EDITORS’ NOTEPAD

The Transportation Practice Group of ALFA International has published the Transportation Update since approximately 1990. Please note that in addition to this issue of the Transportation Update we have an archive of many recent issues on the ALFA website at ALFA Transportation Update Archives.

If your first contact with the Transportation Update is through this email or our website, you can be added to our email distribution list by contacting us through Katie Garcia (kgarcia@alfainternational.com). Please add the Transportation Update to the subject line, and we will email the current issue and each subsequent issue to you as it is published. If you want to receive the Transportation Update in hard copy format, contact an ALFA attorney listed at the end of this newsletter, and they can provide this service for you.

Our primary method of distribution of the Transportation Update is by email. Electronic publication allows us to include hyperlinks for the use of our readers. We encourage you to use the hyperlinks feature and our section headings to quickly get to the information that is most interesting to you. The substantive/informative section headings are as follows: The Editors’ Notepad (this section) where the Editors often provide sources of information and points of interest; ALFA Member Publications and Speaking Engagements; Cases, Regulations, and Statutes; Verdicts, Appeals, and Settlements; Practice Tips; and Articles.

The ALFA Member Publications and Speaking Engagements section lets you know what your ALFA lawyers are doing to share their knowledge and experience to assist in the defense of claims and cases. Under the Cases, Regulations, and Statutes section of the Transportation Update, we report to you about developments in the statutory, regulatory, and common law around the country that are of general interest to the trucking community. The Verdicts, Appeals, and Settlements section addresses the results of litigation affecting the trucking industry and also provides information about significant results achieved by ALFA firm lawyers. We encourage you to report to the Editors any verdict, appeal, or settlement that you think is of interest to the trucking community. In this edition, we have several previously unpublished verdicts. The Practice Tips section of the Update features articles which address matters of practical interest to those who manage litigation for motor carriers and those who represent them. The essays in this section generally

1 All hyperlinks are in blue. Hyperlinks can be activated by placing the cursor on them and left clicking with the mouse. Links in the contents go to specific points in the newsletter; links to websites take you to the website; and links to email addresses open an email addressed to that person.
have widespread application throughout the country. **Articles** provide in depth analysis of issues, developments, and concerns that are relevant to the transportation industry.

After several years of serving as Co-Editor of the *Update*, **Marc Harwell** has decided to “pass the torch” to **J. Philip Davidson** of the Hinkle Elkouri Law Firm in Kansas. **Paul J. (Jay) Skolaut** will assist Philip. **Will Fulton** will continue to serve as Co-Editor.

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The Regional Directors help the *Transportation Update* Editors gather materials for each issue from their areas. If you have any suggestions for content, feel free to contact them or the Editors.
9. ARTICLES
Compliance with the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007. Includes information concerning CMS February 24, 2010 Alerts and Version 3 of the User Guide – by Tom Charchut and Kevin Crisp of Haight Brown & Bonesteel LLP (Given the importance of this topic to the industry, the Editors decided to publish this essay again; it was published in the Spring issue).

10. TRANSPORTATION PRACTICE GROUP DIRECTORY OF MEMBER FIRMS

FUTURE EVENTS
Each year, the Transportation Practice Group of ALFA International presents a multi-day seminar for members of the Trucking Industry. The 2011 Transportation Seminar will be held at the Ritz-Carlton Laguna Niguel (address: One Ritz-Carlton Drive, Dana Point, California 92629; telephone: (949) 240-2000) from May 4 to May 6, 2011. Please check out this special venue at http://www.ritzcarlton.com/en/Properties/LagunaNiguel/Default.htm. This luxurious hotel sits atop a 150 foot bluff that overlooks the Pacific Ocean and is located between Los Angeles and San Diego.

Our Program Chair for the 2011 seminar is Joseph R. Swift of Brown & James, P.C., who can be reached at (314) 421-3400 and jswift@bjpc.com.

At the upcoming ATA conference, the following ALFA lawyers will be speaking:

Schaun Henry of McNees, Wallace & Nurick, LLC will be speaking on “Managing Employment Decisions”.

Doug Kotarek of Hall & Evans will be speaking on “Administering Workers Compensation Programs”.

J. Phillip Davidson of the Hinkle Elkouri Law Firm will be speaking on “Navigation Intermodal Depths”.

James Jarrow of Baker, Sterchi, Canden & Rice, LLC and Sheila Kerwin of Nilan, Johnson, Lewis, PA will be speaking on “Controlling Electronic Record Costs”.

The Chairman of the Transportation Practice Group for
2010–2011 is Peter S. Doody of Higgs, Fletcher & Mack, LLP, San Diego, California, who can be reached at (619) 236-1551 and doody@higgslaw.com. Our Vice-Chair is P. Clark Aspy of Naman, Howell, Smith & Lee, LLP, who can be reached at (512) 479-0300 and aspy@namanhowell.com. Our Chair Emeritus is Danny M. Needham of Mullin, Hoard & Brown, LLP, Amarillo, Texas, who can be reached at (806) 372-5050 and dmneedham@mhba.com. Please contact any of these individuals or the Editors with any suggestions for the program. For more information, please also consider contacting Katie Garcia at kgarcia@alfainternational.com.

**ALFA'S GO TEAM HOTLINE**

**PLEASE NOTE:** THE ALFA GO TEAM HOTLINE NUMBER HAS CHANGED. The new number is 888-520-ALFA (2532). Please update your records to reflect this change. Thank you!

The ALFA Transportation Practice Group operates a service for its transportation clients: The **ALFA Go Team Hotline**. ALFA knows that its member firm transportation clients must often confront time-sensitive emergencies. The ALFA Go Team Hotline is designed to offer ALFA clients immediate legal and other support services, 24 hours a day and 7 days a week.

The service works as follows: An ALFA client needing immediate legal support calls the **ALFA Go Team Hotline** at 1-888-520-ALFA (2532). An ALFA operator will provide location-specific contact information about experienced transportation lawyers, accident reconstructionists, and other transportation industry experts. When you contact the ALFA Go Team Hotline, you are connected to a full-service emergency response team, when you need it. Contact your ALFA lawyer today for more details about the ALFA Go Team Hotline. Remember, 1-888-520-ALFA (2532).

**FUTURE ISSUES OF TRANSPORTATION UPDATE**

The Fall 2010 issue of *Transportation Update* will be published in October 2010.

**DISCLAIMER**

The ALFA *Transportation Update* does not create an attorney-client relationship between the reader and any attorney nor does it render legal advice on any specific matter. No reader should act or refrain from acting on the basis of any statement in the ALFA *Transportation Update* without seeking advice from qualified legal counsel on the particular facts and circumstances involved. Readers are responsible for obtaining such advice from their own legal counsel.
CASES, REGULATIONS, & STATUTES

ALABAMA

Alabama Supreme Court Holds Twenty-Year Rule of Repose Does Not Bar Asbestos Claims

The Alabama Supreme Court recently addressed whether the twenty-year common law rule of repose begins to run at the time of the defendant’s actions giving rise to the claim or when all of the essential elements of the claim, including injury, are present. In Owens-Illinois, Inc. v. Wells, 2010 WL 1640962 (Ala. Apr. 23, 2010), the court, in a 7-2 decision, held that Alabama’s rule of repose does not begin to run until all of the elements of the claim co-exist so that the plaintiff has a valid cause of action. *Id. at *4.*

The Majority Reaffirms that Rule of Repose Begins to Run When Cause of Action Accrues

In Wells, the plaintiffs in six asbestos cases alleged that they or their family members were injured or died because of exposure to block insulation and pipe covering known as Kaylo that was manufactured or installed by Owens-Illinois.1 It was undisputed that Owens-Illinois sold its Kaylo business in 1958 and that it did not manufacture or install any Kaylo product after 1958. Owens-Illinois moved for summary judgment in each of the six cases, arguing that the plaintiffs’ claims were barred by Alabama’s twenty-year rule of repose. The trial court concluded that there was no evidence to suggest that the plaintiffs’ alleged injuries occurred more than twenty years before the filing of their lawsuits and denied Owens-Illinois’ motions. However, the trial court certified the orders for interlocutory review because it concluded that the motions presented a question of law “as to which there is a substantial ground for difference of opinion.” Owens-Illinois petitioned the Alabama Supreme Court for permission to appeal the trial court’s ruling denying summary judgment, and the court granted Owens-Illinois’ petition.


In *Collins,* the Alabama Supreme Court expressly held that the rule of repose does not begin to run until the plaintiff has suffered an actionable injury. *Collins,* 2009 WL 1875575, at *5. In that case, the residents of an apartment building sued the designer of the building alleging that injuries they received when the building was set on fire by an arsonist were proximately caused by the designer’s failure to construct a building with appropriate fire suppression safeguards and escape routes. The designer moved for summary judgment, arguing that the residents’ claims were barred by the twenty-year rule of repose. The trial court granted summary judgment in favor of the designer, and the residents appealed.

On appeal, the Alabama Supreme Court reversed the trial court and held that the rule of repose could not bar the residents’ claims because it did not begin to run until the residents suffered an injury and could have filed suit. *Id.* Citing its prior opinions discussing the policy reasons for the twenty-year rule, the court explained, “it is inequitable to allow those who have slept upon their rights for a period of 20 years . . . to bring an action.” *Id.* at *4 (internal quotations omitted). The court distinguished the residents’ claims and concluded:

[B]ecause the 20-year common-law rule of repose is premised upon a preexisting right to assert a claim and because the residents did not have such a right until the fire occurred and they sustained injuries as a result of an alleged breach of duty by [the designer] and because the residents sued within 20 years of their injuries, the rule of repose is inapplicable to this case.

*Id.* at *5. The supreme court, therefore, held that the trial court erred by granting summary judgment in favor of the designer and remanded the case. *Id.* at *5–6. The *Wells* Court applied the same reasoning to the asbestos-plaintiffs’ claims and concluded, “[t]he rule of repose does not depend solely on the actions of the defendants . . . [Rather,] the rule of repose does

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1 Wells involved six separate asbestos actions that were consolidated for appeal.
not begin to run until all of the essential elements of that claim, including an injury, coexist so that the plaintiff could validly file an action.” Wells, 2010 WL 1640962, at *4. The supreme court, therefore, held that the trial court properly denied summary judgment in favor of Owens-Illinois. *Id.*

**The Dissent Asserts that Majority Confuses Rule of Repose with Statute of Limitations**

The two dissenters in Wells, Justices Glenn Murdock and Greg Shaw, adopted their dissent in the Collins case. Wells, 2010 WL 1640962, at *5 (dissenting). In Collins, Justice Murdock concluded that prior Alabama decisions addressing whether the rule of repose begins to run upon the occurrence of the wrongful act or omission or the accrual of a cause of action were “conflicted and confusing.” Collins, 2009 WL 1875575, at *6 (Murdock, J., dissenting). He noted that prior decisions stated that the passage of time is the only element of the rule of repose and that this was consistent with the policy objective of avoiding antiquated claims. *Id.* at *6-7. He explained that these policy reasons support that a period of repose should begin to run from the time of the defendant’s wrongdoing. *Id.* at *7. Justice Murdock further wrote, “[c]onsistent with these policy concerns, general American jurisprudence draws a distinction between statutes of limitation and statutes of repose and recognizes that the latter run from the defendant’s wrongful act or omission.” *Id.* at *7–8 (citing 54 C.J.S. *Limitations of

**Conclusion**

As the dissenters note, if the rule of repose, like a statutory limitations period, begins to run when the cause of action accrues, presumably the statute will always run first. It is, thus, difficult to imagine a scenario in practice where the rule of repose would actually be applied.

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ALABAMA

Alabama Federal District Court Holds That Product Recall Does Not Establish Defect

The Federal District Court for the Southern District of Alabama recently ruled on whether a product recall is sufficient to establish a defect in the recalled product under the Alabama Extended Manufacturer’s Liability Doctrine (“AEMLD”) or whether expert testimony is necessary. See Hughes v. Stryker Sales Corp., No. 08-0655-WS-N, 2010 WL 1961051, at *2–3 (S.D. Ala. May 13, 2010). In Hughes, the court held that, under the AEMLD, the mere fact that a product has been recalled will not establish a defect in that product absent other corroborating evidence. Id. at *3.

The Court Refuses to Find a Causal Link between an Internal Recall and a Product Defect

In Hughes, the plaintiff’s hip was replaced with a prosthetic device that was designed, manufactured, and marketed by Stryker Sales and Howmedica. Less than a year later, the hardware in the plaintiff’s hip failed, and the plaintiff underwent a revision surgery. As a result of the device’s failure, the plaintiff brought, among other claims, a cause of action for products liability under the AEMLD against Stryker Sales and others.

