

## TRANSPORTATION Update

**A regular publication of the ALFA International Transportation Practice Group**

ALFA International Transportation Practice Group Reports from around the country concerning Legislation, Regulations and Decisions of Interest.

**EDITORS' NOTEPAD**

The Transportation Practice Group of ALFA International has published the *Transportation Update* for about twenty years. 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@alfa-international.com](mailto:kgarcia@alfa-international.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.<sup>1</sup> 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. In addition, we are beginning a multi-issue accumulation of all verdicts listed here in the last five years. In the future we will do this in our Spring issue from the previous year. The **Practice Tips** section of the Update features articles which address matters of practical



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<sup>1</sup> 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.

interest to those who manage litigation for motor carriers and those who represent them. The essays in this section generally have widespread application throughout the country. **Articles** provide in depth analysis of issues, developments, and concerns that are relevant to the transportation industry.

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## FUTURE EVENTS

Each year, the Transportation Practice Group of ALFA International presents a multi-day seminar for members of the Trucking Industry. The 2010 Transportation Seminar will be held Marco Island, Florida at the Marriott Beach Resort from April 28, 2010 to April 30, 2010. The official web site of this venue is <http://marcoislandmarriott.com>. On the site, the web cam tool is particularly useful. The golf course and the beach are beautiful.



Both beach lovers and golf lovers will be delighted with this wonderful facility. Our Program Chair for the 2010 seminar is **P. Clark Aspy** of Naman, Howell, Smith & Lee, LLP, who can be reached at (512) 479-0300 and [aspy@namanhowell.com](mailto:aspy@namanhowell.com). If you have a topic that you would like to suggest, please contact Clark Aspy by email or phone.

The Chairman of the Transportation Practice Group for 2009-2010 is Danny M. Needham of Mullin Hoard & Brown, LLP, Amarillo, Texas, who can be reached at (806) 372-5050 and [dmneedham@mhba.com](mailto:dmneedham@mhba.com). Our Vice-Chair is Peter Doody of Higgs, Fletcher & Mack, LLP, San Diego, California, who can be reached at (619) 236-1551 and [doody@higgslaw.com](mailto:doody@higgslaw.com). Our Chair Emeritus is Paul T. Yarbrough of Butt Thornton

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For more information, please also consider contacting Katie Garcia at [kgarcia@alfainternational.com](mailto:kgarcia@alfainternational.com).

## **ALFA'S GO TEAM HOTLINE**

The ALFA Transportation Practice Group now presents a new service for its transportation clients. The **ALFA Go Team Hotline**. ALFA knows that its 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 1-866-540-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, **1-866-540-ALFA (2532)**.

## **FUTURE ISSUES OF TRANSPORTATION UPDATE**

The Summer 2010 issue of *Transportation Update* will be published in July, 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

### FEDERAL - US SUPREME COURT

#### *Where is Your Nerve Center? Establishing Corporate Jurisdiction in Federal Courts*

In February 2010, the United States Supreme Court issued a unanimous decision that clarifies a corporation's state of jurisdiction in the federal courts. *Hertz Corp. v. Friend, et al.*, No. 08-1107, 2010 WL 605601 (U.S. February 23, 2010). The Court announced a simple test: The "principal place of business" shall be the corporation's "nerve center" which is typically its headquarters. *Id.* at \*11.

Essentially "headquarters" can be construed to mean the place where a corporation's high level officers direct, control, and coordinate the corporation's activities. *Id.* The Court instructed all Federal Appellate Circuits to begin employing this "nerve center" test.

This is good news for corporations because it should reduce the amount of discovery necessary to establish a corporation's "principal place of business" under the diversity jurisdiction statute. See *28 U.S.C. §1332(c)(1)*. The

diversity statute states that "a corporation shall be deemed to be a citizen of any State by which it has been incorporated *and of the State where it has its principal place of business.*" *Id.* (emphasis added).

A corporation is still a citizen of any State by which it has been incorporated, but the Court clarified what is meant by a corporation's "principal place of business." In 1959, Congress codified a version of the current diversity jurisdiction statute containing the "principal place of business" language. Since that time, the Federal Appellate Circuits have applied many different tests to determine a corporation's "principal place of business." The circuits' different tests have created a conflict between circuits. The courts combined the factors involved in the "nerve center" and "business activity" tests to evaluate a corporation's "total activities."

The Ninth Circuit, from which the *Hertz* case originated, employed a test that analyzed the "substantial predominance" of a corporation's activities within a state. The Eighth Circuit applied a "total activity" test which analyzed the company's purpose, type of business, and place of operations. Several other circuits used variations of this test. The Third Circuit evaluated the "center of corporate activity." *Hertz* at \*10. Amid all of these

various tests, the Court chose the Seventh Circuit's "nerve center" approach because of its simplicity and identification of "one" place in a state. *Id.* at \*11-13.

The Court cautioned that the burden of persuasion for establishing diversity jurisdiction remains on the party asserting it. *Id.* at \*14. However, a corporation must produce proof of its "principal place of business" only when challenged. The corporation will still need to demonstrate that its headquarters is the place where actual direction, control, and coordination occur.

A corporation cannot simply submit an SEC filing form identifying its headquarters as the nerve center. *Id.* The corporation must provide proof with sworn executive affidavits to the location of the headquarters or "nerve center." Upon a showing that a corporation has deceived by creating a "nerve center" such as an executive retreat location, the courts will instead reexamine the corporation's principal place of business by determining where direction, coordination, and control actually occur.

This ruling effectively eliminates the various tests employed by the different circuits and establishes a single test for the determination of a corporation's

“principal place of business.”  
The “nerve center” test should make determining diversity jurisdiction less complicated for the courts and less burdensome for the litigants.



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## FEDERAL - 4TH CIRCUIT COURT

### *Fourth Circuit Adopts Last-Served Defendant Rule*

Section 1446(b) of Chapter 28 of the U.S. Code provides the statutory basis for removal jurisdiction:

The notice of removal of a civil action or proceeding shall be filed within thirty days after the receipt by the defendant, through service or otherwise, of a copy of the initial pleading setting forth the claim for relief upon which such action or proceeding is based, or within thirty days after service of summons upon the defendant if such initial pleading has then been filed in court and is not required to be served on the defendant, whichever period is shorter.

28 U.S.C. § 1446(b). The statute does not explicitly address the timeliness of removal in cases involving multiple defendants. As such, some circuits have held that if the first served defendant chooses not to remove the case or fails to timely remove the case, later served defendants are barred from removal. See e.g. *Getty Oil Corp. v. Insurance Co. of North America*, 841 F.2d 1254 (5th Cir. 1988). This became known as the “first-served defendant” rule.

In *McKinney v. Bd. of Tr. of Mayland Cmty. Coll.*, 955 F.2d 924 (4th Cir. 1992), the Fourth Circuit Court of Appeals touched upon the issue of the timeliness of removal in multiple defendant cases with a footnote in which it seemed to adopt

the first-served defendant rule. See *McKinney*, 955 F.2d at 926 n.3. However, the *McKinney* rule was considered dicta by many of the district courts in the Fourth Circuit. See, e.g., *Guyon v. Basso*, 403 F.Supp.2d 502, 508 (E.D. Va. 2005); *Ratliff v. Workman*, 274 F.Supp.2d 783, 787 (S.D.W.Va. 2003); *Superior Painting & Contracting Co. v. Walton Tech, Inc.*, 207 F.Supp.2d 391, 393 n.4 (D.Md. 2002).

In *Barbour v. International Union*, 594 F.3d 315 (4th Cir. 2010), the Fourth Circuit Court of Appeals directly addressed the issue of the timeliness of removal in a multiple defendant case and joined with the Sixth, Eighth and Eleventh Circuits by adopting the “last-served defendant” rule. See *Barbour v. International Union*, 594 F.3d 315, 326 (4th Cir. 2010). Under this rule, in cases involving multiple defendants, each defendant, once served with formal process, has thirty days to file a notice of removal pursuant to 28 U.S.C. § 1446(b) in which earlier-served defendants may join regardless of whether they have previously filed a notice of removal. *Id.* at 326. *Barbour* involved multiple defendants who were served with process at different times. *Id.* at 324. The first defendant did not file a notice of removal within 30 days after it was served, but instead, joined in the second defendant’s notice of removal, which was filed within 30 days of the date the second defendant was served. *Id.* The district court refused to apply the first-served defendant rule and instead, held that the notice of removal was timely. The Fourth Circuit held that *McKinney’s* first-served defendant rule was non-binding

dicta and therefore, was not controlling. *Id.* at 326. The court determined that the last-served defendant rule more closely matched Congress’ equitable intent in enacting 28 U.S.C. § 1446, since the rule did not put subsequently served defendants at the mercy of previously served defendants. *Id.*



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## FEDERAL - 8TH CIRCUIT COURT

### *Cat and Mouse Game: Not The Proximate Cause of a Rear End Collision*

The Eighth Circuit Court of Appeals has affirmed summary judgment in favor of a common carrier involved in a rear end accident. The plaintiff was a passenger in a tractor-trailer that rear-ended a Teton Transportation, Inc. tractor-trailer driven by Tony Johnston. The accident happened on an Interstate while the road was being re-striped. Another defendant, Swanston Equipment Company was operating a pickup truck traveling slowly on the left shoulder of the highway and displaying a sign that read "Left Lane Closed Ahead." Mr. Johnston slowed his truck, and when the vehicle immediately in front of him came to a sudden stop, he applied his brakes and stopped about ten feet behind it. The plaintiff's tractor-trailer then collided with the back of the Teton trailer. The plaintiff, relying on Mr. Johnston's deposition testimony, argued that Teton contributed to the collision by engaging in a "cat-and-mouse game." Johnston testified that the two trucks had traveled together for sometime before the collision occurred. Johnston further declared that, during this time period, plaintiff's tractor-trailer had tried to pass Johnston's tractor-trailer about five times and attempted to engage another driver to assist him in getting around Johnston. However, Johnston did not allow him to pass and admitted to slightly exceeding

the speed limit to prevent the plaintiff's tractor-trailer from passing him.

The Eighth Circuit affirmed the district court's entry of summary judgment for Teton. The district court reasoned that while the "cat and mouse game" was part of the evidence; it was not the proximate cause of Mr. Huggins' injuries.

The Eighth Circuit reversed the district court's judgment in favor of FedEx Ground Package System, Inc. and found that a factual question existed as to the amount of control FedEx exerted over these drivers whose direct employer was, allegedly, an independent contractor. *Huggins v. FedEx Ground Packaging System, Inc.; Teton, Inc.; Swanston Equipment Company*, No. 09-3144 (8th Cir. Jan. 19, 2010) Teton Transportation Inc. was represented by St. Louis ALFA lawyer Joseph R. Swift.



