# THEODORE ROOSEVELT INN OF COURT

# SEMINAR ON CURRENT ISSUES IN PERSONAL INJURY LAW

March 18, 2010

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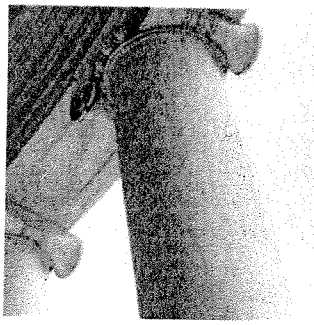


# Products: Class Action, Trade & Industry Representation Alert

Developments in products law

A publication of Nixon Peabody LLP

DECEMBER 15, 2009


## Federal regulations effective January 2010 impose strict reporting requirements on defendants regarding Medicare beneficiaries

*By Raymond L. Mariani*

The federal government has added a significant new consideration for every tort case filed in the United States after January 1, 2010: whether the plaintiff is on Medicare or about to become a beneficiary due to the alleged illness or injury. If the answer to that question is "Yes," the defendant must be prepared to comply in a timely manner with a series of strict new regulations and reporting requirements. The penalty for failure to comply is as high as $1,000 per day per claim, and double damages.

The new Medicare regulations are based on a short but important piece of federal legislation—the Medicare, Medicaid, and SCHIP Extension Act (MMSEA). Congress included the amendment to existing law so Medicare can more easily recover, from insurance companies and self-insureds, the monies that it has paid to recipients who become plaintiffs in lawsuits. The Center for Medicare and Medicaid Services (CMS) stands to collect hundreds of millions of dollars per year.

CMS was provided the right, as far back as 1980, to seek recovery of the benefits it has paid under these circumstances. CMS likewise has been empowered to sue claimants themselves for its payments. This process is referred to as recovery of Medicare "overpayments," and is technically different from but similar in concept to a lien. With no way to know whether a lawsuit has been commenced, however, CMS has been missing the opportunity to exercise its right against most claimants and insurers.

In an effort to tighten up this process, Congress passed 42 USC 1395y with one important new requirement: Every insurer (or self-insured) that becomes obligated to pay a Medicare beneficiary must report that event to CMS. Congress left the details of time and manner to be specified in future regulations. Those regulations were subsequently enacted and have been supplemented by a large number of CMS publications available at its website, http://www.cms.hhs.gov/MandatoryInsRep/. This includes a manual of more than 200 pages, with details on how every affected entity should have electronically registered with CMS by October 1, 2009.

Actual reporting applies to any judgment entered or settlement agreement signed by a Medicare beneficiary after January 1, 2010. The penalty for an insurer or self-insured not reporting such a settlement or judgment in a timely manner is up to $1,000 per day. Further, if CMS must sue to recover its overpayment from the responsible insurer, it is allowed to collect double the amount to which it is entitled. 42 CFR 411.24.

Once an insurer is registered, it must determine—in every lawsuit—whether the plaintiff is a Medicare recipient. Medicare is not just for those over age 65, but also is provided to the disabled and some people affected by organ failure. This determination will be undertaken by both an electronic means of "query" to CMS, as well as more conventional discovery devices. The importance of accurate information (SSN, DOB, spelling of name, etc.) to identify the plaintiff cannot be overstated.

If the plaintiff is a beneficiary, CMS will issue a preliminary letter (Conditional Payment Letter) advising how much it has paid to date. When a settlement or judgment occurs, the insurer must report the settlement amount to CMS in the next quarterly electronic reporting cycle. Plaintiff is likewise obliged to report the settlement. If the plaintiff has become disabled or ill to the point that future Medicare involvement is likely, the case would also require the parties to take into account the interests of CMS, by setting aside part of the settlement for future medical needs. This may require a third-party administrator with experience in such set-aside agreements.

Settlement agreements with Medicare beneficiaries will require many new conditions and acknowledgments. This will include the defendant's right to withhold funds until the final CMS demand amount is known; the potential for the CMS demand to equal or exceed the settlement; the waiver of payment requirements under state statutes that would require tendering settlement funds before the CMS final demand is received; and other considerations related to the timing and scope of payment obligations to CMS.

Payments are made by insurers directly to CMS once it issues a "final demand" letter. If the payment is not made within 60 days of the letter being issued, interest accrues from the date of issue. CMS will turn noncompliant insurers over to the Treasury Department for collection action after 120 days. If payment of the CMS portion of a settlement is made to plaintiff and never reaches CMS, the insurer is liable for paying the full amount a second time when CMS sues (or effectively treble damages, if CMS then seeks double the amount under the regulations).

CMS has created a second entity to perform the compliance function: the Medicare Secondary Payer Recovery Contactor. That entity has its own website, http://www.msprc.info/.

The site includes examples of the dozens of possible letters that parties to a case may receive with regard to filings with CMS.

Liability insurers or those companies with significant self-insured retentions should already have registered with CMS electronically and be ready to report as of January 1, 2010. The many nuances of the regulations and other publications that implement this entire recovery mechanism are too numerous and complex to detail here. The best practice will be to constantly seek any indication of Medicare benefits; verify the "overpayment" amount; negotiate a settlement with that amount

addressed by the parties; notify CMS of a settlement; craft a settlement agreement that takes all of these new variables into account; and make payment directly to CMS within 60 days of receiving the final demand amount. Counsel should be highly familiar with this process so clients can avoid the severe penalties attendant on noncompliance.

For further information on the information contained in this alert, please contact your regular Nixon Peabody attorney or:


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# II. Insurance Company and Medicare Liens

## A. GOL § 5-335A

Westlaw

McKinney's General Obligations Law § 5-335



C

**Effective: November 12, 2009**

Mckinney's Consolidated Laws of New York Annotated Currentness
General Obligations Law (Refs & Annos)
Chapter 24-A. Of the Consolidated Laws (Refs & Annos)
Article 5. Creation, Definition and Enforcement of Contractual Obligations
Title 3. Certain Prohibited Contracts and Provisions of Contracts (Refs & Annos)
**→ § 5-335. Limitation of non-statutory reimbursement and subrogation claims in personal injury and wrongful death actions**

(a) When a plaintiff settles with one or more defendants in an action for personal injuries, medical, dental, or podiatric malpractice, or wrongful death, it shall be conclusively presumed that the settlement does not include any compensation for the cost of health care services, loss of earnings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by a benefit provider, except for those payments as to which there is a statutory right of reimbursement. By entering into any such settlement, a plaintiff shall not be deemed to have taken an action in derogation of any nonstatutory right of any benefit provider that paid or is obligated to pay those losses or expenses; nor shall a plaintiff's entry into such settlement constitute a violation of any contract between the plaintiff and such benefit provider.

