

MSPRC Conditional Payment Investigation and Reconciliation Request

You have requested my office be engaged to investigate and/or reconcile Medicare conditional payment information. Below you will find a general overview of what you can expect, my fee schedule and appropriate authorizations your client will have to sign and return to me to commence the investigation. Please indicate which services you request, return appropriate signed authorization, and remit payment with the completed forms. Please note that you should allow 90-120 days for this process to be completed.

General Process: What to Expect

The Medicare Secondary Payer Act gives rise to Medicare conditional payments. The Medicare Secondary Payer Act (MSP) is found at Section 1862(b) of the Social Security Act 42 USC 1395y(b)(2). Applicable regulations are found at 42 CFR Part 411(1990). The MSP provides that Medicare may not make payment for medical services or prescription drug therapy charges where payment has been made or can reasonably be expected to be made under a workers' compensation law or plan of the United States or a State or under a liability, no-fault or group health policy. Under this authority Medicare has a priority right of recovery from the primary payer, as well as, from parties in receipt of third-party payments such as a beneficiary provider, supplier, physician, attorney, state agency or private insurer pursuant to 42 CFR 411.25(g).

Notifying of the potential settlement the Coordination of Benefits Contractor (COBC) is the first step in the process of requesting a Medicare conditional payment letter or "CPL". Upon receipt of this request the COBC will assign the case to a Medicare contractor (MSPRC) which will release a "Rights and Responsibility Letter" to your client and any authorized individual(s) listed on the Proof of Representation authorization. This letter provides general information on Medicare's rights and the Claimant's rights, as well as, other parties' responsibilities. It does not any conditional payment information. MSPRC will issue interim conditional payment amounts automatically as soon as an interim conditional payment amount is available. The Claimant and any authorized individuals will receive the CPL within 65 days of the issuance of the "Rights and Responsibilities Letter." Reconciliation of any disputed CPL entries is then commenced.

If your client has registered under <http://www.mymedicare.gov> it would be helpful if my office was provided with the password as this may expedite the process.

ONLY AFTER THE SETTLEMENT AS BEEN APPROVED OR A JUDGMENT ENTERED WILL MSPRC FINALIZE ITS RECOVERY CLAIM. This means you must advise your client that you will not be able to guarantee what the actual Medicare conditional payment recovery amount will be at the time of settlement. It is my recommendation that you retain twice the recommended reconciliation Medicare conditional payment amount in your client's fund account until the Final Demand Letter (see below) is received from Medicare.

At this point the "Final Settlement Detail Statement" is sent to MSPRC. This document includes the total settlement amount, itemization of procurement costs including attorney fees and costs, and date of settlement.

Upon receipt of the Final Settlement Detail Statement MSPRC will send a “Final Demand Letter” indicating the amount of recoupment MSPRC is seeking from the settlement. Interest begins to accrue on this amount 60 days after issuance of the Final Demand Letter regardless of whether the practitioner is disputing or appeal the amount claimed. Appeals follow the normal adjudicatory Medicare appeals process.

My office does not make direct inquiry with your client and will not engage in ex parte conversations with your client.

What is “Proof of Representation”?

This is the form wherein the Claimant has authorized my office to act on the Claimant’s behalf **BUT ONLY WITH RESPECT TO OBTAINING MEDICARE CONDITIONAL PAYMENT INFORMATION AND/OR RECONCILIATION OF CONDITIONAL PAYMENTS**. My office has no independent standing, but may receive or submit information/requests on behalf of the Claimant, including responding to requests from the MSPRC, receiving a copy of the MSPRC correspondence, and filing an appeal (if appropriate) when that Claimant is involved in a liability, workers’ compensation, or auto/no-fault situation.

What is “Consent To Release”?

This is the form wherein the Claimant authorizes my office to receive certain information from the MSPRC for a limited period of time. This release does not give my office the authority to act on behalf of the Claimant and therefore reconciliation of disputed CPS is not authorized when only this authorization has been signed.