The defendants moved for summary judgment, arguing that the plaintiff was required to present expert testimony to support her claim that the hip prosthesis was defective and caused her injuries. In opposition, the plaintiff submitted three pieces of evidence: (1) medical records proving that the defendants’ implant hardware had been installed in the plaintiff and had failed; (2) a “Warning Letter” sent to a Stryker manufacturing facility in Ireland stating that the facility was in violation of regulations promulgated under the Food, Drug, and Cosmetic Act; and (3) a recall letter from Stryker stating that certain products manufactured at the Ireland facility, including plaintiff’s hip device, were being recalled.

Relying primarily on Stryker’s recall letter, the plaintiff argued that Stryker had admitted the existence of a manufacturing defect in her hip implant. The court disagreed.

First, the court found that Stryker did not admit a manufacturing defect in all hardware because the language used in the recall letter was qualified and expressly stated that their testing indicated hardware problems arose in “some cases.” Id. In addition, the testing criteria that the letter referenced were self-imposed by Stryker and were more stringent than industry norms. Id. The letter further stated that people implanted with the recalled product were not at an increased risk of danger. Id.

Second, the court applied Rule 407 of the Federal Rules of Evidence. Id. at *4. Rule 407 states, in pertinent part, that evidence of subsequent remedial measures “is not admissible to prove negligence, culpable conduct, a defect in a product, a defect in a product’s design, or a need for a warning or instruction.” FED. R. EVID. 407. However, Rule 407 also provides that only remedial measures undertaken after an injury or harm has occurred are inadmissible. Id. The court emphasized that the recall letter was dated four months after the plaintiff’s hip device was implanted, but it was unclear whether the letter was drafted before or after the device’s failure occurred. See Hughes, 2010 WL 1961051, at *4. Despite this, the court determined that the recall letter fell within Rule 407’s province and was therefore inadmissible to show a defect in the plaintiff’s implant. Id.

Lastly, the court noted that the plaintiff failed to explain how a product recall results in the inference that the particular device implanted in the plaintiff had a defect. Id. The court also found relevant the fact that many factors unrelated to the hip implant could have caused the device to fail. Id. at *5.

The Court Considers Expert Testimony Essential to Recovery under the AEMLD

The Hughes court cited the Alabama Supreme Court’s decision in Brooks v. Colonial Chevrolet-Buick, Inc., 579 So. 2d 1328 (Ala. 1991), and acknowledged that expert testimony is usually required to establish a product defect under the AEMLD. Id. at *4. The plaintiff in Hughes “made no expert disclosures and proffered no expert opinions that the prosthetic hip . . . was defective.” Id. at *3.
The plaintiff argued that her case was one in which expert testimony was unnecessary because Stryker admitted there was a manufacturing defect and information relating to the performance of a hip implant “is a matter within the common knowledge of jurors.” *Id.* The *Hughes* court disagreed, holding that “[t]he interaction between a complex and technical medical device and the unique physiological and medical circumstances of the patient in which it is implanted is a subject on which no ordinary juror could rationally be expected to have knowledge.” *Id.* at *5. The court stated that there are “compelling reasons why expert testimony is often deemed essential” for a plaintiff to establish a prima facie case of products liability. *Id.* The court explained that if a case involves a complex product, such as a medical device, jurors must speculate on issues of defect and causation without expert testimony. *Id.*

**Conclusion**

As the *Hughes* court observes, the mere fact that a product was recalled may not establish a defect in the recalled product absent expert testimony. *Hughes* may be distinguishable on several grounds, including the qualified nature of the language in the recall letter, but the court’s intent to minimize juror speculation by requiring expert testimony is well represented in the opinion.
NEVADA

No Sudden Emergency Jury Instruction for the Negligent

The Nevada Supreme Court recently issued a ruling that precludes drivers from receiving a sudden emergency jury instruction where the driver’s negligence contributes to the purported emergency. *Posas v. Horton*, 228 P.3d 457 (Nev. 2010).

In a rear-end automobile collision, appellant Posas was driving in slow, stop-and-go traffic when a jaywalking woman pushing a stroller attempted to cross directly in front of Posas. *Id.* at 458. Posas stopped suddenly to avoid striking the pedestrian, and respondent Horton struck Posas from behind. *Id.* Notably, Horton admitted she was not exercising due care in following behind Posas, stating “I was following too close . . . I made a mistake.” *Id.* Over Posas’ objections, the district court gave a “sudden emergency” jury instruction, after which the jury found Horton had not been negligent. *Id.* The instruction stated:

A person confronted with a sudden emergency which (1) he does not create [and] (a) who acts according to his best judgment, or (b) because of insufficient time to form a judgment fails to act in the most judicious manner, is not guilty of negligence if he exercises the care of a reasonably prudent person in like circumstances.

*Id.* at 458 n. 1 (emphasis added). Reversing the district court and remanding the case for a new trial, the Nevada Supreme Court reasoned that to receive the instruction, Horton was required (and failed) to show the emergency with which she was purportedly faced was not of the type normally encountered in driving situations and was not caused by her own negligence. *Id.* at 460–61. The court noted that a vehicle’s rapid stop to avoid hitting a pedestrian was of the type normally encountered in driving situations. *Id.* at 460. Furthermore, the court reasoned that Horton’s own admission that she “was following too close” indicated that the emergency, if there had been one, was caused by Horton’s own negligence; had Horton been following at a safe distance, Posas’ sudden stop would not have created an emergency. *Id.* 460–61

Thus, the court held that while the jury instruction correctly stated the sudden emergency doctrine, the district court committed reversible error when it gave the instruction to the jury, as Horton failed to show she was entitled to the instruction and the instruction tended to prejudicially mislead or confuse the jury. *Id.* at 461.
NORTH CAROLINA

Authority of Judges to Discipline Pro Hac Vice Attorneys

In Sisk v. Transylvania Community Hospital, No. 67PA09, 2010 WL 2403438 (N.C. June 17, 2010), the North Carolina Supreme Court held that trial court judges have independent inherent authority and discretion to discipline attorneys, even where the attorney is appearing pro hac vice and the appearance of impropriety occurs in a separate lawsuit filed in another state.

Facts and Procedural History

This case arose from ongoing products liability litigation involving infant formula. The plaintiff alleged that her infant son developed brain-damaging meningitis after ingesting formula made by Defendant Abbott Laboratories. Plaintiff filed suit in North Carolina, and retained two out-of-state lawyers who were admitted pro hac vice to serve as Plaintiff’s counsel.

Several months after suit was filed, Defendant Abbott moved to disqualify the two out-of-state attorneys based on the allegation that, during previous similar litigation in Kentucky wherein Abbott was also a named defendant, improper ex parte contact was made with one of Abbott’s experts. It was alleged that, during the Kentucky litigation, the out-of-state attorneys retained Abbott’s consulting expert prior to adding Abbott as a defendant in an effort to disqualify the expert.

Abbott’s consulting expert with respect to the infant formula litigation had been disclosed to the out-of-state attorneys in a previous case and, prior to the conclusion of that case, was contacted by the out-of-state attorneys with respect to another, similar case where Abbott was not yet named a defendant (although the out-of-state attorneys admitted they were contemplating adding Abbott as a defendant at the time contact with the expert was made). Shortly thereafter, Abbott was added as a defendant and the expert found himself on both sides of the case. On Abbott’s motion for sanctions with respect to the attorneys’ conduct, the Kentucky trial court denied the motion, concluding that Abbott failed to prove any ethical violation. However, in the subsequent North Carolina litigation, the North Carolina trial court disqualified the out-of-state attorneys, revoking their pro hac vice status, finding the attorneys’ conduct had the appearance of impropriety and was inconsistent with fair dealings pursuant to Rule 4.3 of Rules of Professional Conduct. The North Carolina Court of Appeals reversed the trial court’s disqualification, holding that the predominant effect of the attorneys’ conduct would occur in Kentucky, and conformed to the rules of the jurisdiction as found by the Kentucky courts; therefore, Rule 8.5 of the North Carolina Rules of Professional Conduct did not allow the attorneys’ conduct to be subject to discipline in North Carolina.

Analysis

The North Carolina Supreme Court reversed, and reinstated the trial court’s revocation of the lawyers’ pro hac vice status. Rejecting the court of appeals’ strict analysis under Rule 8.5(b)(2) of the Rules of Professional Conduct, the court instead held that the trial court has independent inherent authority to discipline attorneys appearing before it. According to the court, two methods exist for enforcing attorney discipline in North Carolina courts: (1) the State Bar may proceed against an attorney pursuant to statute, and (2) a court possesses inherent authority to discipline attorneys appearing before it. The court concluded that an attorney admitted pro hac vice is as much subject to this inherent authority as is an attorney licensed in North Carolina.

Therefore, despite the out-of-state attorneys’ conduct having occurred in a separate case in another state, the conduct was improper under the North Carolina Rules of Professional Conduct and, as such, the attorneys were disqualified from the case at bar. This holding is particularly important to note as one may consider such conduct by the out-of-state attorneys as strategy. What is permitted as strategy in one state, however, may be considered improper in another jurisdiction and should be carefully considered before implementing as such conduct could prove detrimental in future cases. Further, the case serves...
as an important reminder to fully inform expert witnesses as to the scope of their roles to ensure experts are prepared if contacted by opposing parties at any time.

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TENNESSEE

Notice and Governmental Immunity – The Test

In *Bivins v. City of Murfreesboro*, No. M2009-01590-COA-R3-CV, 2010 WL 2730599 (Tenn. Ct. App. May 13, 2010), the Tennessee Court of Appeals addressed the proper scope of the notice determination in assessing whether governmental immunity was unavailable for an action under the Governmental Tort Liability Act arising out of a fatal accident on a purportedly unsafe roadway.

Brandon Bivins was killed while driving on South Rutherford Boulevard in Murfreesboro, Tennessee. His mother filed a wrongful death action against the City of Murfreesboro pursuant to the Governmental Tort Liability Act, Tenn. Code Ann. § 29-20-101 et seq. She alleged that the city was not entitled to governmental immunity because it had actual or constructive knowledge that the road was unsafe or dangerous. To support her claim, Ms. Bivins cited two prior fatal accidents that had occurred on a different segment of South Rutherford, twenty to twenty-five reported accidents on South Rutherford in the three years immediately preceding the accident, and several remedial measures taken by the city to prevent future accidents at the spot of the prior fatalities.

The trial court held that the city did not have actual or constructive notice that the segment of roadway where Brandon Bivins’ accident occurred was dangerous or unsafe. In making its determination, “[t]he trial court focused on the city’s knowledge of the condition at the Bivins accident location: ‘The larger question, I think, is whether or not there was notice of this precise issue at this precise location. And respectfully, I don’t think that we can find that.…’” Thus, the trial court took a narrow view of the notice determination. The court thought that “it [was] incumbent upon [them] to separate the portions of the roadway.”

In overturning the trial court’s decision, the court of appeals rejected the trial court’s narrow construction of the notice determination. The appellate court noted that “[t]he appropriate inquiry on notice is, on July 5, 2005, the date of the Bivins accident, what did the city know and when did the city know it.” Thus, the court adopted a totality of the circumstances test. In applying the test, the court held that the city did have actual or constructive knowledge of “safety problems” on South Rutherford, citing the two prior fatalities, the past accidents, and the remedial measures adopted by the city.

The court of appeals reversed the trial court and remanded the case for a determination of whether the safety problems amounted to an unsafe or dangerous condition under Tenn. Code Ann. § 29-20-203.
Texas Supreme Court: Experts Must Address Alternative Theories

In *Wal-Mart Stores, Inc. v. Merrell*, 53 Tex. Sup. J. 869, 2010 Tex. LEXIS 447 (Tex. June 18, 2010) (per curiam), the Supreme Court of Texas addressed the following: two individuals died from smoke inhalation in the bedroom of their rented home. When police officers arrived, they found in the living room a burned recliner, a damaged floor lamp, candles, melted wax, an ashtray, a blunt, and other marijuana smoking paraphernalia.

The family members brought suit against Wal-Mart, claiming that the halogen lamp in the apartment was purchased from Wal-Mart and caused the fire (whether it was halogen and whether it was bought at Wal-Mart were disputed). The plaintiffs’ expert attributed the fire to the “‘nonpassive failure’ of the lamp igniting the recliner below,” and he ruled out the smoking materials because they were not found in the immediate area where the fire originated. Additionally, the expert discounted the candles as the cause because, as he opined, the candle wax would have not survived the exposure if the candles were the source of the ignition.

