



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Baylor Surgical Hospital of Fort Worth

Respondent Name

PIE Insurance Company

MFDR Tracking Number

M4-26-0570-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

October 27, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 4, 2024	C1781	\$283.50	\$0.00
December 4, 2024	C1713	\$1,584.89	\$0.00
Total		\$1,868.39	\$0.00

Requester's Position

"Per EOB received CPT codes C1713 and C1781 was not paid correctly per TX work comp guidelines. According to TX Rule 134.402, implants should be reimbursed at manual cost plus 10%."

Amount in Dispute: \$1,868.39

Respondent's Position

"The HCP was reimbursed according to the rule outlined above after referring to the OP report. ...Under the *Description of Procedure* of the OP report the Surgeon implanted a SwiveLock anchor and referenced the Regeneten patch."

Response submitted by: CorVel

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 resolving medical fee disputes.
2. [28 TAC §134.403](#) sets out the reimbursement guidelines for implants utilized during outpatient surgical services.

Denial Reasons

- 234 – This procedure is not paid separately.
- B13 – Payment for service may have been previously paid.
- RN – Not paid under OPPS: services included in APC rate.
- P14 – Payment is included in another svc/procedure occurring on same day.
- 97 – Charge Included in another Charge or Service.
- IM7/IM5 - Implant records reviewed, Invoice based payment.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Appeal/Reconsideration

Issues

1. Did the requester support the cost of the implants?

Findings

1. The requester is seeking additional payment of code C1781 – Mesh Implantable and C1713 – Anchor/Screw rendered as part of outpatient hospital surgery on December 4, 2024. Separate reimbursement was requested by the health care provider.

DWC Rule 28 TAC §134.403 (g) states, Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission.

The submitted medical bill indicates,

- C1713 units 3 amount billed \$2509.00, and
- C1781 units 1 amount billed \$2835.00

The itemized statement indicates,

- Anchors Bone 3 W arthro (C1713)
- Staple Tendon Arthroscope (C1713)
- Implant System 4.75BC (C1713)
- Implant Mesh Bioinductive (C1781)

The submitted documentation (page 20 of 71) indicates an invoice for LNT Implant System, 4.75 BC SwiveLock. The ship date and order date is December 6, 2024. The date of service in dispute is December 4, 2024. The submitted invoice does not support the cost of the implant on the date of service. The calculation per the applicable fee guideline cannot be done.

The submitted documentation (page 22 of 71) indicates an invoice for Bone Anchors 3 w arthro Del and Bioinductive Implant w/arth. The date of this invoice is June 26, 2024. The date of service in dispute is December 4, 2024. The submitted invoice does not support the cost of the implant on the date of service. The calculation per the applicable fee guideline cannot be done.

The requester sought additional payment of implants rendered as part of an outpatient hospital procedure on December 4, 2024. The required invoices to support the cost were dated six months prior to the date of service and two days after the date of service.

DWC find the requester did not support the cost of the implants on the date of service. No payment 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 20, 2025

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 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 electrónico CompConnection@tdi.texas.gov.