

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

IN RE: ALL ASBESTOS PERSONAL
INJURY CASES

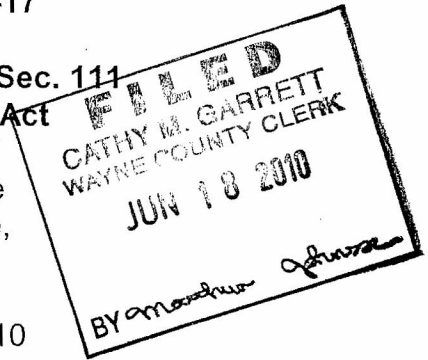
Case No. 03-310422-NP
Hon. Robert Colombo Jr.

CASE MANAGEMENT ORDER #17

**Regarding Requirements of MMSEA Sec. 111
And Medicare Secondary Payer Act**

At a session of this Court , in the
City of Detroit, County of Wayne,
State of Michigan on this date:

JUN 18 2010 2010



The Motion for Entry of Case Management Order # 17 having been filed, served on all Counsel in the above litigation, and heard in open court, with all interested parties having been given an opportunity to be heard, and in an effort to a) comply with the requirements of the federal Health Insurance Portability and Accountability Act, (HIPAA), b) to establish a Social Security Number (SSN) privacy policy as contemplated by Administrative Order 2006-2 of the Michigan Supreme Court, c) to facilitate the compliance of the parties to this litigation with the requirements of the Medicare, Medicaid and SCHIP Extension Act of 2007, (PL 110-173) (MMSEA) Section 111, ("Section 111"), and to facilitate Medicare's right of recovery under "Medicare Secondary Payer

Act” 42 USC Sec. 1395y, (MSP) and any rules and regulations promulgated there under, with the Court being fully advised of the premises for the pending motion:

IT IS HEREBY ORDERED that the Motion for Entry of Case Management Order # 17 is hereby GRANTED.

IT IS FURTHER ORDERED that the privacy policy adopted by entry of this Order shall be subject to the following terms and conditions:

Procedures for Distribution of Query and Reporting Information For MMSEA Sec. 111 Compliance:

1. **For Future Filings in Wayne County Asbestos-Related Personal Injury Actions:**
 - a) **Form A – Query Information:** In cases filed after the date of entry of this Order, within 90 days of filing complaint, each Plaintiff shall complete and file electronically, on Lexis/Nexis or other service as the Court may order, Form A, attached, enabling Defendants to obtain by query to CMS a determination as to whether Plaintiff is Medicare eligible at the time of the query. No signature of a Plaintiff or counsel is required on Form A;
 - b) **Form B – Reporting Information:** As soon as practicable after receiving a response to the CMS query, lead defense medical counsel shall electronically inform all parties of the CMS response on Lexis/Nexis or other service as the Court may order. Where it has been determined that Plaintiff or Plaintiff’s decedent is/was Medicare eligible, Plaintiff shall complete and file electronically Form B, attached, (except for information requested in boxes 12, 13 and 100 - 102 on that Form that shall be discussed at time of settlement), thus providing all defense counsel with information necessary to comply with reporting requirements of MMSEA Sec. 111. No signature of a Plaintiff or counsel is required on that form. No settlement is final and enforceable until Form B is provided by Plaintiff.
 - c) **Form B Filing Deadline – Reporting Inconsistencies:** On the due date of Plaintiff’s Discovery Brochure, Medicare eligible Plaintiffs or decedent’s representative shall complete and file Form B to the extent required in paragraph (1)(b). This filing will be made electronically, on Lexis/Nexis or other service as the Court may order. If a Defendant intends to report information that is inconsistent with the information provided by Plaintiff on Form B as to ICD diagnosis codes and description of illness, prior to doing

so, Defendant will reasonably notify Plaintiff of the information to be reported, and will agree to meet and confer prior to the filing of the report so as to resolve inconsistencies to the extent possible.

2. For Cases Filed and Pending Further Proceedings:

- a) **Cases with 2010 Trial Dates:** For cases filed before the date of this Order, with trial dates scheduled in 2010, each Plaintiff shall provide Defendants with full social security numbers for Plaintiff or Plaintiff's decedent, by way of a spreadsheet or otherwise, filed electronically, on Lexis/Nexis or other service as the Court may order, within 30 days of entry of this Order, enabling Defendants to obtain by query to CMS a determination as to whether Plaintiff is currently Medicare eligible. On or before the trial date every Medicare eligible Plaintiff or Plaintiff's decedent shall complete Form B and file same electronically on Lexis/Nexis or other service as the Court may order. No settlement is final and enforceable until Form B is provided by Plaintiff.
- b) **Cases With Trial Dates In And After 2011, Or Not Yet Scheduled For Trial:** In cases set for trial after January 1, 2011, and other cases pending at the time of entry of this Order, each Plaintiff or Plaintiff's decedent shall complete and file electronically, on Lexis/Nexis or other service as the Court may order, Form A, attached, on the date Plaintiff's Discovery Brochure is due. Form B shall be completed by Medicare eligible Plaintiff's or Plaintiff's decedent and filed electronically, on Lexis/Nexis or other service as the Court may order, on or before the trial date. No settlement is final and enforceable until Form B is provided by Plaintiff.

