



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Andrew Brylowski, M.D.

Respondent Name

Standard Fire Insurance

MFDR Tracking Number

M4-26-0596-01

Insurance Carrier's Austin Representative

BOX 5 Travelers Co Inc

DWC Date Received

October 31, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 16, 2025 – July 27, 2025	99082	\$520.00	\$0.00
July 16, 2025 – July 27, 2025	99199	\$175.00	\$0.00
July 16, 2025 – July 27, 2025	90792	\$3,757.10	\$0.00
July 16, 2025 – July 27, 2025	96116	\$196.51	\$0.00
July 16, 2025 – July 27, 2025	96121	\$1,607.10	\$0.00
July 16, 2025 – July 27, 2025	96132	\$3,051.63	\$0.00
July 16, 2025 – July 27, 2025	96133	\$2,894.85	\$0.00
July 16, 2025 – July 27, 2025	96136	\$0.00	\$0.00
July 16, 2025 – July 27, 2025	96137	\$777.47	\$0.00
Total		\$12,979.66	\$0.00

Requester's Position

"Dr. Andrew Brylowski has tried to collect the amount owe from Travelers without any success...
99082 51-59: Physician unusual travel CPT code 99082 is billed at \$2 per mile.

AMOUNT: \$520.00

"99199 51-59: This code was used for record organization, tagging, sorting, linking of specific records to report, and having the record available in the cloud for immediate viewing by stakeholder(s).

AMOUNT: \$175.00

"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 Section 127.10 - General procedures for Designated Doctor Examinations ...

"AND 28 TAC Section 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 Section 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: \$5,560.71

"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. 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 20 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 29, 2025, June 30, 2025, July 16, 2025, July 17, 2025, July 18, 2025, July 20, 2025, July 21, 2025, July 22, 2025, July 24, 2025, July 25, 2025, July 26, 2025, and July 27, 2025. This process involved approximately 19 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. A total of 140 minutes and 51 seconds were spent reviewing records.

AMOUNT: \$6,723.95 ...

Total Amount Due: \$12,979.66"

Amount In Dispute: \$12,979.66

Respondent's Position

"The Provider contends they are entitled to additional reimbursement for multiple CPT codes related to the testing and evaluation. As to CPT code 99082 (unusual travel), the Provider contends they are entitled to reimbursement. Per the Medicare edits, this code is not reimbursable when the primary codes are performed in office. Consequently, the Provider is not entitled to additional reimbursement.

"As to CPT code 99199 (unlisted special service described as record organization), the Provider contends they are entitled to reimbursement. This miscellaneous code is not supported with documentation. Additionally, a more specific code should be used to document the services rendered. Consequently, the Provider is not entitled to additional reimbursement.

"As to CPT code 90792 (psychiatric diagnostic evaluation), the Provider contends they are entitled to additional reimbursement. The Provider billed 10 units for this CPT code. The Medicare edits limit reimbursement for this code to 1 unit per day under the Medicare Unlikely Edits which cannot be overridden by a modifier. The Carrier reimbursed the maximum Medicare allowable units. As the documentation supports one unit of this CPT code, which the Carrier has reimbursed, the Provider is not entitled to additional reimbursement.

"As to CPT code 96116 (neurobehavioral exam, per hour), the Provider contends they are entitled to reimbursement. This code is inclusive to 90792, which the Carrier has reimbursed. Consequently, the Provider is not entitled to additional reimbursement.

"As to CPT code 96121 (cognitive testing, per hour), the Provider contends they are entitled to reimbursement. This code is inclusive to 90792, which the Carrier has reimbursed. Consequently, the Provider is not entitled to additional reimbursement.

"As to CPT code 96132 (neuropsychological testing, per hour), the Provider contends they are entitled to additional reimbursement. The Provider billed 12 units for this CPT code. The Medicare edits limit reimbursement for this code to 1 unit per day under the Medicare Unlikely Edits. The Carrier reimbursed the maximum Medicare allowable units. As the documentation supports one unit of this CPT code, which the Carrier has reimbursed, the Provider is not entitled to additional reimbursement.

"As to CPT code 96133 (neuropsychological testing, per hour), the Provider contends they are entitled to additional reimbursement. The Provider billed 12 units for this CPT code. The Medicare edits limit reimbursement for this code to 7 units per day under the Medicare Unlikely Edits. The Carrier reimbursed the maximum Medicare allowable units. As the documentation supports one unit of this CPT code, which the Carrier has reimbursed, the Provider is not entitled to additional reimbursement.

"As to CPT code 96137 (neuropsychological testing, per hour), the Provider contends they are entitled to additional reimbursement. The Provider billed 21 units for this CPT code. The Medicare edits limit reimbursement for this code to 11 units per day under the Medicare Unlikely Edits. The Carrier reimbursed the maximum Medicare allowable units. As the documentation supports one unit of this CPT code, which the Carrier has reimbursed, the Provider is not entitled to additional reimbursement."