Except where there is a statutory right of reimbursement, no party entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by a benefit provider and a benefit provider shall have no lien or right of subrogation or reimbursement against any such settling party, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said benefit provider.

(b) This section shall not apply to a subrogation claim for recovery of additional first-party benefits provided pursuant to article fifty-one of the insurance law. The term "additional first-party benefits", as used in this subdivision, shall have the same meaning given it in section 65-1.3 of title 11 of the codes, rules and regulations of the state of New York as of the effective date of this statute. [FN1]

CREDIT(S)

(Added L.2009, c. 494, pt. F, § 8, eff. Nov. 12, 2009.)

[FN1] Nov. 12, 2009.

HISTORICAL AND STATUTORY NOTES

# II. Insurance Company and Medicare Liens

## B. *NYLJ,* 1/28/10
## "New Laws After 'Fasso'"

# New York Practice

## New Laws After 'Fasso' Leave Health Insurer Out in the Cold

By Patrick M. Connors

January 28, 2010

One of the most significant cases handed down by the Court of Appeals in 2009, *Fasso v. Doerr*, 12 N.Y.3d 80 (2009), was notable in part because it did not resolve important issues regarding a health insurer's rights to intervention and subrogation. The war that has been waged in this realm, which centered on who would bear the cost of plaintiff's medical expenses sustained by reason of defendant's negligence, was primarily between the plaintiff's health insurer and the defendant's liability insurer, with the plaintiff also sustaining casualties. While the resolution of these matters remains subject to conflicting Appellate Division case law, the Legislature passed a piece of blockbuster legislation, which became effective on Nov. 12, 2009, that will likely silence most of the debate in this area, leaving both plaintiffs and liability insurers very content with the outcome.

This article will begin with a brief description of the intervention/subrogation problem, which arises to some degree in most substantial personal injury cases. We will then examine the outcome of the Court's decision in *Fasso*, describing the rights of the parties and their insurers after the decision. Finally, we will outline and apply the new law to the *Fasso* facts to ascertain the broad impact of this legislation.

The Problem

When a plaintiff is severely injured at the hands of an insured defendant, she must often wait several years before receiving compensation through a settlement with the defendant's liability insurer, or by prosecuting the case against the defendant to a final judgment. During this interim, the plaintiff may need substantial medical care and will turn to her health care insurer to pay those costs.

While the plaintiff is free to pursue recovery of those health care costs as damages at trial, there is limited incentive to do so because of the collateral source reduction embodied in CPLR 4545. Under the statute, which governs in actions for personal injury, injury to property or wrongful death, the defendant is entitled to a reduction from the jury's award for any "past or future cost or expense [that] was or will, with reasonable certainty, be replaced or indemnified, in whole or in part, from any collateral source," such as health insurance. Therefore, if the jury's award includes any amount for medical expenses that were paid by the plaintiff's health care insurer, the defendant and his liability insurer benefit through the operation of the collateral source offset

rule in CPLR 4545.

CPLR 4545's collateral source offset rule, which altered the common law, was first enacted in 1975, but only applied in medical malpractice actions. By 1986, the rule was extended to apply to all personal injury, wrongful death and property damage actions. The statute had two primary legislative goals: 1) to avoid double recovery by plaintiffs, who previously were permitted to obtain an award for medical expenses that were already paid by their health insurer, and 2) to reduce the costs of liability insurance. See *Humbach v. Goldstein*, 229 A.D.2d 64, 67-68 (2d Dep't 1997).

It appeared that in the adoption of CPLR 4545 and its various amendments, the Legislature left the plaintiff's health insurer out in the cold. In fact, as noted above, it was the defendant's liability insurer who frequently received the benefit of the health insurer's payments when CPLR 4545's collateral source offset was calculated to reduce any jury award. The health insurer seemed willing to accept this cruel fate.

During the 1990s, however, many health care insurers that paid substantial sums to the plaintiff turned to the courts for relief by commencing equitable subrogation claims against the tortfeasor in an attempt to recover those medical expenses. The doctrine of equitable subrogation allows an insurer who has paid for losses sustained by its insured to seek recovery directly from the wrongdoer who caused the loss. Commonly, the health care insurer sought to intervene in the plaintiff's action to assert its equitable subrogation claim and to ensure that plaintiff's medical expenses were adequately presented to the jury.

Intervention also assisted the health insurer in avoiding a statute of limitations problem on the equitable subrogation claim, as it could be deemed to "relate back" to the interposition of plaintiff's main claim. See *Fasso*, 12 NY3d at 85, n. 1. Three Departments refused to allow the health insurer to intervene, but the Fourth Department ultimately began to permit it. See, e.g., *Oakes v. Patel*, 23 A.D.3d 1023, 1024 (4th Dep't. 2005) (holding that Supreme Court abused its discretion in denying health insurer's motion to intervene in plaintiff's action).

'Fasso' and Aftermath

The *Fasso* case, which emanated from the Fourth Department, presented a classic example of the problem outlined above. Plaintiff sued defendant doctor for medical malpractice. Plaintiff's health insurer paid plaintiff's medical and surgical expenses incurred after the alleged malpractice, which totaled approximately $780,000. The health insurer's unopposed application to intervene in plaintiff's action was granted by the trial court, which was bound by the Fourth Department's rule permitting intervention in these circumstances, thereby allowing the insurer to assert an equitable subrogation claim against the defendant doctor for reimbursement of the $780,000 in payments made on plaintiff's behalf.

After the first day of the trial in *Fasso*, the plaintiff settled with the defendant for $900,000. The Fourth Department affirmed the Supreme Court's dismissal of the equitable subrogation claim, ruling that the health insurer had no right to control the settlement of the injured plaintiff's action and that the settlement agreement between the plaintiffs and defendant was expressly conditioned on the satisfaction of both plaintiffs' medical malpractice action and the health insurer's equitable subrogation claim. In that the continued prosecution of the health insurer's action against the defendant would have nullified the plaintiffs' settlement, the Fourth Department concluded that the Supreme Court properly dismissed the health insurer's equitable subrogation claim.

