

## **Workers= Compensation CMS Referral Request & Worksheet**

### **Scope of Service**

If your workers= compensation settlement meets certain review thresholds as developed by The Centers for Medicare & Medicaid Services (CMS) your settlement is eligible to be referred to CMS by way of a Workers= Compensation Medicare Set-aside (WCMSA) arrangement. Referral of a WCMSA to CMS is entirely voluntary and there are no statues or regulations mandating you refer your settlement to CMS. However, all settlements must give Medicare due consideration and referral of a WCMSA is thought to be the best method to objectively document that your settlement has given Medicare due consideration.

My office provides complete referral services for the WCMSA including initial CMS submission via CMS= web portal, as well as, advising you of resolution options of any CMS counter proposal.

### **Workers= Compensation CMS Review Thresholds**

#### **Category A: Current Medicare Beneficiary**

A referral to CMS is allowed 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 work related medical services and prescription drug expense reimbursement or payment, future work related 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 years of age or if they have been receiving Social Security disability benefits for at least twenty-four months. Individuals found eligible for Social Security disability benefits due to end stage renal disease or Lou Gehrig's disease (ALS) will qualify for Medicare earlier than 24 months.

## **Category B: Not on Medicare but has a Reasonable Expectation of being so.**

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 months, if at the time of settlement: is at least 62 2 years of age; has applied for or has received Social Security disability benefits; has been denied Social Security disability benefits but anticipates appealing the decision, or has end stage renal disease or Lou Gehrig's (ALS) disease

### **Fee Schedule**

The fee to refer a Medicare Set-aside proposal to CMS is a flat \$1,000 which includes filing the referral via the WCMSA web portal; responding to CMS's post submission inquiries; providing periodic status updates to client; and obtaining the initial CMS approval or CMS counter-proposal.

The charge to file a *Are-Review* (discussed below) is a flat \$750.

All fees are the responsibility of the submitting party and are not contingent upon any contractual relationship between the submitting party and the client or upon the ultimate settlement or approval of the settlement.

All fees are due and payable in advance. Interest of 1.5% per month is charged for all outstanding invoices.

### **CMS Counter Proposal**

CMS may reply to the initial WCMSA referral with a "counter" proposal. This may either be a *Acounter-higher* representing an increase in the proposed Medicare Set-aside amount or a *Acounter-lower* representing a decrease in the proposed Medicare Set-aside amount. While there is no direct right of appeal to a counter proposal received from CMS a *Are-review* of the submission is available in limited circumstances:

1. **Mathematical Error:** Where you disagree with CMS decision because CMS determination contains obvious mistakes (e.g., a mathematical error or failure to recognize medical records already submitted showing a surgery, priced by CMS, which has already occurred.
2. **Missing Documentation:** Where you disagree with CMS decision because the submitter has additional evidence, not previously considered by CMS, which was dated prior to the

submission date of the original proposal and which warrants a change in CMS determination.

3. Re-Review: Where the following criteria are met CMS will permit a one-time request for re-review in the form of a submission of (a) a new cover letter, (b) submission of all medical documentation related to the settling injury(s) body part(s) since the previous submission date, (c) submission of the most recent 6 months of pharmacy records, (d) submission of a Consent to Release authorization and (d) a summary of expected future medical services and prescription drug dosage and frequency.

The criteria are:

- a. CMS has issued an approved amount at least 12 months but no more than 48 months prior to the re-review request
- b. the case has not yet settled as of the date of the request for re-review
- c. projected care has changed so much that the submitter's new proposed amount would result in a 10% or \$10,000 change (whichever is greater) in CMS's previously approved amount
- d. where a re-review request is reviewed and approved by CMS, the new approved amount will take effect on the date of settlement, regardless of whether the amount increased or decreased

## Worksheet

### 1. General Information

**Case Type:** Workers= Compensation

**State of Jurisdiction:** [ ] Connecticut [ ] Other: \_\_\_\_\_

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

**Body Part(s)/System(s) to be included in the WCMSA:**

**Body Part(s)/System(s) to be excluded from the WCMSA** (which have been disclaimed, a finding and dismissal entered as to that body part/system, or is medically determined to exist prior to the work-related injury or illness):

**Claimant Name:**

Address:

SSN:

HICN (as shown on the Medicare card):

Telephone:

Date of Birth:

Gender

**Claimant=s Attorney:**

Address:

Telephone :

**Employer Name:**

Address:

Telephone:

**Insurer:**

Address:

Telephone:

Claim Number:

**Employer/Insurer=s Attorney:**

Address:

Telephone:

**2. Settlement Information**

**Total Gross Settlement Amount:**

(If not yet known provide your best estimate)

**Proposed Settlement Date:**

**Indemnity Settlement Type:**  lump sum

structured (please provide quotation summary)

**Medical Settlement Type:**  lump sum

structured (please provide quotation summary)

**3. Medicare Entitlement**

(Check appropriate boxes)

The Claimant *is* on Medicare (traditional Part A and/or B), Medicare Part C (Medicare Advantage Plan) or Medicare Part D (Prescription drug). Indicate the month and year for each coverage. Note, dates may differ per coverage part.

