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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
Ace American Insurance Co.

MFDR Tracking Number
M4-25-3077-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
July 25, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 15, 2025 – May 2, 2025	99456-W5	$449.00	$0.00
April 15, 2025 – May 2, 2025	99456-SP	$600.00	$0.00
April 15, 2025 – May 2, 2025	99199	$252.00	$0.00
April 15, 2025 – May 2, 2025	90792	$5,337.40	$0.00
April 15, 2025 – May 2, 2025	96116	$193.70	$0.00
April 15, 2025 – May 2, 2025	96136	$89.13	$88.93
April 15, 2025 – May 2, 2025	96137	$1,650.60	$0.00
	Total	$8,571.83	$88.93

Requester'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: $449.00

"99456-25-SP: 28 TAC §134.240 states 'The designated doctor can bill for neuropsychiatric testing based on their assessment of the musculoskeletal examination.
AMOUNT: $600.00

"**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: $252.00
"90792 51-59, 96116 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 there is no procedural definition established in the fee (Medicare) guidelines for a COMPREHENSIVE FORENSIC INDEPENDENT MEDICAL EXAMINATION.
AMOUNT: $5,531.10

"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. Dr. Brylowski was asked to determine all or part of the following issues: 1. Impairment rating, 2. Maximum medical improvement date, 3. Ability of the employee to return to work, 4. Extent of the employee's compensable injury, 5. Whether the employee's disability is a direct result of the work injury, 6. Other similar issues. Neuropsychiatric testing interpretation, report preparation, as well as a review of medical records were accomplished. This process involved approximately 22 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 April 14, 2025, April 15, 2025, April 17, 2025, April 18, 2025, April 20, 2025, April 21, 2025, April 27, 2025, April 28, 2025, April 29, 2025, April 30, 2025, May 1, 2025, and May 2, 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 27 hours.
AMOUNT: $1,739.73"

Total Amount in Dispute: $8,571.83

Respondent's Position

"Upon notification of the dispute, CorVel performed an in-depth review of the billing submitted by the Requester for the above listed DOS. Original billing was received by the Carrier on 5/5/2025.

1. Designated Doctor exams are reimbursed under rule §134.240 as these are Texas Workers' Compensation Specific Services. Designated doctors must perform examinations in accordance with Labor Code §§408.004, 408.0041, and 408.151 and division rules.
   Note: Division rules do not allow Carriers to change a provider's codes.

2. 99456-59-W5 MMI -

> Rule §134.240(d)(2)(A) - If the designated doctor determines that MMI has not been reached, the MMI evaluation portion of the examination must be billed and reimbursed in accordance with subsection (d) of this section. The designated doctor must add modifier 'NM.'
>
> The DWC69 indicates the DD determined that the IW was not at MMI. As a result, and per the rule above, the Requester has not billed per state rule and has not included modifier 'NM'… To date, a corrected CMS1500 form has not been received notating the correct modifier for the DD's determination of Not at MMI. No rule has been found that exempts a Designated Doctor from the requirement to bill this modifier.

3. 99456-SP

Rule §134.240(g)(1) and (2):

(1) The designated doctor must add modifier '25' to the appropriate examination code.

(2) The designated doctor must add modifier '25' once per bill when addressing issues on the same day, regardless of the number of diagnoses or the number of issues the division ordered the designated doctor to examine… The Requester has submitted 99456 with modifier SP. Effective 6/1/2024, modifier SP is no longer valid… To date, no billing has been received correcting this billing error. No rule has been found that provides any exceptions for requiring the Requester to bill the correct modifier…

4. 99199-51-59 –

Record organizing, tagging, sorting, linking of specific record to report and having available in the cloud – does not warrant a separate charge or reimbursement. No rule has been found that requires the DD to bill and be reimbursed separately for this process.

5. 90792-51-59, 96116-51-59 Comprehensive Forensic Independent Medical Examination from a neuropsychiatric point of view. There was no referral to a specialist. As a neuropsychiatrist, the DD is also a specialist; however, the exam was for the purpose of determining MMI/IR that required psych testing. As a Specialist determining MMI for a diagnosis that falls within the list under §127.10, the DD is allowed $300 (when billed correctly). Aside from that, there is nothing that allows Dr. Brylowski any additional payment over what other Designated Doctors – specialists or otherwise – receive for a 'forensic independent medical evaluation'.