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## GEORGIA

### *Georgia's Personal Injury Statute of Limitation is Turned on Its Head*

The Georgia Supreme Court recently issued a ruling that will dramatically affect the statute of limitation in personal injury cases, and specifically motor vehicle accidents, based on its interpretation of Georgia Statute O.C.G.A. § 9-3-99. In *Beneke v. Parker*, the Supreme Court determined that a traffic citation for following too closely constituted a “crime” so as to toll the statute of limitation in a motor vehicle accident, until the prosecution of the traffic citation became “final.” 285 Ga. 733, 734-35, 684 S.E.2d 243 (2009). This holding creates different triggering dates for the statute of limitation in every motor vehicle accident that results in the issuance of a traffic citation to one or more of the parties involved, and is especially of interest to a motor carrier, whose defense of personal injury actions often involve a citation being issued to its driver.

The Georgia personal injury statute of limitation requires that all claims for personal injuries must be brought within two years from the date the cause of action accrues. O.C.G.A. § 9-3-33. The cause of action typically “accrues” in motor vehicle accidents on the date of the plaintiff’s injury, which is most always the date of the accident. In *Beneke*, the plaintiff was injured on April 27, 2005, when the vehicle in which she was a passenger was

struck by the vehicle driven by the defendant. 285 Ga. at 733. The defendant received a traffic citation for following too closely in connection with the accident. *Id.*

Under the Georgia personal injury statute of limitation, the plaintiff was required to file her complaint on or before April 27, 2007, or so it was believed. However, the plaintiff did not file her complaint until May 11, 2007. The defendant answered and thereafter filed a motion for summary judgment on the grounds that the plaintiff’s complaint was time-barred by the statute of limitation. *Id.* The trial court initially granted the defendant’s motion for summary judgment, but later denied summary judgment on a motion for reconsideration, relying on a fairly new and somewhat obscure tolling provision of O.C.G.A. § 9-3-99. *Id.* at 733-34.

O.C.G.A. § 9-3-99, which became effective on July 1, 2005, tolls tort statutes of limitation when the basis of the tort involves or arises out of a “crime,” and provides as follows:

The running of the period of limitations with respect to any cause of action in tort that may be brought by the victim of an alleged crime which arises out of the facts and circumstances relating to the commission of such alleged crime committed in this state **shall be tolled from the date of the commission of the alleged crime or act giving rise to such action in tort until the prosecution of such crime or act has become final** or otherwise terminated, provided that such time does not exceed six years.

O.C.G.A. § 9-3-99 (emphasis added).

On appeal, the Georgia Court of Appeals affirmed the trial court’s denial of summary judgment to the defendant, but vacated the trial court’s determination that the defendant had actually committed a crime as a matter of law, which the trial court found triggered the tolling provisions of O.C.G.A. § 9-3-99. *Id.* at 734; and *Beneke v. Parker*, 293 Ga. App. 186, 189-90, 667 S.E.2d 97 (2008). The Court of Appeals held that the question of whether the defendant committed the crime as a matter of law to toll the statute of limitation under O.C.G.A. § 9-3-99 was one for the jury. *Beneke*, 293 Ga. App. at 189.

The Georgia Supreme Court first affirmed the Georgia Court of Appeals’ affirmation of the denial of summary judgment, agreeing that the rules of statutory construction require a finding that the term “crime” in O.C.G.A. § 9-3-99 must encompass violations of the Rules of the Road, such as following too closely, as there is no distinction between felony crimes or misdemeanor crimes (such as traffic citations) in the plain reading of O.C.G.A. § 9-3-99. *Beneke*, 285 Ga. at 734. However, the Georgia Supreme Court reversed the Court of Appeals’ ruling that the jury should decide whether the defendant committed the alleged crime as a matter of law: “no factual determination need be made as to whether [the defendant] acted with criminal intent or criminal

negligence. i.e., whether his violation [of the following too closely statute] constituted a crime . . . in order to apply O.C.G.A. § 9-3-99 here.” *Id.*

The Georgia Supreme Court recognized the effect that its holding will have on personal injury litigation arising from motor vehicle accidents:

Like the Court of Appeals, we recognize that our holding in this case will have a significant impact on personal injury actions arising out of vehicle accidents by tolling the statute of limitation in these situations where a traffic citation is issued. Nonetheless, we are constrained by the language of the statute to reach this result. If the Legislature had intended to limit the application of O.C.G.A. § 9-3-99 to tort actions arising from only certain types of crimes, e.g., felonies or specific intent crimes, it certainly could have done so. It did not, and any undesirable result is a matter properly addressed by the General Assembly rather than the courts.

*Id.* at 735 (internal citations omitted).

In conclusion, in those motor vehicle accident cases involving a motor carrier where the truck driver has received a traffic citation in Georgia, it will be difficult, at least initially, for the motor carrier, its insurer, and defense attorneys to determine the date on which the statute of limitation will or has run. Motor carriers operating in Georgia should be especially cognizant of monitoring the handling and/

or disposition of its driver’s traffic citations in order to determine the proper date upon which the statute of limitation has expired or will expire.



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## ILLINOIS

### *Leasing Company Liability and Expert Testimony Regarding Preventability*

The First District Illinois Appellate Court, in *U.S. Bank v. Lindsey*, recently held that a leasing company was not immune for the negligence of the truck's driver, instead ruling that it was vicariously liable under the "logo liability" doctrine. *U.S. Bank v. Lindsey*, 2009 Ill. App. LEXIS 1186 (1st Dist. Dec. 7, 2009). In addition, the court in *Lindsey* ruled that expert testimony that the accident was "preventable" was properly admitted into evidence at trial.

In *Lindsey*, the defendant/driver Harold Lindsey worked for Open Kitchens, a food delivery company. On the date of the accident, he was driving a truck leased to Open Kitchens from Carmichael Leasing Company, Inc., which owned the vehicle. The decedent Willie Taylor was also employed as a helper for Open Kitchens. While Mr. Taylor was working loading and unloading trucks that were delivering milk, Mr. Lindsey accidentally backed his truck into Mr. Taylor, crushing him between it and another parked truck

During trial, the plaintiff called an expert in motor fleet safety, who testified that the Carmichael truck was subject to federal regulations that required Mr. Lindsey to be qualified and trained to possess a commercial driver's license. He further testified to the minimum safety

standards, federal regulations and industry standards, and opined Mr. Lindsey did not meet minimum training requirements, nor did he possess the necessary technical knowledge to properly maintain his vehicle or to safely operate it. He further opined that the accident could have been prevented had Mr. Lindsey: (1) avoided backing up his truck altogether; (2) planned a better route; (3) exited the truck to inspect the area behind it before backing up; or (4) waited for the other parked truck to leave before backing up.

The jury eventually returned a verdict for \$3 million in favor of the plaintiff. The defendant Carmichael appealed, arguing, among other things, that it was entitled to judgment notwithstanding the verdict because Mr. Lindsey was immune from liability for his negligence by operation of the Workers' Compensation Act and that Carmichael could not be vicariously liable for Mr. Taylor's injury and death. Carmichael also alleged on appeal that the trial court's admission of evidence that the accident was preventable constituted reversible error.

With respect to Carmichael's claim that it was immune from liability due to the operation of the exclusive remedy provided by the Illinois Workers' Compensation Act, the court recognized that the evidence was undisputed that both the defendant and decedent were employees of Open Kitchens. Therefore, Mr. Lindsey and Open Kitchens were immune from liability pursuant to the Workers' Compensation Act.

This however, did not mean that Carmichael might not be held responsible for the negligent acts Mr. Lindsey. Because the Illinois Workers' Compensation Act expressly permits an injured employee to seek recovery for damages from another party in instances when compensation is required under the Act, the Court held that Carmichael was not necessarily immune from the imposition of liability.

The court recognized the "well-established line" of Illinois case law<sup>2</sup> holding that interstate carriers operating pursuant to a grant of authority evidenced by an Interstate Commerce Commission license number and a company name displayed on a truck are vicariously liable for the negligent actions of their drivers. Thus, even though Carmichael was not the lessee in this instance, the facts that it owned the truck that Mr. Lindsey was operating and that the truck bore both Carmichael's ICC number and corporate name were enough for the court to impose vicarious liability upon Carmichael for Mr. Lindsey's actions. Therefore, the Illinois Appellate Court upheld the circuit court's denial of its motion for judgment *n.o.v.*

With regard to Carmichael's argument that the testimony pertaining to the accident's preventability was improper, the court, without much in the way of a detailed explication, thought otherwise. It simply

<sup>2</sup> - *Schedler v. Rowley Interstate Transp. Co.*, 68 Ill. 2d 7, 368 N.E.2d 1287 (1977); *Kreider Truck Service, Inc. v. Augustine*, 76 Ill. 2d 535, 394 N.E.2d 1179 (1979); and *Fulton v. Terra Cotta Truck Service, Inc.*, 266 Ill. App. 3d 609, 639 N.E.2d 1380 (1st Dist. 1994)

held that the testimony in this vein was merely elicited to establish liability, as it advised the jury as to the recognizable risk of Mr. Lindsey's conduct and provided a basis for concluding that the harm flowing from the consummation of that risk was reasonably preventable. *Lindsay*, 2009 Ill. App. LEXIS 1186, \* 43, citing *Heiden v. Cummings*, 337 Ill. App. 3d 584, 587, 786 N.E.2d 240, 242-243 (2d Dist. 2008) (Wherein the court affirmed a judgment for a defendant golfer sued by another golfer seeking to recover for alleged personal injuries suffered when she was struck by his stray ball.)

The court further held that even if the testimony was improperly admitted, it did not necessarily constitute grounds for reversal if there was sufficient competent evidence to support the ruling. Because the evidence of Mr. Lindsey's negligence was thought to be overwhelming, even without Mr. Atkinson's testimony as to the accident's preventability, the alleged error was held to not have prejudiced Carmichael or have affected the outcome. Therefore, reversal was not warranted.

It should be noted that the Illinois District Court, in construing Illinois negligence principals, has held that such evidence of preventability may be properly excluded pursuant to the probative versus prejudicial analysis set forth by Federal Rule of Evidence 403. *Villalba v. Consolidated Freightways Corp.*, 2000 U.S. Dist. LEXIS 11773 (N.D. Ill. Aug. 10, 2000).

In *Villalba*, the defendant made an internal finding that the complained-of accident was preventable, and its rules were modeled after those promulgated by the National Safety Council. The National Safety Council defines a preventable accident as one in which the driver failed to do everything that reasonably could have been done to avoid an accident.<sup>3</sup> It further states that this preventability standard is not solely based on or determined by legal liability. In contrast, Illinois' negligence standard is defined as a failure to do something which a reasonably careful person would do, or the doing of something which a reasonably careful person would not do, under circumstances similar to those shown by the evidence.

Because the standard for determining preventability and the standard for determining negligence under Illinois law are not necessarily the same, the court in *Villalba* held that these two differing standards may serve to only confuse and mislead the jury. Therefore, the evidence that the accident was preventable was properly excluded. Because the probative value of such evidence was not discussed by the court in *Lindsey*, it is unclear as to whether or not such an argument was made or brought to its attention.

