fected its lien as to Bell’s treatment in the manner provided by Ala. Code §35-11-371 after Bell was discharged from the hospital. At the time of the accident, Smith maintained liability coverage with Progressive. A Progressive adjuster received actual notice of USAMC’s lien. She wrote to USAMC stating that “if liability is decided that we will owe for

In University of South Alabama v. Progressive Insurance Company, 904 So.2d 1242 (Ala. 2004), the Alabama Supreme Court issued an important opinion which will have an impact upon any claims settled by an insurance company in Alabama where a hospital lien exists. The Court held that an insurance carrier that impairs a hospital lien by paying a settlement directly to the hospital’s patient is liable to the hospital for the hospital lien.

At Smith, Spires and Peddy, P.C., a Martindale-Hubbell AV rated law firm, we know that each client is unique and has specific legal needs. Smith, Spires and Peddy is committed to providing our clients with superior client service and legal counsel. We strive to provide prompt, professional interaction and responses to ensure that value is rendered for each client. We adhere to this practice on an individual basis and as a team so that clients receive effective and outstanding service every time.

The Attorneys of Smith, Spires & Peddy, P.C.

The OPENING STATEMENT

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MEDICARE: Mandatory Reporting Requirements
by Jennie Pickett

As many in the insurance industry are aware, on December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 [42 U.S.C. § 1395y (b)(8)] was signed into law. The Act is intended to protect Medicare’s subrogation interests in matters involving personal injury claims.

The Act has many ramifications for the insurance industry, not the least of which are the reporting requirements set forth in the Act, which apply equally to liability insurers, no-fault insurers, workers compensation insurers and self-insurers. Failure to comply with the reporting requirements may lead to civil penalties and/or fines. These reporting requirements are intended to determine whether a claimant is eligible or may become eligible for...

(Continued on Page 4)

Hospital Liens: What You Need to Know
by Jody Peddy & Rob Stewart

In this case, Clarence Bell was injured when the bicycle he was riding was struck by a motor vehicle being driven by Timothy Smith. Bell was transported from the accident scene to USAMC Hospital and was admitted for treatment. He remained there for approximately three weeks. The “reasonable” charges for Bell’s hospital care, treatment and maintenance were $57,097.00.

USAMC Hospital perfected its lien as to Bell’s treatment in the manner provided by Ala. Code §35-11-371 after Bell was discharged from the hospital.

(Continued on Page 3)
RECENT DEVELOPMENTS IN THE LAW
by Thomas Little

Supreme Court of Alabama

A driver’s momentary inattentiveness does not amount to wantonness under the Alabama guest statute. The Court held that a teenage driver, who had taken her eyes off the road to wave at a friend, was not guilty of wantonness, even though she had recently taken a driver’s education course, and had been instructed that inattentiveness could result in a collision. Phillips v. United Service Auto Assn.

Mere ownership of a utility pole does not confer a duty to a homeowner, where the electric lines attached to the pole were owned by another entity. The Court held that an electric cooperative did not owe a duty to a man who was electrocuted when he touched an uninsulated power line owned by a utility company with which the cooperative had a pole sharing agreement, as the injury was not foreseeable. DiBiase v. Joe Wheeler Electric Membership Corp.

Witness statements taken by claims representative not discoverable. The Court held that statements of an insured and two eyewitnesses were not discoverable, where the claims representative testified by affidavit that she had received correspondence from an attorney representing the plaintiff. In this instance, the Court reasoned, litigation could be reasonably anticipated. Ex parte Flowers.

Bad faith not applicable to uninsured motorist policy where liability and damages not established. The Court held that where an insured had prior, unrelated health conditions, and carrier had requested medical records, which had not been provided, insured could not show that she was “legally entitled to recover,” and therefore could not maintain a claim for bad faith, which had been filed in conjunction with a claim for UM benefits. Ex parte Safeway Ins. Co.

Statute of limitations does not bar personal injury action based on exposure to hazardous chemicals. As a matter of first impression, the Court held that the plaintiff’s cause of action accrued when the injury first manifests itself through observable symptoms, rather than when he was last exposed to the chemicals. Therefore, the two-year statute of limitations for negligence or wrongful death begins to run at that time. Griffin v. Unocal Corp.