The lower court overruled Wal-Mart’s objection to the evidence, and Wal-Mart sought review asserting that there was no evidence that the lamp was defective or that it caused the fire. Wal-Mart contended that the expert’s testimony constituted no evidence of defect because his opinion constituted “no evidence that the lamp was more likely to have caused the fire than any other obvious potential sources.”

The Texas Supreme Court has previously held that “an expert’s testimony that failed to account for the sequence of events was legally insufficient to support a jury verdict.” *See Volkswagen of Am., Inc. v. Ramirez*, 159 S.W.3d 897, 910–12 (Tex. 2004). Similarly, the plaintiffs’ expert here did not opine why a burning cigarette could not have caused the fire, and he even dismissed post-mortem toxicology reports which revealed that the decedents had been smoking on the night of the fire. The expert did not think this evidence was relevant to the cause of the fire in the “area of origin,” presumably the recliner itself. However, the recliner likewise had no evidence of charred or exploded glass from the lamp, which would have supported his theory that the lamp was the cause of the fire.

Citing *General Motors Corp. v. Iracheta*, 161 S.W.3d 462 (Tex. 2005), the supreme court once again held that an expert’s failure to explain or adequately disprove alternative theories of causation makes his or her own theory speculative and conclusory. Even more importantly, while the plaintiffs’ expert laid a foundation that halogen lamps generally cause fires, he did not establish that the lamp in question caused this fire. Ultimately, the Texas Supreme Court ruled that the expert’s testimony lacked objective and evidence-based support for his conclusions.
UTAH

No Independent Tort of Spoliation in Utah

In Hills v. United Parcel Service, Inc., 2010 UT 39, the Utah Supreme Court affirmed the Utah Third District Court’s decision that Hills’ complaint against two third-parties was properly dismissed under Rule 12(b)(6) of the Utah Rules of Civil Procedure for failure to state a claim upon which relief could be granted. In doing so, the Utah Supreme Court declined to adopt an independent tort for first-party or third-party spoliation of evidence under the factual circumstances in the case.

Hills initially brought suit against Skyline Electric Co. (“Skyline”) for the wrongful death of their son. Their son was fatally electrocuted as a result of Skyline’s faulty wiring of a light fixture in the United Parcel Service (“UPS”) truck that he was using in the course of his employment. After learning during discovery that UPS and its insurer, Liberty Mutual Fire Insurance (“Liberty”) may have misplaced or destroyed evidence relating to the accident, Hills filed a separate spoliation lawsuit against UPS, Liberty, and Skyline. This suit included claims for negligence, intentional misconduct, and tortious interference.

Ultimately, Skyline admitted liability in the wrongful death claim suit, leaving damages the only issue before the court. Upon this admission, UPS and Liberty resubmitted motions (which were initially stayed pending the outcome of the wrongful death suit) to dismiss the Hills’ third-party spoliation claims against them in the second suit. The Third District Court determined that the Hills were claiming an independent act of spoliation of evidence. Noting that Utah had not adopted intentional or negligent spoliation of evidence as an independent tort, the district court dismissed the case on the grounds that there were no damages because liability had been admitted in the wrongful death action.

On appeal, Hills requested that the Utah Supreme Court adopt an independent tort of spoliation of evidence. The court determined that the alleged spoliation that had occurred was of no consequence to the wrongful death action because Skyline admitted liability for the wrongful death and the only purpose of the evidence was to prove who was liable for the accident. Because the spoliation issue was essentially moot, the court declined to adopt a tort for spoliation of evidence under the facts of the case.

This did not prevent Justice Nehring from writing a lengthy discourse about the history of the tort of spoliation of evidence that included a discussion of the California cases and the fact that only twelve states had adopted the independent tort in some form. His dictum suggests that he would be favorable to adopting a tort of intentional spoliation of evidence by third parties in appropriate cases. This part of the opinion was not joined by the other four justices of the court, and the dissenting judge was actually criticized for suggesting guidance to the lower courts and future litigants in regards to an issue that the court declined to address.

The Hills case contains a good discussion about cases involving a claim of an independent tort for spoliation of evidence, but it is not of strong precedential value for those resisting an effort to adopt a tort of spoliation of evidence except in cases involving similar facts. But the case does reveal that at least one member of the Utah Supreme Court appears to be prepared to adopt the tort in cases involving third parties intentionally destroying evidence, and the case reminds that the courts have strong non-tort judicial tools to address the spoliation of evidence by first parties.

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VERDICTS, APPEALS AND SETTLEMENTS

Editors Note – Because members of the ALFA Transportation Practice Group try many types of cases in addition to trucking cases, the Editors have asked them to submit for publication a wider variety of verdicts than those limited to trucking cases, if those additional verdicts would be of interest to a trucking industry audience.

Arkansas

Trial Date: February 1, 2010

Venue: Cleveland Circuit No. CV 2006-6-6; Lucretia Greenwood v Evines E. Rainey, Floyd’s Chipmill, Inc.

Counsel for the Defendant: David Glover of Wright, Lindsey & Jennings L.L.P

Case Type: Motor Vehicle Accident

Verdict: $260,000

Case Summary: This negligence action arose from a motor vehicle accident involving a vehicle operated by the plaintiff Lucretia Greenwood and a vehicle operated by the defendant Evines E. Rainey. On the morning of December 21, 2004, Greenwood was traveling in the southbound lane of Arkansas Highway 63 while Rainey was traveling in the northbound lane. At the time, Rainey was hauling a load of logs on his double bunk trailer. According to scene witnesses and the defendant’s own testimony, Rainey was speeding and overturned as he entered a curve while traveling northbound on Highway 63. The defendant’s load shifted causing his truck to overturn and resulted in the crushing of the plaintiff’s vehicle, which was traveling southbound, by the load of logs. The plaintiff sought compensatory damages for extensive injuries which required multiple surgeries. The plaintiff sought punitive damages based on the “callous disregard” of the safety of others by the defendant because the responding officer found the defendant’s truck to be in disrepair by having broken welds on the trailer and had multiple treadless tires. In addition, the defendant had twenty-two moving traffic and improper vehicle maintenance citations in a ten-year period, which the court allowed into evidence. After two weeks of testimony and after asking for over seven figures in damages, the jury returned a verdict for compensatory damages only in the amount of $260,000.

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Trial Date: April 2008

Venue: Mississippi – Utz v. Running & Rolling Trucking, Inc., 32 So. 3d 450 (Miss. 2010)

Counsel for the Defendant: Steve Hazard and Jason Strong of Daniel Coker Horton & Bell, P.A.

Case Type: Tractor-trailer accident

Verdict: For the defense

Case Summary: This wrongful death case was tried in April 2008 to a defense verdict by Steve Hazard and Jason Strong of ALFA firm Daniel Coker Horton & Bell, P.A.’s Jackson office. The plaintiff’s husband, Preston Utz, who allegedly had been smoking crystal methamphetamine earlier in the day, was killed when his vehicle crashed into the rear of a Running & Rolling tractor-trailer late at night on an unlit divided highway. The trailer was not equipped with conspicuity (reflective) tape as mandated by the Federal Motor Carrier Safety Regulations (“FMCSR”). After nearly a week of testimony, the jury deliberated only twenty-three minutes before returning a full defense verdict.

The plaintiff raised more than forty issues on appeal to the Mississippi Supreme Court, which affirmed the verdict on April 15, 2010.

One issue raised was that the trial court improperly excluded the plaintiff’s experts from testifying that the defendants were strictly liable because the trailer lacked reflective tape and, based upon the FMCSR, should not have been in operation. Witnesses at the scene and photographs taken the night of the accident in fact proved the trailer lacked the required reflective tape. The Mississippi Supreme Court held that while violations of traffic laws and regulations may constitute negligence per se, a plaintiff must still prove the defendants’ negligence was also the proximate cause of the plaintiff’s injury: “[T]his Court has held that violations of traffic laws, in and of themselves, do not amount to strict liability. This Court requires that in order to incur liability when a party is negligent, that negligence must also be the proximate cause of the injury.” Utz, 32 So. 3d at 466.

The trial court peremptorily instructed the jury that the defendants were negligent in failing to comply with the FMCSR, but the jury had to find such negligence was a proximate cause of the accident before returning a verdict for the plaintiff. The plaintiff appealed the denial of several of her jury instructions, which would have instructed the jury concerning the defendants’ general failure to comply with the FMCSR, failure to conduct pre and post-trip inspections, and failure to equip the trailer with reflective tape. Because the trial court chose to instruct the jury that the defendants were negligent, it found the plaintiff’s other liability instructions superfluous. The Mississippi Supreme Court upheld their denial.

The plaintiff also appealed the trial court’s in limine ruling that prohibited her experts from testifying that the trailer was difficult to perceive from the rear without reflective tape and that such reduced visibility caused the accident. The supreme court agreed with the trial court, holding that the experts did not have sufficient facts or data to opine as to the visibility of the trailer from the deceased’s perspective. The supreme court also reasoned that the jury had ample information to fairly consider the issues pertaining to visibility, as the jury was presented evidence that the trailer had no reflective tape, that the tape was designed to alert other drivers that a vehicle was ahead, and that the absence of the tape reduced visibility.

The plaintiff also argued the trial court erred in excluding expert testimony relating to the taillights on the trailer. The plaintiff contended that photographs of the rear of the trailer appeared to show dirt over its taillights, but the trial court reasoned expert testimony was unnecessary to educate the jury on the contents of a photograph. The defendants, however, were allowed to present lay witnesses who testified that they easily saw the taillights from considerable distances as they arrived on the scene in response to the accident. The supreme court found that since the plaintiff’s proffered experts had no basis for their opinions outside of what was depicted in the photographs their testimony was unnecessary to educate the jury on the contents of a photograph. The defendants, however, were allowed to present lay witnesses who testified that they easily saw the taillights from considerable distances as they arrived on the scene in response to the accident. The supreme court found that since the plaintiff’s proffered experts had no basis for their opinions outside of what was depicted in the photographs their testimony was properly excluded. The admission of the defendants’ lay testimony was proper given that it was based on personal knowledge and observation and was not dependent upon the photographs.
The plaintiff further claimed the trial court erred by excluding photographs of exemplar tractor-trailers equipped with reflective tape as mandated by the FMCSR. The plaintiff argued the photographs were proper evidence of how the defendants’ trailer should have appeared and what the deceased would have seen had the trailer complied with the FMCSR. The trial court denied the photographs, as one was taken during daylight and the other was taken from a side angle not presented to the deceased. The supreme court upheld the trial court’s ruling because the photographs would not have been helpful to the jury and were irrelevant. The court also noted the jury had other exhibits, including literature from the Federal Motor Carrier Safety Administration, which featured numerous colored illustrations of trailers with proper reflective tape.

The defendants’ primary liability argument was that the deceased’s use of crystal methamphetamine inhibited his ability to properly operate his vehicle and maintain awareness of other vehicles on the roadway. A toxicologist retained by the defendants testified that as methamphetamine is metabolized, depressant side effects such as decreased perception and reaction can emerge. The plaintiff challenged the trial court’s admission of this evidence. The Mississippi Supreme Court rejected all of the plaintiff’s arguments, emphasizing that the evidence was relevant to the issues of proximate cause and fault and was admissible.
**TENNESSEE**

**Trial Date:**
April 2008

**Venue:**
Rutherford County Circuit Court; *Dorothy Watson v. Robert Payne*, Docket No. 58027 before Judge Royce Taylor

**Counsel for the Defendant:** Jim Catalano and Christen Blackburn of Leitner, Williams, Dooley & Napolitan, P.L.L.C

**Counsel for the Plaintiff:**
Stanley Davis

**Case Type:**
Motor vehicle accident

**Verdict:**
For the defense

**Case Summary:**
On November 5, 2007, the plaintiff, Dorothy Watson, was a passenger in a car owned by her but driven by her grandson when they were rear-ended on Thompson Lane in Murfreesboro by the defendant, Robert Payne. Due to rush hour traffic and the torrential rain, traffic was stop-and-go. There was conflicting testimony as to the speed of the vehicle driven by the defendant, but all agreed that the plaintiff was stopped. The plaintiff told the treating physician that she was struck from behind by a vehicle that was traveling at a speed of approximately fifty mph. However, she and her grandson admitted at trial that they were not in a position to testify as to the speed of the vehicle driven by the defendant. No airbags deployed, and photos showed minimal damage to the rear of the plaintiff’s pickup truck with some minor damage to the front of the defendant’s pickup. An ambulance was dispatched, but the plaintiff refused treatment. She went to see the doctor the next day.

