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

General Information

Requester Name
John Sklar, M.D.

Respondent Name
Bryan ISD

MFDR Tracking Number
M4-26-0202-01

Carrier's Austin Representative
Box Number 43

DWC Date Received
September 19, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 20, 2024	Required Medical Exam 99456	$1,659.00	$1,602.00
November 20, 2024	99456	$664.00	$642.00
November 20, 2024	99456	$664.00	$642.00
	Total	$2,987.00	$2,886.00

Requester's Position

Excerpt from the request for reconsideration dated May 19, 2025: "The following bill was audited and paid incorrectly. TDI-DWC addresses the 95-day period for timely submission with rule 134.240(e). This rule states: (1) The 95-day period for timely submission of the designated doctor bill for the examination begins on the date of service of the additional testing or evaluation. (2) The dates of service (CMS-1500/field 24A) are as follows: the 'From' date is the date of the designated doctor examination, and the 'To' date is the date of service of the additional testing or evaluation."

Amount in Dispute: $2,987.00

Respondent's Position

The Austin carrier representative for Bryan ISD is Sedgwick York Risk Services. The representative was notified of this medical fee dispute on September 23, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §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) §133.307 sets out the procedures for Medical Fee Dispute Resolution requests.
2. 28 TAC §133.20 sets out requirements of medical bill submission by health care providers.
3. Texas Labor Code §408.0272 sets out certain exceptions for the untimely submission of a medical claim.
4. 28 TAC §134.235 sets out the fee guidelines for Required Medical Examinations.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes.

- 4271 - PER TX LABOR CODE SEC. 408.027, PROVIDERS MUST SUBMIT BILLS TO PAYORS WITHIN 95 DAYS OF THE DATE OF SERVICE.
- 29 - THE TIME LIMIT FOR FILING HAS EXPIRED.
- 247 - A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.
- 18 – EXACT DUPLICATE CLAIM/SERVICE.

Issues

1. Has the requester waived their right to medical fee dispute resolution?
2. What rules apply to the services in dispute?
3. Is the requester entitled to reimbursement for the services in dispute?

Findings

1. The requester is seeking $2,987.00 for a required medical examination (RME) involving additional testing and evaluation rendered on November 20, 2024. The insurance carrier denied reimbursement for the disputed services based on untimely submission of the medical bill.

   28 TAC §133.20 which sets out requirements of timely medical bill submission, states in pertinent part "(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day **after** the date the services are provided."

   DWC finds that 95 days **after** the disputed date of service fell on Sunday, February 23, 2025. The following business day is Monday, February 24, 2025. A review of the submitted EOBs finds that the workers' compensation carrier first received the medical bill on Monday, February 24, 2025. Therefore, DWC finds in accordance with 28 TAC §133.20, the insurance carrier's reason for denial of the disputed RME services is not supported.

   Based on the submitted documentation, DWC finds the requester is entitled to medical fee dispute resolution review. Therefore, the disputed services will be reviewed for the maximum allowable reimbursement (MAR).

2. This medical fee dispute involves an RME service for the purpose of establishing: if maximum medical improvement (MMI) has been reached; what date MMI was reached if applicable; to provide impairment ratings (IR) if MMI has been reached; to determine the extent of the injured employee's compensable injuries; and to determine the ability of the injured employee to return to work.

   On the disputed date of service, the requester billed a total amount of $2,987.00 for CPT code 99456. CPT code 99456 indicates the service of a work-related examination by a doctor other than the treating doctor.

   DWC finds that 28 TAC §134.235, adopted to be effective June 1, 2024, applies to the reimbursement of the services in dispute. 28 TAC §134.235, states in pertinent part, "(c) When conducting an insurance carrier-requested examination to determine impairment or attainment of maximum medical improvement (MMI), the RME doctor must bill, and the insurance carrier must reimburse, using CPT code 99456, with the modifiers and at the rates specified in paragraphs (c)(2) - (3).

   > (1) The total maximum allowable reimbursement (MAR) for an MMI or impairment rating (IR) examination is equal to the MMI evaluation reimbursement plus the reimbursement for the body area or areas evaluated for the assignment of an IR. The MMI or IR examination must include:

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

(D) the preparation and submission of reports (including the narrative report and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and

(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.

(2) RME doctors 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 RME doctor determines that MMI has not been reached, the RME doctor must bill, and the insurance carrier must reimburse, the MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(3) of this section. The RME doctor must add modifier "NM."

(B) If the RME doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, and an IR evaluation was not warranted, the RME doctor must only bill, and the insurance carrier must only reimburse, the MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(3) of this section.