Court of Civil Appeals of Alabama

Passenger whose father owned vehicle not a “guest” under Alabama guest statute. A driver’s estate and the parents of the deceased driver brought an action for declaratory judgment against the deceased driver’s passenger seeking a ruling that the passenger was a guest, and that the driver’s estate’s liability was limited by the Alabama guest statute. The driver and passenger traveled to the passenger’s home in Georgia in a vehicle owned by the passenger’s father. The driver was the passenger’s guest on the trip, and the passenger and his family paid all of the expenses associated with the trip. During the return trip, the passenger fell ill, and slept in the front passenger seat. While he slept, the driver lost control of the vehicle. The accident resulted in the driver’s death, and the passenger was paralyzed from the chest down. The Court held that the owner of a vehicle is not a guest in the vehicle merely because another party is driving and he is the passenger. Furthermore, the Court held that, even though the passenger did not hold title to the vehicle, he had sole possession of it, and was therefore the “operator or person responsible for the operation” of the vehicle, and the driver was his guest. Tonini v. Campagna.

Insurance carrier not obligated to afford coverage retroactive to a cancellation date, even where it had knowledge of a collision. The insured’s policy had lapsed for non-payment, and was reinstated 14 days later. During the period in which it had lapsed, the insured and his children were involved in an accident which resulted in their hospitalization. The insured sued for UM benefits, and the Court held that the carrier did not waive its right to deny coverage by accepting a belated payment, even if it had knowledge of the collision. Jackson v. State Farm Fire & Casualty.

Court reaffirms abolition of collateral source rule. In an automobile accident case, the plaintiff proved gross medical special damages in the amount of $16,413.36. Of this amount, $14,713.36 were paid by his health insurer, and $1700 was classified as “out of pocket.” The jury returned a verdict for the plaintiff in the amount of $5100. On the plaintiff’s motion, the trial court ordered a new trial, holding that the jury’s verdict should have been in an amount greater than $16,413.36, which it stated were the “uncontradicted special damages” incurred by the plaintiff. On appeal, the Court of Civil Appeals held that Alabama Code §12-21-45, which abolished the “collateral source rule,” allowed the defendant to admit evidence that the majority of the plaintiff’s medical expenses had been paid by his health insurer. The jury’s verdict, which awarded the plaintiff $1700 for medical expenses and $3400 for pain and suffering, was therefore proper. Melvin v. Loats.
the injuries sustained by Clarence Bell as a result of the accident we will protect the hospital’s interest when payment is made.” Subsequent to the Progressive investigation, it informed Bell by letter that Progressive was “denying any and all claims he might assert as a result of the accident.”

After Progressive denied the claim, Bell continued to pursue the matter and ultimately agreed that he would not sue Smith if Progressive paid him a compromised amount of $6,000.00 to settle the claim. Progressive paid Bell $6,000.00 and Bell executed a full release of his claims and demands against Smith. USAMC did not join in on the release nor did it execute a separate release of its lien.

After learning that Progressive had paid Bell $6,000.00 and had obtained a release from him, USAMC filed an action against Progressive alleging that Progressive had impaired its statutory hospital lien and sought damages “for the reasonable cost of Bell’s hospital care, treatment and maintenance, plus costs and reasonable attorney fees pursuant to Ala. Code §35-11-372.” The trial court concluded that Progressive had, in fact, impaired USAMC’s lien by entering into the underlying release. However, it further concluded that the trial court erred in holding that the hospital was only entitled to the amount of the settlement or $6,000.00. The trial court concluded that pursuant to §35-11-372, USAMC was entitled to recover “the reasonable cost of its care, treatment, and maintenance of the injured party . . . .” In so holding, the Alabama Supreme Court confirmed that although the underlying compromised settlement was for $6,000.00, the hospital was nevertheless entitled to its full lien ($57,097.00) from Progressive.

This same premise has been extended to an insurer’s payment under the medical payments coverage provision of its policy where payment was made directly to the patient/insured. Progressive Specialty Insurance Company v. University of Alabama Hospital, 953 So.2d 413 (Ala.Civ.App. 2006). In this case, Progressive issued an automobile policy to its named insured, Deborah McFarland. The policy provided for $2,000 of “medpay” coverage. On January 19, 2004, Nick Williams was involved in a single-vehicle automobile accident while driving McFarland’s automobile. He was hospitalized at University of Alabama Hospital, where he accrued $27,898.57 in hospital charges, between January 20 and January 24, 2004 for treatment of injuries resulting from the January 19, 2004 accident.

Progressive was placed on either actual or constructive notice of the hospital lien, but thereafter made a $2,000 payment under the medpay portion of its policy directly to Williams. The hospital contended that Progressive’s actions impaired the hospital’s lien, and Progressive filed a declaratory judgment action contending that the Hospital Lien Statute applied only to settlements of a third party tort claim. In affirming the trial court’s ruling, the Court of Civil Appeals held that the Hospital Lien Statute is not limited to actions arising in tort, but also extends to actions arising under contract, which would include the payment under the “medpay” provision of the Progressive policy. The particularly harsh result of this case is that the Court’s ruling resulted in Progressive’s liability for the entire lien of $27,898.57 . . . even though its contractual liability under the ‘medpay’ portion of its policy was only $2,000.”