The plaintiff was treated for injuries to her head, neck, and low back. While she never had surgery, she did accumulate just under $21,000 in medical expenses that she claimed were incurred as a result of the accident. Moreover, her treating physician testified that she would need an additional $2,500 per month for medical care for the rest of her life as a result of her injuries. The plaintiff estimated this to be approximately $300,000 (she was 77). She further claimed she could not engage in many of the pre-accident activities that she once enjoyed. However, her medical records revealed a different story. She had been treated for low back problems for some time prior to the collision. In fact, she had been to physical therapy earlier on the same day of the accident. In the therapy note from that visit, the defendant revealed that she had a pain level of 9/10, trouble with activities of daily living, and many related problems all of which came about for no apparent reason. While there was no prior head or neck therapy or treatment, the MRI of the head was normal, and the medical records were devoid of any objective studies on the neck.

Dr. Hemal Mehta was her treating physician, and his deposition was read to the jury. The plaintiff and her grandson also testified.

The defendant retained Dr. Gray Stahlman to testify about the unrelated prior back pain, the lack of objective proof of head and neck injuries, and the speculative nature of the claim for future medicals. Dr. Stahlman’s deposition was played for the jury. Additionally, the defendant Payne took the stand to describe the accident and to explain that the plaintiff refused medical care at the scene.

At trial, the defendant admitted fault but attacked the medical causation, future medicals, and nature and extent of injury. The plaintiff presented the jury with an amount of damages exceeding $550,000. The jury deliberated for less than an hour and returned with a defense verdict.

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Comprehensive Safety Analysis 2010 (CSA 2010) has been as eagerly anticipated as it has been dreaded. Just as motor carriers were getting acclimated to the Federal Motor Carrier Safety Administration’s (FMCSA) SafeStat rating system, CSA 2010 comes along and changes the rules of the road for the commercial transportation industry. While fear of the unknown can be overwhelming, these materials are intended to give you a better understanding of CSA 2010 and answer the ultimate question: What now?

To answer that question, we undertake a three-step review and discuss: (1) what is CSA 2010; (2) how does CSA 2010 differ from SafeStat; and (3) how to comply with CSA 2010.

I. CSA 2010: What is it?

Comprehensive Safety Analysis 2010 is a FMCSA initiative to improve large truck and bus safety and ultimately reduce commercial motor vehicle-related crashes, injuries and fatalities. It introduces a new enforcement and compliance model, the Safety Management System (SMS), which focuses largely upon the results of roadside testing to determine safety compliance by motor carriers. The SMS is intended to give the FMCSA, and the States, a more effective and accurate mechanism by which to contact a larger number of carriers and address safety problems, before crashes occur.

CSA 2010 wholly re-engineers the existing enforcement and compliance system. By leveraging the roadside data FMCSA already maintains in its Motor Carrier Management Information System, CSA 2010 aims to achieve a more accurate account of motor carrier safety compliance. While FMCSA presently uses roadside data as a "pointing tool" in the SafeStat system, it has taken the position that such data is not used to penalize a motor carrier. CSA 2010, however, will use all data collected during roadside inspections to assess, penalize, and ultimately determine the safety fitness of motor carriers.

Notably, there is presently no meaningful mechanism to challenge the results of a roadside inspection with the FMCSA. Challenges to data provided by State agencies must be resolved by the appropriate State agency. Once a State office makes a determination on the validity of a challenge, FMCSA considers that decision as the final resolution of the challenge. Without alternative procedures to challenge roadside inspections, carriers will be stuck with the results of such inspections.

A. What Does CSA 2010 Cover?

CSA 2010 covers the full spectrum of safety issues—from how data is collected, evaluated, and shared—to how enforcement officials can intervene most effectively and efficiently. It measures safety performance by analyzing inspection and crash data in an effort to identify and evaluate carriers whose behaviors could reasonably lead to crashes. Roadside testing and crash data is used by officials to contact more carriers and drivers, with interventions tailored to their specific safety problem.

CSA 2010 incorporates several key attributes:

- FLEXIBILITY – CSA 2010 endeavors to accommodate changes to the transportation environment, such as evolutions in technology.
- EFFICIENCY – CSA 2010 seeks to improve enforcement staff productivity, as well as the safety performance of the motor carrier community.
- EFFECTIVENESS – CSA 2010 identifies behaviors associated with safety risks and focuses compliance, enforcement, and remediation efforts on those unsafe behaviors.
- INNOVATION – CSA 2010 leverages data and technology to improve safety by tracking safety performance data.
- EQUITABILITY – CSA 2010 assesses and evaluates motor carrier safety to ensure consistent treatment of similarly situated members of the community.

Now that we know what CSA 2010 purports to be, and whom it covers, we turn to how it differs from the present FMCSA SafeStat program.

II. How does CSA 2010 differ from SafeStat?

Motor carriers are presently evaluated by the FMCSA through a Compliance Review
in accordance with SafeStat (short for Motor Carrier Safety Status Measurement System). A Compliance Review is an on-site examination of a motor carrier’s operations by a federal safety investigator to determine a motor carrier’s safety fitness. This review is lengthy, time consuming and involves heavy paperwork, but is the current method by which the FMCSA assigns safety ratings. Because of the heavy workload involved with the Compliance Review, only a handful of motor carriers are reviewed each year.

One of the biggest problems with SafeStat is that the safety rating given to the motor carrier does not change until the carrier has gone through another Compliance Review. A motor carrier with a poor compliance review is stuck with their safety rating, no matter how significant the gains that they make thereafter. Similarly, motor carriers with a high safety rating can potentially discount their safety efforts once they achieve a high rating.

In significant contrast with SafeStat, CSA 2010’s new compliance system involves the monthly updating of SMS scores. By updating SMS scores on a monthly basis, CSA 2010 confronts the static rating system that made SafeStat rating unreliable, and often times out-of-date.

Additionally, under CSA 2010 SMS replaces the SafeStat measurement system as FMCSA’s assessment tool to identify high-risk motor carriers. CSA 2010 also implements two new safety measurement systems: motor carrier safety systems and driver safety systems.

There are six important differences between the SMS and SafeStat:

- SMS is organized by seven specific behaviors, while SafeStat is organized into four broad Safety Evaluation Areas.
- SMS identifies safety performance problems to determine the intervention level, while SafeStat identifies carriers for a Compliance Review.
- SMS emphasizes on-road performance using all safety-based inspection violations, while SafeStat uses only out-of-service and selected moving violations.
- SMS uses risk-based violation weightings, while SafeStat does not.
- SMS will eventually be used to propose adverse safety fitness determination based on a carrier’s own data, while SafeStat has no impact on an entity’s safety fitness rating.
- SMS provides a tool that allows investigators to identify drivers with safety problems during carrier investigations.

Additional, but less significant, differences include: SMS evaluates the safety of individual motor carriers by considering all safety-based roadside inspection violations (not just out-of-service violations), as well as State-reported crashes using 24 months of performance data.

A. How Does SMS Work?
The SMS is a tool for assessing available roadside performance data. Data is used to rank carriers’ performance relative to their peers in any of six BASICS, as well as crash involvement. The BASICS represent behaviors that can lead to crashes. The categories were developed by the FMCSA based on information from a number of studies that quantify the associations between violations and crash risk. The SMS calculates a measure for each BASIC by combining time and severity weighted violations/crashes (more recent violations are weighted more heavily), normalized by exposure (e.g., number of units or inspections). Applying a similar approach to that used in SafeStat, the SMS converts each carrier’s BASIC measures into percentiles based on rank relative to peers.

Below are the seven BASICS and their corresponding Code of Federal Regulations (CFR) parts:

- Unsafe Driving — Dangerous or careless operation of commercial motor vehicles.
  - Data includes driver traffic violations and convictions for speeding, reckless driving, improper lane change, inattention, and other unsafe driving behavior. (Federal Motor Carrier Safety Regulations [FMCSR] Parts 392 and 397)
- Fatigued Driving (Hours-of-Service [HOS]) — Driving a commercial motor vehicle when fatigued. This is distinguished from incidents where unconsciousness or an inability to react is brought about by the use of alcohol, drugs, or other controlled substances.
o Data includes (1) hours-of-service violations discovered during an off-site investigation, on-site investigation, roadside inspection, or post-crash inspection, and (2) crash reports with driver fatigue as a contributing factor. (FMCSR Parts 392 and 395)

- Driver Fitness — Operation of a commercial motor vehicle by drivers who are unfit due to lack of training, experience, or medical qualification.

  o Data includes (1) inspection violations for failure to have a valid and appropriate commercial driver’s license or medical or training documentation, (2) crash reports citing a lack of experience or medical reason as a cause or contributory factor, and (3) violations from an off-site investigation or an on-site investigation associated with pre-trip inspections, maintenance records, and repair records. (FMCSR Parts 393 and 396)

- Controlled Substances/Alcohol — Operation of a commercial motor vehicle while impaired due to alcohol, illegal drugs, and misuse of prescription medications or over-the-counter medications.

  o Data includes (1) roadside violations involving controlled substances or alcohol, (2) crash reports citing driver impairment or intoxication as a cause, (3) positive drug or alcohol test results on drivers, and (4) lack of appropriate testing or other deficiencies in motor carrier controlled substances and alcohol testing programs. (FMCSR Part 392)

- Vehicle Maintenance — Failure to properly maintain a commercial motor vehicle.

  o Data includes (1) roadside violations for brakes, lights, and other mechanical defects, (2) crash reports citing a mechanical failure as a contributing factor, and (3) violations from an off-site investigation or an on-site investigation associated with pre-trip inspections, maintenance records, and repair records. (FMCSR Parts 393 and 396)

- Cargo-Related — Failure to properly prevent shifting loads, spilled or dropped cargo and unsafe handling of hazardous materials on a commercial motor vehicle.

  o Data includes (1) roadside inspection violations pertaining to load securement, cargo retention, and hazardous material handling, and (2) crash reports citing shifting loads, or spilled/dropped cargo as a cause or contributing factor. (FMCSR Parts 392, 393, 397 and HM Violations)

- Crash Indicator (Reportable Crashes) — Histories or patterns of high crash involvement, including frequency and severity.

  o Data includes law enforcement crash reports and crashes reported by the carrier and discovered during on-site investigations.

**B. What Happens With BASIC Scores?**

Increased BASIC scores may make a carrier subject to more severe interventions. Higher scores will cause a motor carrier to enter, or remain, in the pool of carriers with deficient BASICs. Additionally, recent roadside violations and violations that correlate most with crashes will be weighted more heavily than other violations.

Motor carriers enter the intervention process based on the nature and severity of their safety problems. If a carrier’s safety problems are serious, it may enter the process through receiving an offsite, onsite focused, or onsite comprehensive investigation. According to the FMCSA, if a carrier’s safety problems are just emerging, FMCSA will issue a warning letter. If a carrier’s safety performance does not improve, or diminishes, after receipt of a warning letter, the carrier will enter the progressive process and receive an investigation. If performance improves, the carrier will no longer be identified for intervention. (See Part D for a further discussion of intervention under CSA 2010).

Clean inspections can be an asset to a motor carrier, particularly those scores relating to Fatigued Driving, Driver Fitness, Vehicle Maintenance, and Cargo-Related BASICs. These BASICs all use “relevant inspections” as a denominator for assessment of carrier performance. For example, any time a driver is
examined in an inspection, there is an opportunity for a violation that would impact the Driver Fitness BASIC. Since there is an opportunity for a violation, it is considered a “relevant inspection” for that BASIC. An inspection in which a driver was looked at with no Driver Fitness violations recorded (i.e. a “clean inspection”) would have a positive impact on the Driver Fitness BASIC.

Put simply, “clean inspections” help prevent the Fatigued Driving (HOS), Driver Fitness, Vehicle Maintenance, and Cargo-Related BASICs from becoming deficient, and can help to improve those BASICs if they are already deficient.