Additionally, 90792 is not paid hourly or per unit. Only one unit is payable…

96116 - Behavioral exam with interpretation and report… CCI edits do not allow 90792 and 96116 to be billed together and do not allow a modifier to override the bundling. As indicated by the description of 90792, it includes other diagnostic evaluations. As such, payment for 96116 is included with 90792. The services provided under 96116 are redundant to 90792, thus no additional payment warranted. There is no known rule that provides exemption to CCI edits for Designated Doctors or Referral Providers.

6. 96136-51-59, 96137-51-59

Psychological test with physician interpretation and report. Standardized tests can be used to assess multiple facets of personality, emotion, intellect and mental illness.

CCI edits bundle 96136 into 99456. Per rule 134.240(d)(1) The MMI or IR examination must include (E) - tests used to assign the IR, as outlined in the American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title.

As 96137 is an add-on code whose primary code was not paid, code 96137 was denied…

Finally, please note that modifier SP is no longer valid as of 6/1/2024…

To date, a corrected billing has not been received by the Respondent."

Response Submitted by: Corvel

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 §134.240 sets out the medical fee guidelines for designated doctor examinations.
3. 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:

- 4 – Procedure code inconsistent with modifier used.
- 6 – 100% of allowable charges.
- 51 – Multiple procedure.
- 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.
- 236 - This proc or proc/mod combo is not compatible.
- 234 -This procedure is not paid separately.
- R09 - CCI: CPT Manual and CMS coding manual instructions.
- R79- CCI; Standards of Medical/ Surgical Practice.
- 107 - Denied- qualifying svc not paid or identified.

- SP – Specialty area.
- R1 & 18 – Duplicate claim/service. Duplicate billing.
- W5 - DD exam with IR or MMI.
- W6 - Designated Doctor Examination for Extent.
- W3 - Bill is a reconsideration or appeal.

Issues

1. As of the date of this review, have any of the services in dispute received reimbursement?
2. Is Dr. Brylowski entitled to additional reimbursement for procedure code 90792?
3. What are the applicable rules for reviewing the disputed services billed under procedure code 99456?
4. Is Dr. Brylowski entitled to reimbursement for procedure code 99456-W5 and 99456-SP?
5. Is Dr. Brylowski entitled to reimbursement for procedure code 99199?
6. Is Dr. Brylowski entitled to reimbursement for procedure code 96116?
7. Is Dr. Brylowski entitled to reimbursement for procedure codes 96136, and 96137?

Findings

1. A review of the submitted explanation of benefits (EOB) documents finds that procedure code 90792 x 14 units is the only procedure code in dispute, which has received reimbursement. The insurance carrier allowed $410.30 out of $5,747.70 charges for this procedure code. The requester is seeking additional reimbursement in the amount of $5,337.40 for CPT code 90792 x 14 units. Therefore, DWC will review this service for additional reimbursement.

   DWC finds that all other procedure codes in dispute have received $0.00 and therefore will be reviewed for possible reimbursements due.

2. Dr. Brylowski is seeking additional 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 were provided in addition to the diagnostic evaluation. Interviews and communication with family members or other sources are included in these codes."

   On the disputed date of service, the requester charged 14 units of CPT code 90792-51-59.

   Procedure code 90792 is not a timed procedure, therefore only one unit is payable per date of

service. DWC finds that the insurance carrier paid a reduced amount of $410.30 for CPT code 90792-51-59 rendered on the disputed date of service.

A review of the submitted documentation supports the performance of this service as defined. Therefore, the disputed service will be reviewed and adjudicated for additional reimbursement.

In his position statement, Dr. Brylowski 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.

DWC finds that 28 TAC §134.203, which sets out the billing and reimbursement policies for professional services, applies to procedure code 90792 and 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."

28 TAC §134.203(c), 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 …"

To determine the maximum allowable reimbursement (MAR) for procedure code 90792, the following formula is used:

(DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Fee = MAR.

- 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 Medicare locality 04412-11, "Dallas."
- The Medicare participating amount for CPT code 90792 in this locality on the disputed date of service is $189.11.
- Using the formula above, DWC finds that the MAR = $410.30.
- Dr. Brylowski billed 14 units for CPT code 90792, however provided no evidence that

multiple assessments as defined were performed.

- The total MAR for CPT code 90792 at one unit is $410.30.
- The insurance carrier paid $410.30.
- Additional reimbursement is not recommended.