From the above, one can see that the imposition of "logo liability" can have serious

<sup>3</sup> - It should be noted that the Federal Motor Carrier Safety Regulations also define what constitutes a "preventable accident," stating that it is an accident (1) that involved a commercial motor vehicle, and (2) that could have been averted but for an act, or failure to act, by the motor carrier of the driver. See 49 C.F.R. 385.3

implications for third-parties such as leasing companies. Its risk management policies should be adjusted accordingly. With respect to the potential introduction of whether or not an accident was "preventable" at trial, one may be well-served in arguing that the introduction of such evidence will only serve to obfuscate the issues and prejudice the jury, rather than present issues of negligence in a fair light.



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## KANSAS

### *I'm Still Standing – Kansas' Statutory Cap on Noneconomic Damages Upheld by the Kansas Court of Appeals As Other States Deem Similar Statutes Unconstitutional*

There has been a flurry of activity already this year with respect to the constitutionality of statutes limiting noneconomic damage awards, with each month bringing a new decision on the issue. In January, Kansas upheld two statutes which limit noneconomic damages to \$250,000.00. In *McGinnes v. Wesley Medical Center*, 224 P.3d 581 (Kan.App.2010), the plaintiffs filed suit following the death of a 38 year-old man who was admitted to the hospital with gastrointestinal discomfort, but died a few days later following complications resulting from an endoscopic retrograde cholangiopancreatography (ERCP). Following trial, the jury awarded plaintiffs \$2,000,000.00, which award was comprised of \$1,000,000.00 for conscious pain and suffering and \$250,000.00 for past noneconomic loss, future noneconomic loss, past economic loss, and future economic loss. The award was subsequently reduced to \$1,000,000.00 by the trial court pursuant to Kansas' statutory caps on damages.

The two statutes at issue in *McGinnes*, K.S.A. 60-19a02 and 60-1903, limited "nonpecuniary" loss in personal injury actions and "noneconomic" loss

in wrongful death actions to \$250,000.00. Under both statutes, the court cannot instruct the jury on the statutory caps but must subsequently revise any award in excess of the caps.

The plaintiffs in *McGinnes* first challenged the procedure undertaken by the defendants, asserting that the limits of the statutory caps must be pled as an affirmative defense or be pled in avoidance. The Kansas Court of Appeals disagreed, noting that the language of the statute makes the application of the caps mandatory and that the duty to enforce the caps was on the trial court, not the parties.

The plaintiffs then challenged the constitutionality of the caps, claiming the caps violated their right to trial by jury under the Kansas Constitution, their right to remedy by due course under section 18 of the Kansas Constitution's Bill of Rights, their equal protection rights under the Kansas Constitution, and the Separation of Powers doctrine. This, of course, was not the first challenge to the constitutionality of the statutory caps, and in upholding their constitutionality, the Kansas Court of Appeals followed prior precedent from the Kansas Supreme Court. See *Leiker v. Gafford*, 245 Kan. 325 (1989), *disapproved in part on other grounds, Martindale v. Tenny*, 250 Kan. 621, 628-29, 829 P.2d 561 (1992) (upholding the constitutionality of K.S.A. 60-1903) and *Samsel v. Wheeler Transport Services, Inc.*, 246 Kan. 336, 789 P.2d 541 (1990) (upholding the constitutionality of K.S.A. 60-19a02). In *McGinnes*, unlike the cases discussed

below, the court deferred to the legislature, noting that although harsh in some cases, under proper circumstances the legislature could limit the recovery of noneconomic losses.

Subsequently, two other states have found similar statutes unconstitutional. In February, the Illinois Supreme Court, in *Lebron v. Gottlieb Memorial Hosp.*, 2010 WL 375190 (Ill. Feb. 04, 2010), concluded that 735 ILCS 5/2-1706.5(a), which limited noneconomic damages in medical malpractice cases to \$500,000.00 or \$1,000,000.00, depending on the entity sued, was unconstitutional because it violated the separation of powers clause of the Illinois Constitution. In so ruling, the court questioned *any* statute that requires a court to reduce a jury's award of noneconomic damages to a predetermined limit.

And in March, the Georgia Supreme Court held that O.C.G.A. 51-13-1, which limited noneconomic damages in medical malpractice actions to \$350,000.00, was unconstitutional. In *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 2010 WL 1004996 (Ga. March 22, 2010), the court concluded that the "very existence of the caps, in any amount, is violative of the right to trial by jury" guaranteed by the Georgia Constitution. One day after the Georgia Supreme Court filed its opinion, the Missouri Supreme Court side-stepped the issue in *Klotz v. St. Anthony's Medical Center*, 2010 WL 1049422 (Mo. March 23, 2010). However, two justices who submitted concurring

opinions said that the statute, which limited noneconomic damages against health care providers to \$350,000.00, violated the right to trial by jury and the equal protection clauses of the Missouri Constitution. In addition to these opinions, there is still at least one state (Mississippi) with a case pending which opinion should be filed by the end of the year. However, due to the recent push for health care reform and the ever-present issue of tort reform, the constitutionality of statutory caps will undoubtedly remain a hot button issue for some time.



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## KANSAS

### *Update on Negligent Entrustment and Negligent Hiring, Retention, and Supervision Claims in Kansas.*

In *Stallings v. Werner Enterprises, Inc.*, 598 F.Supp.2d 1203 (D. Kan. 2009), a motorist injured in a motor vehicle collision sued the operator of a tractor-trailer that allegedly ran into the back of the motorist's minivan and the company with whom the driver (an owner/operator) was employed for negligent vehicle operation and negligent hiring, retention, and entrustment of the commercial motor vehicle, respectively. *Id.* at 1205. The court denied the defendant trucking company's motion for summary judgment on the motorist's claims for negligent hiring and retention, and negligent entrustment but found that the trucking company was not liable for punitive damages under Kansas law. *Id.* at 1208, 1212-13, 1215-16. This case was initially reported as a decision of interest in the Spring 2009 ALFA Transportation Update, but it focused on the issues of right of control of a leased vehicle and its owner-operator and on the issues of liability of derivative negligence claims against an admittedly vicariously liable employee for the acts and omissions of its employee. This update expands on the prior analysis to include a discussion of the application of *Stallings* on the issues of negligent hiring, training, supervision, and retention in the recent case of *Chubb v. Ryder Integrated Logistics, Inc.*, Case No. 07-CV-

05397 in the District Court of Johnson County, Kansas.

In analyzing the motorist's claims for negligent hiring and retention in *Stallings*, the federal district court there found that even if the trucking company's investigation and hiring of its driver did not violate the requirements of the Federal Motor Carrier Safety Regulations ("FMCSR"), a jury could find that the trucking company breached its common law duty to use reasonable care in the selection of its agents because it was aware of the history of accidents and violations by the driver from which it should have known that his employment as a truck driver would create an undue risk of harm. *Stallings*, 598 F.Supp.2d at 1212-13.

In *Chubb v. Ryder Integrated Logistics, Inc.*, following a collision in which the driver of a car was killed as a result of a collision between the decedent's car and a tractor-trailer owned by Ryder Integrated Logistics, Inc. ("Ryder") and driven by its leased driver, the plaintiffs filed a cause of action against Ryder alleging, *inter alia*, negligence in the hiring, retention, supervision, education, training, and instruction of that leased driver on the reasonable, safe operation of Ryder's tractor-trailers. Ryder moved for partial summary judgment on the plaintiffs' claims of negligent hiring, retention, supervision, education, training, and instruction because there was no evidence that the driver had a known propensity such that Ryder had a reason to believe that an undue risk of harm existed to others as a result of the contract leasing of the driver, and there was no evidence that

Ryder had failed to comply with the FMCSR's when it leased the driver from the leasing company.

The plaintiffs, in response, attempted to use the federal court's holding in *Stallings* to support the proposition that Ryder was negligent in the hiring and retention of its driver despite the lack of evidence that Ryder violated the requirements of the FMCSR's in the hiring and retention of its driver. The state trial court found, however, that *Stallings* was in stark contrast to the case at bar because the plaintiffs' failed to present any evidence establishing a genuine issue of material fact as to what Ryder should have known that made its driver either unfit or unqualified to drive a commercial motor vehicle (i.e. a tractor-trailer). In other words, there was no driving history on the part of the leased driver that would or should have caused Ryder to decline hiring or retaining him and no evidence of requisite training that he should have had but did not. Thus, the court found that Ryder was entitled to judgment as a matter of law on plaintiffs' claims of negligent hiring, training and retention.

The application of *Stallings* in *Chubb* is important because it demonstrates that even if the trucking company's investigation and hiring of its driver did not violate the requirements of the FMCSR's, the plaintiffs are proceeding under the common law theory that a trucking company may be liable for negligent entrustment and negligent hiring, training, supervision, and retention if

it breaches its duty to use reasonable care in the selection of its agents or employees because it was aware of the history of accidents and other violations by the driver, or the driver's lack of training or inadequate supervision, from which it should have known that employing (or continuing to employ) the driver could have created an undue risk of harm. The key is knowledge or awareness of any propensity that would create an undue risk of harm. Thus, the defendant transportation companies should be prepared to defend against future claims by plaintiffs brought under the common law theories advanced by plaintiff in *Stallings and Chubb*.



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## KENTUCKY

*Dortch vs. Con-Way Transportation and Fowler*, 588 F.3d.396, 81 Fed.R.Evid.Serv.193, 6th Cir. 2010, decided and filed November 30, 2009, Rehearing and Rehearing *En Banc* denied January 28, 2010

This case was tried in September 2007 for two weeks to a defense verdict by Will Fulton and Craig York of Dinsmore & Shohl, LLP's Louisville office. The plaintiff had numerous serious orthopedic injuries and a mild to moderate brain injury as a result of crossing the center line and striking Con-Way's local delivery tractor trailer, left front to left front.

The plaintiffs raised a number of issues on appeal to the United States Court of Appeals for the Sixth Circuit. One of the issues raised was that the court ruled *in limine* that the plaintiff could not cross-examine on a rather confusing issue. The investigating police officer pointed to a series of deep gouges beginning in the Con-Way truck's lane and running to the left front of plaintiffs' Explorer, as having been all caused by the Explorer post-impact. The police officer identified the gouge as first starting in the Con-Way truck's lane and denominated the initial gouge as the area of impact. While the plaintiff's expert agreed those marks were made as a result of the accident, he found an isolated gouge in the plaintiff's lane which he testified showed the real area of impact. The jury chose not to believe him.

The accident was in a curve that had dozens of accidents each year. Counsel for Conway were able to get five years of police reports of accidents which happened in the immediate vicinity of the Dortch wreck. Unfortunately, the police only took photos in two accidents and they were not close enough to the Dortch accident to be of benefit. The plaintiff's counsel wanted to cross-examine Conway's experts to establish that they could not find the gouge in Ms. Dortch's lane with any of the prior accidents. The Magistrate Judge, sitting as trial judge at the request of the parties, refused to allow the cross-examination on the grounds that it did not begin to establish that the gouge in the plaintiff's lane was made in the accident.