Fee Schedule¹:

Commencing MSPRC search and production of preliminary CPL: \$350.00

Reconciliation of MSPRC conditional payment information including Final Settlement Detail Statement submission to MSPRC and receipt of Final Demand Letter: \$975.00

Please note that if reconciliation services are requested you will need to provide my office with the last two years medical reports and billing records including ICD-9 billing codes.

Appeals to Administrative Law Judge will require a retainer and will be billed at an hourly rate of \$395.00 per hour. Appeals are not automatically filed by my office and require a separate retainer agreement to be entered between the client and myself. \$1250.00

¹ All fees are prepaid. Please check www.sevarino.lawoffice.com for most recent forms and fee schedules

Services Requested:

- MSPRC notice of claim and CPL letter only \$350
Please submit Consent To Release form

- MSPRC notice of claim, CPL letters and reconciliation \$1325
Please submit Proof of Representation form
and Final Settlement Detail Document

- Appeal to Administrative Law Judge \$1250
\$1250 retainer; fees billed at \$395/hr.

I have read the above and agree to its terms:

_____ or _____
Claimant's Signature Claimant's Attorney's Signature

Date: ___/___/___

Date: ___/___/___

PROOF OF REPRESENTATION

Type of Medicare Beneficiary Representative

Attorney other than an Attorney of record:

Name: Angelo Paul Sevarino, Esq.
Address: 26 Barber Hill Road, Broad Brook, CT 06106
Telephone: 860-870-3803

Attorney Relationship to the Medicare Beneficiary:

MSPRC investigator/reconciliation representative

Medicare Beneficiary Information and Signature/Date:

Claimant/Plaintiff's Name (please print exactly as shown on your Medicare card):

Claimant/Plaintiff's Health Insurance Claim Number (number on client's Medicare card):

□□□-□□-□□□□-□□

Date of Illness/Injury for which the Claimant/Plaintiff has filed a liability insurance, no-fault insurance or workers' compensation claim: _____

Claimant/Plaintiff's Signature: _____

Date signed: _____

Representative Signature/Date:

Representative's Signature: _____ **Date signed:** _____
Angelo Paul Sevarino, Esq.

CONSENT TO RELEASE FORM

I, _____ hereby authorize The Centers for Medicare & Medicaid Services
(Print Name)
(CMS), its agents and/or contractors to release, upon request, information related to my injury/illness
and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

**CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE
INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:**

(If you intend to have your information released to more than one individual or entity, you must complete a separate
release for each one.)

Workers' Compensation Carrier Liability Carrier My Attorney
 Other

Name of Individual/Entity: Angelo Paul Sevarino, Esq.
Address: 26 Barber Hill Road, Broad Brook, CT 06016
Telephone: 860-870-3803 860-870-3805(fax)

**CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE
YOUR INFORMATION** (The period you check will run from when you sign the date below)

One Year Two Years Other _____
(Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE

Claimant/Plaintiff's Signature: _____ Date Signed: _____

Note: If the Claimant/Plaintiff is incapacitated, the submitter of this document will need to include
documentation establishing the authority of the individual signing on the Claimant/Plaintiff's behalf.
Please visit www.msprc.info for further instructions.

Medicare Health Insurance Claim Number (The number as shown on your Medicare card):

□□□-□□-□□□□-□□

Date of Injury/Illness

FINAL SETTLEMENT DETAIL DOCUMENT

Beneficiary Name:

Medicare Number: □□□-□□-□□□□-□□

Date of Incident:

42 CFR 411.37(c) stipulates that Medicare will recognize a proportionate share of the necessary procurement costs incurred in obtaining a settlement. In order for Medicare to properly calculate the net refund it is due, please supply the information outlined below. This information will also be used to update the Claimant/Plaintiff's Medicare records to show resolution of this matter.

Total amount of settlement:

\$ _____

Amount of any medical payment or PIP benefits paid in addition to the settlement amount:

\$ _____

Attorney fee :

\$ _____

**Additional procurement expenses:
(submit an itemized listing of these expenses)**

\$ _____

Date the case was settled:

___/___/___

Settlement information provided by:

Name

Address

Date submitted: ___/___/___