DWC finds that Dr. Brylowski is not entitled to additional reimbursement for procedure code 90792 rendered on the disputed date of service.

3. This medical fee dispute involves, in part, an examination by a designated doctor for the purpose of establishing: whether 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.

   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, states in pertinent part,

   > "(2) A designated doctor must only bill and be reimbursed for an MMI or IR examination if they are an authorized doctor in accordance with the Labor Code and Chapter 130 and §180.23 of this title.
   >
   > (A) If the designated doctor determines that MMI has not been reached, the MMI evaluation portion of the examination must be billed and reimbursed in accordance with subsection (d) of this section. The designated doctor must add modifier 'NM.'
   >
   > (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."

4. The requester is seeking reimbursement in the amount of $449.00 for CPT code 99456-W5 and in the amount of $600.00 for CPT code 99456-SP.

   A review of the submitted medical records and Report of Medical Evaluation, form DWC069, finds that the designated doctor, Dr. Brylowski, determined that the employee's injuries had not reached MMI and therefore an impairment rating could not be provided.

   On the disputed date of service, the requester billed $449.00 for disputed procedure code 99456-W5 and billed $600.00 for 2 units of disputed procedure code 99456-SP. CPT code 99456 indicates the service of a maximum medical improvement (MMI) and/or impairment rating (IR) examination by a designated doctor.

   Because the employee's injuries had not yet reached MMI and the designated doctor examination service was not billed in accordance with 28 TAC §134.240 (2)(A), using the appropriate modifier "NM" DWC finds that the requester is not entitled to reimbursement for the designated doctor examination billed under 99456-W5 on the disputed date of service.

   The requester is seeking reimbursement in the amount of $600.00 for a designated doctor service billed under 99456-SP x 2 units. A review of the applicable DWC Rules finds that

modifier "SP" is not a current, valid modifier. As a result, DWC finds that Dr. Brylowski is not entitled to reimbursement for the designated doctor service billed under 99456-SP on the disputed date of service.

5. Dr. Brylowski is seeking $252.00 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 stating, "This procedure is not paid separately."

   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.

6. 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 of Neurobehavioral status exam."

   Dr. Brylowski billed one unit of procedure code 96116 with appended modifiers 51 and 59. On the same date and medical bill, Dr. Brylowski billed procedure code 90792-51-59.

   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 conflict 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.

7. Dr. Brylowski is seeking reimbursement for procedure code 96136, billed on the same disputed date and medical bill with timed add-on procedure code 96137, also in dispute.

   Procedure code 96136 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.

The insurance carrier denied this service, due to a CCI edit conflict with the billing of CPT codes 96136 with 99456 on the same date of service. The requester appended both procedure codes with modifiers "51" and "59". Modifier "51" indicates multiple procedures performed during the same session by the same healthcare provider. Modifier "59" indicates a separately identifiable service performed during the same session by the same healthcare provider.

A review of the medical record submitted finds documentation to support that the service of procedure code 96136, as defined, was provided as a separately identifiable service from the service of procedure code 99456. Therefore, DWC finds that the use of modifier "59" appended to CPT code 96136 on the disputed date of service is supported. As a result, DWC finds that the use of modifier "59" appended to CPT code 96136 overrides the CCI edit conflict in this case. DWC will review this code for reimbursement. The report does not list the start and end time to support the number of hours billed for the add-on timed procedure code 96137; therefore, Dr. Brylowski is not entitled to reimbursement for CPT code 96137 as defined.

DWC finds that 28 TAC §134.203, quoted above in finding number two, applies to the reimbursement of disputed procedure code 96136.

To determine the MAR for procedure code 96136, the following formula is used:
(DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Fee = MAR.

- 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 Medicare locality 04412-11, "Dallas."
- The Medicare participating amount for CPT code 96136 in this locality on the disputed date of service is $40.99.
- Using the formula above, DWC finds that the MAR = $88.93.
- The insurance carrier paid $0.00.
- Reimbursement in the amount of $88.93 is recommended.

DWC finds that the requester is entitled to reimbursement in the amount of $88.93 for CPT code 96136-51-59 rendered on the disputed date of service.

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 established that additional reimbursement is due in the amount of

$88.93 for the services in dispute.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for some of the services in dispute. It is ordered that the Respondent, Ace American Insurance Co., must remit to the Requester, Andrew Brylowski, M.D., $88.93 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 17, 2025
Signature	Medical Fee Dispute Resolution Officer	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.