On appeal, the Sixth Circuit determined by a 2-to-1 vote that the existence of the search for prior accidents was relevant, with Judge Ronald Lee Gillman writing and Justice Sandra Day O'Connor, sitting by designation. Judge Julia Smith Gibbons wrote a concurring opinion disagreeing that the evidence was relevant under Federal Rule of Evidence Rule 403, which was argued by Conway's counsel before both Judge Moyer and the Sixth Circuit. She grounded this on her view that "the probative value of the evidence was slight and its potential for prejudice in jury confusion significant." 588 F.3d. 396 at 406.

The Sixth Circuit went on to determine that, even though the evidence of the search of other accidents was relevant, the decision of Judge Moyer to

disallow the cross-examination was harmless error.

In reaching this conclusion, the panel followed a standard the Sixth Circuit first articulated in *Morales v. Am. Honda Motor Co.*, 151 F.3d 500, 514 (6th Cir.1998):

We will reverse the district court only if we find that "the abuse of discretion caused more than harmless error." *Tompkin v. Philip Morris USA, Inc.*, 362 F.3d 882, 897 (6th Cir.2004). "Even if a mistake has been made regarding the admission or exclusion of evidence, a new trial will not be granted unless the evidence would have caused a different outcome at trial." *Morales v. Am. Honda Motor Co.*, 151 F.3d 500, 514 (6th Cir.1998).

This standard is not followed by all Circuits. One panel of the Sixth Circuit has refused to follow this standard but eleven separate panels of the Sixth Circuit have followed the standard. Mrs. Dortch's lawyers chose to file on this issue alone a Petition for Rehearing *En Banc*. Nevertheless, due to the uniformity of the Sixth Circuit's rulings in this case, the polling of the current sitting judges of the Sixth Circuit on whether to allow a Petition for Rehearing *En Banc* on this issue was unanimously to deny the petition.

On appeal, the plaintiffs' counsel also attacked the admission into evidence of the police report of Officer Beauford. The report of the officer, a highly trained

accident reconstructionist, was deemed by the plaintiffs to lack trustworthiness under Federal Rule of Civil Procedure 803. The Sixth Circuit, however, found:

We find no error in the district court's analysis of this issue. To begin with, Rule 803(8)(B) is directly applicable to this case. Officer Beauford clearly had a legal duty, as a police officer investigating the accident, to issue a report. The issue then becomes whether his report lacked trustworthiness. And the factors listed in the Advisory Committee Notes and used in *Miller* and *Baker* indicate that the report was trustworthy. See *Baker*, 588 F.2d at 558.

The court also reaffirmed an older case, *Dallas & Mavis Forwarding Co. v. Stegall*, 659 F.2d 721 (6th Cir.1981), in reaching this conclusion:

Dortch also cites *Dallas & Mavis Forwarding Co. v. Stegall*, 659 F.2d 721 (6th Cir.1981), and notes that it is "remarkably similar to this case." The *Dallas & Mavis* court affirmed the exclusion of a police report detailing the investigation of a traffic accident. *Id.* at 721-22. But the report's factual findings and conclusions in that case were not based on any physical evidence, and instead related only the hearsay statements of biased witnesses. *Id.* at 722. Due to the total lack of "physical data or evidence," the *Dallas & Mavis* court determined that the report failed to meet Rule 803(8)'s trustworthiness requirement. *Id.* This contrasts sharply \*405 with the present

case where the report is founded on extensive physical evidence gathered by unbiased officers.



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## OHIO

### *Ohio Law Upholds Limits on Injured Worker Suits*<sup>®</sup>

#### **Kaminski: The Final Word on Ohio's Employer Intentional Tort Law**

In a 6-1 decision issued March 23, 2010, the Ohio Supreme Court ruled in *Kaminski v. Metal & Wire Prods. Co.*, Slip Opinion No. 2010-Ohio-1027, that Ohio's employer intentional tort statute in R.C. 2745.01 is constitutional, and it reinstated summary judgment in favor of the employer. After two prior unsuccessful attempts by the Ohio General Assembly to enact a statute limiting the scope of the employer intentional tort, the Ohio Supreme Court is finally satisfied that the third time is the charm.

In *Kaminski*, a press operator was injured in the course of her employment at the defendant employer. The employee applied for and received workers' compensation benefits. About two months after the accident, the employee filed suit alleging her employer committed an employer intentional tort under R.C. 2745.01. The trial court granted the employer's motion for summary judgment on the plaintiff's complaint and on the employer's counterclaim (seeking a declaratory judgment that R.C. 2745.01 is constitutional). The employee appealed.

On appeal, the 7th District Court of Appeals (Columbiana County) held that R.C. 2745.01

was unconstitutional in its entirety, relying on *Johnson v. BP Chems., Inc.* (1999), 85 Ohio St.3d 298, which struck an earlier employer intentional tort statute as unconstitutional in light of Sections 34 and 35, Article II of the Ohio Constitution. The appeals court remanded the cause back to the trial court as it also decided the employee presented sufficient evidence under the common law test for an employer intentional tort. The employer appealed.

The Ohio Supreme Court concluded, after detailing the historical development of employer intentional tort law in Ohio – both common law and intentional tort legislation – that “although Sections 34 and 35 do not specifically authorize legislation in the area of employer intentional torts, those sections do not limit the General Assembly's power to legislate in the area” and further, that the employer intentional tort statute should be upheld if it does not violate any other constitutional provision. The Ohio Supreme Court acknowledged that the General Assembly's intent in enacting R.C. 2745.01 (effective April 7, 2005) was to permit recovery for employer intentional tort only when an employer acts with specific intent to cause injury. This was a significant departure from the common law test articulated by the Ohio Supreme Court in *Fyffe v. Jenos, Inc.* (1991), 59 Ohio St.3d 115.

According to the court, Section 34 did not limit the General Assembly's authority to legislate as to the employer intentional tort, so the statute did not violate

Section 34. The statute did not violate Section 35 since the General Assembly's authority to legislate outside this workers' compensation arena was not restricted. And the statute did not alter the employee's and employer's rights and obligations under the state workers' compensation system. The court acknowledged difficulty squaring its decision with the court's 1999 decision in *Johnson* which struck down as unconstitutional a prior version of R.C. 2745.01. Rather than overrule *Johnson*, the majority simply limited its ruling to the facts of that case so it would have no impact on *Kaminski* or subsequent cases before the court. Because the current employer intentional tort statute differs in key aspects to the earlier statute considered in *Johnson*, the court limited the reach of *Johnson* to the particular statute considered at the time.

As additional justification for its holding, the court noted the statute constrains rather than abolishes the cause of action for an employer intentional tort. The court also noted that the statute harmonizes Ohio's law with the law in a “clear majority of states.” And the statute did not violate any other constitutional provision considered in the *Stetter* decision issued the same day (discussed below).

#### *Stetter v. R.J. Corman Derailment Servs. LLC*

In *Stetter v. R.J. Corman Derailment Servs. LLC*, Slip Opinion No. 2010-Ohio-1029, a companion case to *Kaminski*, the Ohio Supreme Court was

asked by the United States District Court for the Northern District of Ohio, to respond to eight questions of state law regarding the constitutionality of the employer intentional tort statute, R.C. 2745.01. The court determined in each instance that the statute did not run afoul of the Ohio Constitution.

1. R.C. 2745.01 does not eliminate the common-law cause of action for an employer intentional tort. Although the statute significantly limits lawsuits for employer intentional torts, it does not abolish the tort completely.
2. R.C. 2745.01 does not conflict with the legislative authority granted to the Ohio General Assembly by Sections 34 and 35, Article II of the Ohio Constitution for the reasons articulated in *Kaminski*.
3. R.C. 2745.01 does not violate the right to an open court or the right to a remedy because: the statute is not retroactive and has no effect on employees whose causes of action arose before the statute's effective date; the statute still allows employees to recover for an intentional tort due to injuries resulting from a deliberate intent to injure; it allows recovery for an intentional tort where there is deliberate removal of an equipment safety guard or deliberate misrepresentation of a toxic or hazardous substance; claims for discrimination, sexual harassment and retaliation

are unaffected; and workers' compensation is a meaningful remedy for workers injured from conduct with an intent less than deliberate intent, including the potential for additional recovery when injury results from an employer's violation of a specific safety requirement.

4. R.C. 2745.01 does not violate the right to trial by a jury because it does not intrude on the traditional province of the jury (i.e., fact finding function) and it allows the jury to determine the damages when they are legally available. The right to a trial by jury does not prevent the General Assembly from altering a cause of action.
5. R.C. 2745.01 does not violate the right to due process in Ohio for multiple reasons including: the statute does not impinge upon fundamental rights; the statute is not unreasonable or arbitrary as it appears to harmonize the law of Ohio with the law of a clear majority of states; and it is rationally related to the legitimate purposes of maintaining the balance of sacrifices between employer and employee in the substitution of no-fault liability for tort liability in workers' compensation, and minimizing litigation.
6. R.C. 2745.01 does not violate the right to equal protection of the law. The Ohio Constitution itself distinguishes between employees injured on the job and persons injured other than in a workplace, and provides a no-fault method of recovery for employees, while also minimizing litigation.

7. R.C. 2745.01 does not violate the separation of powers. Because the General Assembly acted within its power to define scope and remedies for workplace intentional injury, the separation of powers doctrine is not violated by requiring all employees injured in the workplace other than as the result of an employer intentional tort to recover within the workers' compensation system. And the statute does not remove the courts' powers to adjudicate claims of employer intentional torts.



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## PENNSYLVANIA

### *Distraction*

Distracted driving has become a catch-phrase to summarize the many things that take our concentration away from the task at hand when we are behind the wheel of a vehicle. It has also become a hot topic in transportation law, as organizations lobby for legislation, and governmental agencies and legislative bodies scramble to develop a fix. The statistics on distracted driving are quite compelling: According to NHTSA nearly 6,000 people died in 2008 in crashes involving a distracted or inattentive driver, and more than half a million were injured. Texting while driving is a subset of distracted driving that gets particular attention. A Virginia Tech study found that texting while driving made a person 23 times more likely to be in an accident.

The statistics support doing something, but the devil is in the details. What constitutes a distraction? This question results in many answers. According to US DOT, distracted driving includes behaviors such as eating, drinking, talking to passengers, and changing the radio station. Since no legislator wants to take on banning those activities while driving, the focus has centered on use of hand held electronic communication devices. However, banning that source of

distraction comes with its own set of challenges, as demonstrated by a piece of legislation that passed the Pennsylvania House of Representatives on January 26, 2010 and is now pending in the Pennsylvania Senate.

