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

Dallas Area Rapid Transit

MFDR Tracking Number

M4-26-0922-01

Insurance Carrier's Austin Representative

BOX 53 Hoffman Kelley LLP

DWC Date Received

December 1, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
June 19, 2025 – July 1, 2025	99456	$138.00	$0.00
July 16, 2025 – July 27, 2025[sic]	99199	$125.00	$0.00
July 16, 2025 – July 27, 2025[sic]	90792	$2,874.10	$0.00
July 16, 2025 – July 27, 2025[sic]	96132	$3,284.40	$273.31
July 16, 2025 – July 27, 2025[sic]	96133	$4,332.93	$0.00
July 16, 2025 – July 27, 2025[sic]	96137	$1,650.60	$0.00
	Total	$12,405.03	$273.31

Requester's Position

"Let this letter serve as notice that Dr. Andrew Brylowski has tried to collect the amount owe from Sedgwick without any success…

"**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: $138.00

"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: $125.00

"90792 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 §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: $2,874.10

"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 16 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 23, 2025, June 24, 2025, June 27, 2025, June 28, 2025, June 29, 2025, and July 1, 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 22 hours. Specific time reviewing records 117 minutes and 7 seconds.

AMOUNT: $9,267.93 …

Total Amount Due: $12,405.03"

Amount In Dispute: $12,405.03

Respondent's Position

"Respondent is a governmental entity that provides medical benefits by directly contracting with health care providers pursuant to Labor Code section 504.053(b). Employees are required to obtain healthcare through Respondent's healthcare network (the Network) ...My Texas Direct.

"The rights granted, or provisions contained within Texas Labor Code Chapter 413 titled Medical Dispute Resolution, except for 413.042, do not apply to health care providers who provided serv ices to an injured employee enrolled in a network…

"The requestor, has failed to demonstrate that it has the right to medical fee dispute pursuant to Texas Labor Code Sec. 413.031(c) and 28 Texas Administrative e Code §133.307

"Carrier/Respondent would like to uphold their previous payment.

"Carrier is unable to find any documentation for dates of service **7/16/25–7/27/25.** The original bill was paid correctly. Any time-based code was denied because the provider did not document specific times for each code which they should be doing. No additional due."

Response Submitted By: Hoffman Kelley, LLP

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. Texas Labor Code (TLC) Section 504 sets out the rights and responsibilities related to workers' compensation insurance coverage for political subdivisions.
3. Texas Insurance Code, Chapter 1305 sets out the rights and responsibilities related to workers' compensation certified health care networks.
4. 28 TAC Section 134.203 sets out the fee guidelines for professional medical services.
5. 28 TAC Section 134.240 sets out the fee guidelines for designated doctor examinations.

Adjustment Reasons

The insurance carrier reduced or denied payment for the disputed services with the following reasons:

16 – Claim/service lacks information or has submission/billing error(s).
P12 – Workers' compensation jurisdictional fee schedule adjustment.
277 - 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 S ERVICE(S) PERFORMED.
309 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
4097 - PAID PER FEE SCHEDULE; CHARGE ADJUSTED BECAUSE STATUTE DICTATES ALLOWANCE IS GREATER THAN PROVIDER'S CHARGE.
4150 - AN ALLOWANCE HAS BEEN PAID FOR A DESIGNATED DOCTOR EXAMINATION AS OUTLINED IN 1 34 .2040) FOR ATTAI NMENT OF MAXIMUM MEDICAL IMPROVEMENT. AN ADDITI ONAL ALLOWANCE IS PAYABLE IF A DETERMINATION OF THE IMPAIRMENT CAUSED BY THE COMPENSABLE INJURY WAS ALSO PERFORMED.
5346 - PLEASE SPEC I FY TIME SPENT ON B I LLED PROCEDURE FOR FURTHER REVIEW.
561 - ACCORDING TO THE STATE FEE SCHEDULE, THIS PROCEDURE CODE IS NOT CONSIDERED A VALID REIMBURSABLE CODE. PLEASE RE-SUBMIT WITH A VALID CODE.
86 - SERVICE PERFORMED WAS DISTINCT OR INDEPENDENT FROM OTHER SERVICES PERFORMED ON THE SAME DAY.
250 - THE ATTACHMENT/OTHER DOCUM ENTATION THAT WAS RECEIVED WAS THE INCORRECT ATTACHMENT/DOCUMENT. THE EXPECTED ATTACHM ENT/DOCUMENT IS STILL MISSING.
N706 - Missing documentation.
N600 - Adjusted based on the applicable fee schedule for the region in which the service was rendered.