(C) If the RME doctor determines MMI has been reached and an IR evaluation is performed, the RME doctor must bill, and the insurance carrier must reimburse both the MMI evaluation and the IR evaluation portions of the examination in accordance with this subsection.

(3) MMI. MMI evaluations will be reimbursed at $449 adjusted per §134.210(b)(4).

(4) IR. For IR examinations, the RME doctor must bill, and the insurance carrier must reimburse the components of the IR evaluation. Indicate the number of body areas rated in the units column of the billing form.

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

(i) Non-musculoskeletal body areas are:

(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).

"(d) When conducting an insurance carrier-requested examination to determine the extent of the employee's compensable injury, whether the injured employee's disability is a direct result of the compensable injury, the ability of the injured employee to return to work, other similar issues, or appropriateness of medical care, the RME doctor must bill, and the insurance carrier must reimburse, using CPT code 99456 and at the rates specified in paragraphs (d)(1) - (5).

(1) Extent of injury. The reimbursement rate for determining the extent of the injured employee's compensable injury is $642 adjusted per §134.210(b)(4).

(2) Disability. The reimbursement rate for determining whether the injured employee's disability is a direct result of the work-related injury is $642 adjusted per §134.210(b)(4).

(3) Return to work. The reimbursement rate for determining the ability of the injured employee to return to work is $642 adjusted per §134.210(b)(4)."

DWC finds that 28 TAC §134.210 applies to the annual fee adjustment of the disputed services, stating in pertinent part, "(b)(4) Fees established in §§134.235, 134.240, 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) adjusted annually 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."

3. The requester, John Sklar, M.D., is seeking reimbursement in the amount of $2,987.00 for an RME service by a doctor other than the treating doctor. According to information known to DWC, the examination in question was ordered for the purpose of establishing: if maximum medical improvement (MMI) has been reached; what date MMI was reached if applicable; to provide impairment ratings (IR) if MMI has been reached; to determine the extent of the injured employee's compensable injuries; and to determine the ability of the injured employee to return to work.

   The submitted medical record supports that the requester performed an evaluation of MMI as ordered by DWC. Per 28 TAC §134.235, the MAR for this examination on the disputed date of service is $449.00.

   A review of the submitted medical record supports that the requester performed an IR evaluation of two musculoskeletal body areas. The rule at 28 TAC §134.235 defines the fees for the calculation of an IR for musculoskeletal body areas. The MAR for the evaluation of the first musculoskeletal body area on the disputed date of service is $385.00. The MAR for each additional musculoskeletal body area on the disputed date of service is $192.00. The MAR for the IR examination of two musculoskeletal body areas on the disputed date of service is $577.00.

   A review of the submitted medical record additionally supports that the requester performed an IR evaluation of three non-musculoskeletal body areas. The rule at 28 TAC §134.235 defines the fees for the calculation of an IR for non-musculoskeletal body areas. The MAR for the evaluation of each non-musculoskeletal area performed on the disputed date of service is $192.00. The requester provided an IR for three non-musculosketal body areas, therefore, the MAR for the non-musculosketal body area IR examinations on the disputed date of service is $576.00.

   The medical record submitted supports that the requester performed an examination to determine the extent of the injured employee's compensable injuries as requested by DWC.

The rule at 28 TAC §134.235 defines the fee for determination of extent of injury examinations. The MAR for extent of injury determination in 2024 is $642.00.

The submitted medical record further supports that Dr. Sklar performed, documented, and billed for the service of "Return to Work" in accordance with 28 TAC §134.235. Per 28 TAC §134.235, the MAR for this examination in 2024 is $642.00.

In accordance with 28 TAC §134.235, the reimbursements which apply to the disputed examination rendered on November 20, 2024, are:

- For an MMI examination, reimbursement is $449.00.
- For IR of two musculoskeletal body areas, reimbursement is $577.00.
- For IR of three non-musculoskeletal body areas, reimbursement is $576.00.
- For an examination to determine extent of injury, reimbursement is $642.00.
- For a Return-to-Work determination, reimbursement is $642.00.
- DWC finds that the total MAR for the examination in question is $2,886.00.
- The insurance carrier paid $0.00 as of the date of this review.
- Reimbursement in the amount of $2,886.00 is recommended.

DWC finds that reimbursement in the amount of $2,886.00 is due for the services in dispute.

Conclusion

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

DWC finds the requester has established that reimbursement is due in the amount of $2,886.00.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Bryan ISD must remit to John Sklar, M.D. $2,886.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature:

January 6, 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 §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, call CompConnection at 1-800-252-7031, option 3 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 3 o correo electronico CompConnection@tdi.tas.gov.