3. Electronic Filing Only: Except as provided in Paragraph 7, below,

filing/distribution of all forms required by this order and all related

correspondence to the parties shall be made electronically only on Lexis/Nexis or

other service as the Court may order so as to limit distribution of Social Security

numbers or other personal/private information to the parties and their insurers;

4. Limited Purpose: Forms A & B are to be completed and served on defense

counsel of record for the limited purpose of facilitating compliance with MSP and

MMSEA Section 111 rules and regulations and not for any other purpose;

5. **Other Forms Prohibited:** The Court is satisfied that Forms A & B are sufficient to facilitate the determination of the status of a Plaintiff or Plaintiff's decedent as a Medicare beneficiary, thus precluding the use of any other such forms the Defendants might submit to Plaintiff's Counsel for this purpose. Plaintiffs will not be compelled to complete any forms submitted for this limited purpose other than the Data Form attached, except upon order of the Court;
6. **Confidentiality:** Plaintiffs, their Counsel, the Recipients of completed Forms A & B, meaning Defendants, Defendant's insurers, any person or entity defined as an RRE (Responsible Reporting Entity) under Section 111, and their authorized representatives and agents), shall not file Forms A & B with this Court, or in any other state or federal judicial forum, except as provided in paragraph 7 of this Order, without an order of leave from this Court;
7. **Permissible Use/Distribution:** Defendants' Counsel are allowed to distribute completed Forms A & B to their clients, their client's insurers and any person or entity defined as an RRE and/or their third party administrators for their use in reporting under MMSEA Sec. 111 and for other purposes associated with facilitation of Medicare's right of recovery under Medicare Secondary Payer (MSP) laws and regulations. Attorneys for the parties, the parties themselves, their insurers and any person or entity defined as an RRE and/or their third party administrators are prohibited from disclosing or disseminating Forms A & B or the information obtained solely from Forms A & B to any other person or entity other than the Center for Medicaid/Medicare Services (CMS), or its contractors,

except as is reasonably required to a) effectuate the determination of Medicare/Medicaid Beneficiary status, b) report as required under Section 111, or c) communicate with the U.S. Government or its designee or any other person or entity in connection with the defense of any claim relating to the requirements of MSP and MMSEA Sec 111. If production or use of Forms A & B may occur Defendant and/or its insurers and any person or entity defined as an RRE and/or their third party administrators shall give adequate notice to Plaintiff prior to production or use of Forms A & B. To the extent that the SSN's have been used by Defendants and their insurers in the past for purposes of, but not limited to, the monitoring and evaluation of new claims, to determine, for example, if they have defended a suit or claim made by or on behalf of the same claimant previously, such use of the data and such practices shall be allowed;

8. **Sanctions for Impermissible Use or Distribution:** Unauthorized use or unlawful distribution of the SSN's collected under this Order, or other violations of this Order, will be subject to penalties that fall within the Court's contempt powers, or such other penalties as may issue in further orders of this Court.

Procedures for Protection of Medicare's Right of Recovery:

9. Upon the settlement of a claim, the Court will proceed as outlined in subparagraphs 9(a) through (c) below, if the parties explicitly adopt those provisions by reference in their release and/or settlement agreement;
 - a) **Escrow/Trust Account:** If Plaintiff, Defendant and/or their insurers determine that Plaintiff is, or Plaintiff's decedent was, Medicare eligible, Plaintiff's counsel shall hold the net (after distribution of attorney's fees and costs) settlement amount pursuant to that agreement in an escrow account, client trust account or other like account. If there is a Medicare claim that

puts into question the sufficiency of the escrowed or trust account proceeds to satisfy Medicare's right of recovery, then Plaintiff's counsel shall return all attorneys fees paid to it on Plaintiff's case to the escrow or trust account pending resolution of the Medicare claim;

b) Payment of Medicare Reimbursement; Release of Funds From Escrow/Trust Account: Once Plaintiff's counsel has received a waiver, final demand or no conditional payment letter from CMS, and Plaintiff's counsel has paid the Medicare recovery claim, if any, Plaintiff's counsel may then pay the net settlements to the client(s) upon providing to Defendants a copy of the waiver, final demand, or no conditional payment letter and proof of payment of said amount. Proof of payment pursuant to terms of the release and this Order means a copy of a draft payable to Medicare or its recipient entity with an amount matching that of the final demand. Plaintiff's counsel may redact the bank name, routing number, account number and signature from the check.

