

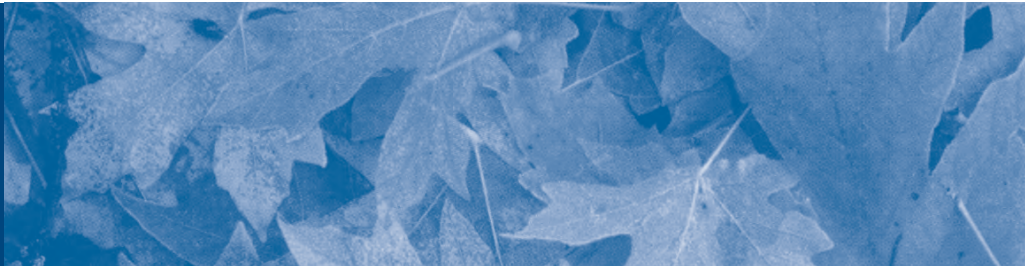
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**LUTHER-ANDERSON**  
**NEWSLETTER**

*Winter 2009-2010*

**LUTHER-ANDERSON**

• FIRM NEWS •

**AMANDA ROGERS ELECTED PRESIDENT-ELECT OF SETLAW**

Amanda Rogers has been elected President-elect of the Southeast Tennessee Lawyers Association for Women for the 2009-2010 term.

**LUTHER-ANDERSON WELCOMES NEW ASSOCIATES**



Luther-Anderson is pleased to welcome Kathryn M. Russell to the firm. Mrs. Russell received a B.A. from Florida State University in 1997 and a B.A. in Spanish from the University of Tennessee-Chattanooga in 1999. She then attended the University of Tennessee in Knoxville, where she received her M.B.A. in 2003, and her law degree in 2004. Mrs. Russell practices general civil litigation, insurance defense, and family law. She is licensed to practice in both Georgia and Tennessee. Mrs. Russell has been elected President of the Southeast Tennessee Lawyers Association for Women for the 2009-2010 term.



Luther-Anderson is pleased to welcome Greta Locklear to the firm. Ms. Locklear received her B.S. from Covenant College in 1998 and her J.D. from Mississippi College of Law in 2003. Ms. Locklear is currently licensed in Mississippi only but has pending request to be waived into Tennessee and Georgia. Ms. Locklear was in private practice before joining the firm but also has had extensive experience in handling Asbestosis cases. Prior to practicing law Ms. Locklear had ten years of paralegal experience working in various Georgia law firms. Ms. Locklear will be handling general Insurance defense cases.



# LUTHER-ANDERSON NEWSLETTER



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## • LAW UPDATES •

### TENNESSEE

#### TENNESSEE SUPREME COURT RECOMMENDS ALLOWING DISCOVERY OF INSURANCE

The Tennessee Supreme Court subject to approval of general assembly recommend changes to Rule 26 of the Tennessee Rules of Civil effective July 1st 2010 to allow discovery of insurance in litigated cases. The proposed changes are as follows:

Rule 26.02. Discovery Scope and Limits. -

(1) \* \* \* \*

(2) INSURANCE. A party may obtain discovery of any insurance agreement under which an insurance business may be liable to satisfy all or part of a possible judgment in the action or to indemnify or reimburse for payments made to satisfy the judgment.

(3) \* \* \* \*

#### MEDICAL MALPRACTICE

The **Tennessee Medical Malpractice Act of 2009** went into effect on July 1, 2009. This Act brings several significant changes to Tennessee's 2008 Act. Generally, the new Act makes it easier to give notice of a potential medical malpractice claim, and provides details about what the notice and the complaint must include. Following is a more specific description of the changes brought by this Act:

- The Act clarifies that the following information must be included in the medical malpractice claimant's notice and in the complaint:
  1. Full name and date of birth of patient whose treatment is at issue.
  2. Name and address of claimant, and claimant's relationship to patient (if not patient).
  3. Name and address of attorney sending notice, if applicable.
  4. List of names and addresses of all providers being sent notice.
  5. HIPAA-complaint medical authorization allowing providers receiving notice to obtain complete medical records from all other providers who were sent notice.
- Effective personal service on a healthcare provider can now be made by serving "an identified individual

whose job function includes receptionist for deliveries to the provider or arrival of the provider's patients at the provider's current practice location." *Tenn. Code Ann. § 29-26-121(a)(3)(A)*.