“The particularly harsh result of this case is that the Court’s ruling resulted in Progressive’s liability for the entire lien of $27,898.57 . . . even though its contractual liability under the ‘medpay’ portion of its policy was only $2,000.”

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Medicare benefits.

Reporting

While the implementation of the reporting requirements under the Act have been delayed from the original implementation date of July 1, 2009 to January 1, 2010, the reporting requirements are retroactive to July 1, 2009.

Failure to properly report in accordance with the Act can subject the insurer to civil penalties in the amount of $1,000 for each day a report is not made following a settlement, judgment, award or other payment. Furthermore, the burden rests with the insurer to identify potential Medicare beneficiaries.

In order to comply with reporting requirements, an insurer must obtain the social security number for the claimant. Of course, a claimant is under no obligation to supply her social security number to an insurer outside of litigation; thus, the Act can have onerous, and presumably unintended, consequences to an insurer which is unable to obtain a claimant’s social security number.

In the course of conducting its investigation into a claim, an insurer must place the Centers for Medicare and Medicaid Services (CMS) on notice of any loss involving a Medicare/Medicaid beneficiary in which there is an expectation on the part of the insurer to make a payment on the claim.

When there is a claim that potentially involves a Medicare beneficiary, there is a procedure to verify with CMS whether the individual is a Medicare beneficiary. Once a month, a carrier can submit all claims it wishes to check to CMS. The information submitted must include the name, social security number, date of birth and gender of the individual. CMS’s response will issue within 14 days. If the claimant is determined to be a Medicare beneficiary, a Medicare Health Insurance Claim Number (HICN) will be provided to the carrier to be used on all future reporting.

To determine whether an injured party is a Medicare beneficiary, the Medicare Coordination of Benefits Contractor (COBC) must match the claimant’s data to Medicare’s. The insurer is required to send either an HICN or the claimant’s social security number. Once a match is found, the insurer will be provided the correct HICN, which is to be used on all future transactions/reports.

In the case of a settlement, judgment, award or other payment (without separate, ongoing responsibility for medical payments), only one (1) report is required to be submitted per carrier contributing to the payment.

When reporting ongoing responsibility for medical expenses, the carrier must report the following two (2) events: an initial record to reflect the acceptance of ongoing payment responsibility (“add”) and a second update record to reflect the end date of ongoing payment responsibility (“update”).

The initial file submission includes information for all claims where the injured party is/was a Medicare beneficiary and which are addressed/resolved (or partially addressed/resolved) through a settlement, judgment, award or other payment on or after July 1, 2009.

Subsequent quarterly claim input file submissions must include records for any new claims, as well as update records for previously submitted claims. If a claim record was submitted in error (e.g., there was no settlement, judgment, award or other payment), the carrier must submit a “delete” record on its next quarterly claim input file to remove that claim information from the database. If the individual was not a Medicare beneficiary at the time responsibility for ongoing medicals was assumed, the carrier must monitor the status and continue to report to confirm that she has not subsequently become a beneficiary. If the carrier doesn’t have new information to supply on a quarterly update file, it must submit an “empty” claim input file.

For every claim input file sent to the COBC, a carrier will receive a claim response file in return within 45 days.

Medicare Lien Reimbursement

After the COBC has been put on notice of a loss, the carrier is to use ICD-9 codes to reference which injuries are related to the claim. Up to five (5) codes may be used to characterize the injuries involved. The COBC will enter that information into the database and create a working file. The information is then submitted to a Medicare Secondary Payor Recovery Contractor (MSPRC) which will assemble the data and issue interim payment statements to the claimant. Once the claim is resolved, the Medicare beneficiary is required to sup-
ply the specific settlement terms, including the amount of attorney’s fees and expenses, to the MSPRC. The Medicare beneficiary will be informed of CMS’s subrogation rights, which must be satisfied consistent with the demand and/or an amount that is equal to the settlement payment, if less than the subrogation demand amount; therefore, it is important to ensure that unrelated injuries are not reported, and carriers should continually monitor and correct inaccurate information in the database as the claim progresses.

Penalties
In addition to the $1,000 per day fines associated with the failure to report, there is also a private cause of action allowed for under the Act. A claimant or CMS can sue the carrier, or even the attorneys involved, to recover twice the amount of the Medicare benefits if they are suspended as a result of a failure to protect Medicare’s interests.

Conclusion
Overall, the Act is a burdensome piece of legislation for both carriers, litigants and attorneys. It seems inevitable that the requirements will slow the litigation process significantly, as carriers may elect to await the Medicare demand letter before issuing any payment to best protect themselves, and it could conceivably take months before the demand letter is issued. Releasing the proceeds along with an indemnity agreement may not sufficiently protect the carrier, as CMS can seek reimbursement from the carrier directly despite the indemnity agreement, leaving the carrier’s only recourse a collection action against the claimant.

