CMS Referral Request

CMS Review Thresholds

A workers’ compensation settlement may qualify for referral to The Centers for Medicare & Medicaid Services (CMS) under the following review threshold criteria. Note that at present there are no published liability settlement review thresholds.

1. A referral to CMS is indicated if the Claimant is a current Medicare beneficiary and the “total settlement amount” is equal to or greater than $25,000.

   Total settlement amount includes attorney fees, indemnity payments for lost time, disfigurement, permanent partial impairments, mileage, past medical services and prescription drug expense reimbursement or payment, future Medicare covered and non Medicare covered medical services and prescription drug expenses, and any Medicare conditional payments or group health liens to be satisfied from the settlement proceeds. Any previously settled portion of the claim must be included in computing the total settlement amount. The annuity lifetime or guaranteed payout totals over the entire term of any annuity contract which is used to fund the settlement, whether indemnity and/or medical, rather than the cost or present cash value of the annuity is used to calculate the value of the annuity for total settlement amount purposes.

   Claimants are generally eligible to receive Medicare benefits if, they are sixty-five (65) years of age, or if they have been receiving Social Security Disability benefits for at least twenty-four (24) months. Individuals found eligible for SSDIB benefits due to end stage renal disease or Lou Gehrig’s disease (ALS) will qualify for Medicare earlier than 24 months.

   OR

2. A referral to CMS is indicated if the Claimant is not a current Medicare beneficiary but there is a "reasonable expectation" that the Claimant will be Medicare entitled within thirty (30) months of the date of the settlement and the total settlement amount exceeds $250,000.00.

   A Claimant can "reasonably" expect to become a Medicare beneficiary within thirty (30) months, if at the time of settlement: (a) is at least 62 ½ years of age; (b) has applied for or has received SSDIB benefits; (c) has been denied SSDIB benefits but anticipates appealing the decision, or (d) has end stage renal disease or Lou Gehrig’s (ALS) disease.
Fee Schedule

The fee to refer a settlement for CMS approval is a flat $1,000 which includes making the referral, following-up with periodic status inquires and obtaining CMS approval. CMS may reply to the CMS referral with a “counter” proposal. While there is no direct right of appeal to a counter proposal received from CMS the counter proposal may be “challenged”. This usually involves providing CMS with counter medical evidence or other evidence supportive of the original proposed Medicare Set-aside figure. Fees may be higher should a “challenge” be filed to a counter CMS proposal. Before any additional fees are incurred my office will discuss in advance what is required. These additional fees are billed at the hourly rate of $395.00 over the initial fee.

All fees are the responsibility of the submitting party and are not contingent upon any contractual relationship between the submitting party and client or upon the ultimate settlement or approval of settlement. All fees are due and payable in advance. Interest of 1.5% per month is charged for all outstanding invoices.

Additional Services

My office can provide additional services including (1) Medicare Set-aside analysis, (2) Medicare Conditional Payment Investigation and Reconciliation and (3) Settlement Document Preparation including Social Security offset, Informed Consent as to Medicare Set-aside/Medical Costs and Consequences of Your Settlement forms. To learn more about these services please visit my web site at www.sevarino.lawoffice.com.

The submitting attorney or party warrants to Angelo Paul Sevarino, Esq. that s/he has explained to his or her client that (a) no attorney-client relationship is being established between their client and Angelo Paul Sevarino, Esq., and (b) their client consents to Angelo Paul Sevarino, Esq. reviewing the submitted documents and communicating with the Social Security Administration or The Centers for Medicare & Medicaid Services as may be required. Further, the Submitting attorney or party warrants to Angelo Paul Sevarino, Esq. the accuracy of all the information contained herein.

The signature of the Client or authorized representative below is required before the referral to CMS may be made, as well as, the completion of the CMS Request Worksheet and two (2) attached authorizations.

Client

Recording Information

Date:___________________

Submitting Attorney/Party

Date:___________________
CMS Referral Request Worksheet

1. General Information:

Case Type:  [ ] Workers’ compensation  [ ] Liability

State of Jurisdiction:  [ ] Connecticut  [ ] Other: ____________________

Date of Injury/Illness: Note, if more than one date of injury or illness provide specific details as to nature of injury/illness, who the responsible insurance carrier(s)/employer/defendants are and how the settlement proceeds are allocated to each injury or illness.

Body Part(s)/System(s):

Claimant Name:

Address:
SSN/HICN:
Telephone:
Date of Birth:

If Spouse/Dependents are payees under the settlement please provide specifics.

Claimant’s Attorney:

Address:
Telephone:

Employer/Defendant:

Address:
Telephone:

Insurer:

Address:
Telephone:
Claim Number:

Employer/Insurer’s Attorney:

Address:
Telephone:
2. Settlement

Total Settlement Amount:
If not yet known provide best estimate.