- Effective service of notice by mail is now made by sending *two* notices, via certified mail, to the health care provider. For service on individual providers, one notice goes to the provider's current business address, and the other goes to the address listed for the provider on the website for the TN Dept. of Health (if different). For service on a business entity provider, one notice goes to the address of the agent for service of process, and the other goes to the provider's business address (if different). It is not necessary for the recipient of the notice to sign or return the receipt card for service to be effective.
- The previous 90-day extension for compliance with the notice provision has been increased to 120 days. The 2009 Act also clarifies that the extension is measured from the date the statute of limitations would have expired without the extension.
- The 2009 Act, like the 2008 Act, requires that compliance with the notice provision must be plead in the complaint. The 2009 Act clarifies that if there is personal service of notice on the health care provider, the complaint should include a statement that the statute has been complied with, as well as an affidavit "stating that such notice was personally delivered, and the identity of the individual to whom the notice was delivered." *Tenn. Code Ann. § 29-26-121(a)(3)(A)*.
- Notice given by mail must also be referenced in the complaint and confirmed by an affidavit of the party mailing the notice, "establishing that the specified notice was timely mailed by certified mail, return receipt requested." *Tenn. Code Ann. § 29-26-121(a)(4)*. The notice must be attached to the affidavit, along with a date-stamped "certificate of mailing" from the post office.
- Under the 2008 Act, the certificate of good faith had to be filed within 90 days of the filing of the complaint. The certificate of good faith must now be filed *with* the complaint. There are only two exceptions to this requirement: (1) failure of the defendant to provide medical records as required

by statute or (2) a showing of extraordinary cause. Otherwise, failure to file the certificate with the complaint will result in dismissal of the complaint.

- The 2009 Act states that a health care provider can produce records in the following ways:
  1. Mail a copy of the requested portions of the records with a statement for the cost.
  2. Request advance payment of the cost of the records. Requests for advance payment must be made in writing, 20 days after receipt of the request. The provider must send the records within 3 business days after receipt of payment for the records.
  3. Such other method as the provider and the individual requesting the records have agreed to in writing.

## MOTION FOR SUMMARY JUDGMENT STANDARDS

Last year the Tennessee Supreme Court made significant changes to the summary judgment standards in Tennessee. For over fifteen years, the case of *Byrd v. Hall* was the main source of Tennessee's summary judgment standards. 847 S.W.2d 208 (Tenn. 1993). The understanding of summary judgment after *Byrd* was that a movant could assert that the nonmoving party lacked any evidence creating a genuine dispute. This assertion would shift the burden, so that the nonmoving party would be required to "put up or shut up." Basically, the nonmoving party would need to put up evidence raising a genuine dispute as to a material fact—if they failed to do so, then summary judgment would be granted.

On October 31, 2008, in the case of *Hannan v. Alltel*, the Tennessee Supreme Court stated that it "did not adopt a 'put up or shut up' approach to burden-shifting in *Byrd* or in subsequent cases." The Court clarified that the burden does not shift until the moving party either (1) affirmatively negates an essential element of the nonmovant's claim; or (2) shows that the nonmoving party cannot prove an essential element of the claim at trial. This drastic change in Tennessee's summary judgment standards has created confusion as to what exactly is required to shift the burden of production at the summary judgment stage.

***Hannan v. Alltel*, 2008 WL 4790535 (Tenn. Oct. 31, 2008).** – The Hannans were the owners and operators of Magnolia House Bed and Breakfast and Tellico Plains Realty. Both businesses were advertised in telephone directories published by Alltel. Certain ads and listings for which the Hannans had contracted were not published in the directory, and the Hannans filed suit.