In short, the effect, both intended and unintended, of the Medicare, Medicaid, and SCHIP Extension Act of 2007 are, and will be, far reaching, with numerous pitfalls; thus, this article is not intended to be a comprehensive review of the Act, but is instead designed to provide a brief introduction and reference for claims professionals who may find themselves dealing with this issue in earnest for the first time.

The attorneys of Smith, Spires & Peddy, P.C. are available to respond to any additional questions or concerns you may have with respect to the pending implementation of this Act.

VENUE: Where am I?
by Jody Peddy

Let’s take a simple but common scenario. You have completed your initial investigation and have obtained enough information to evaluate the claim and set your reserve. It is a personal injury claim and one of probable liability on behalf of your insured. As usual, you review all of the medical records and bills, wage documentation and any other relevant information to assess your exposure. Have you missed anything? Is there anything else of significance to consider before you place a value on the claim?

In Alabama, like many other states, it is often critical to include an analysis of the venue (county where claim will be tried) in your evaluation. Most counties in Alabama can be easily identified on a scale ranging from conservative to liberal based primarily on historical verdict information. Although not absolute, consistently large verdicts can be tracked to a particular group of counties in this state. Verdict research is easily assessable from a generalized database, is relatively inexpensive, and can often be tailored to the particular type of claim involved. This database also contains information on settlements in significant cases.

The importance of assessing your venue cannot be overemphasized. A seemingly solid defense to a claim may be good in one county but not so good in another. A claim that might seem insignificant may otherwise become much more significant in a liberal venue. Simply stated, your exposure can vary greatly from one county to the next.

In addition to assisting you with verdict research, our firm is available to discuss these issues with you. We have also developed a color coded map which specifically identifies each county in the state as conservative, moderate or liberal. If you would like one of these, feel free to contact us and we will send one to you. Remember, know your venue!

“[T]he reporting requirements under the Act have been delayed from the original implementation date of July 1, 2009 to January 1, 2010, [but] the reporting requirements are retroactive to July 1, 2009.”

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Smith, Spires & Peddy, P.C. is pleased to present to you its first quarterly edition of THE OPENING STATEMENT.

Founded in 1990, Smith, Spires and Peddy, P.C. has enjoyed steady success, growing from six to fourteen attorneys over the past 18 years. Our law firm is headquartered in Birmingham, Alabama, and serves a wide range of clients and corporate interests across the Southeast. We litigate throughout the states of Alabama, Georgia and Mississippi in all state and federal courts.

The contents of this newsletter are intended to be for general informational purposes only and should not be construed as legal advice and/or a legal opinion. This publication is not intended to create an attorney/client relationship and is not a privileged attorney/client communication. Please consult an attorney to seek specific legal advice and/or to address your own specific needs and/or situation.

SMITH, SPIRES & PEDDY IN THE NEWS

Thomas S. (Spin) Spires and A. Joe (Jody) Peddy, for the second year in a row, have been listed in Super Lawyers, a publication which recognizes the top lawyers in Alabama as chosen by their peers.

Spin Spires was recently named to "The Best Lawyers in America" 2009 edition. Spin has received this recognition each year from Best Lawyers for the past 14 years since 1995.

Jody Peddy was recently inducted into the American Board of Trial Advocates, an exclusive national organization of attorneys selected by their peers, recognizing the advocacy skills of its members.

Jennifer (Jennie) W. Pickett was recently named a partner of Smith, Spires & Peddy, P.C., and Jonathan L. Brogdon recently became the firm’s newest associate.

Smith, Spires & Peddy, P.C. was recently recognized in Birmingham Magazine’s March 2009 Special Promotional edition devoted to top lawyers and law firms in the area.

In the past few years, Spin Spires’ mediation practice has continued to grow. He currently mediates a wide variety of cases including products liability, automobile and trucking accidents, premises liability, personal injury, wrongful death, as well as insurance and coverage issues.

Todd N. Hamilton was a featured speaker at Lorman’s March 12, 2009 Trucking Litigation and D.O.T. Regulations seminar in Birmingham, Alabama.

Tamera K. Erskine was recently elected "Woman of the Year" for the Shelby County Eta Xi chapter of Beta Sigma Phi. Beta Sigma Phi International is a non-academic social, cultural and civic enrichment sorority with 200,000 members in chapters around the world.

Todd N. Hamilton, Robert B. (Rob) Stewart, Clarence R. (Chip) Rivers, IV and Tamera K. Erskine will all be serving as guest lecturers at the National Association of Legal Secretaries (NALS) Samford After Sundown Legal Training Course for the Fall 2009 semester.

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