



Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name

Samuel John Alianell, M.D.

Respondent Name

United Airlines Inc.

MFDR Tracking Number

M4-25-0149-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

September 19, 2024

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
March 21, 2024	80307	\$300.00	\$0.00
Total		\$300.00	\$0.00

Requestor's Position

"The Charges referenced herein were filed with the carrier and been denied first based on 'not related to the injury, denied per customer request, and, not authorized' and when appealed it was last denied for 'time limit for filing expired'. We disagree with this decision. On the above referenced date, the Claimant was seen by Dr. Samuel Alianell for an interim office visit regarding treatment and medication management for their work-related injury. We believe the UDT falls within the standards for medical necessity according to both CMS and ODG."

Amount in Dispute: \$300.00

Respondent's Position

The Austin carrier representative for United Airlines is Downs Stanford. The representative was notified of this medical fee dispute on September 24, 2024. Per 28 Texas Administrative Code §133.307 (d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the 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 resolving medical fee disputes.
2. [28 TAC §134.203](#) sets out the fee guideline for professional medical services.

Denial Reasons

The insurance carrier denied the payment for the disputed service with the following claim adjustment codes:

Explanation of benefits (EOB) dated April 12, 2024

- 109 & XAO – Claim not covered by this payer/contractor.
- 245 – Denied per customer request.
- 972 – This is not related to the injury and is denied.
- PC5 – Treatment not authorized.
- M15 – Separately billed services have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
- N29 – Missing documentation...

EOB dated July 25, 2024

- P12 - Workers' Compensation Jurisdictional Fee Schedule Adjustment.
- B13 – Re-evaluated. No additional payment is recommended.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

EOB dated August 13, 2024 & August 30, 2024

- 29 – The time limit for filing has expired.
- 892 – Billed date exceeds 95 days from date of service.
- W3 & 350 – Bill has been identified as a request for reconsideration or appeal.

Issues

1. Is the requestor entitled to reimbursement for CPT Code 80307 rendered on the disputed date of service?

Findings

1. The requestor is seeking reimbursement in the amount of \$300.00 for disputed CPT code 80307 rendered on March 21, 2024.

CPT Code 80307 is defined as, ""Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers... utilizing immunoassay... chromatography... and mass spectrometry either with or without chromatography."

A review of the submitted medical records finds that on March 21, 2024, the requestor also rendered a follow up office visit appointment. A review of the medical bill submitted finds that the only procedure code on the bill for date of service March 21, 2024, was 80307.

28 TAC §134.203(b)(1) states, "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."

Per Medicare article [A56915; Billing and Coding: Urine Drug Testing](#), which applies to procedure code 80307, "All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same claim."

After a review of the submitted documentation, DWC finds that all the procedures rendered by the requesting provider on the disputed date of service, March 21, 2024, were not included on the same bill. As a result, DWC finds that the requestor is not entitled to reimbursement.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor 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 reimbursement is due.

ORDER

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January 16, 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, 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.