PERRINE DUPONT SETTLEMENT CLAIMS OFFICE
ATTN: EDGAR C. GENTLE, CLAIMS ADMINISTRATOR
C/O SPELTER VOLUNTEER FIRE DEPARTMENT OFFICE
55 B Street
P. O. BOX 257
Spelter, West Virginia 26438
(304) 622-7443
(800) 345-0837
www.perrinedupont.com
perrinedupont@gtandslaw.com

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PERRINE MEDICAL MONITORING PROGRAM (THE "PROGRAM") MEDICAL PROVIDER QUESTIONS AND ANSWERS

Q1: WHICH MEDICAL SERVICES ARE COVERED BY THE PROGRAM AND WHICH SERVICES ARE NOT COVERED?

A. The Program is only designed to provide medical monitoring and not medical care. Program services are described in the Schedule of Benefits, attached. All additional services will not be paid by the Program and must be paid for by the Claimant. Before any medical services not described in the Schedule of Benefits are provided, the Program Medical Provider and the Claimant should discuss them to make sure that the Claimant understands that the Claimant, and not the Program, will pay for them.

Q2: WHICH SPECIALIST SHOULD I USE?

A. CTIA has secured all of the required Program specialists. Please contact CTIA for a comprehensive list that is periodically updated, with the exception of toxicology specialists and CT scan services.

Q3: WHO IS THE APPROVED TOXICOLOGIST?

A. All toxicology services are provided by the Department of Emergency Medicine ("UPP") at the University of Pittsburg Medical Center ("UPMC").

Q4: WHO IS THE APPROVED CT SCAN PROVIDER?

A. All CT scans are facilitated by the University Hospital Center ("UHC"), in conjunction with Radiological Physicians Associates ("RPA"). A CT scan Physician Verification form must be completed and sent to CTIA before any listed CT scan will be paid.

Q5: WHAT KIND OF CT SCANS ARE UTILIZED AND APPROVED?

A. Both CT scans with contrast and CT scans without contrast have been approved, as listed in the Schedule of Benefits.

Q6: WHAT IF I AM THE CT SCAN PROVIDER AND I DO NOT SECURE A CT SCAN RELEASE FORM FROM THE REFERRING PHYSICIAN?

A. The Program will not reimburse for CT scan services in the absence of the CT Scan Release form.

Q7: IF I AM A MEDICAL MONITORING PROVIDER, CAN I PERFORM AND BILL FOR ANY SPECIALTY SERVICES?

A. You can bill for (i) a dermatology 30 minute office visit; and (ii) ordering a biopsy tissue exam. These are the only two specialty services for which you can perform and bill to the Program.

Q8: CAN I RE-TEST RATHER THAN REFER TO A SPECIALIST?

A. Yes. You may order another urine test if (i) the test specimens were lost or damaged by the laboratory; (ii) the test results appear to be unreliable, unrealistic, or improbable based upon the Claimant's medical history; or (iii) test results were very close to exceeding the normal range and other symptoms of poor health were present. The additional codes for billing for re-tests have been provided by CTIA.

Q9: I HAVE CLAIMANTSWITH CRYSTALS IN THEIR URINE. IS IT OK TO REFER TO UROLOGY?

A. As the physician, use your best medical judgment within the applicable standard of care to make the best decision for the Claimant.

Q10: IS THERE A DESCRIPTION OF CLAIMANT SKIN LESIONS THAT YOU WANT THE PROVIDERS TO LOOK AT, SPECIFICALLY?

A. Please refer to the Provider Orientation Package, including the Dr. Werntz Report.

Q11: SHOULD I REFER A CLAIMANT TO A SPECIALIST WHEN I'VE SEEN RASHES?

A. As the physician, use your best medical judgment within the applicable standard of care to make the best decision for the Claimant.

Q12: IF THE CLAIMANT'S LABORATORY RESULTS ARE SLIGHTLY ABNORMAL, CAN THE TEST BE REPEATED (AND BE PAID BY THE PROGRAM) OR DO I NEED TO MAKE A DECISION NOW ON WHETHER OR NOT TO REFER THE CLAIMANT TO A TREATING PHYSICIAN?

A. Under the Program, Claimants are to be tested every two years. Therefore, you decide whether or not to make a referral at this time based on current test results.

