TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Andrew Brylowski, M.D.

Respondent Name
Standard Fire Insurance Co

MFDR Tracking Number
M4-25-2756-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
July 1, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 15, 2025 – June 1, 2025	99082	$1,154.00	$0.00
	99199	$640.00	$0.00
	90792	$5,434.93	$0.00
	96116	$196.51	$0.00
	96121	$1,928.52	$0.00
	96132	$3,060.07	$0.00
	96133	$2,938.60	$0.00
	96137	$827.41	$0.00
	Total	$16,180.04	$0.00

Requester's Position

"**99082 51-59:** Physician unusual travel CPT code 99082 is billed at $2 per mile.
AMOUNT: $1,154.00

"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: $640.00

"90792 51-59, 96116 51-59, 96121 51-59: … 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 …

"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: $7,559.96

"**96132 51-59, 96133 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 28 hours of staff and physician time. Neuropsychiatric testing administration and interpretation, report preparation, review of medical records, literature search … as necessary were accomplished on May 11, 2025, May 14, 2025, May 15, 2025, May 16, 2025, May 19, 2025, May 20, 2025, May 21, 2025, May 23, 2025, May 24, 2025, May 26, 2025 and May 27, 2025, May 30, 2025, May 31, 2025, and June 1, 2025. This process involved approximately 23 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 28 hours.
AMOUNT: $6,826.08"

Amount in Dispute: $16,180.04

Respondent's Position

"As to CPT code 99082 (unusual travel), … Per the Medicare edits, this code is not reimbursable when the primate codes are performed in office. Consequently, the Provider is not entitled to additional reimbursement.

"As to CPT code 99199 (unlisted special service), … This miscellaneous code is not supported with documentation …

"As to CPT code 90792 (psychiatric diagnostic evaluation), … The Provider billed 10 units for this CPT code. The Medicare edits limit reimbursement for this code to 1 unit per day … The Carrier reimbursed the maximum Medicare allowable units …

"As to CPT code 96116 (neurobehavioral exam, per hour), … This code is inclusive to the 90792, which the Carrier has reimbursed …

"As to CPT code 96121 (cognitive testing, per hour), … This code is inclusive to the 90792, which the Carrier has reimbursed …

"As to CPT code 96132 (neuropsychological testing, per hour), … The Provider billed 12 units for this CPT code. The Medicare edits limit reimbursement for this code to 1 unit per day … The Carrier reimbursed the maximum Medicare allowable units …

"As to CPT code 96133 (neuropsychological testing, per hour), … The Provider billed 21 units for this CPT code. The Medicare edits limit reimbursement for this code to 1 unit per day … The Carrier reimbursed the maximum Medicare allowable units …

"As to CPT code 96137 (neuropsychological testing, per hour), … The Provider billed 21 units for this CPT code. The Medicare edits limit reimbursement for this code to 1 unit per day … The Carrier reimbursed the maximum Medicare allowable units."

Response Submitted by: Travelers

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 42 sets out the guidelines for medical benefits for workers' compensation claims with dates of injury prior to January 1, 1991

2. 28 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 reduced or denied payment for the disputed services with the following claim adjustment codes:

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
- 3243 – The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely Edits amount for the amount of times this procedure can be billed on a date of service. Since the allowance for the procedure is to be determined by report, an allowance has not been paid.
- 3247 – The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely Edits amount for the number of times this procedure can be billed on a date of service. The correct use of a modifier to report the same code on a separate line permits an additional unit of service to be allowed.
- 5526 – Please provide correct CPT codes for all services rendered.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 3244 – The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely Edits amount for the number of times this procedure can be billed on a date of service. An allowance has not been paid.
- 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.
- 292 – This procedure code is only reimbursed when billed with the appropriate initial base code.
- 5513 – Separate reimbursement is not permitted for this procedure code.
- 947 – Upheld. No additional allowance has been recommended.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 18 – Exact duplicate claim/service
- 247 – A payment or denial has already been recommended for this service.
- DUPL – These services have already been considered for reimbursement.

Issues

1. What are the applicable rules for reviewing services in 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?

5. 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 testing services requested 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, in part, based on rules found in "28 TAC §127.10" and "28 TAC §42.15."

   28 TAC §127.10(c), as referenced by Dr. Brylowski, does not allow denial of testing based on preauthorization, medical necessity, extent of injury, compensability, or network issues. No evidence was provided indicating that these denial reasons were applied by the insurance carrier. Therefore, this rule does not apply 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 only applicable to claims with dates of injury prior to January 1, 1991. The date of injury for the injured employee considered in this dispute is after January 1, 1991. Therefore, this rule does 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 reimbursement for procedure code 99082. This procedure code is defined as "Unusual travel (eg, 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."

   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."

   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 supporting that Dr. Brylowski provided unusual travel for the purpose of transportation or accompanying the patient. No reimbursement is recommended for this service.

3. Dr. Brylowski is seeking reimbursement 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."

   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)."

   The requester has failed to demonstrate its reasoning why this disputed fee should be paid; how the relevant Labor Code and DWC rules, including fee guidelines, impact the disputed fee issues; and how the submitted documentation supports the request for the disputed fee issue in accordance with 28 TAC §133.307(c)(2)(N). No reimbursement is recommended for this service.

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."

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."

He also billed 12 units of timed add-on code 96121 with modifiers 51 and 59. The insurance carrier denied this procedure, in part, stating, "Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim."

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. The insurance carrier reimbursed procedure codes 90792, 96132, 96133, and 96137 in part. Dr. Brylowski is seeking additional reimbursement for these services. DWC will review these services in accordance with applicable fee guidelines.

   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 78218 which is in Medicare locality 0441299.

   Procedure code 90792 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."

The Medicare participating amount for CPT code 90792 is $184.94. The MAR is calculated as follows: (70.18/32.3465) x $184.94 = $401.25. Dr. Brylowski billed 14 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. Per explanation of benefits dated June 6, 2025, the insurance carrier paid $401.25. No additional reimbursement is recommended for this service.

Procedure code 96132 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.

The Medicare participating amount for CPT code 96132 is $122.81. The MAR is calculated as follows: (70.18/32.3465) x $122.81 = $266.45. Dr. Brylowski billed 12 units for this service. By definition, this code is used for only the first hour of evaluation and interpretation, which is one unit. Per explanation of benefits dated June 6, 2025, the insurance carrier paid $266.45. No additional reimbursement is recommended for this service.

Procedure code 96133 is an add-on code to procedure code 96132. The insurance carrier paid $1,394.33 for procedure code 96133. Procedure code 96137 is an add-on code to procedure code 96136. The insurance carrier paid $829.07 for procedure code 96137. The report does not indicate the start and end times supporting the number of hours billed for these services. Therefore, DWC finds that Dr. Brylowski is not entitled to additional reimbursement for these codes.

DWC finds that no additional reimbursement is recommended for the services in this dispute.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 19, 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.