Medicare Part A: Month/Year of Entitlement:

Medicare Part B: Month/Year of Entitlement:

Medicare Part C: Month/Year of Entitlement:

Name of Plan:

Medicare Part D: Month/Year of Entitlement:

Name of Plan:

Please provide a copy of the applicable Medicare card(s).

Claimant *is not* on Medicare but expected to be on as of: \_\_\_\_\_

I do not know Claimant=s Medicare status. I will complete the attached *A*Form for Requesting Social Security Information<sup>®</sup> and have my client bring it to any local SSA District office for completion. Once received I will return the completed form to your office.

#### 4. Social Security Disability Entitlement (check all that apply)

- Claimant is receiving Social Security disability benefits effective: \_\_\_\_\_
- Claimant has applied for Social Security disability
- Claimant has applied but has been denied Social Security disability and anticipates an appeal
- Claimant appealed and/or re-filed for Social Security disability
- Claimant is 622 years old
- Claimant has end stage renal disease but does not yet qualify for Medicare based on ESRD
- Claimant has Lou Gerig=s disease (ALS)

#### 5. Workers= Compensation Medicare Set-aside

A Workers= Compensation Medicare Set-aside (WCMSA) analysis is necessary as part of the submission to CMS if future work related medical services or prescription drug therapy charges are part of the settlement. Indicate:

- A WCMSA analysis has been completed within the last 4 months and is attached.
- I am requesting a WCMSA analysis be completed. Please log onto <http://sevarinolaw.com> and click *A*Attorney Services @ then *A*Workers= Compensation Medicare Set-aside (WCMSA) Analysis & Evaluation @.

#### 6. WCMSA Administration

- Self-administered
- Professional administered by: \_\_\_\_\_

#### 7. Medicare Conditional Payments

If your client is on Medicare at the time of the settlement or has been on Medicare in the past 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 an additional service. Attach a copy of Final Demand Letter received from CMS. Please indicate amount of Medicare conditional payments to be repaid:  
\$ \_\_\_\_\_.

Ⓒ I am requesting a Medicare Conditional Payment investigation and/or reconciliation be completed. Please log onto <http://sevarinolaw.com> and click *Attorney Services* and review *Medicare Conditional Payment Reconciliation Request*.

## 8. Settlement Document Preparation

Ⓒ I will prepare my own settlement documents.

Ⓒ Settlement document preparation including Social Security offset language; Informed Consent as to Medical Costs and Notice of Consequences of Your Settlement forms is being requested. Please log onto <http://sevarinolaw.com>, and click *Attorney Services* and review *Workers' Compensation Settlement Document Preparation*.

## 9. Required Information To Be Submitted

The following required material is to be included along with the return of this completed Workers= Compensation CMS Referral Request Worksheet and returned to: Angelo Paul Sevarino, Esq., 26 Barber Hill Road, Broad Brook, CT 06016 or emailed to [wclawyer@aol.com](mailto:wclawyer@aol.com).

**a. Medical Records:** A complete set of **medical reports** for the *last two years of treatment* including all surgical reports and hospital discharge records from date of injury forward

**b. Pharmacy printout** (or statement from treating physician(s) if drug is physician supplied) for all prescribed drugs for the *last two (2) years of treatment*. Include name of drug, unit form (capsule, tablet, patch etc.), prescribed strength, dosage and prescribed frequency. **THIS MUST BE A CURRENT VERSION OF THE PRINTOUT NO OLDER THAN 6 MONTHS FROM THE DATE SUBMITTED.**

**c. Medical payment recap history** from the workers= compensation carrier covering the *last two years of treatment*. **THIS MUST BE A CURRENT VERSION OF THE RECAP HISTORY NO OLDER THAN 6 MONTHS FROM THE DATE SUBMITTED.** The recap history must contain a “date printed” and have some identification as to the name of the carrier supplying the information. If this is not something the carrier’s system generates then attach a cover letter on carrier’s letter head certifying when the recap record was printed. If the Claimant has not received any work related treatment in the two year period prior to submission of the WCMSA to CMS the attending physician must so state in a letter printed on the doctor=s letterhead.