Pennsylvania House Bill 2070 (HB 2070) was introduced with bipartisan support and seeks to prohibit the use of an "interactive wireless communication device" ("IWCD") while driving. IWCD is defined to include a wireless, telephone, personal digital assistant, smart phone, portable or mobile computer, or similar device which can be used for voice communication, texting, e-mailing, browsing the internet or instant messaging. It specifically does not include a device being used exclusively as a gps or navigation system or a device physically or electronically integrated into the vehicle. The bill expressly allows the use of an IWCD for voice communication in hands-free mode and "reading, selecting or entering a telephone number or name into an [IWCD] for the purpose of voice communication." The bill also states that it does not authorize seizure or forfeiture of an IWCD. When taken as a whole, the difficulty for law enforcement created by HB 2070 emerges. The bill would make it a primary offense to use an IWCD while driving. As a primary offense, a police officer could initiate a traffic stop based on probable cause that the driver is using an IWCD. What would constitute "probable cause" seems to be

limited to visual observation by the police officer that the driver was pushing the buttons or otherwise manipulating an IWCD. However, the driver may be doing something entirely legal under the bill as written – "reading, selecting or entering a telephone number or name . . . for the purpose of voice communication." Since the officer could not seize the IWCD as evidence, it would seem that the burden of proof that what was occurring was something legal versus illegal would shift to the driver.

The driver could show the officer the call log or the text log to demonstrate that he or she was dialing and not texting or checking email. But what if the driver was simply looking for a phone number and never dialed the phone? How will the driver prove he or she was not checking email or viewing a text message? These will be challenges that will undoubtedly require a resolution in the court system. The current version of HB 2070 only provides for a \$50 fine and no points on the driver's license. It is unlikely, therefore, that many people will challenge a citation under this bill if it becomes law. The more likely challenge will come when an officer uses the prohibition to initiate a traffic stop and then observes some other criminal activity (i.e. open container of alcohol, indicia of intoxication by the driver, contraband in plain view) that results in more serious charges.

We all can see the dangers of distracted driving. From the myriad of electronic devices that we carry, the new technology in our vehicles, the passengers we are carrying, the drive-through food or coffee, or the billboard we drive by, there are many things to take our attention away from the road. We should all strive to pay more attention to our driving and less to the things that distract us. The difficulty is in finding an effective way to force us to do that.



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## SOUTH CAROLINA

### *New Case Addressing Limits on Expert Testimony in State Court*

In a brand new opinion, South Carolina's Supreme Court proclaimed an end to the seemingly limitless breadth of the admissibility of expert testimony. In *Watson v. Ford Motor Company*, Op. No. 26786 (Filed March 15th, 2010) the court gave additional analytical heft to its 2009 decision in *State v. White*, 382 S.C. 265, 676 S.E.2d 684 (2009), which has been read as the court's direct instruction to the trial courts that they more stringently enforce Rule 702 of the South Carolina Rules of Evidence, which sets forth the admissibility criteria for expert testimony. In *Watson*, the court articulated analytical instructions so clear that they suggest the court had been eager for the right case to declare its preference for more selective admissibility of expert testimony.

The case involved a single car motor vehicle accident which was caused by the Ford Explorer in which the plaintiffs were travelling, and which was under the apparent control of the vehicle's cruise control feature, unexpectedly and without human stimulus accelerating, causing the vehicle to roll over and the plaintiffs to be ejected. The injuries were severe, and the jury awarded eighteen million dollars actual damages to the two plaintiffs. Ford appealed on several bases, most notably that the trial court erred in admitting

the testimony of plaintiffs' experts Bill Williams and Dr. Antony Anderson.

According to the court's recitation of the facts, "[the plaintiffs'] theory of the case was that the Explorer's cruise control system was defective because it allowed electromagnetic interference (EMI) to affect the system." Bill Williams, testifying in the field of "cruise control diagnosis", was presented in order to offer evidence from third parties of similar cruise control failures in other Ford products. Anderson, an expert in EMI, offered his theory as to how EMI can cause the very malfunction which allegedly caused the subject accident. After reviewing the record, the South Carolina Supreme Court ruled that both experts should have been excluded.

With respect to Williams, the court noted that in the course of the motion *in limine* concerning Williams' testimony, Williams had described his experience as involving training, consulting, and developing and writing software for the automotive industry, with particular current emphasis on issues involving brake failures. He acknowledged that prior to being retained in the lawsuit, he had no professional experience of any kind in cruise control systems, never had compared the cruise control system in the Explorer in question to any other system, and never had published a paper on cruise control systems. Despite these limitations, the trial court qualified Williams as an expert in "the training and operation of the cruise control and brakes" and permitted him to testify on "cruise control diagnosis." While

the casual reader might believe this was obvious error on the trial court's part—and while, indeed, that conclusion is clear from a reading of Rule 702—in practice qualification of experts on so specious a basis has been utterly routine.

So the South Carolina Supreme Court's determination that Williams was not qualified and should have been excluded was no small surprise. Specifically, the court ruled that Williams' lack of pre-litigation experience with the subject matter of the litigation—during the motion *in limine* he described "how he taught [himself] the Explorer's cruise control, or speed control system"—was fatal. Because it appeared he "merely studied the Explorer's system just before trial", he was not qualified to discuss the cruise control system, despite his vast qualifications in other aspects of automotive engineering. South Carolina's trial judges undoubtedly will hear this principle argued frequently in the years to come.

While Williams should have been excluded due to inadequate qualification, the court's finding concerning Dr. Anderson concerned the other cornerstone of expert testimony's admissibility: methodological reliability. Dr. Anderson's testimony was damning to the defense: it established not only that EMI could cause a malfunction in the cruise control system, but that Ford had a technically and economically feasible alternative at hand: the use of a "twisted pair" wiring schematic. Examining

Anderson's qualifications, the South Carolina Supreme Court noted that while an eminently qualified electrical engineer, Dr. Anderson had no particular experience with cruise control mechanisms, or even with the automotive industry as a whole. Coupling this experiential inadequacy with Dr. Anderson's inability to support with meaningful explanation his theory that "twisted pair" wiring would have prevented the particular malfunction that he theorized, the court found that testimony concerning the twisted pair wiring theory—i.e., the feasible alternative—should have been excluded as unreliable.

The court went a step further, ruling that Dr. Anderson's testimony concerning the specific mechanism by which the EMI caused the cruise control malfunction should have been excluded as well. While acknowledging that Dr. Anderson was qualified to testify to EMI and to its effects generally, the court concluded that his testimony was the product of unreliable methods. He had not published any peer reviewed paper on EMI's effect on cruise control systems and could not identify the source of the EMI he claimed had caused the malfunction. Further, he had not tested his theory and, indeed, testified that his theorized EMI reaction could not be replicated in a laboratory or other testing environment. In light of this, the court found that Dr. Anderson's EMI theory was the product of unreliable methods and should have been excluded.

Encapsulating the trial court's error, the South Carolina Supreme Court rendered what to litigants and practitioners in South Carolina must be considered the opinion's critical statement: "In our view, the trial court's error in admitting Dr. Anderson's testimony is largely based on solely focusing on whether he was qualified as an expert in the field of electrical engineering and failing to analyze the reliability of the proposed testimony." This statement must be taken as an exceedingly clear signal to trial courts in South Carolina: the days of admitting any testimony solely because its subject matter falls within the expert's general area of expertise—the standard practice in this state—are over. That an expert's methodology makes no sense and cannot be confirmed by scientific methods affects the opinion's admissibility and not merely its weight, as so often had been proclaimed. Should the trial courts heed the South Carolina Supreme Court's obvious intent, this opinion has the potential to effectuate a fundamental shift in personal injury litigation from motor vehicle accidents to product liability to premises liability.



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## WASHINGTON

### *Washington Passes Stricter Regulations for Intrastate Commercial Vehicles*

On October 4, 2005, Doctors Anthony “Tony” Qamar and Daniel Johnson were driving on Washington State Route 101 on their way to test seismic activity on the Olympic Peninsula. Without warning, a speeding and overloaded logging truck spilled its load of logs onto the highway, crushing Qamar and Johnson’s vehicle and killing both men. The truck’s driver had methamphetamine in his system, and he had a history of safety violations. This incident helped lead to Washington’s enactment of the 2007 Tony Qamar and Daniel Johnson Act.

The Act, which is codified under Chapter 46.32 RCW requires commercial motor vehicles operating in Washington to obtain a transportation number through the Federal Department of Transportation and to comply with the rules of the Utilities and Transportation Commission (UTC). RCW 46.32.080. Previously only commercial vehicles traveling interstate were required to comply with the UTC and obtain the transportation numbers. Trucks operating solely in Washington State were largely unsupervised.

The statute also enables the Washington State Patrol to monitor intrastate commercial vehicles and enforce safety regulations under the rules of the UTC:

- (d) The state patrol may (i) place a motor carrier out of service or (ii) refuse to issue or recognize as valid a department of transportation number to an applicant who ... (C) as an individual licensee, or officer, director, owner, or managing employee of a nonindividual licensee, had a department of transportation number and was placed out of service for cause, and where cause has not been removed....
- (e) Upon a finding by the chief of the state patrol or the chief's designee that a motor carrier is an imminent hazard or danger to the public health, safety, or welfare, the state patrol shall notify the department, and the department shall revoke the registrations for all commercial motor vehicles that are owned by the motor carrier....

RCW 46.32.080.

Under these rules, the State Patrol has the authority to remove from Washington roads drivers and owners with a history of safety violations, such as the driver responsible for the deaths of Doctors Qamar and Johnson. It also implements a method for the State to monitor commercial vehicles with the use of the USDOT transportation numbers. The State Patrol may issue an out-of-service order to the carrier and refuse to re-issue the department of transportation number until the carrier corrects all safety violations. RCW 46.32.100(2).

Not only do unsafe carriers risk revocation of their department of transportation number, they also face higher fees and penalties

for safety violations. A high risk carrier must pay double the amount of a penalty of a prior violation if that carrier repeats the same violation during a follow-up compliance review period. RCW 46.32.100(1) (d). First-time offenses carry penalties of \$100 to \$11,000. Thus, high risk drivers face fines of up to \$22,000 per repeat violation. Each violation is considered distinct and separate and carries its own individual penalty. See generally RCW 46.32.100. Additionally, high risk carriers must pay a fee of up to \$250 for compliance reviews.

Activities that are regulated under the Act include: driver training, controlled substance and alcohol use and testing, compliance with the federal driver's license requirements and penalties, vehicle equipment and safety standards, hazardous material practices, financial responsibility, driver qualifications, hours of service, vehicle inspection. RCW 46.32.085(1). And the rules apply to those who own, control, manage, or operate commercial vehicles. In other words, the rules apply equally to the drivers as well as those engaged in commercial vehicle ownership and management.

