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PREMIER ISSUE

Beginning with this issue, Mintzer Sarowitz Zeris Ledva & Meyers, LLP, hopes to bring you periodic newsletters of interesting legal decisions and trends that affect the claims community.

DEFENSE COUNSEL

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NY OFFICE BACK ON TRACK

Thankfully, we lost no personnel during the horrific attacks in New York City. Our New York Office, situated approximately four blocks from the World Trade Center Complex was without electricity for two weeks following the disaster.

We join the nation in mourning the loss of loved ones.

MEYERS PAVES WAY FOR EXPANSION

On March 1, 2001, long-time friend Addison "Sonny" Meyers joined our firm as a named partner. Sonny, with 21 years of litigation experience, has established the firm's south Florida Office in Coral Gables.

THE "CAUSATION DEFENSE" in NY Premises Claims

By James Zeris, Esq.

Similar to the "Threshold Defense" in claims for personal injuries caused by motor vehicle accidents, New York defense attorneys have been successful in dismissing actions that allege inadequate or negligent security in multiple dwelling buildings in what is now called "The Causation Defense."

HISTORY OF THE CAUSATION DEFENSE

In actions involving a claim for injuries sustained by an alleged assault in a multiple unit dwelling, many plaintiffs have argued that the lack of security inside the building or defective locks

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PA COURT UPHOLDS \$0 DAMAGES

By Lawrence M. Kelly, Esq.

A three-judge panel of the Pennsylvania Superior Court has upheld a jury verdict of zero damages in a conceded liability trial. This means that plaintiffs who are successful in proving liability are no longer guaranteed a financial reward.

Previous to Simon v. Schwartzman, when a defense doctor had testified that a plaintiff's injuries had resolved, the logic was that some monetary compensation was due. In Simon, however, the defendant's IME doctor testified that the plaintiff's herniated disc was not caused by the defendant's accident, testimony the jury accepted.

ASSIGNMENT OF PIP BENEFITS IN NEW JERSEY

By Christopher Carlson, Esq.

An opinion that could have a significant impact upon Personal Injury Protection (PIP) suits in New Jersey in general—and American Arbitration Association filings in particular—is Parkway Insurance Company v. New Jersey Neck and Back. The opinion arises out of a suit brought in Morris County by Parkway insurance Company against two medical providers, New Jersey Neck and Back Center and Injury Treatment Center.

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THE IMPORTANCE OF PLAN DOCUMENTS IN THE DEFENSE OF DISABILITY CLAIMS

By Phillip B. Silverman, Esq.

Employers frequently provide both short- and long-term disability benefits to their employees. The short-term benefits are usually self-insured, and the long-term benefits are most likely purchased from an insurance company. Since these are employee benefits, the administration of and disputes arising out of these claims are usually governed by the Employee Retirement Income Security Act of 1994 (ERISA).

In order to properly defend a disability claim, it is essential to have all the necessary records and documents concerning how the claim was administered, as well as a description of what will happen if the claim is denied and the matter winds up in court. One of the necessary documents is the insurance policy, which is held by both the insurance company and the policyholder-employer. Another necessary document is the summary plan description, or SPD, which is often held by the claimant-employee. It is also important to have the ERISA Plan Documents as well, which can be found in the employer's office of personnel, general counsel or labor attorney.

One of the reasons these plan documents are so crucial in defending disability claims is that ERISA can limit the right of the court to reverse the decision of the plan administrator in making determinations about the claim. If that right exists at all in a given situation, the language that delegates that right and responsibility is found in the ERISA Plan Documents, not the insurance policy or the SPD.

Another reason the documents are important is that when a claim is denied by the insurance company and a lawsuit is subsequently filed, the language in the insurance policy, SPD or ERISA Plan Documents determines the standard of review, establishing it by the court to be either "de novo" or "arbitrary or capricious." While there have been questions raised about the applicability of the arbitrary and capricious standard for review by the court when an insurance company serves a dual role by administering an ERISA benefit plan and insuring its members, it is clear that knowledge of the proper standard of review is essential for handling and defending these types of claims.

