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

**Requester Name**
Andrew Brylowski, M.D.

**Respondent Name**
Hartford Casualty Insurance Co.

**MFDR Tracking Number**
M4-25-3373-01

**Carrier's Austin Representative**
Box Number 47

**DWC Date Received**
August 22, 2025

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| June 18, 2025 – July 1, 2025 | 90792 | $4,516.30 | $0.00 |
| | 96121 | $1,752.60 | $0.00 |
| | 96132 | $3,558.49 | $0.00 |
| | 96133 | $4,303.53 | $0.00 |
| | 96136 | $89.13 | $88.93 |
| | 96137 | $1,650.60 | $0.00 |
| | **Total** | $15,870.65 | $88.93 |

## Requester's Position

"**90792 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 …

"AND 28 TAC §42.15 also applies …

"Please note there is no procedural definition established in the fee (Medicare) guidelines for a COMPREHENSIVE FORENSIC INDEPENDENT MEDIAL EXAMINATION
**AMOUNT:** $6,268.90

"**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 June 18, 2025, June 19, 2025, June 20, 2025, June 23, 2025, June 26, 2025, June 27, 2025, June 28, 2025, June 30, 2025, and July 1, 2025. This process involved approximately 21 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. Specific time reviewing records 169 minutes and 19 seconds.
**AMOUNT:** $9,601.75"

**Amount in Dispute:** $15,870.65

## Respondent's Position

"96133, 96136 and 96137 are time-based codes that must document the amount of time that was spent performing each service. No such documentation exists; therefore, no further reimbursement is owed for these services.

"90792 can only be billed as 1 unit per exam, unless the exam takes place over multiple days. Dr. Brylowski billed 12 units, which implies that this service was provided over 12 different days/hours, which is very unlikely. No further reimbursement is owed for this service due to a lack of proper documentation.

"96121 should be billed based on the number of hours spent after the first hour is billed under 96116. Dr. Brylowski billed for 12 additional hours of interview time under 96121, but again, there is no documentation to show that this interview took a total of 13 hours.

"96132 should be billed as the first hour of neuro-psychological testing with each subsequent hour or half hour billed under a separate CPT code. Dr. Brylowski improperly billed 14 units under this CPT code and was reimbursement was included with another service."

**Response Submitted by:** Burns Anderson Jury & Brenner, L.L.P.

## 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 the payment for the disputed services with the following claim adjustment codes:

- 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.
- 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 services.
- 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.
- 306 – Billing is a duplicate of other services performed on same day.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 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.
- 2008 – Additional payment made on appeal/reconsideration.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 5346 – Please specify time spent on billed procedure for further review.
- 86 – Service performed was distinct or independent from other services performed on the same day.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 250 – The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

- MA46 Alert – The new information was considered but additional payment will not be issued.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- 5141 – Bill has been reviewed by a nurse or under the direction of a nurse.

Issues

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

2. Is Andrew Brylowski, M.D., entitled to additional reimbursement for the procedure code 90792?

3. Is Dr. Brylowski entitled to reimbursement for procedure code 96121?

4. Is Dr. Brylowski entitled to reimbursement for procedure codes 96132, 96133, 96136 and 96137?

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 associated with a designated doctor examination. 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 "TAC §127.10" and "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.

   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. The date of injury for the injured employee considered in this dispute is after 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 additional reimbursement for CPT 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 the performance of this service as defined. The requester is therefore entitled to reimbursement for CPT code 90792. DWC will review this code for additional reimbursement.

3. Dr. Brylowski is seeking additional reimbursement for CPT code 96121, which is a timed add-on code for CPT code 96116 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 12 units for this service. The insurance carrier paid in part, based on workers' compensation fee guidelines. The submitted documentation does not list a start and end time to support the number of hours billed for add-on timed CPT code 96121.

4. Dr. Brylowski is seeking additional reimbursement for CPT 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."

   The insurance carrier denied these testing services, in part, based on missing or insufficient documentation.

A review of the documentation provided supports that the services described above for procedure code 96132 were performed by the requester for tests evaluated and interpreted within the billed dates of service. 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 add-on timed procedure code 96133. Therefore, Dr. Brylowski is not entitled to reimbursement for this codes as defined.

A review of the documentation provided supports that the services described above for procedure code 96136 were performed by the requester for tests evaluated and interpreted within the billed dates of service. 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 add-on timed procedure code 96137. Therefore, Dr. Brylowski is not entitled to reimbursement for this codes as defined.

5. 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) x $189.11 = $410.30. 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. Per explanation of benefits dated July 8, 2025, the insurance carrier paid $410.30. No additional reimbursement is recommended for this service.

    The Medicare participating amount for CPT code 96132 is $125.97. The MAR is calculated as follows: (70.18/32.3465) x $125.97 = $273.31. Dr. Brylowski billed for 14 units. By definition, this code is only allowed one unit. Per explanation of benefits dated August 13, 2025, the insurance carrier paid $273.31. No additional reimbursement is recommended for this service.

    The Medicare participating amount for CPT code 96136 is $40.99. The MAR is calculated as follows: (70.18/32.3465) x $40.99 = $88.93. This amount is recommended.

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 of $88.93 is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Hartford Casualty Insurance Co. must remit to 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**

| | | |
|---|---|---|
| | | October 9, 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.