During April 2009, the Act was expanded to include among other things, a broader definition of commercial carriers. The law now applies to all carriers that are regulated by the UTC and operating intrastate within Washington. These are defined as vehicles operating

in commerce that (1) have a gross rate of 26,001 pounds or more, including a towed unit of a gross vehicle weight of 10,000 pounds or more; (2) has a gross vehicle weight rating of 26,001 pounds or more; or (3) is used in the transportation of hazardous materials. RCW 46.32.004.

Carriers currently regulated by the UTC must have applied for the transportation number by January 1, 2010. Carriers weighing between 16,001 and 26,000 pounds must apply for the transportation number by January 1, 2011.

The Bill leading to the Act was sponsored by Rep. Ruth Kagi with the support of Drs. Qamar and Johnson's widows, Kathleen Ellsbury and Aylin Llona. Qamar's widow, Ms. Ellsbury, has continued to work with safety organizations to lobby Congress to pass stricter safety regulations for commercial vehicles. She has been widely covered in the local and national press for her work before the US Congress and the Washington Legislature.

The driver responsible for the deaths of Tony Qamar and Daniel Johnson was ultimately convicted of vehicular manslaughter and sentenced to up to 54 months in prison.



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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. We have six verdicts for this issue which have not been previously published.

### ARIZONA

*John Christner Trucking adv. Mary Cameron, et al.*

**Venue:**

Maricopa County Superior Court, Phoenix, Arizona

**Result:**

10 person jury trial. Defense verdict.

**Counsel for John Christner**

**Trucking:** Tamara Cook, Bill Sowders of Renaud Cook Drury Mesaros, Phoenix, Arizona.

**Facts.** A multiple vehicle collision involving 13 commercial trucks and 6 passenger vehicles took place in a blinding dust storm on August 8, 2004 on westbound Interstate 10 west of Phoenix, Arizona. In the end, there were dozens injured and 2 deaths. One of the deceased was Martin Cameron who, while driving with his passenger and wife, Mary Cameron, struck the rear of the trailer pulled by John Christner trucking. Martin and Mary survived the initial impact without injury. But as their vehicle was being struck by another commercial truck, Mary jumped to safety, suffering fractures and a severe degloving injury to her right leg. Martin was crushed and killed when his vehicle and the John Christner trailer were impacted by 1, 2 or even 3 more commercial trucks.

The collision began when a mystery white vehicle caused a commercial tractor trailer unit (TT 1) to stop suddenly in lane 1 and caused a second unit (TT 2) to swerve right and stop suddenly straddling lane 2 and the emergency lane. A touring bus

filled with passengers struck the rear of TT 1 in lane 1. A purple passenger van with three adults and five children, one in a wheelchair, stopped behind TT 2 in lane 2 without striking it. Our client, John Christner Trucking (JCT) at the hands of seasoned driver and extra-cautious grandmother, Kay, pulling a tractor and almost full trailer, stopped behind the purple van without striking it. MARTIN CAMERON hit the rear of the JCT trailer, lodging his car under the ICC bumper.

Evidence suggested that another TT, (TT 3) struck the rear of the Cameron car then swerved right into the desert. There was conflicting evidence whether TT 4 struck the Cameron car. Either TT3 or TT 4 caused injury to Mary Cameron and the death of Martin Cameron. A massive fire erupted. The JCT truck and trailer, TT3, TT4 and the Cameron car with Martin Cameron in it were all completely destroyed by fire.

**Plaintiffs' Allegations:** Kay was illegally stopped in the roadway without her lights on. In the time and distance it took Kay to safely drop her speed and stop behind the purple van without hitting it, she should have exited the freeway entirely.

**Defenses:** There was conflicting evidence whether Kay had her lights on or off. The zero visibility as confirmed by every driver on scene and highway patrol made this a non-issue. Kay was slowing to adapt to the ever changing conditions. Her actions were reasonable while she had visibility

particularly in a dust storm that is unpredictable in duration and severity. When confronted with a sudden emergency, losing sight of the purple van, she stopped immediately. The vehicles behind her did not.

Plaintiffs' claims: Degloving injury to Mary Cameron's right leg, multiple fractures to leg and ankle. Good recovery. Stipulated medicals of \$162,000. Wrongful death of Martin Cameron with wife, three children, two parents as statutory beneficiaries.

Demand at Trial: \$500,000 for Mary Cameron's personal injury. \$1M - \$1.5M for each child. Parents never mentioned. \$10M-\$30M for Mary Cameron for a total of \$13.5M - \$35M.

Defendants Proposed Verdict Value at Trial: \$0. The jury was asked to find that Kay was not negligent since she brought her truck to a controlled stop. The jury was also asked to consider that no one was at fault - that this was truly an accident and everyone did the best they could despite the tragic outcome.

Verdict Form included JCT, TT4, and two other TT companies as non-parties at fault, and Martin Cameron for comparative fault.

Jury out 5 hours (over two days). Defense verdict. Jury applied Arizona's Sudden and Unexpected Emergency instruction and focused a great deal of attention on the hindsight clause which states as follows:

“In determining whether a person acted with reasonable care under the circumstances,

you may consider whether such conduct was affected by an emergency.

An “emergency” is defined as a sudden and unexpected encounter with a danger, which is either real or reasonably seems to be real. If a person, without negligence on his or her part, encountered such an emergency and acted reasonably to avoid harm to self or others, you may find that the person was not negligent. This is so even though, in hindsight, you feel that under normal conditions some other or better course of conduct could and should have been followed.

The existence of a sudden emergency and a person's reaction to it are only some of the factors you should consider in determining what is reasonable conduct under the circumstances.” (Revised Arizona Jury Instruction).

The jury found that no one was at fault. Finally, we found a jury willing to accept that accidents DO just happen now and then.



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## ILLINOIS

*Thornton v. Garcini,*  
2009 WL 3471065  
Illinois Supreme Court,  
October 29, 2009

### **Introduction**

Although this recent case is a medical malpractice case it has two important points for defending transportation cases:

- (1) A plaintiff does not have to prove emotional injury by way of expert testimony in order to establish the requisites for a valid claim of negligent infliction of emotional distress.
- (2) A defendant waives his right to a setoff if he files a motion raising the claim for a setoff, for the first time, after trial.

### **Facts and Procedural History**

The plaintiff was in labor and began to deliver her baby. During delivery, the child presented in breech position (positioned to exit the womb feet first) with its head becoming stuck inside the plaintiff's womb. While the child was entrapped, there were no doctors present. Nurses were unable to complete the delivery, and the child died inside of the plaintiff's womb. The plaintiff's obstetrician, Dr. Garcini, was contacted by the hospital and informed of the circumstances of the child's death. The obstetrician arrived at the hospital over an hour later. During this hour long period, the plaintiff's deceased child remained partially inside of her womb. Upon arrival, Dr. Garcini completed the delivery.

The plaintiff sued Dr. Garcini, the hospital, and the nurses, for wrongful death, survival, and intentional infliction of emotional distress. A jury found all the defendants not liable on the wrongful death and survival counts. Similarly, the jury returned a verdict of not liable on the intentional infliction of emotional distress count, with respect to Dr. Garcini and the nurses. However, the jury found the hospital liable for intentional infliction of emotional distress and awarded plaintiff \$175,000. The plaintiff filed post-trial motions against all defendants. Before the post-trial motions were heard, the hospital and the nurses entered into a settlement agreement with the plaintiff. In exchange for payment of \$175,000, the plaintiff agreed to release the hospital and the nurses. The plaintiff's post-trial motion against Dr. Garcini was denied. The plaintiff appealed the trial court's judgment. The appellate court reversed and ordered a new trial.

At the second trial, the plaintiff brought the same wrongful death and survival actions as in the first trial. However, the plaintiff substituted a claim for negligent infliction of emotional distress in place of the prior intention infliction of emotional distress. In addition, the plaintiff did not provide any expert testimony to support her claim for negligent infliction of emotional distress. All claims were submitted to the jury and Dr. Garcini was not found liable in the wrongful death or survival action. However, Dr. Garcini was found liable for negligent infliction of emotional distress. The jury awarded plaintiff \$700,000.

Dr. Garcini filed a post-trial motion seeking judgment notwithstanding the verdict. The trial court denied the post-trial motion, and the appellate court affirmed.

### **Analysis**

Dr. Garcini appealed to the Illinois Supreme Court. Dr. Garcini's first argument was that the plaintiff had failed to establish a cause for negligent infliction of emotional distress. Dr. Garcini argued that the plaintiff failed to establish, by expert testimony, that she had suffered emotional distress between the time of child's death and the time delivery was completed. As such, he argued that he could not be liable for her injuries. The Illinois Supreme Court disagreed finding that expert testimony is not a requisite for a valid claim of negligent infliction of emotional distress. The court found that the "existence or nonexistence of medical testimony [concerning emotional distress damages] goes to the weight of the evidence but does not prevent this issue from being submitted to the jury." In other words, the court held that "expert testimony, while it may assist the jury, is not required to support a claim for negligent infliction of emotional distress."

Dr. Garcini then argued that the judgment against him could only be in the amount of \$530,000, the full verdict amount less the settlement amount paid by the hospital and nurses. The court stated that while Dr. Garcini may have been entitled to a set-off in an amount equal to that paid by the settling parties, he had waived his right to such a

set-off in this case. Dr. Gacini waived his right for a set-off by not filing a counter-claim against the plaintiff seeking a set-off after the settlement. The court, citing its decision in *MidAmerica Bank, FSB v. Charter One Bank, FSB*, 232 Ill.2d 560, 574-75 (2009), explained that, with no counterclaim for setoff appearing in Dr. Gacini's pleadings, the plaintiff had no "notice or opportunity to defend against the setoff claim until after the completion of the second trial.



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## KENTUCKY

### *Dortch v. Fowler*

On October 13, 2004, Angela Dortch, a forty-one year old mother of two, was driving her Ford Blazer in light rain on a two lane asphalt road in northeastern Jefferson County, Kentucky. She was on her way home from her children's school early in the afternoon and knew the road extremely well. She was going home and then to interview for a part-time job at a private school.

There were two curvy areas in the road between the school and her home, and she was approaching a poorly banked right hand curve that also dropped down a small hill. Instead of making the curve, she crossed into the opposite lane of travel and hit a Con-Way local delivery truck consisting of a tractor and a pup trailer driven by Loren Fowler, an experienced driver. The overlap between the two vehicles pushed the left hand steer wheel and tire of the truck into a 90° left turn and pushed the road wheel so far to the rear that it crushed the left saddle tank six inches and pushed it to the rear an additional 4-5 inches.

The Louisville Metro Police called their accident reconstruction unit to the scene and excellent photos were taken. Counsel was engaged for Plaintiff almost immediately

and they brought an accident reconstructionist to the scene within a few days. Mr. Bereza, formerly a Michigan State Police officer, also took very good photos. In addition, a fire chief at the scene took a limited number of high quality photos.