Assignment of PIP Benefits in New Jersey

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These providers had billed Parkway a combined total of well over \$100,000,000 in the late 1990's. Parkway, having had difficulty securing the cooperation of their assureds and the facilities, filed an Order to Show Cause and Verified Petition seeking a declaration that medical provider assignees had no standing to have filed for Arbitration through the American Arbitration Association. This precluded coverage for the claims under the applicable Parkway policy. Parkway also sought a declaration that it was not obligated to pay any medical bills submitted by the defendant providers as assignees, as well as dismissal of all pending AAA Arbitration matters filed by the defendant providers. The Honorable Charles E. Villanueva granted each of Parkway's requests.

The Court noted that N.J.S.A. 39:6A-13 does require cooperation from insureds, passengers and medical providers in the investigation of PIP claims. The Court stated that an insurer cannot adequately defend its interests if its investigation of a claim has been thwarted by the patients and their treating physicians. The Court then provided a concise analysis of the history of the law in New Jersey and other jurisdictions in interpreting the assignment issue. The Court noted that Parkway was a member of the Insurance Services Office, Inc., or "ISO," and, as such, Parkway's policy stated that "your rights and duties under this policy may not be assigned without our written consent."

The Court noted that N.J.S.A. 39:6A-4 does not completely prohibit the assignment of benefits to an insured's treating physician, though the Court observed that the assignment provision of N.J.S.A. 39:6A-4(2) contemplates payment of medical benefits at the option of the Insurance Company.

The Court summarized case law by saying that one may not ordinarily claim standing to assert the rights of a third party under a contract. Although the Court did acknowledge that treating medical providers are incidental beneficiaries of automobile insurance policies carrying PIP coverage, it stated that they have no independent standing to pursue these claims. The Court then went on to hold that the purported assignments of benefits to the medical providers in this case, when compared with the prohibition against assignment contained in the Parkway policy, rendered the assignments void and unenforceable, given that public policy favors freedom of contract and an insurer's right to deal with only the party with whom it contracts. The Court also decided that insureds and medical providers should not have the right to selectively determine which portions of an insurance contract they wish to honor. As such, given that the alleged various assignments were held to be void and unenforceable, all American Arbitration Association arbitrations instituted by the defendants were dismissed.

CHIPPING AWAY AT McCULLOUGH: THE DILEMMAS IN DEFENDING THE NURSING HOME CONTINUE

by Scott D. Kirschbaum, Esq.¹

The recent flux in the Florida Legislature with its turbulent Tort Reform campaign has apparently had an effect upon the Courts in Florida as well. This is true at least when it comes to dealing with causes of action pursued against nursing homes by their residents and families. In the past few months the Second, Third, and Fourth District Courts of Appeal in Florida have written opinions that may have the effect of setting back the clock at least ten years on nursing defense. Ultimately, this will re-create the unchecked safe haven for Plaintiffs to pursue unlimited verdicts that has existed for years. These recent decisions have had the effect of invalidating earlier decisions by Florida Courts which try to limit the apparent slippery slope of outrageous verdict awards in these cases throughout the State.

THE PRE-SUIT INVESTIGATION REQUIREMENTS

For years, there existed a conflict in the way courts handled nursing home and medical malpractice litigation in Florida. In Florida, all claims for medical malpractice must be predicated upon reasonable grounds to believe that a claim for medical negligence exists. These reasonable grounds must be established through an investigation which is governed by a very complex and comprehensive statutory process. *Fla. Stat. sec 766.102, et. seg.* The failure of either side to abide by the terms of the pre-suit requirements may result in serious sanctions. For instance, if there is bad faith on the part of the Plaintiff, the claim can be dismissed. If the Defendant fails to comply in good faith, its defenses can be stricken after suit is filed.

On the other hand, nursing home litigation is governed by the Nursing Home Act under Chapter 400, Florida Statutes. Prior to 1993, Chapter 400 had absolutely no pre-suit investigation requirements. However, the statute made nursing homes vicariously liable for all medical personnel employed by them for any breaches of professional standards in rendering medical care to the residents. As a result, many defense attorneys took the position that the Plaintiffs should be required to comply with the same pre-suit investigation mandated by the Medical Malpractice Act when filing claims against nursing homes. Since the standard for liability would be predicated upon professional negligence, it logically followed that pre-suit requirements were applicable. The first such relief came to the defense in the Second District Court of Appeal.