At trial, the Hannans would be required to show (1) that they had suffered damage and (2) the amount of that damage, if any. At the summary judgment stage, however, the burden was on Alltel to prove the opposite: that the plaintiffs had not suffered damage, or that they would be unable to prove they had suffered damage. In moving for summary judgment, Alltel relied on the following evidence: "(1) the Hannans' tax returns showing an increase in gross income during the year the advertisement was omitted and Mr. Hannan's deposition testimony that he could not explain the increase . . . and (2) Mrs. Hannan's deposition

testimony that neither she nor anyone else could determine the amount of damages." *Id.* at 10. The Hannans responded by saying that they would prove damages at trial.

The Supreme Court found Alltel's evidence to be insufficient to shift the burden of production because the evidence did not affirmatively negate an element of the claim. Instead, the evidence only showed that the Hannans were unable to calculate the amount of damages, and that they would not be able to use the tax returns to prove damages. The Court stated that "[t]he moving party may not . . . merely point to omissions in the nonmoving party's proof and allege that the nonmoving party cannot prove the element at trial." *Id.* at 10. The Court noted that the Hannans would not be required to assert a specific amount of damages at trial. Thus, Alltel's evidence would need "to show affirmatively that the Hannans cannot provide proof sufficient to allow the trier of fact to make a fair and reasonable assessment of damages." *Id.*

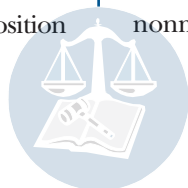
***Martin v. Norfolk Southern Railway Company*, 271 S.W.3d 76 (Tenn. 2008).** – Kathryn Martin was killed when her vehicle was hit by a train. Her husband and adult children sued Norfolk and the operating engineer, alleging that Norfolk allowed overgrowth of vegetation which blocked Mrs. Martin's view of the train, and that the engineer failed to blow the train's whistle as it approached the crossing.

The defense moved for summary judgment, setting forth photographic evidence and witness testimony to show that Mrs. Martin had ample visibility when she initially stopped; that she moved from her initial position and stopped again in a place where she had even better visibility; that she had plenty of time to safely move her vehicle once the train became visible; and that the engineer blew the whistle several times. The Supreme Court found that "the defendants' motion negated the elements of breach of duty and causation by setting forth facts that tend to show that Norfolk and [the engineer] acted reasonably and that Mrs. Martin did not exercise reasonable care." *Id.* at 84. This negation shifted the burden of production to the plaintiffs.

The plaintiffs responded with expert and eyewitness testimony regarding Mrs. Martin's visibility from her initial stopped position; whether she stopped a second time; whether she had sufficient time to see the train and stop; and whether the engineer blew the train's whistle. Based on this evidence, the Court found that the "plaintiffs . . . demonstrated the existence of several genuine issues of material fact," and that summary judgment was therefore not appropriate. *Id.* at 87.

## SUMMARY OF MSJ STANDARDS AFTER HANNAN/MARTIN

In Tennessee, a summary judgment movant has the ultimate burden of persuading the court that there are no genuine issues of material fact. To do this, the movant must do something more than assert that the nonmoving party lacks evidence. Before the burden will shift, the moving party must either affirmatively negate an essential element of the claim, or it must show that the plaintiff cannot prove an essential element at trial. When the burden of proof does shift, the nonmovant can defeat the motion by producing evidence that creates a genuine dispute as to a material fact. If the nonmovant is unsuccessful, the motion will be granted.



