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
WOMENS HEALTH BOUTIQUE

Respondent Name
Employers Insurance of Wausau

MFDR Tracking Number
M4-26-1262-01

Insurance Carrier's Austin Representative
BOX 60 Downs Stanford PC

DWC Date Received
December 23, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
August 3, 2024	Code E1399	$2,580.00	$0.00
	Total	$2,580.00	$0.00

Requester's Position

"Liberty Mutual Has a history of running us around for payment of items they are supposed to cover. We are a small business with limited resources for fighting."

Amount In Dispute: $2,580.00

Respondent's Position

"This bill for DOS 08/03/2024 will not be reviewed as this dispute has been submitted past the timely filing deadline per Rule 133.307: A request for MFDR that does not involved issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. The MFR was filed on 12/23/2025 which is greater than time allotted."

Response Submitted By: Texas Mutual

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 133.305 sets out the procedures for resolving medical disputes.

Adjustment Reasons

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

1. 8806 – The services reported were not sufficiently identified or documented. We are unable to make a payment decision without the HCPCS/CPT code which most comprehensively describes the services performed and supporting documentation. For reconsideration, please submit appeal with the most appropriate HCPS/CPT Code, EOP and documentation to support service
2. 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rules apply to the services in dispute?

Findings

1. Review of the submitted documentation finds the requester billed code E1399 on August 3, 2024. The insurance carrier issued a $0.00 payment, and the requester is seeking reimbursement in the amount of $2,580.00. Insurance carrier denied the service with the following denial codes: 8806 – The services reported were not sufficiently identified or documented. We are unable to make a payment decision without the HCPCS/CPT code which most comprehensively describes the services performed and supporting documentation. For reconsideration, please submit appeal with the most appropriate HCPS/CPT Code, EOP and documentation to support service and 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

2. According to 28 Texas Administrative Code (TAC) 133.307(c)(1), a request for Medical Fee Dispute Resolution (MFDR) must be submitted no later than one year after the date of the disputed service, except in certain limited circumstances outlined in subsection (B) of the

same provision.

Specifically, 28 TAC 33.307(c)(1)(B) allows for a later filing if one of the following conditions applies:

(i) A related dispute concerning compensability, extent of injury, or liability under Labor Code Chapter 410 has been filed. In such cases, the medical fee dispute must be submitted within 60 days after the requester receives the final decision on compensability, extent of injury, or liability, including all appeals.

(ii) A dispute regarding medical necessity has been filed. Here, the medical fee dispute must be filed within 60 days after the requester receives the final decision on medical necessity, including all appeals, for the specific health care services in question that were previously denied by the insurance carrier based on medical necessity.

(iii) The dispute arises from a refund notice issued following a division audit or review. In this situation, the medical fee dispute must be filed within 60 days after the requester receives the refund notice.

In this case, HCPCS code E1399 was provided on August 3, 2024. The Division received the MFDR request on December 23, 2025, which is more than one year after the date(s) of service. Upon review of the documentation provided, there is no indication that the dispute falls within any of the exceptions described in 28 TAC 133.307(c)(1)(B).

The Division finds the requester has not established that reimbursement is due.

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 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

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.