In 1991, the Second District Court of Appeal, in a decision called *NME Properties, Inc. v. McCullough*, 590 So.2d 439 (Fla. 2DCA 1991), loosely held that in any case against a nursing home where the nursing home employees are alleged to be the agents of the facility, a Plaintiff must first comply with the pre-suit investigation requirements embodied in Florida Statutes, Chapter 766, governing medical malpractice. The Court reasoned that nursing homes should be afforded the same investigation privileges as are required in medical malpractice cases, since the employees of most nursing homes would qualify as "health care providers" under Chapter 766. If suit were brought directly against those employees, the Plaintiff would have to comply with the pre-suit requirements under Chapter 766 anyway.

In practical application, since most nursing home cases involve claims for vicarious liability for medical employees, such as nurses, as well as for the nursing home's violation of the resident's Bill of Rights, afforded by Florida Statutes, most Plaintiff attorneys have simply acquiesced and participated in a pre-suit investigation. This afforded the defense with its first chance at an opportunity to assess the true merits of the claim and perhaps to resolve it early on to avoid attorneys' fees and other costs.

Recently however, the Second District Court of Appeal was faced with a conflict between certain causes of action that may be brought under Chapter 400 and the pre-suit requirements mandated under the *McCullough* decision pursuant to Chapter 766. The Second District Court of Appeal noted that there are essentially two types of nursing home cases. The first deals with the claim that the nurses and other medical employees of the nursing homes failed to provide adequate medical and nursing care. In such a case, the nursing home would be vicariously liable for the malpractice of such employees, and should be afforded the benefit of a pre-suit investigation as is available under Florida's Medical Malpractice Act pursuant to Chapter 766. However, the Second District Court of Appeals recognized another type of claim brought against nursing homes that seeks redress not for negligence, but for statutory violations of the resident's Bill of Rights embodied in Chapter 400. The question then became what investigation is required under these types of claims. This very question was certified to the Florida Supreme Court in the case of *Integrated Health Care Services, Inc. v. Lang-Redway*, 26 Fla. L. Weekly D699 (Fla. 2DCA 2001).

In certifying the question, the Second District provided the Supreme Court with a comprehensive analysis of its own reasoning for the Court's consideration.

In the *Integrated Health Care* case, the Second District noted that Chapter 400, Florida Statutes was amended in 1993 to implement an investigation scheme for any action alleging a violation of the resident's Bill of Rights under Chapter 400. Prior to alleging a violation of rights under Chapter 400, the claimant must conduct an investigation that includes a review by a licensed physician or registered nurse prior to filing any complaint. The complaint must attach a verified statement from that reviewer. This is required as per the 1993 amendments to Chapter 400, specifically Section 400.023(4).

This apparent conflict between the investigation requirements of Chapter 400 and the medical malpractice pre-suit investigation process of Chapter 766, is what prompted the Second District to certify the question to the Florida Supreme Court. However, the very same issue recently came up before the Fourth District Court of Appeals which seemed to reconcile the conflict in the *McCullough* precedent with relative ease. Quite frankly, based upon the language of the Chapter 400 statute and the reasoning of both the *Integrated Health Care* and *McCullough* cases, it would be of no great surprise to see the Florida Supreme Court follow the reasoning of the Fourth District in resolving the Second District's certified question, as is explained below.

In the case of *Preston v. Health Care and Retirement Corporation of America*, 26 Fla. L. Weekly D9191 (Fla. 4 DCA 2001), the Court reconciled the pre-suit requirements of the Medical Malpractice Act and the investigation requirements of the Nursing Home Act. In that case, the trial court sitting in Broward County, Florida, dismissed a claimant's lawsuit for violations of the claimant's resident rights under the Nursing

Home Act, for the claimant's failure to comply with the Medical Malpractice Act's pre-suit investigation requirements. The Fourth District Court of Appeal reversed the decision of the trial court and found that the Nursing Home Act, specifically Florida Statute section 400, was a special statute governing nursing home actions and that the Medical Malpractice Act's pre-suit requirements was an earlier and general statute. Thus, the special statute would take precedence over the general statute.

Accordingly, the Fourth District held that by the enactment of the 1993 amendments, the legislature clearly intended that the less comprehensive investigation requirements imposed by Florida Statute section 400.023(4) should apply where the plaintiff alleges only that a nursing home violated a resident's right to adequate health care. The Fourth District expressly stated that there was absolutely no need to harmonize Chapter 766 and Chapter 400 where there is only an action brought under Chapter 400.