Issues

1. What is DWC considering in this medical fee dispute?

2. Is the requester eligible for DWC medical fee dispute resolution (MFDR) for the service(s) in question?
3. What rules apply to the services in dispute?
4. Is the requester entitled to additional reimbursement for CPT code 99456?
5. Is the requester entitled to additional reimbursement for CPT code 90792?
6. Is the requester entitled to reimbursement for procedure code 99199?
7. Is the requester entitled to reimbursement for disputed procedure codes 96132, 96133, and 96137?

Findings

1. This MFDR review involves an examination by a designated doctor for the purpose of establishing whether maximum medical improvement (MMI) has been reached and to provide impairment ratings (IR) if MMI has been reached, in addition to further testing by the designated doctor to resolve issues required to arrive at MMI and IR determinations. Because the respondent asserts that the requester is contracted with an intergovernmental network, DWC will first consider whether the requester is eligible for DWC MFDR in accordance with applicable DWC Statutes and Rules.
   DWC notes that the "Dates of Service in Dispute" fields of the DWC Form-060, *Medical Fee Dispute Resolution Request* (DWC Form-060) are partly populated with dates July 16, 2025, through July 27, 2025, while all submitted medical bills, explanation of benefits (EOB) and medical documentation reports only reference dates of service June 19, 2025, through July 1, 2025. Therefore, the only dates of service to be considered in this MFDR review are June 19, 2025, through July 1, 2025.
   The requester has previously been reimbursed $1,233.30 for the disputed CPT codes 99456 and 90792. The total reimbursement amount issued for the claim in question is $4,174.20 as of the date of this review, which includes payment for other charges billed on the same dates of service not in dispute.
   The requester is seeking additional reimbursement for specific disputed CPT codes, as shown in the "Summary of Findings" table above, which were unpaid or received reduced payments. If findings determine that the requester is eligible for MFDR, DWC will review the submitted documentation to determine if the requester is entitled to additional reimbursement in accordance with applicable DWC Statutes and Rules.

2. The requester filed this MFDR request to DWC asking for resolution through 28 TAC Section 133.307.
   The insurance carrier representative asserts in its position statement that the right to file MFDR does not apply in this case because the respondent is a governmental entity that provides medical benefits by directly contracting with health care providers pursuant to Labor Code Section 504.053(b) and that employees are required to obtain healthcare

through the respondent's healthcare network, My Texas Direct.

Per information known to DWC, the injured employee's worker's compensation claim is covered within My Texas Direct Network. According to its public webpage at https://www.mytexasdirect.com/, My Texas Direct is a workers' compensation healthcare provider panel formed through an Interlocal agreement among participating political subdivisions that joined together to exercise the option to contract directly with health care providers for workers' compensation medical benefits. DWC finds that the respondent's assertion that the injured worker's claim is contracted within My Texas Direct network pursuant to Labor Code Section 504.053(b) is supported.

However, TLC Section 504.053(c)(1) excludes designated doctors from the contract stating, "If the political subdivision or pool provides medical benefits in the manner authorized under Subsection (b)(2), the following do not apply:

(1) Sections 408.004 and 408.0041, unless **use of** a required medical examination or **designated doctor** is necessary to resolve an issue relating to the entitlement to or amount of income benefits under this title;"

A review of the submitted documentation confirms that the services involved in this medical fee dispute, tracking number M4-26-0922-01, were provided by Andrew Brylowski, M.D., a **designated doctor**, under order of the Commissioner. Therefore, DWC finds that the requester is eligible for MFDR in accordance with Texas Labor Code Section 413.031 and 28 TAC Section 133.307. Therefore, this MFDR request will be reviewed in the following findings.

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 Section 134.240, adopted to be effective June 1, 2024, applies to the reimbursement of the services in dispute. 28 TAC Section 134.240(d), 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) <u>If the designated doctor determines that MMI has not been reached</u>, the MMI evaluation portion of the examination must be billed and reimbursed in accordance with subsection (d) of this section. <u>The designated doctor must add</u> <u>modifier 'NM</u>.'

   (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 <u>IR examinations</u>, the designated doctor must bill, and the insurance carrier must reimburse the components of the IR evaluation. The designated doctor must apply the additional modifier 'W5.' Indicate the number of body areas rated in the unit's column of the billing form.

(A) For musculoskeletal body areas, the designated doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

(I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4); and

(II) the reimbursement for each additional musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(B) For non-musculoskeletal body areas, the designated doctor must bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area examined.

(i) Non-musculoskeletal body areas are defined as follows:

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(iv) The test or tests required by Chapter 127 of this title for the assignment of IR, as outlined in the AMA Guides, must be billed using the appropriate CPT code or codes and reimbursed under the applicable division fee guideline in addition to the fees outlined in subsection (b) and (d)(1) - (3) of this section."