Ms. Dortch had significant orthopedic injuries and was in a coma for three weeks, even though she was belted at the time of the accident. She had a mild brain injury, which improved in a few areas over time. Ms. Dortch had a Master in Fine Arts and a high IQ. Her focus was musical theatre, and she was an accomplished singer and dancer with regional professional appearances on her resume. The accident resulted in Ms. Dortch registering lower IQ scores, and it particularly affected her abilities in spatial orientation. She could no longer sing or dance after the accident.

Con-Way had a very strong defense based upon deep gouge marks from Ms. Dortch's vehicle, which started in Mr. Fowler's lane and arched over into the other lane, ending after about 60 feet back in the truck's lane again. The gouge marks stopped under the left front suspension of the Blazer. Mr. Bereza found a single gouge mark in Ms. Dortch's lane he designated as the point of impact between the vehicles. Con-Way countered with Bill Cloyd, an accident reconstructionist, and Frank Entwisle, a truck engineer, who rebutted testimony from Bereza

about the behavior of the truck in the accident. Entwisle was a particularly strong witness. Mr. Fowler had one very minor accident on his record but also had numerous prior problems in backing up to loading docks. His record for the year preceding the accident included the minor accident and four separate "incidents" involving bumping into docks and backing into low hanging telephone wires. His last evaluation prior to the accident included the lowest safety rating a driver can receive – "unacceptable."

Con-Way filed twelve Motions in Limine and two Motions for Partial Summary Judgment. The Judge granted the Motion for Partial Summary Judgment on negligent hiring and retention prior to trial, stating that the incidents and minor property damage accident were so different from the accident in question that they could not be considered as predictive for Con-Way's supervisors of the type of accident that occurred.

The second Motion for Partial Summary Judgment on punitive damages was deferred to the end of the plaintiff's proof and was renewed as a Motion for Partial Directed Verdict. It was granted at that time in favor of the defendants.

The plaintiff left a female machinist on the jury panel, who served as foreperson. The verdict was unanimous for the defendants. An appeal was

taken to the Sixth Circuit, which dismissed the appeal with a published opinion. See *Dortch v. Fowler*, 588 F. 3d 396 (6th Cir. 2009), *rehearing and rehearing en banc denied* (January 28, 2010). A petition for rehearing *en banc* was then filed which has recently been dismissed after a unanimous vote to reject the petition. The time for filing a petition for *writ of certiorari* will run at the end of April 2010.

Will H. Fulton and D. Craig York with Dinsmore and Shohl's Louisville office tried the case for Con-Way and Fowler with an associate in September 2007, over a two week period. The jury deliberated about an hour and a half.



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## MISSOURI

See **Joe Swift's** excellent result in Cases, Regulations, and Statutes under [Federal – Eighth Circuit](#).

## NEW MEXICO

In December 2009, Paul Yarbrough and Alfred Green, Jr. of Butt Thornton & Baehr PC obtained a defense verdict on behalf of their client, Ozzie's Pipeline Padder, Inc. ("Ozzie's"), in the United States District Court for the District of New Mexico. Following a four day trial, the ten-person jury reached a unanimous verdict in favor of Ozzie's. The only question answered by the jury on the verdict form was whether or not the plaintiff, John Ensey, was a dual employee of both Ozzie's and Rockford Corporation ("Rockford").

The plaintiff was hired to work for Ozzie's in August 2005 as the operator of a pipeline padding machine. A pipeline padding machine is used primarily in the petroleum industry. It scoops large amounts of earth and, using a conveyor, pulls the earth up through the center of the machine. The earth is then deposited into a shaking sifter, where rocks and other impurities are removed. The debris-free dirt then falls through the sifter and onto another conveyor (running cross-wise from the first conveyor), where it is deposited to either side of the machine depending on the

direction the conveyor is moving. The purpose of using the pipeline padding machine is to remove rocks and other debris from dirt that is used to bury an oil pipeline so that they do not pose a threat to the integrity of the pipeline.

Ozzie's trains the operators it hires to run a pipeline padding machine. It also designs and manufactures the machine. The plaintiff was trained in two different locations and on two different models of the machine before the accident that formed the basis of the lawsuit.

While operating the machine on October 19, 2005, the plaintiff stepped on the conveyor that deposits the debris-free dirt into the pipeline trench and was pulled underneath the shaker (a 17 inch gap). He suffered significant injuries as a result of the accident. The accident occurred in the morning while the plaintiff was checking the pipeline padding machine before beginning actual operations. He claimed that he was stepping on the rails framing the conveyor to remove debris from the shaker when the conveyor started by itself. The plaintiff sued Ozzie's under the theories of strict liability, negligence, and breach of warranty. Once expert testimony proved the conveyor could not start by itself, the plaintiff amended his strategy and proceeded to trial on the theories of negligent design and negligent training and warnings.

The plaintiff was working for and on the payroll of Ozzie's during the time that he was training to operate the machine. At the time of the accident, however, the plaintiff was on the payroll of

Rockford, a general contractor that leased the pipeline padding machine from Ozzie's. As part of the lease agreement, Ozzie's agreed to provide Rockford with the name of operators qualified to operate the machine. Rockford was contractually bound to put any operators on its payroll and to pay for workers' compensation insurance. However, Rockford never instructed the plaintiff regarding how to operate the machine and the plaintiff was to contact Ozzie's with any questions regarding the machine.

Rockford was not named as a party to the lawsuit because, in New Mexico, the exclusive remedy against an employer for injuries suffered by an employee on the job is generally under the New Mexico Workers' Compensation Act. The Act provides an exclusive remedy against an employer for injuries sustained by an employee in an accident arising out of and in the course of employment. See, NMSA 1978, §52-1-9. The employer and the employee surrender their rights to any other method, form or amount of compensation or determination on account of personal injuries or death of the worker except as provided in the Act. See, NMSA 1978, §52-1-6(D). No cause of action can be maintained outside the Act against an employer for any matter relating to the occurrence of any injury covered by the Act. See, NMSA 1978, §52-1-6(E).

Ozzie's argued during trial that the plaintiff had dual employers (Ozzie's and Rockford) at the time of the accident and,

therefore, it was also immune from suit under the Act. In New Mexico, an employee may have two employers for purposes of the Act. In certain situations, an employee of a company becomes a special employee. A special employer borrows a worker from another employer and directs the borrowed worker in specific work details. *Vigil v. Digital Equipment Corp.*, 1996 NMCA 100, ¶17, 122 N.M. 417, 925 P.2d 883. The Supreme Court in New Mexico adopted a three part test to determine whether an employer qualifies as a special employer, as follows: “(1) the employee made a contract of hire, express or implied, with the special employer; (2) the work being done is essentially that of the special employer; and (3) the special employer has the right to control the details of the work.” *Hamberg v. Sandia Corporation*, 2008 NMSC 015, ¶11, 143 N.M. 601, 179 P.3d 1209. It is the totality of the circumstances that determines whether the employer has the right to exercise control over the details of the work. *Headley v. Morgan Management Corp.*, 2005 NMCA 045, 137 N.M. 339, 110 P.3d 1076.

Despite considerable opposition from the plaintiff’s attorneys, the Judge ruled that the first question on the verdict form would be whether or not Ozzie’s was a dual employer of the Plaintiff at the time of the accident. If the jury answered in the affirmative, then the jury was to return a verdict in favor of Ozzie’s based on the protections in the Act. On the other hand, if the jury found that

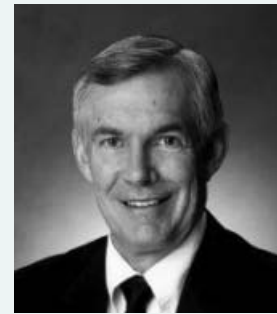
Ozzie’s was not a dual or special employer, then it was to proceed to evaluating negligence.

During trial, Ozzie’s presented the jury with evidence that the work being done at the time of the accident was essentially its work and that it had the right to control the plaintiff in the details of his work. Ozzie’s trained the plaintiff on how to operate the machine and provided the machine for the plaintiff to operate. The plaintiff was to contact Ozzie’s with any questions regarding the machine. Ozzie’s referred the plaintiff to the job with Rockford and he likely would have been referred to another job with another contractor had he not been injured in the accident. Ozzie’s also had the right to remove the plaintiff from the job or to provide a Rockford with a replacement operator in the event that the plaintiff was absent. Though the plaintiff was on Rockford’s payroll and covered by Rockford’s worker’s compensation insurance, it was done at the contractual direction of Ozzie’s. Finally, the plaintiff was required to comply with Ozzie’s policies while operating the pipeline padding machine.

The jury, based on the instruction provided by the court, found that Ozzie’s was a dual employer of the plaintiff at the time of the accident. The jury answered no other questions on the verdict form and, as such, did not reach the issue of negligence. As a result of the jury’s finding, the court entered judgment in favor of Ozzie’s, because Ozzie’s was immune from suit under the Workers’ Compensation Act as a dual employer of the plaintiff.



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## TENNESSEE

Former DRI Southern Director Thomas A. Williams, managing member of Leitner, Williams, Dooley & Napolitan, PLLC in Chattanooga, Tennessee, teamed with a colleague to secure a defense verdict in a motor vehicle accident case. They represented the owner and driver of a tractor trailer, both of whom were alleged to have negligently caused a motor vehicle accident. At the time of the accident, the driver of the tractor trailer was in the process of making a wide right turn when another defendant driving a pickup truck attempted to pass him on his right, lost control of the pickup truck, and crashed into the plaintiff's vehicle. The plaintiff had been properly stopped at a red light. The tractor trailer was not physically involved in the collision.

The plaintiff, who suffered significant physical injury as a result of the accident and lost her spleen, was seeking an ad damnum of \$500,000.00. The plaintiff alleged \$55,000.00 in medical damages, as well as pain and suffering, loss of enjoyment of life, loss of earnings over \$7,000, earning capacity and property damage. At trial, the plaintiff alleged that the driver of the tractor trailer was negligent in making his right turn and that the owner of the tractor trailer was liable under the doctrines of respondeat superior and negligent entrustment. The other defendant driver alleged that the wide right turn that the driver of the tractor trailer was

attempting to make was improper and was the sole cause of the accident.

The plaintiff introduced testimony, over defense objection and under the negligent entrustment theory, that the tractor trailer operator had seven speeding tickets in a 10-year period and thus argued that the employer was negligent in continuing to employ the driver. This was rebutted by testimony that the driver's CDL had never been suspended and that the driver was not incompetent, as alleged.

In addition, the focus of the defense argument was to illustrate, through party testimony and reference to various statutes, that the driver of the pickup truck was speeding and attempted to improperly pass the driver of the tractor trailer on the right and that the wide right turn that the driver of the tractor trailer was making was proper.

The jury deliberated for two hours before returning with a verdict assigning no fault to the driver and owner of the tractor trailer and 100 percent of the fault to the defendant driver of the pickup truck, with a judgment against that driver in the amount of \$150,000.00.