**d. If an implantable device is being used or recommended you should consult with the appropriate physician and provide the following information:**

- Device, electrodes, receiver manufacturer name- Device, electrodes, receiver model # or type- Device, electrodes, receiver cost including tax, freight and handling- Facility fee, whether inpatient or outpatient, procedure code and cost- Surgeon procedure code and cost
- Anesthesiologist procedure code and cost- Programming services procedure code, frequency and cost- Other associated costs

**e. Signed Authorizations (3)**

1. Consent To Release (required)
2. Form for Requesting for Social Security Information (optional)
3. Authorization for Release of Protected Health Information (required)

**10. Authorization**

The submitting attorney/law firm or party warrants to Angelo Paul Sevarino, Esq. that s/he has explained to their client that (a) no attorney-client relationship is being established between the 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 attorney/law firm warrants to Angelo Paul Sevarino, Esq. the accuracy of all the information contained herein.

**The signature of the authorized representative is required before the case can be submitted to CMS.**

\_\_\_\_\_  
Submitting Attorney/Party Signature

Date: \_\_\_\_\_



**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:**

(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:                                    860-716-0320

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

(Check only one)

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

I understand that I may revoke this Aconsent 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.msprc.info](http://www.msprc.info) for further instructions.

Medicare Health Insurance Claim Number (The number as shown on Claimant=s Medicare card):

\_\_\_\_\_  
Date of Injury/Illness

## Form for Requesting 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 (860-716-0320)**

### **Reason I want this information released:**

To establish my Social Security disability status, possible workers' compensation 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 C, 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 (circle applicable answer):

Medicare Part A      Yes No    Date of Entitlement:

Medicare Part B      Yes No    Date of Entitlement:

Medicare Part C      Yes No    Date of Entitlement:

SSI/Medicaid      Yes No    Date of Entitlement:

Is the individual insured for Social Security disability?                      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 Social Security disability benefits but  
is not yet a Medicare beneficiary?    Yes    No    Date of future Entitlement:

Has a claim or request for hearing for Social Security disability/SSI benefits been filed?

Yes    No    Date of Application: \_\_\_\_\_

**SSA Representative Signature:** \_\_\_\_\_

**Authorization for Release of Protected Health Information**  
(In compliance with HIPAA Regulations - 45 C.F.R. 164.508)

To: RE:

SNN#:

Date of Birth:

I authorize the use or disclosure of my protected health information by your office, company or organization as specified below. I understand that signing this Authorization is voluntary and that my medical provider may not require me to sign this Authorization before my doctor, hospital or institution provides me with treatment. I understand that I have the right to revoke this Authorization at any time by providing a signed, written notice of such revocation to my medical provider. I understand that a description of my right to revoke my Authorization is set forth in my medical provider's Notice of Privacy Practices. I understand that information is being released pursuant to this Authorization at my request and that the information may no longer be protected by law or regulation and may be re-disclosed by the recipient.

1. Please use or disclose the following health information if such information exists:

- The entire medical record; or
- The following limited health information:

Your medical institution/provider cannot use or disclose certain information unless you specifically authorize such use or disclosure. **Please initial next to each item below if you specifically authorize the release** of health information relating to the testing, diagnosis or treatment for:

- HIV/AIDS
- Drug and alcohol abuse
- Mental health/psychiatric disorders

2. Please specify the time period for the information you described above to be disclosed:

- All information maintained at any time by my medical provider or
- Information maintained by my medical provider from \_\_\_ / \_\_\_ / \_\_\_ to \_\_\_ / \_\_\_ / \_\_\_

3. Please specify who may receive the information requested by this authorization:

**Angelo Paul Sevarino, Esq., 26 Barber Hill Road, Broad Brook, CT 06016  
(860-716-0320)**

Unless earlier revoked, this authorization will expire one year from the date signed below, unless you specify an earlier date here: \_\_\_ / \_\_\_ / \_\_\_.

By signing below, I understand and acknowledge the following:

- a. I have read and understand this Authorization;
- b. I am authorizing my medical provider to use or disclose the health information to the person(s) and for the purpose(s) identified in this authorization; and
- c. If I have any questions about disclosure of my protected health information pursuant to this Authorization, I may contact my medical provider=s Privacy Officer.

A photostatic copy of this Authorization shall be considered as effective and valid as the original.

\_\_\_\_\_ Date: \_\_\_\_\_  
Signature

If signed by the Patient=s/Client=s personal representative, describe the legal authority of the representative to act on behalf of the Patient/Client. \_\_\_\_\_

Legal authority of representative verified by: \_\_\_\_\_