c) Motion For Partial Distribution; Exigent Circumstances: Plaintiff's counsel may move the court for an order allowing partial distribution of the net settlement proceeds to Plaintiff(s) in exigent circumstances where Plaintiff(s) can show that the amount necessary to satisfy Medicare's right of recovery is less than the entire amount of Plaintiff's net settlement proceeds. In such circumstances, Plaintiff's counsel must produce a copy of any conditional payment, waiver, final demand or no-conditional payment letter from CMS as may exist in order to evidence the extent of Medicare's right of recovery. If this Court allows a partial distribution to Plaintiff from the escrow or trust fund, prior to the full and final satisfaction of Medicare's right of recovery, and if there arises a Medicare recovery claim that puts into question the sufficiency of the remaining escrow or trust account proceeds to satisfy Medicare's right of recovery, then Plaintiff shall return all monies received through any order of partial distribution by this Court to the escrow or trust account pending resolution of the Medicare recovery claim.

10. **Where Plaintiff Is Not Medicare Eligible:** In cases where at the time of settlement the parties agree that Plaintiff or Plaintiff's decedent is not or was not Medicare eligible, the net settlement proceeds do not need to be held in escrow and may be distributed in accordance with other provisions of the Case Management Order and Wrongful Death Act where applicable.

11. **Untimely Settlement Payments By Defendants:** In the event a Defendant fails to submit the settlement proceeds consistent with Case Management Order No. 14, in addition to the interest which shall accrue on the settlement proceeds, Defendant will also be responsible to reimburse Plaintiff for any interest, costs and penalties which accrue on Plaintiff's Medicare recovery claim due to the Defendant's late payment.


CIRCUIT JUDGE

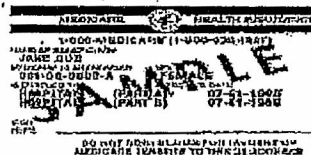
FORM A-1

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?												<input type="checkbox"/> Yes		<input type="checkbox"/> No			
<i>If yes, please complete the following. If no, proceed to Section III.</i>																	
Full Name: (Please print the name exactly as it appears on your SSN or Medicare card, if available)																	
Medicare Claim Number:												Date of Birth (Mo/Day/Year)		-		-	
Social Security Number: (If Medicare Claim Number is Unavailable)												Sex		<input type="checkbox"/> Female		<input type="checkbox"/> Male	

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) _____ Claim Number _____

Name of Person Completing This Form if Claimant is Unable (Please Print) _____

Signature of Person Completing This Form _____ Date _____

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

FORM A-1

Section III

Claimant Name (Please Print)

Claim Number

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Signature of Person Completing This Form

Date

FORM B

MEDICARE CONFIDENTIAL REPORTING INFORMATION FORM

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007

Case Name:		Case Number:		
Is the injured party presently or has he/she ever qualified for or been enrolled in Medicare Part A or B? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Section A		ALLEGED INJURED PARTY INFORMATION (If party is DECEASED, also complete Section F) *Please see footnote at bottom of page		
4. Medicare Claim Number (also known as HICN)				
5. Social Security Number:		6. Injured Party Last Name: (Please print name exactly as it appears on Social Security card.)		
7. Injured Party First Name: (Please print name exactly as it appears on Social Security card.)		8. Injured Party Middle Name: (Please print name exactly as it appears on Social Security card.)		
9. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	10. Date of Birth: (MM/DD/YYYY)	Deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Section B		ALLEGED INCIDENT INFORMATION		
12. CMS Date of Incident: Please state the date of accident or date of first exposure, ingestion, implantation with respect to settling defendant's product and/or premises.				
13. Industry Date of Incident: Please state the date of accident or date of last exposure, ingestion, or implantation with respect to settling defendant's product and/or premises.				
15. Alleged Cause of Injury, illness or incident: Please state the alleged cause of injury, incident or illness and the ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification code(s)) with respect to the same.***				
17. State of Venue	19. ICD-9 Diagnosis Code 1: Please provide valid ICD-9 Codes for any injury or illness you allege arose from the allegations made against settling defendant. NOTE: separate ICD-9 codes are required for each body part you assert was/is affected.**			
21. ICD-9 Diagnosis Code 2:	23. ICD-9 Diagnosis Code 3:	25. ICD-9 Diagnosis Code 4:	27. ICD-9 Diagnosis Code 5:	29. ICD-9 Diagnosis Code 6:
31. ICD-9 Diagnosis Code 7:	33. ICD-9 Diagnosis Code 8:	35. ICD-9 Diagnosis Code 9:	37. ICD-9 Diagnosis Code 10:	39. ICD-9 Diagnosis Code 11:
41. ICD-9 Diagnosis Code 12:	43. ICD-9 Diagnosis Code 13:	45. ICD-9 Diagnosis Code 14:	47. ICD-9 Diagnosis Code 15:	49. ICD-9 Diagnosis Code 16:
51. ICD-9 Diagnosis Code 17:	53. ICD-9 Diagnosis Code 18:	55. ICD-9 Diagnosis Code 19:		
57. Description of Illness/Injury (Free Form Text Description):***				