C. What About My Driver?
Under CSA 2010, individual commercial motor vehicle drivers will not be assigned safety ratings or safety fitness determinations. Consistent with the current safety rating regulations, individual drivers will continue to be rated, as they are today, following an onsite investigation at their place of business when they operate independently as a “motor carrier” (i.e. have their own DOT number, operating authority, and insurance).

   i. Driver Safety Measurement System
The Driver Safety Measurement System (DSMS) enables enforcement personnel to identify drivers with safety performance problems so that those problems can be addressed during carrier investigations. The DSMS assesses both the Fatigued Driving (HOS) BASIC and Driver Fitness BASIC using relevant violations recorded during roadside inspections to calculate a measure in each BASIC for individual drivers. These measures are used to generate percentile ranks that reflect drivers’ safety postures relative to their peers. Currently, the DSMS results are being used strictly as an investigative tool for law enforcement and are not available to carriers, drivers, or the public.

With the introduction of DSMS, most motor carriers will be concerned with what violations are “driver,” as opposed to “carrier,” responsibility. While there is presently a “driver responsible” column in the violation tables, violations count against the carrier whether it is a “driver responsible” violation or not. Although a subset of these violations is applied to evaluate driver safety in cases where the commercial motor vehicle driver is also responsible in part for the occurrence, those violations will count against the carrier, too.

Driver violations incurred prior to that driver entering employment with the carrier do not necessarily contaminate the carrier’s BASIC SMS score. Carriers are only evaluated on inspections and crashes associated with their own DOT number, so only violations that a driver receives while working for a carrier apply to that carrier’s SMS evaluation. Therefore, the driver’s violation history before the driver is hired and after the driver’s employment is terminated will not impact a carrier’s SMS results. If a carrier terminates a driver, all of the driver’s crashes and inspection results that he or she received while operating for that carrier still apply to the carrier’s SMS evaluation for 24 months from the date of occurrence. However, because the data is time-weighted, the effect of those occurrences on the carrier’s score will diminish over the course of time.

D. What Does Intervention Mean Under CSA 2010?
With respect to enforcement actions, there are five important differences between CSA 2010 interventions, and FMCSA’s current Compliance Review (CR) under SafeStat:

   • CSA 2010 provides a set of tools to address carriers' safety problems; the CR is a one-size-fit-all tool.
   • CSA 2010 interventions provide the ability to focus on specific safety problems, while the CR requires a broad examination of the carrier.
   • CSA 2010 interventions focus on improving behaviors that are linked to crash risk; CR is focused on broad compliance based on a set of acute/critical violations.
   • CSA 2010 focused onsite investigations as offsite investigations are less resource intensive and less time consuming for the carrier; CRs are resource intensive.

CSA 2010 investigations may take place at a carrier’s place of business or offsite; CRs are generally conducted onsite. The intervention process under CSA 2010 is triggered by: (1) one or more deficient BASICs, (2) a high crash indicator, or (3) a complaint
or fatal crash. Intervention selection is also influenced by safety performance, hazardous material or passenger carrier status, intervention history and investigator discretion. A motor carrier remains in the CSA 2010 intervention process until the carrier no longer has deficient BASICs.

CSA 2010 mandates proactive and progressive interventions for carriers and drivers that have been identified with safety deficiencies. Interventions range from warning letters to comprehensive on-site investigations that supplement the labor-intensive Compliance Reviews. Interventions under CSA 2010 are broken into three categories: early contact, investigation, and follow-on.

**i. Early Contact**
Low-level or initial interventions will include a warning letter sent to a carrier’s place of business that specifically identifies a deficient BASIC and outlines possible consequences of continued safety problems. The warning letter provides instructions for accessing carrier safety data and measurement as well as a point of contact. Because carriers have access to their BASICs scores, as well as the inspection reports and violations that went into those results, carriers can chart a course of self-improvement. Once safety problems have been identified, CSA 2010 provides roadside inspectors with data that identifies a carrier’s specific safety problems, by BASIC. Carriers should therefore expect targeted roadside inspections at permanent and temporary roadside locations where connectivity to the SMS information is available.

**ii. Investigation**
The next stage of the intervention involves off-site investigations, on-site focused investigations, or on-site comprehensive investigations.

Off-site investigations primarily focus on obtaining and reviewing documents relating to safety concerns. Documents submitted by a carrier to FMCSA, or a State partner, are used to evaluate the safety problems identified through the SMS and to determine their root causes. Documents may include third party records, including toll receipts, border crossing records, or drug testing records.

On-site focused investigations evaluate the safety problems identified through the SMS and their root causes. An on-site focused investigation may be selected when deficiencies in two or less BASICs exist. "Focused" on-site investigations target specific problem areas (for example, maintenance records).

An on-site comprehensive investigation is similar to a CR and takes place at the carrier’s place of business. It is used when the carrier exhibits broad and complex safety problems through continually deficient BASICs, worsening multiple BASICs (three or more), or a fatal crash or complaint.

**iii. Follow-on**
When the FMCSA determines that additional or alternative intervention is appropriate based upon SMS, carriers can implement a Cooperative Safety Plan. This Plan, implemented by the carrier, is voluntary and created jointly with the FMCSA, based on a standard template, to address the underlying problems resulting from the carrier’s substandard safety performance.

Carriers may also be provided a formal Notice of Violation. A Notice of Violation, which requires a response from the carrier, is issued when regulatory violations discovered are severe enough to warrant formal action but not a civil penalty. It is also used in cases where the violation is immediately correctable and the level of cooperation is high.

When the regulatory violations are severe enough to warrant assessment and the issuance of civil penalties, the FMCSA will issue a Notice of Claim. Such a Notice of Claim may be followed by a Settlement Agreement in which the carrier agrees to enact remedies to address the root cause of a safety problem, defer or reduce penalties, or terminate enforcement proceedings.

**E. How Will I Know the Level of Intervention?**
Generally, levels of intervention will be dictated by a motor carriers BASICs score. The SMS does allow, however, for FMCSA to more effectively evaluate safety performance using new measures for identifying which carriers require what type of intervention. FMCSA will use a regulatory process called Safety Fitness Determination
(SFD), a policy-driven process, to determine which carriers should be proposed "unfit" to operate. There are four important differences between FMCSA's current safety rating process, under SafeStat, and the proposed CSA 2010 SFD:

• The proposed SFD would not be exclusively tied to onsite reviews, while the current safety rating process can only be issued or revised via an onsite review.
• The proposed SFD would be updated regularly, while the current safety rating process provides a snapshot of compliance only on the date of the most recent CR.
• The proposed SFD would be based on violations of all safety-based regulations, while the current safety rating process is based only on critical and acute violations.
• The proposed SFD rating labels under consideration are Unfit, Marginal, and Continue to Operate; the current safety rating process labels are Unsatisfactory, Conditional and Satisfactory.

An Unfit Suspension will prohibit a carrier from operating, based on the conclusion of a SFD. The details of Unfit Suspension will be described in the SFD Rulemaking, which has not yet been completed by FMCSA.

F. When Am I Cleared?
The Safety Measurement System (SMS) will stop flagging carriers when the safety performance reflects BASIC scores below the intervention threshold. This can happen in one of two ways: (1) improved performance as demonstrated by clean inspections at roadside; and/or (2) poor inspections count less as they age and eventually fall outside of the 24-month timeframe.

III. Compliance with CSA 2010
It is apparent that CSA 2010 is going to change the way that the commercial transportation industry operates. In light of the fact that CSA 2010 cannot be avoided, we turn to moving forward with CSA 2010 compliance in mind.

A. How Much Time Is Left Before CSA 2010 Becomes Fully Active?
FMCSA will implement CSA 2010 nationwide starting in late summer of 2010, and the program is envisioned to be fully rolled out by the end of 2010. There is no grace period for achieving compliance. Carriers should know that their safety performance in SMS will be based upon the previous 24 months of on-road performance and crash data when CSA 2010 is implemented. As such, current roadside inspections impact the CSA 2010 Operational Model test, even if activity is reported through a presently non-participating state.

B. What About Insurance?
Trucking-related businesses will be able to view the new measurement results when SafeStat is replaced. They will have the same ability to search for carriers and view carrier results much like they can with SafeStat. Results will be presented based on BASICs, as opposed to the four Safety Evaluation Areas (SEAs). In addition, all Safety Violations from roadside inspections feed the new BASICs where only the out-of-service violations feed the SafeStat SEAs.

C. What is the Rest of the Industry Saying?
Generally, the industry is welcoming of CSA 2010’s new regulations. Whether this reaction is a result of disdain for SafeStat, or a welcome development to safety, remains to be seen. The American Trucking Association has indicated that it supports CSA 2010: ATA Chairman Tommy Hodges said CSA 2010 “is going to make us a better, safer industry that’s better able to manage our safety processes, and that makes it worth it.”

Nevertheless, ATA informed the FMCSA that it takes issue with the fact that CSA 2010 uses all crashes in its calculations, not just those that were the responsibility or fault of the carrier or the driver. Simply put, any crash involving a carrier, regardless of fault, will be counted within BASICs. ATA has also asked that the FMCSA look at the agency’s use of the number of trucks a company operates, rather than the number of miles they travel, for determining the frequency of violations. Similarly, ATA has taken issue with the issuance of warnings, rather than citations, because letters arguably deprive the carrier of the opportunity to challenge improper violations.

The Commercial Vehicle Safety Alliance has also expressed its support for CSA 2010. “With full implementation of CSA 2010 activities on the horizon,
such as the new Carrier Safety Measurement System, knowing the ‘Criteria’ in advance can assist a motor carrier ensure the accuracy of the roadside inspection data collected and contained within a motor carrier’s safety profile.” said Larry G. Woolum, Regulatory Affairs Director of the Ohio Trucking Association and Chair of CVSA’s Associate Advisory Committee.

“The information collected during a roadside inspection provides the foundation for data-driven traffic safety initiatives. As a result, the importance of this issue cannot be understated, as it has strong implications to not only CSA 2010 but all of our traffic safety programs,” said Buzzy France, CVSA’s President. “Commercial motor vehicle safety continues to be a challenge and we need the involvement of all affected parties to help us better understand these issues and put into place practical solutions. As commercial vehicle inspectors, our continued diligence will help us reach our ultimate goal of saving lives.”

**IV. Conclusion**

The full impact of CSA 2010 on the industry is unknown, as only time will tell if these new measures successfully decrease accidents. What is known, however, is that compliance with CSA 2010 is imperative, and must be planned for immediately.

Between now and full implementation, FMCSA is launching an outreach effort to inform carriers and drivers of the upcoming changes. FMCSA recently updated "A Carrier’s Guide to Improving Highway Safety", December 2009, which can be found on the FMCSA website (http://www.fmcsa.dot.gov/safety-security/eta/index.htm). This is designed to assist the motor carrier in understanding and complying with the Federal Motor Carrier Safety Regulations.

It is important to note that CSA 2010 is not fully operational, and that there is still extensive rule making going on behind the scenes. The Commercial Vehicle Safety Alliance is continuing to work with Congress, the DOT, and the FMCSA to finalize all of the remaining provisions (i.e., SFD criteria).

The FMCSA has also set up Listening Sessions, which are available in PowerPoint on the FMCSA website. These materials are invaluable for understanding and digesting the complexities of CSA 2010.

In the meantime, keep an eye on your mailbox. The FMCSA has indicated that it plans to begin rolling out the CSA 2010 Warning Letter component of the new intervention process in the summer of 2010. Warning letters are generated when the Carrier Safety Measurement System (CSMS) identifies a problem in one or more of the BASICs. At this time, FMCSA does not plan to send all carriers letters to indicate that CSA 2010 is being implemented.

These materials have barely scratched the surface of CSA 2010 and what its enactment means for the transportation industry in North America. To this end, it is crucial that everyone involved in the industry take a detailed look at the FMCSA materials regarding CSA 2010, which can be found at http://csa2010.fmcsa.dot.gov.2

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“Daubert” refers to a Supreme Court case, *Daubert v. Merrill Dow Pharmaceuticals*, which set the standard for whether an expert witness is qualified to testify in a federal case. An expert, as described in the Federal Rules of Evidence, is anyone who testifies based not on his or her own perception, but rather uses “scientific, technical, or other specialized knowledge” to help the fact-finder understand an issue. *Daubert* designated the judge as the “gatekeeper” of expert witnesses; that is, it is the role of the judge to allow or disallow an expert to testify based upon his or her qualifications. In other words, the judge decides if the expert meets certain minimum qualifications. If allowed to testify, it then becomes the role of the jury (or judge, in a bench trial) to weigh the credibility of the testimony based on the qualifications and analysis presented by the expert. As decided in a later case (*Kumho Tire*), the *Daubert* rules apply to all expert testimony, whether scientific or non-scientific.

