



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Fort Worth Surgicare Partners Ltd

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-26-0682-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

November 7, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
December 12, 2024	C1713	\$9,033.58	\$3,514.66
Total		\$9,033.58	\$3,514.66

Requester's Position

The requester did not submit a position statement. The following is an excerpt from a document dated August 27, 2025 titled, "Reconsideration". "Per EOB received CPT codes C1713 and C1781 were 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: \$9,033.58

Respondent's Position

"I have received the medical fee dispute resolution. It has been forwarded to our bill review team for further review."

Response Submitted By: Gallagher Bassett

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 [134.403](#) sets out the guidelines for outpatient hospital services.

Adjustment Reasons

- 109-1 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12-1 Workers' compensation jurisdictional fee schedule adjustment.
- 00663 – Reimbursement has been calculated based on the state guidelines.
- 90223 – Workers' compensation jurisdictional fee schedule.
- 5853 – The amount paid reflects a fee schedule reduction.
- 6183 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.

Issues

1. What is DWC considering in this medical fee dispute?
2. Has the requester support the cost of the implants?
3. Has DWC determined the requester is entitled to additional benefits?

Findings

1. The requester is seeking additional payment of implants rendered during an outpatient hospital stay with a span date of December 10, 2024 – December 12, 2024 in the amount of \$9,033.58. The reduction in payment was made based on the reasons shown above.
2. 28 TAC Section 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.

Review of the submitted documents found the following items were billed under code

C1713 – Implantable anchor or screw used for bone-to-bone or soft tissue-to-bone fixation in surgical procedures.

- Suture Orthocord Violet/Orthocordviolet w/OS-6 ANDLS PK/12. Billed price \$410.00
- Anchors bone 3 w Arthro/Bone Anchors 2 w Arthro Del. Billed priced \$725.00
- Staple Tendon Arthroscope/Tendon Anchors. Billed price \$450.00
- Suture Anchor 4.75 x 14m/Corkscrew FT, BC, Suturetape. Billed price \$3,848.20
- Suture Anchor Swivelock/DBL Loaded 4.75mm BC SWVLK. Billed price \$4,607.00
- Knotless Tensiontight/Knotless Tension Tigt Button Implant. Billed price \$948.50

Suture Orthocord Violet. The submitted invoice is from 2023. The date of service is 2024. Based on this review, no payment can be recommended for the Suture Orthocord Violet.

Anchors bone 3 w Arthro. The submitted invoice indicates a cost of \$725.00

Staple Tendon Arthroscope. The submitted invoice indicates a cost of \$450.00

Suture Anchor 4.75 x 14. The submitted invoice indicates the cost of one unit is \$1,924.10. Two units were rendered. The total cost is \$3,848.20.

Suture Anchor Swivelock. The submitted invoiced indicates unit of measure is a box. No information was found to indicate how many of this item was in a box. Based on this review, no payment can be recommended for the Suture Anchor Swivelock.

Knotless Tensiontight. The submitted invoice indicates a cost of \$948.50.

The total cost of the implants supported by invoice is \$5,971.70. Based on the fee guideline shown above the MAR is \$5,971.70 plus 10% or \$597.17 = \$6,568.87. The insurance carrier made a payment of \$3,054.01 on February 13, 2025 via check #0205674843. A balance of \$3,514.66 remains.

3. Based on the information available at the time of this review, DWC finds an additional payment of \$3,514.66 remains. This amount is recommended.

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 additional reimbursement is due.

Order

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that New Hampshire Insurance Company must remit to Fort Worth Surgical care \$3,514.66 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

February 19, 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 electrónico CompConnection@tdi.texas.gov.