MEDICAL CONTESTED CASE HEARING NO. 09109
M4-09-2116-01

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUE

A contested case hearing was scheduled for February 26, 2009. By agreement of the parties, it was held on February 27, 2009, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of Medical Review that Petitioner is not entitled to $70.43 for services rendered on June 13, 2008, for the compensable injury of _____?

PARTIES PRESENT

Petitioner appeared and was represented by AP, lay representative. Carrier appeared and was represented by BWJ, attorney.

BACKGROUND INFORMATION

On June 13, 2008, Petitioner's clinic rendered services to claimant for which the total amount sought was $70.43. When the bill was submitted to Carrier, it was signed by Dr. P, M.D.; however, Carrier denied the claimed amount because it was not signed by the MS, R.N., M.S.N., A.N.P., who provided the service at the clinic operated by Dr. P.

Petitioner asserts that Carrier is liable for the claimed amount under Medicare policy regarding "incident to" services because Nurse MS was performing services "incident to" those being provided by Dr. P. Petitioner relies upon a publication of (Healthcare Provider), which states in part,

> "Medicare defines "incident to" services as those services and supplies furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. In other words, these services do not represent the major portion of the overall service provided to a beneficiary by the physician. To be covered incident to the services of a physician, services and supplies must be:
>
> > a. Of a type that is commonly furnished in physicians' offices or clinics;
> > b. Furnished by the physician or by auxiliary personnel under the physician's supervision;
> > c. Commonly rendered without charge or included in the physician's bill; and
> > d. An integral, although incidental, part of the physician's professional service."

Under Petitioner's argument, the licensed nurse was not required to sign the claim form, a CMS-1500.

Carrier asserts it is not liable for the claimed amount under DWC Rule 133.20(d)(2), Rule 133.20(e)(2) and Rule 134.203(a)(7) which provide as follows:

> "Rule 133.20(d) The health care provider that provided the health care shall submit its own bill, unless:
>
> (2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill.
>
> "Rule 133.20(e) A medical bill must be submitted:
>
> (2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care.
>
> "Rule 133.203(a)(7) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies."

Carrier argues correctly that the bill should have been submitted in the name of the licensed nurse who rendered the service in order for Carrier to be liable for the amount in dispute. The same logic was properly followed by Medical Review in Medical Fee Dispute Resolution Findings and Decision under MFDR Tracking No. M4-09-2116-01. The evidence preponderates that Petitioner is not entitled to $70.43 for services rendered on June 13, 2008, for the compensable injury of _____.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On _____, Claimant was the employee of (Employer), when he sustained a compensable injury.

2. Carrier delivered to Petitioner a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Petitioner's claim for $70.43 for services rendered on June 13, 2008, was not submitted in the name of MS, R.N., the licensed health care provider who provided the health care.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of Medical Review that Petitioner is not entitled to $70.43 for services rendered on June 13, 2008, for the compensable injury of _____.

DECISION

The preponderance of the evidence is not contrary to the decision of Medical Review that Petitioner is not entitled to $70.43 for services rendered on June 13, 2008, for the compensable injury of _____.

ORDER

Respondent/Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **TEXAS MUTUAL INSURANCE COMPANY**, and the name and address of its registered agent for service of process is

MR. RUSSELL RAY OLIVER, PRESIDENT
6210 HIGHWAY 290 EAST
AUSTIN, TEXAS 78723

Signed this 27th day of February, 2009.

Charles T. Cole
Hearing Officer