Q13: WHAT DO YOU DO IF A CLAIMANT HAS EXISTING CONDITIONS? SHOULD YOU SEND INFORMATION TO THE CLAIMANT'S REGULAR PRIMARY CARE PHYSICIAN?

A. The Program pays only for the services listed on the Schedule of Benefits. If a Claimant presents with a medical condition(s), the physician should provide follow-up as required by the reasonable standard of care. For example, you could refer the Claimant to his or her primary care physician or to a specialist and you should remind the Claimant that the Program **only** pays for medical monitoring and does not pay for medical care or treatment.

Q14: IS THERE REIMBURSEMENT FOR NO-SHOWS?

A. **No.** The Program does not pay for no-shows for any service. However, regarding no-show Claimants who had their initial laboratory tests completed but did not go back to the Medical Provider for the results and follow-up exam, the Medical Provider should bill a $25 fee for interpreting the results of the initial lab tests and writing a letter to the Claimant explaining the results.

Q15: SOME OF THE CLAIMANTS MAY NOT COME BACK IN FOR A FOLLOW-UP EXAM. WHAT DO I DO?

A. First, you must comply with the applicable standard of care. To the extent it requires something more than the Program provides, the Program does not excuse you from that obligation. Second, the Program requires the following: If a Claimant fails to appear for a follow-up exam in which you intended to relay test results that were paid for by the Program, you should notify the Claimant that you are available to review the results with the Claimant and ask the Claimant to re-schedule the appointment. In addition, if the results are abnormal, you should notify the Claimant of the results and advise the Claimant that the results are abnormal and urge the Claimant to discuss the results with you, the Claimant's primary care doctor or another physician. You should remind the Claimant that the Program pays only for follow-up with you and not with other doctors or for medical treatment.

The following format may be useful as a template:

Dear Claimant_____:

We missed you at your recent appointment, which was scheduled for _____. We intended to discuss your test results with you at the appointment. We ask that you call to re-schedule your appointment. If you prefer, you may discuss your results with your primary care doctor. Remember that the Program pays for your testing and for follow-up with this office but does not pay for follow-up with other physicians or for any medical treatment.

For your information:

_____The results of your testing are attached, and they are normal.

_____The results of your testing are attached and they are abnormal in some respects. We urge you to call us to discuss the test results. The abnormal results are:

_____

Q16: SOME PROVIDERS BELIEVE THAT THE PROGRAM B2 MICROGLOBULIN SERUM TEST IN THE WERNTZ REPORT (AS OPPOSED TO A URINE TEST) IS NOT THE PREFERRED TESTING METHOD. LABCORP SUGGESTS THE SERUM APPROACH. BOTH HAVE THE SAME CPT CODE. THE COST OF THE TWO TESTS ARE $20 AND $24 RESPECTIVELY. WHICH IS CORRECT?

A. The Program has been updated to provide for the Program B2 Microglobulin Serum in addition to the urine test. Additional approved CPT codes have been provided to you by CTIA.

Q17: HOW AND WHEN CAN A PROVIDER DO A CLAIMANT RETEST?

A. As the physician, use your best medical judgment within the applicable standard of care to make the best decision for the Claimant. Only the physician can determine when a retest is necessary.

Q18: WHAT SHOULD WE DO IF THE CLAIMANT REFUSES TO FILL OUT THE MEDICARE FORM?

A. All Claimants are required to complete the Medicare form at their first Medical Monitoring visit. Please note that if the Claimant has previously completed a Medicare form during the first round of testing, the Claimant does not have to complete the Medicare form again thereafter. If they refuse to complete the Medicare form at their first Medical Monitoring visit, they cannot receive Program services. It is for both the protection of the Program and for the protection of the Claimant. None of the Claimants' Medicare or Medicaid benefits will be used for

any service that is covered by the Program.

Q19: IS THERE A FLIER EXPLAINING WHY THE CLAIMANT MUST COMPLETE THE MEDICARE FORM AT THE FIRST MEDICAL MONITORING VISIT?

A. Yes. A copy is attached for your convenience.

Attachments:

1. Schedule of Benefits
2. Description of Medicare Benefits Questionnaire
3. CT scan Physician Verification form