The Court of Appeals granted leave and unanimously reinstated the health insurer's claim for equitable subrogation. The Court noted that "[i]f the recovery the injured party receives, whether determined by settlement or verdict, is greater than the wrongdoer's assets and available insurance coverage, there is nothing left for the insurer to execute its subrogation rights against and the made whole rule prevents the insurer from sharing in the insured's judgment or recovery." In *Fasso*, however, defendant doctor had $2 million in insurance coverage, of which $1.1 million remained after the plaintiff's settlement. The fact that plaintiff accepted a settlement of $900,000 that allegedly did not compensate her for all of her damages did not prevent the health insurer from pursuing subrogation against the

defendant doctor's remaining insurance and assets.

The Court also rejected the argument that the plaintiff/insured's settlement of the main action necessarily extinguished the insurer's subrogation claim. Although the insurer stands in the shoes of the insured when prosecuting an equitable subrogation claim, the Court cited to a "wealth of precedent" recognizing that "[o]nce an insurer has paid a claim and the tortfeasor knows or should have known that a right to subrogation exists, the wrongdoer and the insured cannot agree to terminate the insurer's claim without its consent." Therefore, the Court ruled, that portion of the settlement agreement between the plaintiff and defendant that purported to extinguish the health insurer's subrogation rights was not enforceable against the insurer.

While not necessary to its holding, the Court noted that intervention by the plaintiff's insurer "can create an adversarial posture between a plaintiff/insured and its [health] insurer because neither has an incentive to consider the interests of the other." In *Fasso*, most likely because of the Fourth Department's established rule allowing intervention, neither the plaintiff nor the defendant opposed the insurer's motion to intervene by permission under CPLR 1013. Therefore, the unpreserved issue could not be addressed by the Court. Nonetheless, the opinion invited the Legislature "to reexamine the concept of permissible intervention under CPLR 1013 as it applies to personal injury actions involving a health insurer's claim of equitable subrogation."

After *Fasso*, settlements in substantial personal injury and wrongful death cases were far more difficult to negotiate because of the tripartite conflict between the plaintiff, the defendant and plaintiff's health insurer. The defendant tortfeasor could not buy complete peace in a settlement with the plaintiff because any such agreement could not dispose of the health insurer's equitable subrogation claim.

The defendant often requested that, as part of the settlement, the plaintiff hold the defendant harmless from any equitable subrogation claims being prosecuted by plaintiff's health insurer. This type of settlement, with a hold harmless agreement, often proved to be undesirable to the plaintiff. The scenario was further complicated by the fact that the health insurer often attempted to recover a portion of the settlement pursuant to a right of reimbursement arising from its insurance contract.

Legislature Answers Call

Despite the gridlock that has recently plagued our state government, the Court of Appeals' invitation in *Fasso* was promptly accepted with the passage of Part F of Chapter 494 of the laws of 2009, signed by the Governor on Nov. 12, 2009. Part F makes several important amendments to the CPLR and the General Obligations Law that dramatically change the complexion of the war between the liability insurer and the health insurer, while giving the liability insurer and plaintiff the upper hand. In many ways, the new legislation can be seen as overruling the Court of Appeals' decision in *Fasso* and reinstating the decision of the Fourth Department.

**Protections for the Settling Plaintiff.** Chapter 494 adds new General Obligations Law §5-335, which provides in subdivision (a) that when a plaintiff settles with one or more defendants in an action for personal injuries or wrongful death, and there is no statutory right of reimbursement, "it shall be conclusively presumed that the settlement does not include any compensation for the cost of health care services, loss of earnings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by a benefit provider...." The term "benefit provider" is broadly defined in new subdivision 4 to General Obligations Law §5-101 to include any insurer that provides for payment or reimbursement of health care expenses.

This portion of the amendment appears to be sound. Assuming a health care insurer has paid plaintiff's medical expenses, it is highly doubtful that a defendant would agree to pay a significant sum attributable to those costs in a settlement. If the defendant elected not to settle, he would ultimately be entitled to a deduction of those very amounts from any verdict pursuant to the collateral source offset provisions in CPLR 4545. Therefore, it is certainly reasonable to "conclusively presume" that the settlement of a personal injury or wrongful death action does not include amounts

for medical expenses that were paid by plaintiff's health care insurer.

The first sentence of the new statute, discussed above, represents a significant change in the law, but §5-335(a) goes much further, granting additional benefits to settling plaintiffs and tortfeasors. It provides that, unless there is a statutory right of reimbursement,

no party entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by a benefit provider and a benefit provider shall have no lien or right of subrogation or reimbursement against any such settling party, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said benefit provider.

Therefore, the new statute essentially prevents the plaintiff's health insurer from attempting to claim that plaintiff's settlement with the defendant, like the $900,000 settlement in *Fasso*, included sums for the cost of plaintiff's health care expenses. The legislation appears to legislatively overrule the Court of Appeals' 1996 opinion in *Teichman v. Community Hosp. of W. Suffolk*, 87 N.Y.2d 514, 521-523 (1996), which held that a plaintiff's health insurer could intervene in plaintiff's personal injury action and attempt to recoup, under the terms of its health insurance contract, any medical expenses actually included in the settlement of the action.

The amendment goes on to provide that by entering into a settlement, the plaintiff "shall not be deemed to have taken an action in derogation of any nonstatutory right of any benefit provider that paid or is obligated to pay those losses or expenses; nor shall a plaintiff's entry into such settlement constitute a violation of any contract between the plaintiff and such benefit provider."

**Protections for the Settling Tortfeasor.** More importantly, General Obligations Law §5-335 (a) also shields the settling tortfeasor from a health insurer's equitable subrogation claim, like the one being pursued in *Fasso*, and provides a powerful incentive for a defendant to settle any action in which the plaintiff's health insurer has paid substantial medical expenses. The settlement essentially cuts off the right of the health care insurer to bring a subrogation action.

Section 9 of Part F of Chapter 494 provides that General Obligations Law §5-335 applies to any action commenced prior to Nov. 12, 2009, "where, as of such date, either (a) a trial of the issues has not yet commenced, or (b) the parties have not yet entered into a stipulation of settlement." Therefore, in many actions commenced prior to Nov. 12, 2009, the plaintiff and defendant could settle the action and gain the protections of General Obligations Law §5-335(a), thereby avoiding the problems faced by both the plaintiff and defendant in the aftermath of *Fasso*. Such a settlement would not only bar the health insurer's equitable subrogation claim against the tortfeasor, but also prevent the health insurer from attempting to establish that the settlement monies received by the plaintiff included amounts for medical expenses paid by the plaintiff's health insurer.