DWC finds that 28 TAC Section 134.210 applies to the annual fee adjustment of the disputed services, stating in pertinent part,

"(b)(4) <u>Fees established in</u> §§134.235, <u>134.240</u>, 134.250, and 134.260 of this title will be:

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

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

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

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

Because all other codes involved in this dispute are professional medical services, DWC finds that 28 TAC Section 134.203 applies, stating 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 Section 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 …"

4. The requester is seeking additional reimbursement in the amount of $138.00 for CPT code 99456 rendered on June 19, 2025, through July 1, 2025.

   A review of the submitted medical bill finds that the requester charged $449.00 for one unit of 99456-W5 on the first line of service, indicating the charge is for MMI. The requester also charged $961.00 for three units of 99456-W5 on the second line of service, indicating the charge is for IR of three body areas. Finally, the requester charged $300.00 for one unit of 99456-SP. CPT code 99456 indicates the service of a maximum medical improvement (MMI) and/or impairment rating (IR) examination. Modifier "W5" indicates the service was provided by a designated doctor. A review of the applicable DWC Rules finds that **modifier "SP" is not a current, valid modifier**; therefore, no reimbursement can be recommended for 99456-SP, on the disputed date of service.

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

A review of the submitted medical record additionally finds that the requester performed an IR evaluation of two musculoskeletal body areas. The rule at 28 TAC Section 134.240 defines the fees for the calculation of an IR for musculoskeletal body areas. The MAR for the evaluation of a musculoskeletal body area performed in 2025 is $199.00. The requester performed IR calculations for two musculoskeletal body areas; therefore, the MAR is $398.00 for two musculoskeletal body areas.

The requester also assigned an IR for one non-musculoskeletal body area. The rule at 28 TAC Section 134.240 defines the fees for the calculation of an IR for non-musculoskeletal body areas. The MAR for the evaluation of a non-musculoskeletal body area performed in 2025 is $199.00.

In accordance with 28 TAC Section134.240, the reimbursements which apply to the disputed examination rendered on June 19, 2025, are:

- For an MMI examination, reimbursement is $465.00.
- For an IR of two musculoskeletal body areas, reimbursement is $398.00.
- For an IR of one non-musculoskeletal body area, reimbursement is $199.00.
- DWC finds that the total MAR for the designated doctor examinations in question rendered on June 19, 2025, is $1,062.00.
- Per the submitted EOB dated July 10, 2025, the insurance carrier paid a total amount of $1,572.00 for CPT code 99456.
- Additional reimbursement is not recommended.

5. The requester 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 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 eight 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 per the submitted EOB dated July 10, 2025, 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 Rule 28 TAC Section 134.203, as quoted in previous finding number three, applies to the reimbursement of CPT code 90792.

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 8 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 CPT code 90792-51-59 rendered on the disputed date of service.

6. The requester is seeking reimbursement in the amount of $125.00 for CPT code 99199-51-59. 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.

7. The requester is seeking reimbursement for procedure code 96132-51-59, 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." The requester is also seeking reimbursement for CPT code 96133-51-59, which is a timed add-on code for procedure code 96132.

   On the disputed date of service, the requester billed $3,284.40 for 12 units of CPT code 96132-51-59 and additionally billed $4,332.93 for 21 units of CPT code 96133. The insurance carrier allowed $0.00 reimbursement for both disputed CPT codes.

   The requester is also seeking reimbursement for procedure code 96137, which is a timed add-on code for procedure code 96136. 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." CPT code 96136 has been reimbursed by the insurance carrier and is not in dispute.

   The submitted medical 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, additional reimbursement is not recommended for these codes as defined.

A review of the submitted documentation supports that the services described above for procedure code 96132 were performed by the requester for tests administered, scored, evaluated, and interpreted within the billed dates of service. DWC will review these codes for additional reimbursement.

DWC finds that Rule 28 TAC Section 134.203, as quoted in previous finding number three, applies to the reimbursement of CPT code 96132.

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 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 96132 in this locality on the disputed date of service is $125.97.
- Using the formula above, DWC finds that the MAR = $273.31.
- Dr. Brylowski billed 12 units for CPT code 96132, however provided no evidence that multiple assessments as defined were performed.
- The total MAR for CPT code 96132 at one unit is $273.31.
- The insurance carrier paid $0.00.
- Reimbursement in the amount of $273.31 is recommended.

DWC finds that the requester is entitled to reimbursement in the amount of $273.31 for CPT code 96132-51-59 rendered on June 19, 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 established that reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Dallas Area Rapid Transit must remit to Andrew Brylowski, M.D. $273.31 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 5, 2026 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.