CONCLUSION

Based on these recent decisions, it appears that the Florida Supreme Court has an open avenue to erode the *McCullough* decision which compelled Plaintiffs to comply with the pre-suit investigation requirements of Chapter 766 in nursing home cases. Instead, Plaintiffs can now simply file suit in the form of violation of residents' rights with a simple affidavit from a doctor or registered nurse and proceed to suit with no further investigation.

¹ Mr. Kirschbaum received his Juris Doctor of Law from St. Thomas University in 1992. Since graduation, he has specialized as a defense lawyer in litigation and civil trial. His fields of practice are concentrated in the areas of medical malpractice and nursing home defense. He practices with the law firm of Mitnzer, Sarowitz, Zeris, Ledva & Meyers, in its Miami office.

The “Causation Defense” in NY Premises Claims

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were caused by the defendant property owner’s negligent maintenance of the premises. In response, defendants argued that the alleged defective condition could not have been the cause-in-fact of the assault if the assailant was a tenant or invitee of a tenant or if the perpetrators entered the building through a different entrance. (i.e., “The Causation Defense”)

In light of the fact that the plaintiff holds the burden of proof, it was their responsibility to establish that the assailant was *not* a tenant or invitee of a tenant and that the intruder gained access to the building through the defective condition of the building. Moreover, the plaintiff was required to show that the assailant did not enter through some other entrance. This burden became a major hurdle for plaintiffs and courts increasingly granted pre-trial summary judgment motions in favor of defendants.

In *Rodriguez v. New York City Housing Authority*, the Court held that a plaintiff’s mere speculation that the defendant’s lack of security was the cause of the incident, was not enough to establish the burden. Thus, the defendant’s Motion for Summary Judgment was granted.

Again, in *Burgos v. Aqueduct Realty Corp.*, the Court of Appeals granted the defendant’s Motion for Summary Judgment. In that action, the plaintiff was assaulted as she exited her 4th floor apartment. The plaintiff alleged that her assailant(s) obtained entry into the building through a defective door lock. The plaintiff also argued that she knew all the tenants in the building and therefore the assailant(s) must have gained entry into the building through the defective doorway. However, the Court held that the plaintiff was unable to prove that the intruder(s) entered through the doorway, rather than as invitees of another tenant in the building.

Also, the Court in *Burgos* held that “a plaintiff’s testimony that she had never previously seen the assailant(s) does not raise a triable issue as to whether they were intruders.”

REVERSAL OF “THE CAUSATION DEFENSE”

Recently, the Court of Appeals reversed the decisions of *Rodriguez and Burgos*. Although the Court held that the plaintiff in a security premises action must prove that the assailant(s) was an intruder, it did not support the precedent established by the *Burgos* ruling. The Court of Appeals said that “such a rule would undermine the deterrent effect of tort law on negligent landlords, diminishing their incentive to provide and maintain the minimally required security for their tenants.”

In support of its decision, the Court of Appeals relied on the decision in *Gayle v City of New York*, which held that the plaintiff had to show that the intruder was *likely* an intruder who gained entry via the defendant’s negligence. The Court of Appeals in following the same rationale in *Gayle* explained its decision by saying “[A] plaintiff who sues a landlord for negligent failure to take minimal precautions to protect tenants from harm can satisfy the proximate cause burden at trial even where the assailant remains unidentified, if the evidence renders it more likely than not that the assailant was an intruder who gained access to the premises through a negligently maintained entrance.”

REMAINS OF “THE CAUSATION DEFENSE”

Although the Court of Appeals virtually eliminated the pre-trial “Causation Defense,” it held that plaintiffs must still meet the *Burgos* rule at the time of trial. However, a plaintiff merely needs to establish a triable issue of fact as to whether defendant’s negligence caused the plaintiff’s injuries. By eliminating the possibility of utilizing the “Causation Defense” to dismiss similar cases prior to trial, the impact of the Court of Appeals’ decision is unfavorable to defendants in security premises cases.