Chapter 494 and 'Fasso'

To fully comprehend the impact of Chapter 494, it is helpful to use the facts of *Fasso* as an example on which to impose the new General Obligations Law provision. We suspect there will be debate on the application of Chapter 494 in several cases, but we assume the *Fasso* action is not subject to the new laws because the trial of the personal injury action commenced prior to the settlement. Therefore, the plaintiff in *Fasso* presumably remains subject to the health insurer's attempt to recoup that portion of the $900,000 settlement attributable to medical expenses. Furthermore, the defendant in *Fasso* remains subject to the health insurer's equitable subrogation claim seeking $780,000.

If, however, we apply General Obligations Law §5-335(a) to a set of facts similar to those in *Fasso*, the outcome is dramatically different, resulting in a potential $780,000 monetary swing for all involved. First, after settling the action for $900,000, plaintiff will be immune from any reimbursement claim by the health insurer and it will be "conclusively presumed" that the settlement does not include compensation for any amounts previously paid by the health insurer.

Furthermore, the health insurer's equitable subrogation claim, regardless of its merits, is now extinguished. General Obligations Law §5-335(a) essentially allows the plaintiff and defendant to dictate the terms of the settlement and unilaterally dispose of the health insurer's equitable subrogation claim, a result similar to that reached by the Fourth Department in *Fasso*.

There can be no remaining doubt that the new legislation leaves the health insurer out in the cold after a settlement. After the Court of Appeals' decision in *Fasso*, the health insurer had two avenues to pursue recovery of the $780,000 it paid for plaintiff's medical expenses. It could prosecute its equitable subrogation claim against the tortfeasor while simultaneously pursuing the plaintiff for a claim of reimbursement under the health insurance policy. Now, once plaintiff and defendant agree to a settlement, both avenues are closed and the $780,000 claim is worthless.

Under the new legislation, the defendant has paid out $900,000 to the plaintiff, but has brought peace on all fronts because the equitable subrogation action is now barred under General Obligations Law §5-335(a). Having settled, the defendant can now write the $780,000 equitable subrogation claim off of its books. Similarly, the plaintiff walks away with $900,000 and the consolation of knowing that the money is beyond the reach of the health insurer.

It is important to note that the new law only applies when there has been a settlement. Questions on intervention and the equitable subrogation rights of the health insurer will still burn and need to be resolved in those cases that do not settle. Whether the health insurer can successfully prosecute an equitable subrogation claim against the defendant tortfeasor, or will be thwarted by the affirmative defense of the collateral source offset under CPLR 4545, is still an open question after *Fasso*. See Siegel, "Settlement Between Injured Plaintiff and Tortfeasor Defendant Can't Wipe Out Subrogation Claim of Health Insurer," New York State Law Digest, No. 591 (March 2009), at 2.

It should be rare, however, where a case with a potentially large equitable subrogation claim does not settle. In a case with facts like those in *Fasso*, it appears that it would be beneficial for the defendant to settle with plaintiff in an amount in excess of the $900,000 if defendant believes the health insurer's equitable subrogation claim has any merit. For example, defendant might be willing to pay the plaintiff $1.1 million, a premium of $200,000, if the settlement eradicates a $780,000 equitable subrogation claim.

There is much more to Chapter 494, including important amendments to CPLR 4545, but space limitations prevent additional discussion here. The new law is must reading for every lawyer involved in personal injury litigation.

**Patrick M. Connors** *is a professor of law at Albany Law School, where he teaches New York Practice and Professional Responsibility. He is the author of the McKinney's Practice Commentaries for CPLR Article 31, Disclosure and is a member of the Office of Court Administration's Advisory Committee on Civil Practice.*

# II. Insurance Company and Medicare Liens

## C. *Lawyers USA,* 2/2010 "New Rules Create Controversy over Medicare Set-Asides"

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# New rules create controversy over Medicare set-asides

By Sylvia Hsieh
Staff writer

New rules requiring insurance companies to report information about lawsuit settlements to Medicare are stirring up a heated controversy among personal injury and insurance defense attorneys.

The rules took effect on Jan 1.

The debate is over whether lawyers should be creating Medicare set-aside trusts in personal injury settlements to protect Medicare's secondary payer interest for future medical expenses.

Liability insurers, including self-insurers, must track certain information about Medicare-eligible plaintiffs' claims, including personal information about the plaintiff and the plaintiff's attorney.

Insurers will begin submitting their reporting to Medicare on April 1.