In the *Daubert* decision, the Court listed non-exclusive factors that the judge may consider in deciding whether to admit expert testimony. These factors include:

1. Whether the expert’s methodology has been tested;
2. Whether the theory and/or methodology used has been subjected to peer review;
3. The method’s rate of error;
4. Whether there are standards and controls in the methodology; and
5. Whether the theory or methodology is generally accepted in the field.

It is important to note that no factor is dispositive, and the judge, using his or her discretion, may consider some of these factors or even other, unlisted factors. But, generally speaking, where the proponent can establish that the theory or methodology is generally accepted in the field, the expert testimony is almost always permitted. Another frequently considered question is whether the witness has previously been qualified as an expert on the same issue. Conversely, courts tend to disallow theories and methodologies that were created solely for litigation and do not exist outside the court system.

*Note that Daubert applies only to cases using federal procedure. Each state may have its own standard and procedure for qualifying experts.*

**Procedure**

A “*Daubert* motion” is really a motion *in limine* brought by the party challenging the expert’s qualifications. The judge has a substantial amount of discretion in handling the motion. The judge may choose to hold a hearing, but one is not required if sufficient facts exist in the record—usually in the expert’s resume, deposition transcript, expert reports, or even an affidavit provided in response to the motion. If the judge holds a hearing, the judge has discretion to determine the form and scope of the hearing, including whether there will be live testimony.

Generally, the motion can be brought at any time before or during the trial, unless specifically limited by the trial judge. If challenged, the burden of proving the expert’s qualifications lies with the party offering the expert testimony.

**Daubert Checklist For An Expert Deposition**

1. **BACKGROUND AND QUALIFICATIONS**
   a. **PERSONAL INFORMATION**
      i. NAME/ADDRESS
   b. **EDUCATION**
      i. SCHOOL
      ii. MAJOR/DEGREE
      iii. HONORS/PRIZES/FELLOWSHIPS
   iv. IS THE EXPERT’S EDUCATION IN THE SAME FIELD AS HER EXPERTISE?
   v. HAS THE EXPERT HAD ANY CONTINUING EDUCATION?
   c. **DOES THE EXPERT HAVE ANY CERTIFICATIONS, LICENSES?**
      i. ARE THERE CERTIFICATIONS OR LICENSES FOR THE FIELD IN WHICH THE EXPERT IS TESTIFYING?
      ii. HAVE ANY OF THE EXPERT’S CERTIFICATIONS LAPPED OR BEEN REVOKED?
iii. WHAT DOES IT TAKE TO BE CERTIFIED IN THE EXPERT’S FIELD: IS THERE A QUALIFICATION PROCESS OR DOES IT JUST TAKE THE PAYMENT OF A FEE?

iv. DOES THE STATE REGULATE THE EXPERT’S FIELD?

d. EMPLOYMENT

1. NAME OF EMPLOYER

2. LENGTH OF EMPLOYMENT

3. JOB TITLE/DUTIES

4. EXPERT’S SUPERVISOR AND SUBORDINATES

5. HOW THE EXPERT GETS PAID

6. HOW THE EMPLOYER OR EXPERT BILLS SERVICES

7. WHAT ARE THE EMPLOYER’S DOCUMENT RETENTION POLICIES?

ii. PAST EMPLOYMENT

1. NAME OF EACH PAST EMPLOYER

2. REASON FOR LEAVING EACH POSITION

3. WERE ALL JOBS IN THE SAME FIELD AS CURRENT EXPERTISE?

e. PUBLICATION HISTORY: HAS THE EXPERT EVER BEEN PUBLISHED IN THIS FIELD

i. WAS THE PUBLICATION PEER REVIEWED (DOES THE EXPERT KNOW WHAT “PEER REVIEW” MEANS)??

ii. WERE ANY SUBMISSIONS REJECTED FOR PUBLICATION?

iii. IS THERE ANYTHING PUBLISHED THAT THE EXPERT WOULD NOW REVISE?

iv. WHAT ARE THE AUTHORITATIVE JOURNALS OR PUBLICATIONS IN THE FIELD?

2. PRIOR TESTIMONY

a. IDENTIFY ALL CASES IN WHICH THE EXPERT WAS QUALIFIED

i. IDENTIFY SUBJECT MATTER OF EXPERTISE

ii. IDENTIFY PARTY FOR WHOM EXPERT TESTIFIED

iii. IDENTIFY LAW FIRM THAT RETAINED EXPERT

b. HAS THE EXPERT EVER BEEN DISQUALIFIED AS AN EXPERT?

c. HAS A COURT EVER BARRED ALL OR A PORTION OF THE EXPERT’S OPINIONS PRIOR TO OR DURING TRIAL?

d. HAS THE EXPERT EVER TESTIFIED TO THIS SUBJECT MATTER BEFORE?

3. RETENTION IN THIS CASE

a. DATE RETAINED

b. COMPENSATION ARRANGEMENT

c. EXPERT’S TASK

4. WHAT ARE THE EXPERT’S OPINIONS IN THIS CASE?

a. IDENTIFY OPINION

i. IS OPINION TO A REASONABLE DEGREE OF PROFESSIONAL CERTAINTY?

b. METHODOLOGY

i. WHAT METHODOLOGY WAS USED?

ii. HOW WAS THE METHODOLOGY CHOSEN?

iii. DOES THE METHODOLOGY EXIST OUTSIDE OF LITIGATION?

iv. ON WHAT LITERATURE DID THE EXPERT RELY?

v. ARE THERE ANY RECOGNIZED STANDARDS WITHIN THE EXPERT’S INDUSTRY?

c. TESTING

i. WAS THE TESTING PERFORMED FOR THIS CASE TO SUPPORT THE OPINIONS?

1. WAS THE TESTING PERFORMED UNDER SUBSTANTIALLY SIMILAR CONDITIONS?

2. WHAT VARIABLES WERE ACCOUNTED FOR DURING THE TESTING?

ii. HAD THE EXPERT EVER PERFORMED TESTS PRIOR TO THIS CASE THAT SUPPORTS THE EXPERT’S OPINIONS?
iii. IS THE EXPERT AWARE OF ANY TESTS WITHIN THE INDUSTRY THAT SUPPORT THE OPINION IN THIS CASE?

iv. WHAT IS THE EXPERT’S RATE OF ERROR?

d. DATA SOURCES

i. HOW DID THE EXPERT ACQUIRE DATA/FACTS?

1. WHAT TYPE OF TOOLS OR TECHNOLOGY WAS USED TO COLLECT THE DATA?

2. QUESTIONS REGARDING THE RELIABILITY OF THE TECHNOLOGY OR SOFTWARE USED

a. IS IT RECOGNIZED IN THE INDUSTRY?

b. DID ANYONE ELSE ASSIST IN PREPARING MODELS, DIAGRAMS, ANIMATIONS, ETC....AND WHAT IS THE INDIVIDUAL’S QUALIFICATIONS?

ii. DID THE EXPERT EXCLUDE ANY DATA/FACTS?

iii. WHAT IS THE BASIS OF DATA’S RELIABILITY?

iv. HOW HAS THE EXPERT COMPENSATED FOR INCONSISTENT TESTIMONY BY WITNESSES?

5. HAS THE EXPERT CONSULTED WITH ANY OTHER EXPERTS IN THIS MATTER?

a. HAS THE EXPERT HAD THE OPINIONS REVIEWED BY ANY OTHER EXPERTS?

b. IS THERE ANY METHOD TO TEST THE EXPERT’S OPINIONS?

6. MISSING EVIDENCE OR UNKNOWN VARIABLES

a. HAS THE EXPERT ACCOUNTED FOR THE CHARACTERISTICS OF THIS PARTICULAR PLAINTIFF OR INDIVIDUAL, SUCH AS HEIGHT, EYESIGHT, REACTION TIME, ETC.?

b. WHAT EVIDENCE WOULD BE OF ASSISTANCE THAT IS NOT AVAILABLE?

c. HOW WOULD THE EXPERT USE THIS “UNAVAILABLE EVIDENCE” AND WHY IS IT IMPORTANT?

d. WHICH VARIABLES ARE SIGNIFICANT?

i. IS THERE ANYWAY TO ELIMINATE THE VARIABLES?

ii. ANY METHOD OR INVESTIGATION TO LIMIT THE VARIABLE?

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Useful Resources


Daubert On The Web, http://www.daubertontheweb.com. This website gives an Overview of the Daubert and other decisions, with helpful tips. However it does not appear to have been updated since 2006.


Daubert Tracker, http://www.dauberttracker.com. This is a searchable database of past challenges of experts’ qualifications.

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ARTICLES

Compliance with the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007. Includes information concerning CMS February 24, 2010 Alerts and Version 3 of the User Guide

INTRODUCTION

Recent changes in federal law represent a sea change in the consideration that must be given by defendants to the interests of Medicare. Up until March, 2009, Medicare, when attempting to recover past payments made to beneficiaries, was severely handicapped by a lack of specific information concerning legal settlements pertaining to injuries and illnesses that had resulted in the payment of the Medicare benefits. Effective January 1, 2011, insurers and self-insureds, denoted as "Responsible Reporting Entities" or "RREs," are obligated to report very specific details of personal injury settlements and judgments in excess of $5000, in order to allow Medicare to assert its right to recover past payments from its beneficiaries. As a result of this requirement, Medicare beneficiaries may face severe penalties for non-reporting and failure to properly report settlements and verdicts can be imposed against insurers and self-insureds (RREs). Currently, the federal government is having a small difficulty explaining the implementation of the reporting requirements and answering practical questions concerning the obligations of the reporting entities. The starting date for the formal reporting requirement has been moved at least three times to the current date of January 1, 2011. In recent conference calls regarding details of the program, government participants have been repeatedly stumped by seemingly obvious questions and concerns raised by callers. The answers to many important questions are often unavailable and presently unknowable. To remain current, insurers and self-insureds must monitor the website of the Centers of Medicare and Medicaid Services: www.cms.hhs.gov/MandatoryInsRep/O1_Overview.asp

MEDICARE, A SHORT HISTORY

The Medicare Program came into existence as one of Lyndon Johnson’s “Great Society” programs. The Social Security Act of 1965 established Medicare as a federal health insurance program for persons over 65 and individuals meeting certain other program requirements. The Medicare program is administered by the Centers for Medicare and Medicaid Services ("CMS"), a bureau of the Department of Health and Human Services. Between 1965 and 1980, the Medicare program was the primary payer for medical bills and expenses of beneficiaries in all cases except those involving workers’ compensation. In 1980, in response to rising costs, Congress passed the Medicare Secondary Payer Act ("the MSP"), which prevents Medicare from paying for medical expenses in circumstances where another entity had a legal or contractual obligation to pay for the same medical treatment. By federal statute, Medicare was thus transformed into a payer of last resort – a secondary insurance plan that may pay for medical treatment subject to reimbursement by a primary source. Primary sources include private insurers, self-insureds or third party tortfeasors. In all situations where another entity is required to pay for covered services, that entity must pay before Medicare does, and must do so without regard to a patient’s Medicare eligibility.

In 2007, Congress passed the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"). The Act imposes mandatory reporting requirements on insurers and self-insureds. The requirements of the MMSEA are the main subject of the following discussion.

MEDICARE ELIGIBILITY

It is essential to understand who, exactly, might be a Medicare beneficiary. This is critically important since the beneficiary status of the
determine whether a particular claimant is, in fact, a Medicare beneficiary. To assist in the identification process, a monthly query may be made of the CMS’s Coordination of Benefits Contractor (“COBC”) to determine the Medicare status of the claimant. The query request must include the Social Security Number (“SSN”), name, gender, and date of birth of the injured party. A query can also be made using the injured party’s Health Insurance Claim Number (“HICN”), although the assignment of such a number to the injured party prior to the request is a very strong indicator that the claimant may have received Medicare benefits.4 An HICN is typically the claimant’s SSN with the addition of a single letter suffix. RREs must implement a procedure in their claims review process to determine whether an injured party is a Medicare beneficiary and to gather the information necessary for Section 111 reporting.

CONDITIONAL PAYMENTS

The phrase “conditional payments” is frequently used by the CMS. The term has confused many people who do not understand the ‘secondary payer’ aspect of Medicare as a result of the changes occurring in 1980. After 1980, payments made by Medicare are always subject to recovery from primary payers. In that sense, Medicare considers all its payments “conditional”

2 - 42 CFR 400.202 and 400.202(3), emphasis added.

3 - And, again, if the person is eligible but not actually receiving anything, the person is a beneficiary.