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## PRACTICE TIPS

### *CSA 2010: The Good, The Bad, The Unknown*

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.
  - o 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 for failure to maintain proper driver qualification files, or use of unqualified drivers. (FMCSR Parts 383 and 391)
- 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 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."<sup>4</sup>

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

<sup>4</sup> - <http://www.ttnews.com/articles/basetemplate.aspx?storyid=23868&cSTR=1>

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."<sup>5</sup>

#### **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.

<sup>5</sup> - [http://www.cvsa.org/news/2010\\_press.aspx](http://www.cvsa.org/news/2010_press.aspx)

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>.



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## Don't Look Back: Something Might Be Gaining on You - A Follow Up

Following up on the presentations on plaintiff's lawyers' groups that are targeting the trucking industry, we continue to monitor and report their activity. The most blatant group, APITLA, the Association of Plaintiff Interstate Trucking Lawyers of America, ([www.apitlamerica.com](http://www.apitlamerica.com)), appears to be growing. Their website has added lawyer members.

APITLA continues to "educate" lawyers with presentations. In fact, over the last year, APITLA, in conjunction with Westlaw, has broadcast "Trucking Tuesday" webinars. These presentations are limited to those who pledge they are not employed by or retained by trucking companies and insurers. Most recently, on January 12, 2010, one of the APITLA lawyer-members presented; "Dealing with Daubert in Trucking Cases". Other titles of presentations include: "The Black Box-What is it Telling us?"; "Who Really Owns the Trucking Company: Tracing these Small Companies to the Hidden Deep Pockets"; "Deposing the Truck Driver and Other Personnel"; and "Advanced Combat Training: How to Win Big in the Tough Trucking Case".

The attack on the trucking industry does not end there. Recently, in [The American Trial Lawyer](#), Dan Ransdell published an article entitled, "What to

Do in Every (Fatigued) Trucking Case." Mr. Ransdell, who is the founder of the APITLA, sets out his "Ten Commandments" in every (fatigue) trucking case. He instructs, among other things, To ASSUME:

- in EVERY truck crash, the driver was fatigued and operating in violation of the hours of service rules;
- the trucking company, the driver and the insurance company "will try to, or have already, altered or destroyed some or all the evidence adverse to them";
- the driver's log books are false, and there are two sets;
- the driver's knowing violations of the FMCSA were the results of "pressure for profit" put on the driver by the trucking company to get an on time delivery;
- the driver's qualification file contains false information;
- hours of service rules are intentionally violated for greedy, profit driven motives;
- there are a multitude of inexpensive technologies and safety devices, that would, if implemented, reduce crashes, but the trucking company made a conscious choice not to purchase them because they just didn't care and safety is not a priority;
- these cases have huge punitive damage potential and the insurance company will lie to you about the amount of insurance coverage that exists and both they and the trucking company will lie in an attempt to hide who, how many, and which corporations and persons actually own the trucking company.

Finally, once the bait is before the plaintiff's lawyer, Ramsdell tries to set the hook by asking the reader to consider joining the hundreds of lawyers nationwide who are members of the APITLA. If you are interested, please contact me, so I may forward you more information.

The lessons we learn from this propaganda is to be ever vigilant and on guard to these attitudes and tactics. Also, avail yourself of a network of your own, like the transportation lawyers of ALFA International.



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## ARTICLES

### ***Compliance with the Medicare, Medicaid and SCHIP Extension (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. Additionally, the reporting requirements imposed allow for possible recovery of *future* medical expenses incurred post-settlement or post-judgment. Severe penalties for non-reporting and for failure to

properly report settlements and verdicts can be imposed against insurers and self-insureds (RREs). Currently, the federal government is having a no 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.<sup>6</sup> 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/01\\_Overview.asp](http://www.cms.hhs.gov/MandatoryInsRep/01_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.

<sup>6</sup> - The January 1, 2011 date requires reporting of payment events occurring on or after October 1, 2010.

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

claimant or plaintiff triggers the requirement that settlements and judgments be reported to the CMS. Where it is known that a claimant received Medicare payments for an injury or condition at issue in the litigation or claim, the obligation to take Medicare's reimbursement interests into account presently exists.

In general, persons over age 65 are *eligible* to receive Medicare benefits. This does not necessarily mean that such a person *actually received* any benefits from Medicare for an injury or illness related to the litigation. The Code of Federal Regulations currently defines a beneficiary as "a person who is *entitled* to receive benefits" and also as "[an individual who] *meets* all of the requirements for Medicare benefits."<sup>7</sup> A person over the age of 65 might not have made a claim to Medicare for injuries involved in the claim or suit, due to the existence of private insurance or for some other reason. The failure of the claimant to make a claim to Medicare for an injury or illness, or to even sign up for Medicare in the first instance, does not make the claimant ineligible to receive Medicare benefits. If the person otherwise qualifies, they are still considered Medicare eligible and, by definition, a beneficiary. In other words, a Medicare beneficiary may not have received anything at all from Medicare, but the duty to report still exists.

<sup>7</sup> - 42 CFR 400.202 and 400.202(3), emphasis added.

A person aged 65 or older is highly likely Medicare eligible and a beneficiary. Simple reliance on the claimant's age of less than 65 is, unfortunately, not enough to rule out the possibility of the plaintiff or claimant being a Medicare beneficiary, because there are exceptions to the requirement that a beneficiary be at least age 65. In addition to some extremely serious medical conditions such as total kidney failure, a very significant exception to the age 65 requirement is one that authorizes benefits for anyone of any age receiving *Social Security* disability benefits for a period of at least 24 months. In other words, a very young person who is severely disabled and receiving Social Security disability benefits could well be a Medicare beneficiary, triggering the reporting requirement.<sup>8</sup>

In general, the following should be taken as strong indicators that a claimant or plaintiff is a Medicare beneficiary:

***Claimant is at least age 65;***

***Claimant of any age is severely disabled and possibly receiving Social Security disability benefits;***

***Claimant of any age has end stage renal disease;***

***Claimant of any age has Lou Gehrig's Disease.***

The CMS does not require insurers and self-insureds (RREs) to rely on a claimant's representations -- or their own

<sup>8</sup> - And, again, if the person is eligible but not actually receiving anything, the person is a beneficiary.

guess work – to 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 very strong indicator that the claimant may have received Medicare benefits.<sup>9</sup> 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"

<sup>9</sup> - 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.<sup>10</sup> 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

<sup>10</sup> - Think of where the Internal Revenue Service would be without employer-filed W2's.

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 data with a

previously reported settlement, Medicare may seek recovery from its beneficiary *and/or the settling defendant; including the insurer and the insured.*<sup>11</sup> 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

<sup>11</sup> - 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.

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.<sup>12</sup> 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.

<sup>12</sup> - 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")<sup>13</sup> as of January 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

<sup>13</sup> - "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.

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<sup>14</sup> 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

<sup>14</sup> - 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).

claimant (only excluded until settlement, judgment, or award occurs or appeal resolved).<sup>15</sup>

### > Total Payment Obligation to Claimant (TPOC) Thresholds<sup>16</sup>

- 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.

<sup>15</sup> - 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).

<sup>16</sup> - 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.<sup>17</sup>

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

<sup>17</sup> - 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.

reporting criteria.<sup>18</sup> 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

<sup>18</sup> - See, Appendix A – Claim Input File Layout, User Guide, Version 3.0, February 22, 2010, pp. 121-160.

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<sup>19</sup> should expressly state:

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

<sup>19</sup> - 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.*<sup>20</sup> If the ratio of the settlement or judgment amount to the medical expenses paid by Medicare is high, a defendant *could end*

<sup>20</sup> - See discussion of *US v. Stricker*, below.

*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 sorely tempted not to set aside that allocated portion of the settlement and rather to spend it. The allocation is subject to negotiation, but there is no present mechanism to prevent a claimant from commingling the set-aside and/or spending it. The CMS is being asked to address this uncertainty through a safe harbor provision and/or a statute of limitations to protect RREs who make payments with an agreement from the claimant to respect Medicare's rights.<sup>21</sup>

### UNANSWERED QUESTIONS AND UNINTENDED CONSEQUENCES

It is going to become more difficult to settle cases. With respect to future Medicare payments, we do not presently know what specific conduct the CMS will consider a "reasonable consideration" of its benefits. A settling defendant cannot currently guarantee that settlement proceeds allocated to future medical expenses will in fact be held and preserved for that purpose after the settlement.

If Medicare is slow to pair up its data report from the RRE with the eventual medical bills for litigation or claim related injury, it will likely have paid the bills and will be seeking reimbursement from its beneficiary. If the beneficiary cannot repay Medicare, the CMS will determine whether the

<sup>21</sup> - 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)

settling defendant "reasonably considered" its interests. The inquiry, at that point, would be fundamentally self-serving. The lack of any mechanism to obtain contemporaneous approval of the steps taken to protect Medicare's interests as to future payments, together with the CMS's failure to provide meaningful guidelines on this point, makes it more difficult in many cases for a defendant to "buy its peace" by settling the case. The potential exposure, as noted early, could be the equivalent of paying the claim again. Even a victory in an appeal of Medicare's determination that the settling defendant did not adequately protect its interests will come with a price tag for additional attorneys' fees, post settlement.

From the plaintiff's perspective, the fundamental, longstanding obligation to honor Medicare's secondary payer status on conditional payments is unaffected by the recent changes to the law. What has changed is that the CMS will now have much more information it can use to collect reimbursement. It will receive notice of many more litigation settlements than it did previously. It seems likely that CMS will in many cases over claim reimbursement because its claim will be based on medical diagnostic codes. The diagnostic and procedure codes were not developed for this tracking purpose. A surgery on the left knee as a result of an accident and an unrelated surgery to the right look the same to Medicare, per the reporting codes. To 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 counsel. The claimant could receive nothing. If the settlement exceeds the amount of the conditional payments, Medicare is entitled to full reimbursement of its payments, less the deduction for plaintiff's attorney. The claimant gets the balance.<sup>22</sup> Medicare is not concerned with the liability aspects of a case; if an attorney settles a very thin liability case, Medicare is still

<sup>22</sup> - 42 CFR Sections 411.24 and 411.37

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 MSP mandatory reporting provisions created by Section 111 of the MMSEA in 2007 are codified in 42 U.S.C. section 1395y(b)(7) and (b)(8). See Appendix F – "MMSEA Section 111 Statutory Language," CMS User Guide, Version 3, February 22, 2010; pp. 240-242.

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,<sup>23</sup> 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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<sup>23</sup> - 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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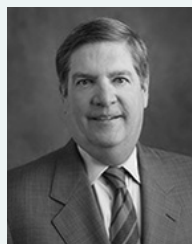
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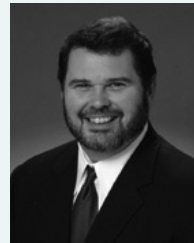
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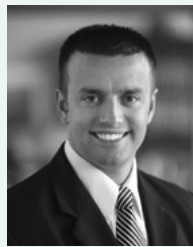
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