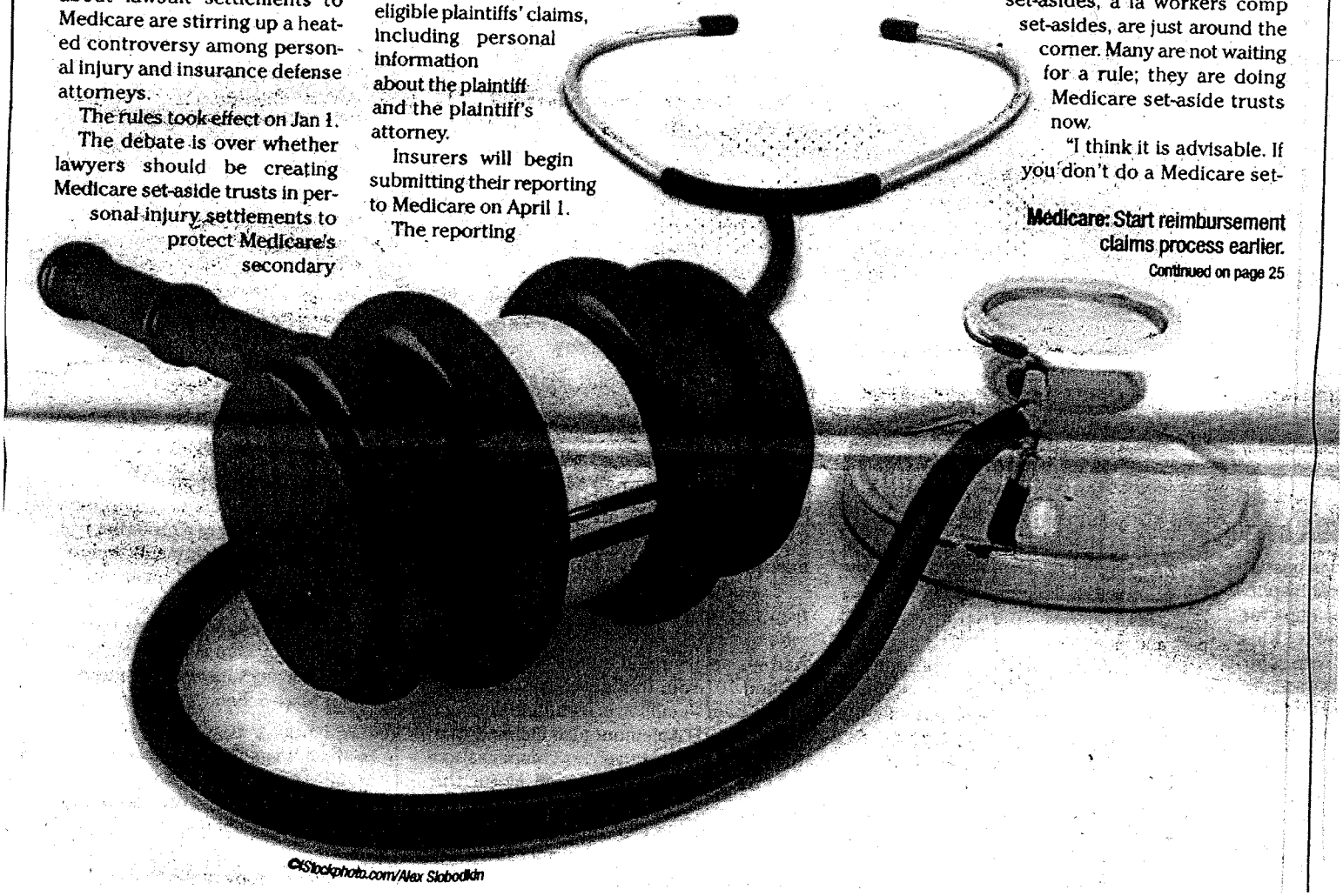
The reporting requirements now give Medicare a way to track settlement payments that some attorneys believe is intended to enforce secondary payer rights against future medical payments, not just past payments.

They predict official Medicare set-asides, à la workers comp set-asides, are just around the corner. Many are not waiting for a rule; they are doing Medicare set-aside trusts now.

"I think it is advisable. If you don't do a Medicare set-

**Medicare: Start reimbursement claims process earlier.**

Continued on page 25



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# Lawyers face absence of regulatory guidance

**Medicare** – Continued from page 1

aside, you take the risk of exposing the entire settlement," said John J. Campbell, an elder law attorney in Denver, Colo.

But some adamantly dispute this approach, noting that there is no law imposing liability for future medical payments, never mind a rule mandating set-asides.

"There is no liability for future medicals. To read [the reporting requirements] as extending obligations that never existed before in the area of future medicals is to read something into the law," said Sally Hart, an attorney at the non-profit Center for Medicare Advocacy in Tucson, Ariz.

She added that setting up an expensive and unnecessary set-aside trust is not in a plaintiff's best interests and could pose ethical concerns.

Matthew Garretson, president of The Garretson Firm in Cincinnati and author of "Negotiating and Settling Tort Cases," agreed.

"Absent guidance from Medicare, I think a lawyer would be committing malpractice to automatically set aside a sum of money and tell clients it is mandated," he said.

Further fueling the debate are mixed signals from the Centers for Medicare and Medicaid Services (CMS).

For example, some regional offices are reviewing and approving proposed Medicare set-asides; others are not responding to lawyers who ask about Medicare set-asides in pure liability

Sally Stalcup, the Secondary Payer Regional Coordinator for CMS in Dallas, did not return a call seeking comment.

"It's still in a state of confusion," said Bradley J. Frigon, an elder law attorney in Englewood, Colo.

## New reporting

The new reporting requirements, passed as part of the Medicare, Medicaid and SCHIP Extension Act of 2007, require insurance companies to provide information on settlements, including the name, address and phone number of the plaintiff and his or her attorney.

The starting date for insurers was delayed from July 1, 2009 to Jan. 1, 2010 to allow more time for testing.

Fines for insurers failing to report are steep: $1,000 per day.

This new ability to keep track of settlement data gives the agency tools to enforce its rights with future medical bills, not just past medical bills, some experts warn.

"Why in the world would an insurer paying in a personal injury case want to talk to Medicare about this? So Medicare can track recoveries. What it's going to do is enable Medicare to track those liability cases where there was a recovery from a tortfeasor and the person has future medicals as well," said Patricia Sitchler, an elder law attorney in San Antonio, Texas.

Medicare's rights as a secondary payer are broad. Medicare can reach back six years and get double damages from anyone who touched the settlement money, including plaintiffs' and defense lawyers.

Some lawyers say it only takes a few connecting dots to conclude that set-asides are the surest way to protect those interests – they are not waiting for an official rule from CMS.

"For people with significant settlements who are on Medicare's doorstep, we are recommending it," said Campbell.

Not only is the plaintiff at risk of losing Medicare benefits for future medical services related to the injury, but he or she is liable to turn around and blame his or her own lawyer and/or the defense attorney for losing coverage, Sitchler warned.

But others say these concerns are exaggerated and that set-asides can even detrimental to elderly plaintiffs.

"How can it be a good idea when it costs [a plaintiff] to set it up and administer and takes away money to spend [elsewhere]?" said Hart.

Garretson, who blames vendors of set-aside services for peddling "fearmongering" to attorneys, said that only in rare cases would he consider a set-aside, such as where there's a clear allocation to future medicals in a settlement, or where the only explanation for the size of a settlement is future medical expenses.

"There's a limited fact pattern of cases where Medicare's future interest needs to be protected," he said.

## Steps some are taking

There are a number of steps lawyers are taking right now in the absence of regulatory guidance.

Plaintiffs' attorneys should start the process of Medicare reimbursement claims much earlier than they have been, to account for the minimum of 90-100 days to process a claim, said Garretson.