QUICK HITS—A ROUNDUP OF RECENT CASES AFFECTING THE CLAIMS COMMUNITY

- **Medical Malpractice – *Parente v. Buch*.** Pennsylvania Superior Court upholds trial court’s decision to preclude testimony regarding the standards for a hysterectomy established by the American College of Obstetrics and Gynecology by plaintiffs in support of their informed consent claim. The reasoning was that such evidence would impose negligence principles into the case.
- **Products Liability – *Phillips v. Cricket Lighters*.** Attempting to clarify Pennsylvania law, the Superior Court has recently held that the user of a product does not necessarily have to be the “intended” user to meet the burden under 401A of the Restatement (Second) of Torts. In a case for the misuse of a lighter, the Court ruled Cricket could not escape liability for not providing a child-proof guard simply because the child, who used the lighter to start a house fire, was not the intended user.

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THE APPLICATION OF COMMON LAW “BAD FAITH” IN PA

By Kevin Steinberg, Esq.

Generally, the Pennsylvania Motor Vehicle Financial Responsibility Law (MVFRL), regulates motor vehicle insurance in the Commonwealth of Pennsylvania. Under the provisions of the MVFRL, liability insurance and first party medical benefits must be included in all automobile insurance policies. In addition, insureds are to be given the option of purchasing uninsured and underinsured motorist coverage. Under each of these scenarios, bad faith exposure on the part of the carrier exists.

Negligent handling of a claim in and of itself does not impose liability for bad faith on the part of an insurance carrier. The principals of bad faith in Pennsylvania essentially only come into play when an insurer decides to litigate, rather than settle, a particular claim against its insured.

For example, our Supreme Court’s landmark decision in *Cowden* involved a carrier’s refusal to participate in a proposed settlement both before and during the third trial of an action against its insured. After reviewing the circumstances surrounding the request for settlement made by the parties, the Court upheld the trial court’s conclusion, saying:

“A careful review of all the circumstances in this case leads inevitably to the conclusion that the defendant’s decision not to compromise was the result of an honest, considerate judgment of its trial lawyer, claims manager and associate counsel. Their judgment coincided with the opinion of the trial court written after the second trial, in which the evidence was substantially the same as that presented in the third trial. It was a judgment well founded, and one clearly justified by the facts, notwithstanding the adversity subsequently encountered by *Cowden* as result of that decision. Plaintiff has produced nothing to show the decision not to accept the settlement proposal was in any way inconsistent with the insurer’s duty to its insured.”

The carrier’s decision to continue the litigation as opposed to settling the case was not just a factor or circumstance to be considered, but was instead the sole focus of the Court’s application of the “bad faith” law.

Thereafter, in *Gedeon v. State Farm Mutual Automobile Insurance Company*, Justice Egan’s concurring opinion contained discussion concerning “bad faith” issues in an attempt to clarify the four rules governing an insurer’s duty to settle or litigate a particular claim. These four rules of bad faith described by Justice Egan in *Gedeon* can be summarized as follows:

- 1) the interest of the insured and the insurer are balanced by requiring the insured to treat the claim as if he alone were liable for the entire amount;
- 2) where there is little possibility of a verdict or settlement within the policy limits, the decision to expose the insured to personal pecuniary loss must be based on a bonafide belief by the insurer that it has a good possibility of winning the suit;
- 3) the insurer cannot risk the well being of the insured; and
- 4) good faith requires the chance of a finding of non-liability be real and substantial and the decision to litigate be made honestly.

Finally, in *Shearer v. Reed*, which involved an insurer’s appeal from a denial of a Motion for Judgment NOV following a jury finding that the insurer had acted in “bad faith” by refusing to settle, our Superior Court held that “the good faith standard requires more than proof of sincerity: a decision not to settle must be a thoroughly honest, intelligent and objective one. It must be a realistic one when tested by the necessarily assumed experience of the company...” Essentially there has not been much change with regard to the common law principals of bad faith in Pennsylvania, and our Supreme Court’s decision in *Cowden* supra. is still the law.

Quick Hits—a roundup of recent cases affecting the claims community
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- **Legal Malpractice – *McGrogan v. Till*.** The New Jersey Supreme Court has held that a six year statute of limitations period is appropriate for actions involving tortious injury to the rights of another in state legal negligence actions.
- **Expert Testimony – *Bambauer v. Wood*.** A New York Trial Court excluded as conclusory a defense expert’s opinion that an automobile driver would not have been injured in a collision had he been wearing a seat belt. The Court excluded the report on the ground that the expert had offered no methodology or scientific basis to support his statements and that he lacked the requisite medical experience.