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
Starr Specialty Insurance Co.

MFDR Tracking Number
M4-25-1909-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 16, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 18, 2025	99456	$163.00	$163.00
	99082	$1,112.00	$0.00
	99199	$76.00	$0.00
	Total	$1,351.00	$163.00

Requestor's Position

"**99456 MMI IR:** 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: $163.00

"**99082 51-59:** Physician unusual travel CPT code 99082 is billed at $2 per mile.
Amount: $1,112.00

"**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: $76.00"

Amount in Dispute: $1,351.00

Respondent's Position

"…there are two additional charges of $1,112 under CPT 99082 and $76 under CPT 99199. He is seeking $1,112 and $76 respectively for those two CPT codes. They are not reimbursable.

"The carrier is re-reviewing the reimbursement under CPT 99456 and will most likely be filing a supplemental response. However, it maintains its position that the provider is not entitled to any reimbursement under CPT 99082 and 99199."

Response Submitted by: Flahive, Ogden & Latson

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.

Adjustment Reasons

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

- 309 - The charge for this procedure exceeds the fee schedule allowance.
- 561 - According to the state fee schedule, this procedure code is not considered a valid reimbursable code. Please re-submit with a valid code.
- 16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 97 - Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- N702 - Decision based on review of previously adjudicated claims or for claims in process for the same similar type of service.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- N600 - Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- 1014 - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional

allowance appears to be warranted.

- 2005 - No additional reimbursement allowed after review of appeal/reconsideration.
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 - Bill is a reconsideration or appeal.

Issues

1. Did the insurance carrier submit a supplemental response to this medical fee dispute resolution (MFDR) request?

2. What are the applicable rules for reviewing the disputed service billed under procedure code 99456?

3. What are the applicable rules for reviewing the disputed service billed under procedure codes 99082 and 99199?

4. Is Dr. Brylowski entitled to additional reimbursement for procedure code 99456?

5. Is Dr. Brylowski entitled to reimbursement for procedure code 99082?

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

Findings

1. In its initial response position statement dated May 6, 2025, the insurance carrier representative stated that "the carrier is re-reviewing the reimbursement under CPT 99456 and will most likely be filing a supplemental response." As of the date of this review, DWC has not received a supplemental response. Therefore, this dispute will be reviewed based on the information available.

2. This medical fee dispute involves, in part, an examination by a designated doctor for the purpose of establishing: if maximum medical improvement (MMI) has been reached; what date MMI was reached if applicable; and to provide impairment ratings (IR) if MMI has been reached.

   On the disputed date of service, the requester billed $1,026.00 for three units of procedure code 99456. CPT code 99456 indicates the service of a maximum medical improvement (MMI) and/or impairment rating (IR) examination by a designated doctor.

   DWC finds that 28 TAC §134.240, adopted to be effective June 1, 2024, applies to the reimbursement of the services in dispute. 28 TAC §134.240 (d), states in pertinent part,

   > "(2) (C) If the designated doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination must be billed and reimbursed in accordance with subsection (d) of this section.
   >
   > (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."

(4) 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 unit's 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 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) …"

DWC finds that 28 TAC §134.210 applies to the annual fee adjustment of the disputed services, stating in pertinent part, "(b)(4) Fees established in §§134.235, 134.240, 134.250, and 134.260 of this title will be:

"(A) adjusted once by applying the Medicare Economic Index (MEI) percentage adjustment factor for the period 2009 - 2024.

(B) adjusted annually by applying the MEI percentage adjustment factor identified in §134.203(c)(2).

(C) rounded to whole dollars by dropping amounts under 50 cents and increasing amounts from 50 to 99 cents to the next dollar. For example, $1.39 becomes $1 and $2.50 becomes $3.

(D) effective on January 1 of each new calendar year."

2. The services in dispute billed under procedure codes 99082 and 99199 are considered professional medical services. DWC will review these services for reimbursement in accordance

with relevant rules and statutes.

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. The requestor, Dr. Brylowski, is seeking additional reimbursement in the amount of $163.00 for a designated doctor examination rendered on February 18, 2025.

   The submitted medical record supports that the requestor, a designated doctor, performed an evaluation of maximum medical improvement (MMI) as ordered by DWC. Per 28 TAC §134.240 (d), the maximum allowable reimbursement (MAR) for this examination, performed on February 18, 2025, is $465.00.

   The documentation submitted supports that the requestor assigned an impairment rating for one musculoskeletal body area. The total allowable reimbursement for the impairment rating in this designated doctor examination performed on February 18, 2025, is $199.00.

   A review of the submitted medical record additionally finds that the requestor provided an impairment rating (IR) of one non-musculoskeletal body area. The rule at 28 TAC §134.240 defines the fees for impairment rating of non-musculoskeletal areas. The MAR for the evaluation of the non-musculoskeletal area performed on February 18, 2025, is $199.00.

   In accordance with 28 TAC §134.240, the reimbursements which apply to the disputed examination rendered on February 18, 2025, are:

   - For an MMI examination, reimbursement is $465.00.
   - For the impairment rating of the first musculoskeletal body area, reimbursement is

$398.00.

- For the impairment rating of one non-musculoskeletal body area, reimbursement is $199.00.
- DWC finds that the total MAR for the examination in question is $1,062.00.
- Per explanation of benefits (EOB) document submitted, dated February 26, 2025, the insurance carrier paid $863.00.
- Per the submitted DWC060 Medical Fee Dispute Resolution Request form, the requester, Dr. Brylowski, is seeking additional reimbursement in the amount of $163.00 for procedure code 99456. This additional amount of reimbursement is recommended for the services in dispute.

DWC finds that the requestor is entitled to additional reimbursement in the amount of $163.00 for the designated doctor examination in dispute.

4. Dr. Brylowski is seeking $1,112.00 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 demonstrate that the travel was very unusual. Reimbursement is not recommended for this service.

5. Dr. Brylowski is seeking $76.00 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.

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 established that additional reimbursement is due in the amount of $163.00.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for some of the services in dispute. It is ordered that the Respondent, Starr Specialty Insurance Co., must remit to the Requestor, Andrew Brylowski, M.D., $163.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 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.