David Rosenbaum, a defense attorney at McDowell Cotter in San Mateo, Calif., who represents third party insurers, calls plaintiffs' counsel early on to obtain the reimbursement codes (ICD-9) for the plaintiff's treatment.

"From the defense perspective, we advocate being very specific about the ICD-9 codes," said Rosenbaum.

If an injury is entered into Medicare's computers as a more specific injury, such as a sprained ankle, as opposed to a more general injury, such as a traumatic leg injury, it is less likely Medicare will deny benefits to a plaintiff who needs future care for an unrelated leg injury.

Seana Thomas, an attorney at Hall Hieatt & Connely in Santa Barbara, Calif., who advises both sides on this issue, recommends that defendants in catastrophic cases where significant future medical care is clearly anticipated – such as a future surgery or ongoing care for a paraplegic – make sure it's clear in the release signed by the plaintiff that a specific amount is allocated for future care.

Lacking a judgment from a trial court, such a release is the next-best thing, said Thomas.

"My hope is that it will give my defense clients … something to hold up and wave in front of Medicare," she said, adding that she also attaches the release and the plaintiff's medical records and sends them to Medicare.

To calculate the appropriate amount, she generally refers to the workers' compensation criteria for set-asides.

Some attorneys have attempted with mixed success to send CMS proposed set-aside arrangements, hoping to get Medicare to sign off on them.

Attorneys can also include a release that protects themselves, in which the plaintiff releases any right to sue over the loss of his or her benefits.

Rosenbaum, the defense attorney, uses such a release.

"It's an attempt to put a barrier of success against a plaintiff later coming back and suing me," said Rosenbaum, who has shared his release with other attorneys.

Questions or comments can be directed to the writer at: sylvia.hsieh@lawyersusaonline.com

# III. Ethics:
# 22 N.Y.C.R.R. §1200.0
# Rules of Professional Conduct

## RULE 1.5:
## FEES AND DIVISION OF FEES

(a) A lawyer shall not make an agreement for, charge, or collect an excessive or illegal fee or expense. A fee is excessive when, after a review of the facts, a reasonable lawyer would be left with a definite and firm conviction that the fee is excessive. The factors to be considered in determining whether a fee is excessive may include the following:

(1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

(2) the likelihood, if apparent or made known to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

(3) the fee customarily charged in the locality for similar legal services;

(4) the amount involved and the results obtained;

(5) the time limitations imposed by the client or by circumstances;

(6) the nature and length of the professional relationship with the client;

(7) the experience, reputation and ability of the lawyer or lawyers performing the services; and

(8) whether the fee is fixed or contingent.

(b) A lawyer shall communicate to a client the scope of the representation and the basis or rate of the fee and expenses for which the client will be responsible. This information shall be communicated to the client before or within a reasonable time after commencement of the representation and shall be in writing where required by statute or court rule. This provision shall not apply when the lawyer will charge a regularly represented client on the same basis or rate and perform services that are of the same general kind as previously rendered to and paid for by the client. Any changes in the scope of the representation or the basis or rate of the fee or expenses shall also be communicated to the client.

(c) A fee may be contingent on the outcome of the matter for which the service is rendered, except in a matter in which a contingent fee is prohibited by paragraph (d) or other law. Promptly after a lawyer has been employed in a contingent fee matter, the lawyer shall provide the client with a writing stating the method by which the fee is to be determined, including the percentage or percentages that shall accrue to the lawyer in the event of settlement, trial or appeal; litigation and other expenses to be deducted from the recovery; and whether such expenses are to be deducted before or, if not prohibited by statute or court rule, after the contingent fee is calculated. The writing must clearly notify the client of any expenses for which the client will be liable regardless of whether the client is the prevailing party. Upon conclusion of a contingent fee matter, the lawyer shall provide the client with a writing stating the outcome of the matter and, if there is a recovery, showing the remittance to the client and the method of

its determination.

(d) A lawyer shall not enter into an arrangement for, charge or collect:

(1) a contingent fee for representing a defendant in a criminal matter;

(2) a fee prohibited by law or rule of court;

(3) a fee based on fraudulent billing;

(4) a nonrefundable retainer fee; provided that a lawyer may enter into a retainer agreement with a client containing a reasonable minimum fee clause if it defines in plain language and sets forth the circumstances under which such fee may be incurred and how it will be calculated; or

(5) any fee in a domestic relations matter if:

(i) the payment or amount of the fee is contingent upon the securing of a divorce or of obtaining child custody or visitation or is in any way determined by reference to the amount of maintenance, support, equitable distribution, or property settlement;

(ii) a written retainer agreement has not been signed by the lawyer and client setting forth in plain language the nature of the relationship and the details of the fee arrangement; or

(iii) the written retainer agreement includes a security interest, confession of judgment or other lien without prior notice being provided to the client in a signed retainer agreement and approval from a tribunal after notice to the adversary. A lawyer shall not foreclose on a mortgage placed on the marital residence while the spouse who consents to the mortgage remains the titleholder and the residence remains the spouse's primary residence.

(e) In domestic relations matters, a lawyer shall provide a prospective client with a Statement of Client's Rights and Responsibilities at the initial conference and prior to the signing of a written retainer agreement.

(f) Where applicable, a lawyer shall resolve fee disputes by arbitration at the election of the client pursuant to a fee arbitration program established by the Chief Administrator of the Courts and approved by the Administrative Board of the Courts.

(g) A lawyer shall not divide a fee for legal services with another lawyer who is not associated in the same law firm unless:

(1) the division is in proportion to the services performed by each lawyer or, by a writing given to the client, each lawyer assumes joint responsibility for the

representation;

(2) the client agrees to employment of the other lawyer after a full disclosure that a division of fees will be made, including the share each lawyer will receive, and the client's agreement is confirmed in writing; and

(3) the total fee is not excessive.

(h) Rule 1.5(g) does not prohibit payment to a lawyer formerly associated in a law firm pursuant to a separation or retirement agreement.

**Comment**

[1] Paragraph (a) requires that lawyers not charge fees that are excessive or illegal under the circumstances. The factors specified in paragraphs (a)(1) through (a)(8) are not exclusive, nor will each factor be relevant in each instance. The time and labor required for a matter may be affected by the actions of the lawyer's own client or by those of the opposing party and counsel. Paragraph (a) also requires that expenses for which the client will be charged must not be excessive or illegal. A lawyer may seek payment for services performed in-house, such as copying, or for other expenses incurred in-house, such as telephone charges, either by charging an amount to which the client has agreed in advance or by charging an amount that reflects the cost incurred by the lawyer, provided in either case that the amount charged is not excessive.