4 - At a minimum, it indicates that the claimant has registered to receive benefits.
because, if a primary payer (insurer or tortfeasor) can be found, Medicare can seek to recover its prior payments made to the beneficiary. For some, conditional payments may be more easily understood as simply amounts Medicare has paid for treatment of an injury before judgment or settlement. To make it easier still, conditional payments are essentially past medicals.

Since 1980, Medicare has had a right to recover conditional payments from primary payers, including tortfeasors and liability insurers. However, there was no effective, enforceable reporting mechanism that assisted Medicare in identifying primary payers and discovering details of settlements and judgments. Medicare could only rely on voluntary disclosures made by the beneficiary or beneficiary’s attorney. As a result, Medicare failed to recover conditional payments because the CMS was unaware that a primary payer existed. Often, Medicare would also pay for post-settlement treatment despite the fact that recovery was made on a claim that included damages for future medical treatment. In that sense, the claimant had been compensated for foreseeable future medical treatment in the settlement or verdict and would then also receive Medicare benefits when treatment was eventually provided. As a result, Medicare both failed to recover conditional payments made for past treatment and made payments for future treatment it never should have, because it had no knowledge of the primary payer making payment intended to include that eventual treatment.

THE MMSEA (2007)

Again prompted by growing program costs, Medicare sought to identify benefit-related litigation or benefit-related primary payers and to aggressively pursue recovery of conditional (pre-settlement or pre-judgment) payments for medical care. The mandatory reporting requirements in the MMSEA take matters a step further, however, and allow Medicare, armed with settlement details, to protect its interests as to post-settlement, post-judgment (future) medical expenses for an injury or condition that was the basis for a claim. On the specifics of how a settling defendant can properly respect Medicare’s rights with respect to future payments to the beneficiary, the CMS remains maddeningly ambiguous and indecisive.

Before addressing the reporting requirements of the MMSEA, practical details of which are still being invented and revised by the federal government, it is important to understand that the obligation of a defendant to take Medicare’s reimbursement interests into account in a settlement presently exists, despite the fact that the mechanism for reporting details of a settlement or judgment remains very much a work in progress. In other words, defendants should now be checking to determine whether a claimant is a Medicare beneficiary and requiring, at a minimum, that a claimant reimburse Medicare for any conditional payments as a provision of any settlement agreement. Where a settlement is being made with a known or verified Medicare beneficiary, adding Medicare as a payee on the settlement draft is currently prudent.

Section 111 of the MMSEA added two short, but powerful, sections to the MSP. One imposes a specific, mandatory reporting requirement on those entities considered primary payers of medical benefits and names such entities Responsible Reporting Entities or “RREs.” RREs are primarily insurers and self-insured entities. The new mandatory reporting requirements, by timing and substance, provide Medicare with timely and detailed information that will enable it to more readily recover conditional payments for pre-settlement or pre-verdict medical care rendered to a Medicare beneficiary. The new information may also alert Medicare to compensation to a claimant that included some component for future medical treatment, thereby allowing Medicare to refuse payment for that treatment on the grounds that a primary payer has previously compensated the beneficiary for it. In some circumstances, particularly where Medicare makes a future payment and then later pairs that payment

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5 - Think of where the Internal Revenue Service would be without employer-filed W2’s.
data with a previously reported settlement, Medicare may seek recovery from its beneficiary and/or the settling defendant; including the insurer and the insured.6 The situation concerning future medicals (in other words, post-settlement payments) by Medicare for an injury that was the subject of a settlement is presently quite murky and will be covered under its own heading, below.

The second addition to the MSP encourages RREs to make the new reports by providing for substantial penalties for failure to make timely reports required by the Section 111.

REPORTING REQUIREMENTS

• Who Must Report?

As indicated above, starting January 1, 2011, with respect to settlements or judgments occurring on or after October 1, 2010, insurers and self-insureds (RREs) must report settlements and judgments relating to Medicare beneficiaries. In the words of the CMS, an RRE is generally the entity that makes any payment for bodily or personal injury involving a Medicare beneficiary. Such a payment may be partial, or in connection with a settlement, judgment, or award.

A third party administrator ("TPA") which merely issues the check is not an RRE. If a company is fully insured, the insurer is the RRE. If a company has some form of a risk retention program or plan, such as a high deductible policy or a self-insured retention ("SIR"), the company may be the RRE at least to the extent of the deductible or retention. The CMS had made some contradictory statements that could lead an entity that was uninsured for the full amount of a judgment, award or settlement to believe that it was not under an obligation to report. In its latest Alert on February 24, 2010, concerning "WHO MUST REPORT," CMS attempts to clarify the situation; entities with a deductible insurance plan no longer meet the definition of an RRE, even if the entity pays the deductible directly to the claimant. In any deductible scenario, the insurer is the RRE for reporting purposes and must include the deductible amount in any total payments it reports. However, the Alert also points out that if the insured entity acts without recourse to its insurance in resolving a case, the insured is the RRE whether it settles the case below or above its deductible.

With respect to self insureds with excess coverage, the identity of the RRE depends on whether the excess insurer reimburses the self insured entity or pays the claimant directly. If the excess insurer pays the claimant, it is the RRE; otherwise the self insured entity is the RRE and must report the total payment. The February 24, 2010 Alert from CMS sets forth additional rules for determining who is an RRE in various circumstances.

If a company is the RRE for some claims and uses a TPA to administer those claims, the company may contract with the TPA to act as the company's agent in reporting the required data to Medicare. However, Medicare will hold the RRE accountable, not the agent, if a problem with reporting occurs. The RRE is responsible for the accuracy of the reporting and for any fines for failure to timely report a claim payment to Medicare in accordance with Section 111 reporting requirements. Any contractual agreement between the RRE and TPA should reflect the cost of the reporting function and who will be responsible for any fines for untimely reporting.

The important thing from the CMS’s perspective is that the settlement or judgment gets reported. If an insured with a high deductible does not have written confirmation from its insurer that the claim has been reported, it should do so itself.7 This is true even where the settlement or judgment was paid with no contribution from an insurer. From Medicare’s perspective, the information that matters is the existence of a primary payer and the details of the payment. Medicare’s interest in recovering payments is the same whether the primary payer is an insurer or not.

6 - See later discussion of US v. Stricker, a civil action recently filed against beneficiaries, insureds, insurers, and beneficiaries’ (plaintiffs’) counsel, for recovery of past conditional payments, among other things.

7 - As discussed below, a carrier and an insured may have different reporting schedules as a part of the registration process.
• Triggering The Reporting Requirement

As of February, 2010, CMS has delayed the first required production data submission by any RRE until January 1, 2011. For liability insurance policies, any kind of payment, subject to the limited thresholds set forth below, made to a Medicare beneficiary on or after October 1, 2010, for a claim or potential claim of personal injury, is considered a payment that triggers a reporting requirement under Section 111. Claims settled before October 1, 2010, do not have to be reported. Also claims with Ongoing Responsibility for Medicals (“ORM”)* as of October 1, 2010, are reportable in any amount under Section 111. Claims with ORM closed administratively before this date are not required to be reported.

In response to requests by the insurance industry, in March, 2009, the CMS announced thresholds below which claims did not have to be reported. In connection with delay of the initial reporting date, CMS also extended the threshold dates. Note, however, that important distinctions are made for claims involving a payment, labeled a "TPOC" (Total Payment Obligation to Claimant), associated with a settlement, judgment, or award, and a claim involving ORM after January 1, 2010, (the latter are all reportable). RREs and their attorneys should review CMS guidelines on this topic closely. There are also special exclusions for cases with ORM and thresholds for cases closed through settlement, judgment, or award, as illustrated by the following guidelines. Remember, as a general rule, where there is no settlement, judgment, award, or other payment, including no assumption of ORM, there is no Section 111 report required, until such an event occurs. Making a query to find out if a claimant is a Medicare beneficiary is not the same thing as reporting a settlement or judgment.

> Reportable Events (Cases Involving Medicare Beneficiaries)
  • Cases with ORM* as of January 1, 2010;
  • Cases with a TPOC calculated after settlement, judgment, or award, on or after October 1, 2010:

> Excluded Events and Thresholds
  • Contested Cases Exclusion: No ORM and no payments have been made to or for the benefit of the claimant (only excluded until settlement, judgment, or award occurs or appeal resolved).  

> Total Payment Obligation to Claimant (TPOC) Thresholds
  • TPOC amounts $5,000.00 or less not reportable between January 1, 2011 and December 31, 2011;
  • TPOC amounts $2,000.00 or less not reportable between January 1, 2012 and December 31, 2012;
  • TPOC amounts $600.00 or less not reportable between January 1, 2013 and December 31, 2013;
  • All TPOC amounts reportable after January 1, 2014;
  • Limited to workers’ compensation and liability claims.

There are other exclusions for workers’ compensation ("WC") claims not considered here. Also, with respect to exposure claims (asbestos and the like), when the last known exposure precedes December 5, 1980, such claims do not have to be reported.

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8 - "Ongoing Responsibility for Medicals" or "ORM" refers to the RRE’s responsibility to pay on an ongoing basis of for the injured party’s (Medicare beneficiary’s) medicals associated with the claim; and typically, ORM only applies in no-fault and worker’s compensation claims.

9 - The duty to report ORM is triggered when the RRE determines to assume responsibility for ORM, not when payment is actually made. In fact, ORM dollar amounts are not reported, just the fact that ORM exists. When ORM ends (a no-fault limit is reached, the injured worker is healed, back to work and the RRE no longer has ORM, etc.) then the RRE reports an ORM termination date. If there was no TPOC for a settlement, judgments, award, or other payment related to the claim, the RRE may never need to report a TPOC amount on a claim with ORM (only the termination date for the ORM).

10 - If a judgment or award is appealed and no payments are being made, any TPOC or ORM is not reportable until the appeal is resolved. If payments are being made during the appeal process, report the TPOC or ORM. (User Guide Version 3.0, February 22, 2010, section 11.10.2, p. 88).

11 - If prior payments have been made in the same claim prior to October 1, 2010, they should be totaled with any TPOC paid on or after that date to determine the threshold value for reporting purposes.
What is a Timely Report?

Subject to the excluded events and thresholds set forth above, claim payments are reported when a Medicare beneficiary receives partial payment (or when payments are made on behalf of the beneficiary), or when a settlement, judgment, or award (TPOC) is reached, without regard to liability. Under the CMS guidelines, reports are transmitted quarterly during a 7 day file submission window assigned to each RRE as part of the certification process. There is one such seven day window per quarter. There is a grace period if the settlement, judgment, award, or other payment is made within 45 days prior to the start of the 7-day reporting window. In that event the RRE (or its agent) may report that payment in the following quarterly reporting window. The parties reach a TPOC when an agreement is signed, or where court approval is required, when the parties receive that approval. Actual payment is not required before making a report. If a payment is made without an agreement, the reporting obligation is triggered so long as the TPOC threshold is exceeded.

CMS requires submissions of many of data elements for each claim that meets CMS's reporting criteria. Many of the data fields are not currently being used during the testing phase for reporters. As noted above, Section 111 reporting requirements that were originally scheduled to go into effect April 1, 2010, have now been extended. The time period between April 1, 2010, and December 31, 2010, will be used to continue testing the data transmission system between RREs and the CMS. RREs must begin submitting actual data to CMS on January 1, 2011. RREs that have completed registration and testing may begin submitting production data during their assigned submission period beginning in the second quarter of 2010 (April 1 to June 30), but no earlier.

FUTURE PAYMENTS

It is clear that the CMS desires to make sure that a claimant is not both compensated in a settlement or judgment for anticipated future medical expenses, and also able to ultimately have Medicare pick up those same expenses when treatment is rendered. The manner by which Medicare will ultimately accomplish this is uncertain, and specific questions in this area, in particular, prompt “we’ll get back to you” responses from the CMS. What is particularly troubling at this stage in the evolution of the CMS’s directives is the uncertainty, and present impossibility, of ensuring that CMS will ultimately accept the manner in which the RRE handled a portion of a settlement or judgment that compensates a claimant for future medical expenses.

At this point, the CMS requires settling defendants to give “reasonable consideration” to Medicare’s interests in connection with a settlement. There are no clear guidelines (and certainly no bright lines) on what the CMS considers “reasonable.” Equally troubling is the lack of meaningful guidance on the nature of the “consideration” required. There is presently no mechanism for obtaining approval of any particular attempt to ‘reasonably consider’ Medicare’s interests. Medicare has indicated it would consider a jury verdict that specifically quantifies future medical damages binding – otherwise it is not bound to accept an allocation. In other words, an agreement that sets forth a specific allocation to future medical expenses is not unhelpful, but is also not binding or conclusive on Medicare.

