



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Andrew Brylowski, M.D.

Respondent Name

City of Fort Worth

MFDR Tracking Number

M4-25-1610-01

Carrier's Austin Representative

Box Number 04

DWC Date Received

March 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 6, 2025 – February 23, 2025	99199	\$1,046.00	\$0.00
	90792	\$4,516.30	\$0.00
	96116	\$193.70	\$0.00
	96121	\$3,284.40	\$0.00
	96132	\$3,284.40	\$0.00
	96133	\$4,303.53	\$0.00
	96136	\$89.13	\$0.00
	96137	\$1,650.60	\$0.00
Total		\$18,368.06	\$0.00

Requestor's Position

"Let this letter serve as notice that Dr. Andrew Brylowski has tried to collect the amount owe from Sedgwick without any success ...

"**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: \$1,046.00

"90792 51-59, 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.

"Please note that 2 Texas Administrative Code rules (TAC) apply:
28 TAC §127.10 – General procedures for Designated Doctor Examinations:

"(c) 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 to 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).

(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).

"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: \$7,994.40

"96132 51-59, 96133 51-59, 96136 51-59, 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 21 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 January 29, 2025, January 30, 2025, February 5, 2025, February 6, 2025, February 7, 2025, February 8, 2025, February 12, 2025, February 13, 2025, February 14, 2025, February 18, 2025, February 19, 2025, February 20, 2025, February 21, 2025, and February 22, 2025. This process involved approximately 20 hours of physician time. Total hours for evaluation, forensic measure ordering, interpretation, and integration, neuropsychiatric testing supervision, scoring, and integration with report integration of this information in addition to the routine designated doctor issues was approximately 26 hours.

AMOUNT: \$9,327.66"

Amount in Dispute: \$18,368.06

Respondent's Position

"The City of Fort Worth stands by its denial of payment for the services requested. The provider is billing time-based codes and not documenting specific time spent on the remaining codes. Billing code 90792 was overbilled by 11 units, which can only be billed more than one unit if the test was completed over multiple days."

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 \(TAC\), Section 41](#) sets out the procedures for administration of workers' compensation claims with dates of injury prior to January 1, 1991.
2. [TAC §127.10](#) 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 denied the payment for the disputed services with the following claim adjustment codes:

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 5141 – Bill has been reviewed by a nurse or under the direction of a nurse.
- 5346 – Please specify time spent on billed procedure for further review.
- 561 – According to the state fee schedule, this procedure code is not considered a valid reimbursable code. Please re-submit with a valid code.

- 86 – Service performed was distinct or independent from other services performed on the same day.
- 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 250 – The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- N706 – Missing documentation.
- 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.
- 247 – A payment or denial has already been recommended for this service.
- 18 – Exact duplicate claim/service.
- N111 – No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.

Issues

1. What are the applicable rules for reviewing the testing services in this dispute?
2. Is Andrew Brylowski, M.D., entitled to reimbursement for procedure code 99199?
3. Is Dr. Brylowski entitled to additional reimbursement for the procedure code 90792?
4. Is Dr. Brylowski entitled to reimbursement for procedure codes 96116 and 96121?
5. Is Dr. Brylowski entitled to reimbursement for procedure codes 96132, 96133, 96136, and 96137?
6. What is the total reimbursement amount recommended for the services in dispute?

Findings

1. Dr. Brylowski submitted this dispute in accordance with 28 TAC §133.307 for documentation and testing services referred by a designated doctor. 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 “28 TAC §127.10” and “28 TAC §42.15.”

28 TAC §127.10(c), as reference by Dr. Brylowski, does not allow denial of testing based on

preauthorization, medical necessity, extent of injury, compensability, or network issues. DWC finds that the insurance carrier did not deny the services in question based on these reasons. Therefore, this rule is not applicable to this dispute.

In reference to 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 it 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 \$1,046.00 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 561, stating, "According to the state fee schedule, this procedure code is not considered a valid reimbursable code. Please re-submit with a valid code."

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 these exams required documentation services "above and beyond the usual" for the conditions in question. No reimbursement can be recommended for this service.

3. Dr. Brylowski is seeking 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 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 this service as defined. Dr. Brylowski billed 12 units for this service, however provided no evidence that multiple assessments as defined were performed. The requester is therefore entitled to reimbursement for one unit of CPT code 90792.

To determine the maximum allowable reimbursement (MAR), the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Amount.

- The DWC conversion factor for 2025 is 70.18.
- The Medicare conversion factor for 2025 is 32.3465.
- Per the submitted medical bills, the service was rendered in zip code 75234 which is in Medicare locality 0441211.

The Medicare participating amount for CPT code 90792 is \$189.11. The MAR is calculated as follows: $(70.18/32.3465) \times \$189.11 = \410.30 .

The total MAR for procedure code 90792 is \$410.30. Per explanation of benefits dated March 10, 2025, the insurance carrier paid this amount in full. No additional reimbursement is recommended.

4. 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.

[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 timed procedure code 96121 is an add-on code for timed procedure code 96116, no reimbursement can be recommended for CPT code 96121.

5. Dr. Brylowski is seeking 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 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.

Dr. Brylowski is also seeking reimbursement for 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."

DWC finds that the documentation submitted with this dispute is not sufficient to support procedure codes 96132, 96133, 96136, and 96137. Therefore, no reimbursement is recommended for these services.

6. Because Dr. Brylowski failed to support reimbursement for the services in question, he is not entitled to reimbursement.

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 17, 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 electrónico CompConnection@tdi.texas.gov.