*NUMBERS REFLECT CLAIM INPUT FILE FIELD NUMBERS AS SET FORTH IN VERSION 2 OF THE OFFICIAL NGHP USER GUIDE

** CLAIMS SUBMITTED PRIOR TO 1/1/11 MUST PROVIDE EITHER: (1) BOTH A VALID ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS CODE (FIELD 15) AND AT LEAST ONE VALID DIAGNOSIS CODE IN THE ICD-9 DIAGNOSTIC CODE 1 (FIELD 19) OR THE DESCRIPTION OF INJURY ILLNESS (FIELD 57) CLAIMS SUBMITTED ON OR AFTER 1/1/11 MUST CONTAIN BOTH THE ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS CODE (FIELD 15) AND THE ICD-9 DIAGNOSTIC CODE 1 (FIELD 19).

***FIELD 57 IS REQUIRED THROUGH 12/31/10 IF NO ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS CODE (FIELD 15) OR NO ICD-9 DIAGNOSTIC CODE 1 (FIELD 19) IS PROVIDED.

****THE CURRENT LIST OF VALID CODES ACCEPTED BY CMS FOR SECTION 111 REPORTED MAY BE FOUND AT:
www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp

FORM B

Case Name:	Case Number:
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Section C ALLEGED INJURED PARTY'S ATTORNEY OR OTHER REPRESENTATIVE INFORMATION

84. Representative Type (please check one):

A=Attorney
 G=Guardian/Conservator
 P=Power of Attorney
 O=Other

85. Representative Last Name:	86. Representative First Name:	87. Representative Firm Name:
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88. TIN/EIN, if Firm Entity; Social Security Number if Individual:	89. Mailing Address:
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91. City:	92. State:	93. Zip Code +4:	94. Phone:	95. Ext. (if any):
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Section D SETTLEMENT INFORMATION

Name of Settling Defendant:	100. Date of Settlement:	101. Amount of Settlement:
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102. Funding Delayed Beyond TPOC (actual or estimated date of funding):

Section E SIGNATURE

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Name of Attorney representing Plaintiff/Claimant	Date	Printed Name

(The signature of the attorney hereto constitutes a certificate by him/her that he/she has read the information supplied in this Form and that all information stated therein is well grounded in fact to the the best of his/her knowledge, information and belief formed after reasonable inquiry.)

FORM B

Case Name:	Case Number:
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ATTENTION

If Alleged Injured Party is NOT DECEASED and you have completed Page 1 & 2, you may stop here.



*Please continue to Section E (Claimant Information) only if Alleged Injured Party in Section A is deceased.
At least Claimant 1 information is required if Alleged Injured Party is deceased.*

FORM B

Case Name:	Case Number:
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Section F CLAIMANT INFORMATION *(Use only if Alleged Injured Party in Section A is deceased.)*

CLAIMANT 1				
104. Claimant Relationship to Alleged Injured Party: <input type="checkbox"/> E=Estate (Individual) <input type="checkbox"/> X=Estate (Entity) <input type="checkbox"/> O=Other (Individual) <input type="checkbox"/> F=Family (Individual) <input type="checkbox"/> Y=Family (Entity) <input type="checkbox"/> Z=Other (Entity)				
105. TIN/EIN, if Entity; Social Security Number, if Individual:			106. Claimant Last Name:	
107. Claimant First Name:				108. Claimant Middle Initial:
109. Claimant Entity/Organization Name:				
110. Mailing Address:				
112. City:	113. State:	114. Zip Code +4	116. Phone:	117. Ext. (if any):
119. Claimant Representative Type: <input type="checkbox"/> A=Attorney <input type="checkbox"/> P=Power of Attorney <input type="checkbox"/> G=Guardian/Conservator <input type="checkbox"/> O=Other				
120. Claimant Representative Last Name:		121. Claimant Representative First Name:		122. Claimant Representative Firm Name:
123. TIN/EIN, if Firm/Entity; Social Security #, if Individual:			124. Representative Mailing Address:	
126. City:	127. State:	128. Zip Code +4	130. Phone:	131. Ext. (if any):

Counsel for Claimant 1

Date

Printed Name

(The signature of the attorney hereto constitutes a certificate by him/her that he/she has read the information supplied in this Form and that all information stated therein is well grounded in fact to the the best of his/her knowledge, information and belief formed after reasonable inquiry.)