[1A] A billing is fraudulent if it is knowingly and intentionally based on false or inaccurate information. Thus, under an hourly billing arrangement, it would be fraudulent to knowingly and intentionally charge a client for more than the actual number of hours spent by the lawyer on the client's matter; similarly, where the client has agreed to pay the lawyer's cost of in-house services, such as for photocopying or telephone calls, it would be fraudulent knowingly and intentionally to charge a client more than the actual costs incurred. Fraudulent billing requires an element of scienter and does not include inaccurate billing due to an innocent mistake.

[1B] A supervising lawyer who submits a fraudulent bill for fees or expenses to a client based on submissions by a subordinate lawyer has not automatically violated this Rule. Whether the lawyer is responsible for a violation must be determined by reference to Rule 5.1, 5.2 and 5.3.

**Basis or Rate of Fee**

[2] When the lawyer has regularly represented a client, they ordinarily will have evolved an understanding concerning the basis or rate of the fee and the expenses for which the client will be responsible. In a new client-lawyer relationship, however, an understanding as to fees and expenses must be promptly established. Court rules regarding engagement letters require that such an understanding be memorialized in writing in certain cases. *See* 22 N.Y.C.R.R. Part 1215. Even where not required, it is desirable to furnish the client with at least a simple memorandum or copy of the lawyer's customary fee arrangements that states the

general nature of the legal services to be provided, the basis, rate or total amount of the fee, and whether and to what extent the client will be responsible for any costs, expenses or disbursements in the course of the representation. A written statement concerning the terms of the engagement reduces the possibility of misunderstanding.

[3] Contingent fees, like any other fees, are subject to the excessiveness standard of paragraph (a). In determining whether a particular contingent fee is excessive, or whether it is excessive to charge any form of contingent fee, a lawyer must consider the factors that are relevant under the circumstances. Applicable law may impose limitations on contingent fees, such as a ceiling on the percentage allowable, or may regulate the type or amount of the fee that may be charged.

**Terms of Payment**

[4] A lawyer may require advance payment of a fee, but is obliged to return any unearned portion. *See* Rule 1.16(e). A lawyer may charge a minimum fee, if that fee is not excessive, and if the wording of the minimum fee clause of the retainer agreement meets the requirements of paragraph (d)(4). A lawyer may accept property in payment for services, such as an ownership interest in an enterprise, providing this does not involve acquisition of a proprietary interest in the cause of action or subject matter of the litigation contrary to Rule 1.8(i). A fee paid in property instead of money may, however, be subject to the requirements of Rule 1.8(a), because such fees often have the essential qualities of a business transaction with the client.

[5] An agreement may not be made if its terms might induce the lawyer improperly to curtail services for the client or perform them in a way contrary to the client's interest. For example, a lawyer should not enter into an agreement whereby services are to be provided only up to a stated amount when it is foreseeable that more extensive services probably will be required, unless the situation is adequately explained to the client. Otherwise, the client might have to bargain for further assistance in the midst of a proceeding or transaction. In matters in litigation, the court's approval for the lawyer's withdrawal may be required. *See* Rule 1.16(d). It is proper, however, to define the extent of services in light of the client's ability to pay. A lawyer should not exploit a fee arrangement based primarily on hourly charges by using wasteful procedures.

[5A] The New York Court Rules require every lawyer with an office located in New York to post in that office, in a manner visible to clients of the lawyer, a "Statement of Client's Rights." *See* 22 N.Y.C.R.R. § 1210.1. Paragraph (e) requires a lawyer in a domestic relations matter, as defined in Rule 1.0(g), to provide a prospective client with the "Statement of Client's Rights and Responsibilities," as further set forth in 22 N.Y.C.R.R. § 1400.2, at the initial conference and, in any event, prior to the signing of a written retainer agreement.

**Prohibited Contingent Fees**

[6] Paragraph (d) prohibits a lawyer from charging a contingent fee in a domestic relations matter when payment is contingent upon the securing of a divorce or upon the amount of alimony or support or property settlement to be obtained or upon obtaining child custody or

visitation. This provision does not preclude a contract for a contingent fee for legal representation in connection with the recovery of post-judgment balances due under support, alimony or other financial orders because such contracts do not implicate the same policy concerns.

**Division of Fee**

[7] A division of fee is a single billing to a client covering the fee of two or more lawyers who are not affiliated in the same firm. A division of fee facilitates association of more than one lawyer in a matter in which neither alone could serve the client as well. Paragraph (g) permits the lawyers to divide a fee either on the basis of the proportion of services they render or if each lawyer assumes responsibility for the representation as a whole in a writing given to the client. In addition, the client must agree to the arrangement, including the share that each lawyer is to receive, and the client's agreement must be confirmed in writing. Contingent fee arrangements must comply with paragraph (c). Joint responsibility for the representation entails financial and ethical responsibility for the representation as if the lawyers were associated in a partnership. *See* Rule 5.1. A lawyer should refer a matter only to a lawyer who the referring lawyer reasonably believes is competent to handle the matter. *See* Rule 1.1.

[8] Paragraph (g) does not prohibit or regulate division of fees to be received in the future for work done when lawyers were previously associated in a law firm. Paragraph (h) recognizes that this Rule does not prohibit payment to a previously associated lawyer pursuant to a separation or retirement agreement.

**Disputes over Fees**

[9] A lawyer should seek to avoid controversies over fees with clients and should attempt to resolve amicably any differences on the subject. The New York courts have established a procedure for resolution of fee disputes through arbitration and the lawyer must comply with the procedure when it is mandatory. Even when it is voluntary, the lawyer should conscientiously consider submitting to it.

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March 12, 2010

A Different Law Firm
321 Litigation Way
Justice, New York 11706

Attention: Mr. Law, Esq.

Re: Chris Client
8/1/09
8/1/09-D

Dear Mr. Law:

Thank you very much for referring Chris Client to this office. We have accepted his case and are proceeding on his behalf.

This firm will forward 1/3 of the net attorneys' fee to you for the work that you have performed or may perform in the future on this matter. I will keep you apprised from time to time of the status of the claim. If at any time there are questions in regard to this case, or any other matter please do not hesitate to contact me. In compliance with the Rules of Professional Conduct, both our firms will be jointly responsible for representing the client in this matter.