Proposed Settlement Date:

Indemnity Settlement Type: [ ] lump sum
[ ] structured. Please provide quotation summary. Please indicate if you need assistance in obtaining structured settlement quotations.

Medical Settlement Type: [ ] lump sum
[ ] structured. Please provide quotation summary. Please indicate if you need assistance in obtaining structured settlement quotations.

3. Medicare Entitlement Date:

A. If the Claimant is on Medicare indicate the month and year for each coverage part (Parts A, B, C or D). Dates may differ per coverage part. If not known check here [ ]. Please provide a copy of the Medicare card(s).

B. If Claimant is not yet Medicare entitled indicate:

[ ] do not know status
Please complete the SSA Request For Information authorization found below and submit to the local Social Security Office. Should you wish my office to obtain this information please return the signed authorization along with a fee of $150.00.
[ ] has applied for SSDIB
[ ] has applied been denied SSDIB but anticipates an appeal
[ ] appealed and/or re-filed for SSDIB
[ ] is 62½ years old
[ ] end stage renal disease but does not yet qualify for Medicare based on ESRD
[ ] Lou Gerig’s disease (ALS)
4. Medicare Set-aside:

   A Medicare Set-aside analysis is necessary as part of the submission to CMS if future medical services or prescription drug therapy charges are part of the settlement. Indicate:

   [ ] A Medicare Set-aside has been completed within the last 4 months and is attached.

   [ ] I am requesting a Medicare Set-aside be completed. Please download and submit the MSA Request from http://sevarino.lawoffice.com

5. MSA Administration:

   [ ] Self-administered

   [ ] Professional administered by:______________________________

6. Medicare Conditional Payments:

   If your client is on Medicare at the time of the settlement a Medicare conditional payment search and reconciliation must be undertaken.

   [ ] A Medicare Conditional Payment search has already been done and is not being requested as part of this service. Please indicate amount of Medicare conditional payments to be repaid: $______________________.

   [ ] I am requesting a Medicare Conditional Payment investigation and/or reconciliation be completed. Please download and submit the MSPRC Request from http://sevarino.lawoffice.com.

7. Settlement Document Preparation:

   [ ] I will prepare my own settlement documents.

CONSENT TO RELEASE

I, __________________________ hereby authorize The Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to release, upon request, information related to my injury or 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

(X ) Other:

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

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

(X ) 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

Beneficiary Signature: __________________________ Date Signed: ___________________

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary’s behalf. Please visit www.mspcr.info for further instructions.

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

____________________-____-______

Date of Injury/Illness
Request for Social Security Information

TO: Social Security Administration

_____________________________  __________________________
Name                              Date/Birth                 Social Security No.

I authorize the Social Security Administration to release information or records about me to:
Angelo Paul Sevarino, Esq., 26 Barber Hill Road, Broad Brook, CT 06016

Reason I want this information released:

To establish my Social Security Disability status, possible offset implications, date of entitlement to Medicare and the basis for Medicare entitlement (disability, age or ESRD) for the purpose of my workers' compensation claim.
I understand there may be a charge for releasing information.

Please release the following information:

(A) Social Security entitlement status; (B) date of Social Security entitlement or date of application if still pending;
(C) basis for entitlement (disability, age, ESRD); (D) Medicare status; (E) date of entitlement for Medicare A, B and/or D; (F) Supplemental Security Income entitlement; (G) Medicaid entitlement; (H) If not a current Social Security recipient, include number of eligible quarters/credits; (I) Initial PIA; (J) ACE and any offset notices or calculations and (K) Family Max

I am the individual to whom the information/record applies, parent or the legal guardian of that person. I know that if I make any representation which I know is false to obtain information from Social Security, I could be punished by a fine or imprisonment or both.

Signature:_________________________ Date:_________ Relationship:_________________________

FOR SSA USE ONLY

Is the individual currently a Medicare and/or Medicaid (SSI) recipient? Yes     No

If yes, Is the individual receiving: Medicare Part A      Yes   No   Date of Entitlement: _____________
Medicare Part B      Yes   No   Date of Entitlement: _____________
Medicare Part D      Yes   No   Date of Entitlement: _____________
SSI/Medicaid        Yes   No   Date of Entitlement: _____________

Is the individual insured for SSDIB? Yes   No   Number of Quarters/Credits: __________________________

Initial PIA__________ 80% ACE $_________ Family Max: $________________

If the individual is NOT receiving Medicare or Medicaid benefits please complete the following

Is the individual receiving SS Retirement Benefits? Yes   No   Effective Date: __________________________

Is the individual receiving SSDIB benefits but Is not yet a Medicare beneficiary? Yes   No   Date of Entitlement: _____________
Has a claim or request for hearing For SSDIB/SSI benefits been filed? Yes   No   Date of Application: ______________

________________________
SSA Representative Signature