## GEORGIA

### **TRINITY OUTDOOR, LLC V. CENTRAL MUTUAL INSURANCE COMPANY, 2009 WL 1505383 (GA.)**

Trinity Outdoor's insurance policy through Central included a no settlement clause, which provided that Trinity could not "voluntarily make a payment, assume any obligation, or incur any expense, other than first aid" without Central's consent. After Central provided Trinity with a defense in an underlying case, Trinity voluntarily contributed more than \$750,000 toward settlement of the case without Central's approval. The Georgia Supreme Court held that, under the facts of this case and the insurance policy in question, the insured, Trinity Outdoor, could not maintain an action against its insurer, Central Mutual Insurance Company, for bad faith failure to settle the underlying injury claim in the absence of a jury verdict.

### **SB 276 / GEORGIA CODE ANNOTATED § 33-7-11**

Effective January 1, 2009, this new Georgia law contains a "stacking" provision, which allows an insured to have coverage which would piggy-back his UM coverage onto another motorist's policy. If the insured is in an accident and the at-fault driver has no insurance or not enough insurance to cover damages and expenses, the insured's UM policy would make up the difference to the extent of the policy limits. This "stacked coverage" is automatic upon renewal of a Georgia policy, although the insured can opt out.

## FEDERAL

### **NEW MEDICARE REPORTING REQUIREMENTS**

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) adds new mandatory reporting requirements for group health plans, liability insurance (including self-insurance), no-fault insurance, and workers' compensation. The reported information will be used by the Center for Medicare and Medicaid Services (CMS) to determine whether money is owed to Medicare.

### **GROUP HEALTH PLANS**

Effective January 1, 2009, insurers, third party administrators, and administrators of self-insured and self-administered group health plans must collect specified information from plan participants and report the information to CMS. For group health plans which did not already have a voluntary data sharing arrangement with CMS, implementation began April 1, 2009. Health Reimbursement Arrangements (HRAs) are subject to the reporting requirements, but are not permitted or required to report until October 2010. Health Flexible Spending Arrangements (FSAs) and Health Savings Accounts (HSAs) are not treated as group health plans, and are thus not subject to the reporting requirements.

CMS uses the information reported by group health plans to discover whether a plan or program is primary to Medicare under the "Medicare Secondary Payer" (MSP) rules. MSP rules dictate whether Medicare or a group health plan is primary when an individual has coverage from both sources. In general, a group health plan is primary for coverage due to current employment status, and Medicare is primary for retiree coverage.

### **LIABILITY INSURANCE, NO-FAULT INSURANCE, & WORKERS' COMP**

Separate reporting obligations apply to liability insurance, no-fault insurance, and workers' comp plans, effective April 1, 2010. Insurers (including self-insurers) are responsible for reporting under this portion of the Act. For workers' compensation, the Federal or State workers' compensation agency may be the responsible entity. Registration of these "Responsible Reporting Entities" (RREs) will be complete as of September 30, 2009. The URL for registration is [www.Section111.cms.hhs.gov](http://www.Section111.cms.hhs.gov).

The reported information will be used by CMS to discover details about personal injury settlements with Medicare-qualified plaintiffs, which will "enable an appropriate determination concerning coordination of benefits, including any applicable recovery claim." The insurers are responsible for finding out whether any plaintiff with whom they settle a case is a Medicare beneficiary. This can be discovered by sending an electronic inquiry to CMS using the plaintiff's social security number. CMS will respond within 45 days. A positive response will include the plaintiff's Health Identification Number, which is used for further reporting by the insurer. The reports are due no later than the quarter after each settlement with a Medicare beneficiary.

CMS has attempted to clarify some "thresholds" (exceptions) for the reporting requirements. These are published in an Alert dated March 20, 2009 on the CMS website: [http://www.cms.hhs.gov/MandatoryInsRep/Downloads/Alert\\_UserGuideSupp\\_NGHP.pdf](http://www.cms.hhs.gov/MandatoryInsRep/Downloads/Alert_UserGuideSupp_NGHP.pdf)

### **NON-COMPLIANCE PENALTIES**

The penalty for non-compliance with reporting requirements is high: \$1,000 per day per individual for whom required information was not submitted. According to the Act, the money collected for non-compliance will be deposited into the Federal Hospital Insurance Trust Fund.

