mental and behavioral disorders.
    (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.
    (iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $192 adjusted per §134.210(b)(4)."

The insurance reimbursed the requestor for four units, including the "upper extremity (thumb/elbow) … CTS/Nerve … mental … [and] skin lacerations." DWC finds no other body areas rated. Dr. Brylowski is not entitled to additional reimbursement for the service in question.

2. Dr. Brylowski is also seeking reimbursement for procedure code 99199, defined as "unlisted special service, procedure or report. A service, procedure or report that is above and beyond the usual for a condition." Dr. Brylowski argued that 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)."

   The insurance carrier denied this service, in part, with denial code CAC-16, "CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION," and 225, "THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION."

   28 TAC §134.250(1) states, "The total maximum allowable reimbursement (MAR) for an MMI/IR

examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

(A) the examination;
(B) consultation with the injured employee;
(C) review of the records and films;
(D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and
(E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title."

Because the services described by Dr. Brylowski represented by the code in question are included in the MAR for an examination of MMI and impairment rating, no reimbursement can be recommended.

3. 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." Disputed procedure code 96133 is a timed add-on code for procedure code 96132.

   The insurance carrier paid $262.81 for procedure code 96132 and $1,795.23 for procedure code 96133. The report does not indicate the start and end times to support the number of hours billed for these services. Therefore, Dr. Brylowski is not entitled to additional reimbursement for these codes.

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	April 4, 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. 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.