Response Submitted By: Travelers

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section [413.031](#) and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section [127.10](#) provides the general procedures for designated doctor examinations.
3. 28 TAC Section [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 reasons:

1. 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
2. 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S).
3. 107 – THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT IDENTIFIED ON THIS CLAIM.
4. P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
5. 3243, 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. SINCE THE ALLOWANCE FOR THE PROCEDURE IS TO BE DETERMINED BY REPORT, AN ALLOWANCE HAS NOT BEEN PAID.
6. 3247, 3246 - 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.
7. 277 - SINCE THE MODIFIER HAS NOT BEEN USED CORRECTLY, AN ADDITIONAL UNIT CANNOT BE PAID. THE UNLISTED OR BY REPORT (BR) SERVICE WAS NOT SUFFICIENTLY IDENTIFIED OR DOCUMENTED. WE ARE UNABLE TO MAKE A PAYMENT WITHOUT A COMPARABLE CODE AND A CLEAR DESCRIPTION OF THE SERVICE(S) PERFORMED.
8. 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.
9. 86 - SERVICE PERFORMED WAS DISTINCT OR INDEPENDENT FROM OTHER SERVICES PERFORMED ON THE SAME DAY.
10. 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.
11. 292 - THIS PROCEDURE CODE IS ONLY REIMBURSED WHEN BILLED WITH THE APPROPRIATE INITIAL BASE CODE.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rules apply to the services in dispute?
3. Is Andrew Brylowski, M.D. entitled to reimbursement for procedure code 99082?
4. Is Dr. Brylowski entitled to reimbursement for procedure code 99199?
5. Is Andrew Brylowski, M.D., entitled to additional reimbursement for procedure code 90792?

6. Is Dr. Brylowski entitled to reimbursement for procedure codes 96116 and 96121?
7. Is Dr. Brylowski entitled to reimbursement for procedure codes 96132, 96133, and 96137?
8. Is the requester entitled to additional reimbursement for the services in dispute?

Findings

1. Dr. Brylowski submitted this dispute in accordance with 28 TAC Section 133.307 for the following procedure codes:
 - 99082-51-59
 - 99199-51-59
 - 90792-51-59
 - 96116-51-59
 - 96121-51-59
 - 96132-51-59
 - 96133-51-59
 - 96136-51-59
 - 96137-51-59

He is seeking \$0.00 for procedure code 96136-51-59. Therefore, this procedure code will not be considered in this medical fee dispute resolution (MFDR).

Per a review of the submitted explanation of benefits (EOB) and a copy of the check for payment, the insurance carrier has previously reimbursed the requester in the amount of \$3,093.41 for the services in dispute.

Dr. Brylowski is seeking additional reimbursement in the amount of \$12,979.66 for the disputed services rendered July 16, 2025, through July 27, 2025. DWC will review the disputed procedure codes in accordance with applicable DWC Statutes and Rules to determine if additional payment is due.

2. 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 "TAC Section 127.10".

While he referenced an older version of Chapter 127, Section 10, DWC finds that this rule in effect for the dates of service in question states in Subsection (c), in relevant part, "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 that 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 Section 180.24 of this title (relating to Financial Disclosure).
- (4) Any additional testing or referrals required for the evaluation of an injured employee under a certified workers' compensation network under Insurance Code Chapter 1305 or a political subdivision under Labor Code Section 504.053(b):
 - (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 Section 1305.101 (relating to Providing or Arranging for Health Care)."

DWC reviewed the explanations of benefits submitted and found that the insurance carrier did not deny payment based on medical necessity, preauthorization requirements, extent of injury, compensability, or network status. Therefore, this rule is not applicable to the dispute in question.

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 Section 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 Section 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. Dr. Brylowski is seeking \$520.00 for procedure code 99082 x 520 units. 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 support that very unusual travel was performed. No reimbursement is recommended for this service.

4. Dr. Brylowski is seeking \$175.00 for procedure code 99199 x 175 units. 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)."

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.

5. Dr. Brylowski is seeking additional reimbursement in the amount of \$3,757.10 for procedure code 90792 x 10 units, 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 procedure code 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. A review of the submitted EOB finds that the insurance carrier reimbursed this procedure code in the amount of \$411.60. DWC will review procedure code 90792 for entitlement to additional reimbursement.

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 and 96121 for each additional hour."

Dr. Brylowski billed one unit of procedure code 96116 with appended modifiers 51 and 59. He also billed 10 units of timed add-on code 96121 with 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. 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.

7. Dr. Brylowski is seeking additional reimbursement for procedure codes 96132 x 12 units and 96133 x 12 units. 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.

Dr. Brylowski is also seeking additional reimbursement for procedure code 96137 x 21 units, which is a timed add-on code for procedure code 96136, not in dispute. Procedure code 96136 is to be billed for the first 30 minutes of "Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method... 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 report 96137 for each additional 30 minutes."

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."

A review of the documentation provided supports that the services described above for procedure code 96132 was performed by the requestor for tests administered, scored, 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 codes 96133 and 96137; therefore, Dr. Brylowski is not entitled to reimbursement for these codes as defined.

8. The requester is seeking additional reimbursement in the total amount of \$12,979.66 for the services in dispute.

In accordance with 28 TAC Section 134.203, to determine the 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 the disputed dates of service is 32.3465.
- Per the submitted medical bills, the service was rendered in zip code 78746 which is in Medicare locality 31, "Austin, Texas."
- The 2025 Medicare participating amount for **CPT code 90792** in locality 31 is \$189.71.
- Using the formula above, the MAR is \$411.60. Dr. Brylowski billed 10 units for this service, however provided no evidence that multiple assessments as defined were performed.
- The total MAR for procedure code 90792 at one unit is \$411.60.
- The insurance carrier paid \$411.60.
- Additional reimbursement is not recommended.
- The Medicare participating amount for **CPT code 96132** in locality 31 is \$126.70.
- Using the formula above, the MAR is \$274.89. Dr. Brylowski billed for 12 units. However, no evidence was provided to support the billed units within the dates of service in dispute.
- The total MAR for procedure code 96132 at one unit is \$274.89.
- The insurance carrier paid \$274.89.
- Additional reimbursement is not recommended.

DWC finds that the requester is not entitled to additional reimbursement for the services in dispute rendered on July 16, 2025 to July 27, 2025.

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented 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 Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	February 12, 2026
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 Section [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 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 this Medical Fee Dispute Resolution Findings and Decision** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.