It seems clear at this point that settlement documentation with a Medicare beneficiary or someone likely to be a beneficiary in the near future should expressly state:

*That the settling parties have considered Medicare’s future interests and have sought to protect them;*

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12 - As discussed elsewhere, Medicare’s statutory right to recover its conditional payments for the same injury which it deems as overpayments only arises when a payment is made or a TPOC is reached.


14 - A beneficiary in the near future? How near? This is unknown. If expenses are ongoing or expected in the future when the claimant is a Medicare beneficiary, then Medicare’s future interests should be addressed in the settlement.
That it is not the intention of the parties to shift to Medicare responsibility for treatment for injuries or illnesses that are the subject of the litigation;

That there has been an allocation of the settlement proceeds to be set aside for payment of anticipated future medical expenses without resort to Medicare (preferably the allocation will be spelled out in the agreement and it will have some reasonable relation to the medical records and opinions of experts);

That the claimant understands that Medicare will require the claimant to pay future medical expenses for the injury or illness from the set aside proceeds of the settlement and that the claimant will keep that portion of the settlement proceeds separate and will use it only for that purpose;

That the claimant understands that the settlement could adversely affect future proceeds from Medicare for injuries and goes forward with the settlement with that risk in mind.

Even if a claimant has not received any Medicare benefits by the time of a settlement, the best practice would be to report the settlement to CMS if there is anticipated future treatment that might occur when the claimant is Medicare eligible.

If the claimant is not Medicare eligible and no future treatment is anticipated that might occur after the claimant becomes Medicare eligible, the settlement does not need to be reported. If there is no reason to believe that a claimant might be a Medicare beneficiary, then a settlement agreement should require them to confirm that fact. It would also be wise to cover the point in deposition, interrogatories, or requests for admission.

PENALTIES

The penalty for failing to report a claim is $1000 per day, per claim. That does not seem terribly egregious until one considers what could happen if the report is more than 7 days late. The RRE would have missed its quarterly window to report, and cannot report the claim until the next one. The $1000 penalty could become a nearly $90,000 penalty, per claim, even if the error is promptly detected and the RRE attempts to comply, but cannot.

The $1000 per day penalty, unfortunately, is not the sole adverse consequence that could result. The failure to consider Medicare’s right to reimbursement of conditional (past) payments could lead to other penalties. If the claimant and/or the plaintiff’s attorney does not honor Medicare’s demand to be reimbursed for its conditional payments, Medicare can seek reimbursement from the claimant, the claimant’s attorney, the defendant, and its insurer.15 If the ratio of the settlement or judgment amount to the medical expenses paid by Medicare is high, a defendant could end up essentially paying the settlement twice. If the claim is not satisfied despite a demand and Medicare (the CMS) has to take legal action, CMS “may recover twice the amount” of the conditional payments. 42 C.F.R. section 411.24(c)(2). The statute provides that CSM has a direct right of action against any primary payer. Section 411.24(e). The section also provides that "CMS has a right of action to recover its payment from any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received a primary payment." Section 411.24(g).

With respect to conditional (past payments), a settling defendant should require the plaintiff beneficiary to settle Medicare’s claims at the same time, and put Medicare on the settlement draft. Such a step would preclude a meritorious Medicare claim against an RRE for those payments. As to future payments, CMS refuses to be specific concerning what an RRE should do to protect itself and make sure that a closed file is truly closed. The specific amount of a settlement allocation in the agreement as to future medicals must be reasonable and defensible in the event of a Medicare challenge. The claimant and the claimant’s attorney will be motivated, of course, to make any set aside as small as possible, despite their extravagant claims for future medical expenses alleged during the course of the litigation. The claimant will, obviously, also be

15 - See discussion of US v. Stricker, below.
be ready for a meaningful settlement conference or mediation, plaintiff’s counsel will have to request conditional payment information from Medicare at least 60 days before the event, as Medicare is reserving for itself 8 weeks to provide such requested information. If the Medicare request for reimbursement is over-inclusive, it may take significantly longer to resolve that complication. If plaintiff’s counsel has not worked through the process of receiving the numbers from Medicare, counsel will be unable to confer with the client and answer the all-important question: “So how much of this will I actually get?” Statutorily, Medicare is entitled to recover all of a settlement up to the amount of conditional payments, less a nominal proportionate reduction to compensate plaintiff’s counsel for the recovery from the primary payer. (The attorney’s efforts are deemed “procurement costs.”) If the settlement is less than the conditional payments, Medicare is entitled to reimbursement for the entire settlement, less a cut for plaintiff’s attorney. The claimant gets the balance.17 Medicare is not concerned with the liability aspects of a case; if an attorney

16 - See discussion in Conclusion and Exhibit “A” concerning very recent proposed legislation. (Editor’s Note: To obtain a copy of “Exhibit A”, please contact the authors of this article)

17 - 42 CFR Sections 411.24 and 411.37
settles a very thin liability case, Medicare is still entitled to reimbursement as above and is not obligated to add a liability factor discount to its claim for reimbursement in order to facilitate settlement. Once Medicare makes its demand, if the beneficiary has received a primary payment, the beneficiary or other party must reimburse Medicare within 60 days. 42 C.F.R. Section 411.24(h).

It is certainly possible that in cases involving many defendants and substantial medical expenses (an asbestos suit, for example) the plaintiff could settle with defendant after defendant after defendant and net nothing, further complicating the client control problems for plaintiff’s attorney. Some clients may be satisfied to learn that each such settlement moves the plaintiff theoretically and incrementally closer to actually netting dollar one, but others may not.

As to the issue of future Medicare payments, it is a realistic possibility that a settled defendant could be called upon many years after a settlement to defend the allocation given to future medicals. With the typical retention cycle for attorney and claims files, such a defense might well be required where there is no claims file, no defense medical report, no attorney evaluations, and no documentation concerning the settlement negotiations that led to the eventual allocation in the agreement.

Given the present amorphous nature of the scheme for addressing future payments, and the fact that a verdict or judgment is presently the only allocation Medicare has indicated a willingness to accept as binding, there may well be increased requests for partial settlement. The defendant will be asked to try just the issue of future medicals. Plaintiffs will naturally push for a written settlement agreement that minimizes or trivializes the allocation to future medicals and the obligation to set aside settlement proceeds for Medicare reimbursement. While agreeing to such terms may make settlement easier, doing so increases the chances of Medicare attacking the allocation as unreasonable and collusive, exposing the settling defendant to the possibility of having to pay substantial portions of the settlement a second time.

If Medicare becomes sufficiently efficient to quickly match up the RRE’s report with future medical bills, the CMS may take the position that it simply is not going to pay the health care providers for the services they thought they were providing to a Medicare beneficiary, further increasing the heavy burden that comes with accepting Medicare payments. There is no present mechanism for warning health care providers that a particular patient is uninsured for the treatment rendered.

### RECENT CASES OF INTEREST

There are at least two recent cases brought by the government that demonstrate Medicare is very serious about enforcing its rights under the MSP.

In *United States of America v. Harris*, USDC, ND of West Virginia, Civil Action No. 5:8CV102, 2009 U.S. Dist. Lexis 23956, filed March 26, 2009, the court determined that the plaintiff beneficiary's attorney was liable under the MSP for the conditional overpayments made by Medicare for the beneficiary's pre-settlement medical treatment.

In *Harris*, the total liability settlement was for $25,000.00, and Medicare had made conditional payments of $22,549.67. However, based upon the amount and details of the settlement, Medicare had agreed to reduce its conditional payments and demanded a payment of only $10,253.59. That amount was not paid to Medicare within the required 60-day time period under the statute, and accordingly, the government filed its complaint against the beneficiary’s attorney.

The defendant attorney filed a motion to dismiss and argued that a lawyer, in representing a client, cannot be individually liable under 42 U.S.C. section 1395y(b)(2) when he or she distributes settlement funds to the clients. The district court disagreed with the argument, and on November 13, 2008, issued an order denying the defendant’s motion to dismiss.
In its decision, the district court discussed the MSP extensively and Medicare's right to recover from any entity that had received a primary payment, including an attorney. Accordingly, attorneys should beware. Also, while the Harris case involved only recovery of conditional payments, it should be noted that the failure to adequately consider and protect Medicare's future interests may, likewise, result in liability for an attorney or an RRE, as illustrated in the next case.

In United States v. Stricker, et al., USDC, ND of Alabama, Civil Action No. CV-09-PT-2423-E, filed in December of 2009, the United States on behalf of the CMS and the Secretary of Health and Human Services, initiated a lawsuit against the defendant corporations, their insurers, the plaintiffs, and the plaintiffs' counsel to obtain recovery for conditional payments made pursuant to the MSP. While prior lawsuits such as Harris discussed above, have generally sought reimbursement from plaintiffs or plaintiffs' counsel for failure to repay Medicare, the Stricker case is slightly different in that it is the first case which seeks reimbursement, in a single action, from all parties subject to MSP reimbursement obligation, including the insureds, their liability insurers and the plaintiffs' counsel.

In Stricker, the plaintiffs had settled their liability case against the defendant corporations in 2003 for approximately $300 million. The complaint filed by the government alleges that none of the 907 Medicare beneficiary plaintiffs reimbursed Medicare as they were legally obligated to do. Likewise, neither the plaintiffs' attorneys, the defendant corporations, nor their insurers investigated Medicare's potential claims, notified Medicare of the settlement, or reimbursed Medicare for its conditional payments made to the beneficiaries. Consequently, just before the statute of limitations expired, the government initiated suit against all parties for double the amount of the outstanding liens.

Of note, in Stricker, in addition to seeking conditional payments, interest and penalties, the government is requesting that "the defendants must give CMS notice of all future payments to Medicare beneficiaries pursuant to 42 C.F.R. section 411.25; and, that all defendants must ensure before any future settlement payment is made to any claimant that appropriate payment is made to the United States." Clearly, the government claim in Stricker seeks to establish a right to proceed against the liability insurers for both pre and post-settlement Medicare expenses. This is a dramatic move from the traditional approach to post-settlement exposure of liability insurers and could be an omen of future government actions. The final decision in the Stricker case may have far reaching effects on liability insurers and their settlements with Medicare beneficiaries.

STATUTORY RESOURCES


The implementation scheme for Medicare’s recovery of conditional payments is contained in the Code of Federal Regulations at 42 C.F.R. section 411.20 et seq. For example, section 411.21 defines key terms such as "conditional payment" and "primary payer," among others. The reimbursement obligations of primary payers and beneficiaries are set forth in section 411.22. A beneficiary must cooperate in CMS's actions to recover conditional payments. 42 C.F.R. section 411.23. The rules for recovery of conditional payments are contained in section 411.24. This section provides, among other things, that Medicare may proceed against primary payers and may recover up to double the amount if it has to file a suit to collect. Finally, section 411.37 describes the amount of a Medicare recovery when a primary payment is made as a result of a judgment or settlement and CMS sues the party (beneficiary) receiving payment.
CONCLUSION

As the foregoing discussion demonstrates, implementation of the new rules relating to the MSP has made settling cases with Medicare beneficiaries a more challenging and difficult process. Settlements will take longer and require the earnest cooperation of all parties to avoid running afoul of Medicare’s enforcement provisions. The attorneys for both sides will have to engage in more leg work and information gathering to prepare for settlement. Without clear guidance from the CMS, the parties and their attorneys will have to do their best to account for consideration of Medicare’s interests in any settlement agreement.

However, with all of this being said, there is hope on the horizon for some clarification of the parties’ responsibilities in satisfying Medicare’s interests. As this article was being completed, the authors received word that a bill, H.R. 4796, has been introduced in the House of Representatives. The announced purpose of H.R. 4796 is to amend Title XVIII of the Social Security Act with respect to the application of Medicare secondary payer rules for certain claims. Based on a quick review, the bill, among other things, provides for: a calculation process for repayment of past conditional payments; establishing thresholds for reporting claims; establishing reporting requirement safe harbors; limiting the obligation of RREs to report beneficiary SSNs or HICNs; and establishing a three-year statute of limitations on any enforcement action brought by the government. Clearly, if the proposed bill is adopted, the prospect for successful settlements with a high degree of certainty will be considerably improved.

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18 - A copy of H.R. 4796 is attached as Exhibit "A". (Editor’s Note: To obtain a copy of “Exhibit A”, please contact the authors of this article)
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