Thank you once again for your confidence in inviting us to handle this matter.

Very truly yours,

Meyer, Suozzi, English & Klein, P.C.

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March 12, 2010

Mr. Chris Client
1234 First Street
Mineola, New York 11501

Re: Chris Client
Date of Accident: 8/1/09

Dear Mr. Client:

This letter will confirm that we have agreed to represent you in the matter involving your automobile accident of August 1, 2009. You have previously signed a retainer agreement with our firm regarding our representation of you.

It should further be noted that you will be jointly represented in your case by both our firm and the firm A Different Law Firm. The law firm of A Different Law Firm and our firm Meyer, Suozzi, English & Klein, P.C. have agreed to divide any potential legal fee after deducting expenses, in the following manner: two-thirds (2/3) to Meyer, Suozzi, English & Klein, P.C. and one-third (1/3) to A Different Law Firm for the work that firm has performed and/or will perform in the future. Both firms will be jointly responsible for representing you in this matter.

You shall not be charged any greater fee as a result of this arrangement.

If you have any questions concerning anything contained herein do not hesitate to contact me. Thank you for having the confidence to let us prosecute this matter on your behalf.

Please acknowledge your understanding and agreement to the division of the prospective fee by signing at the "Acknowledged and Agreed" area on this page and return in the enclosed self-addressed envelope.

Very truly yours,

Your Attorney

ABC:de
Encl.

Acknowledged and Agreed

_____

Chris Client

# IV. Serious Injury

## A. Insurance Law §5102(d)

tion after the initial fifty thousand dollars of basic economic loss has been exhausted. This optional additional coverage shall be made available and notice with explanation of such coverage shall be provided by an insurer at the first policy renewal after the effective date of this paragraph, or at the time of application.

(b) "First party benefits" means payments to reimburse a person for basic economic loss on account of personal injury arising out of the use or operation of a motor vehicle, less:

(1) Twenty percent of lost earnings computed pursuant to paragraph two of subsection (a) of this section.

(2) Amounts recovered or recoverable on account of such injury under state or federal laws providing social security disability benefits, or workers' compensation benefits, or disability benefits under article nine of the workers' compensation law, or medicare benefits, other than lifetime reserve days and provided further that the medicare benefits utilized herein do not result in a reduction of such person's medicare benefits for a subsequent illness or injury.

(3) Amounts deductible under the applicable insurance policy.

(c) "Non-economic loss" means pain and suffering and similar non-monetary detriment.

(d) "Serious injury" means a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment.

(e) "Owner" means an owner as defined in section one hundred twenty-eight of the vehicle and traffic law.

(f) "Motor vehicle" means a motor vehicle as defined in section three hundred eleven of the vehicle and traffic law and also includes fire and police vehicles. It shall not include any motor vehicle not required to carry financial security pursuant to article six, eight or forty-eight-A of the vehicle and traffic law or a motorcycle, as defined in subsection (m) hereof.

# IV. Serious Injury

## B. *NYSBJ* §5102 "Twenty Years of Decisions have Defined Threshold"

New York State Bar Journal
May, 2003

# *36 TWENTY YEARS OF DECISIONS HAVE REFINED "SERIOUS INJURY" THRESHOLD IN NO-FAULT ACCIDENT CASES

Anthony J. Centone [FNa1]



Since the inception of New York's No-Fault Insurance Law in 1973, [FN1] the New York Court of Appeals has ruled on and interpreted the "serious injury" threshold provision in 10 major cases, most recently in a 2002 decision that combined three separate appeals. [FN2]

Starting with *Licari v. Elliott* [FN3] in 1982, the Court has attempted to clarify various aspects of Insurance Law § 5102(d), [FN4] the statute that defines what constitutes a "serious injury" and what entitles certain individuals injured in automobile accidents to sue for and recover "non-economic" damages stemming from those injuries.

Most recently, the Court of Appeals has defined the nature and extent of the "qualitative" objective medical proof a plaintiff must present to establish a triable issue of fact regarding what constitutes a serious injury. Taken together, these Court of Appeals cases provide guideposts for both plaintiff's and defense counsel to assess their case and prepare their strategy for potential "threshold" issues.

## Injury Must Be More Than "Minor, Mild or Slight"

In the seminal threshold case *Licari*, [FN5] the Court determined that a major goal of the Legislature in adopting Insurance Law § 5102(d) was to keep "minor" injury cases out of the courts:

> We begin our analysis of these two categories of serious injury by recognizing that one of the obvious goals of the Legislature's scheme of no-fault automobile reparations is to keep minor personal injury cases out of court. [FN6]

In dealing with the category of a "significant limitation of use of a body function or system," Judge Jason, writing on behalf of a unanimous court, noted: "We believe that a minor, mild or slight limitation of use should be classified as insignificant within the meaning of the statute." [FN7]

Most significantly, however, the Court definitively established that it would be up to the trial court, in the first instance, to determine whether the plaintiff has sustained a serious injury as defined in Insurance Law § 5102(d). [FN8] Should the court find, on defendant's motion for summary judgment (or motion for a directed verdict, as in the case of *Licari*), that the plaintiff did not demonstrate that he or she sustained a serious injury, the case need go no further and the plaintiff's complaint seeking "non-economic" damages must be dismissed as a matter of law.

Finally, the Court noted that the "subjective quality" of certain types of pain, such as headaches and dizziness, cannot form the basis of a serious injury, as a matter of law. [FN9] In *Licari*, the Court held that the plaintiff, a taxi driver, who (1) missed only 24 days from work after the automobile accident; (2) suffered essentially cervical and lumbosacral sprain and strain along with occasional headaches, as a result of the accident; and (3) testified as to very few activities he was unable to do as of time of trial, did not, as a matter of law, sustain a serious injury under Insurance Law § 5102(d). [FN10]

**Physician's Affidavit Cannot Be "Conclusory"**

Soon after this first decision, the term "*Licari* motion" was coined and defendants frequently made motions for summary judgment seeking dismissal of motor vehicle lawsuits based on the plaintiff's lack of any serious injury. Three years after *Licari*, the Court of Appeals discussed the type of proof necessary for a plaintiff to establish a serious injury, when opposing a defendant's summary judgment motion of this kind.

In *Lopez v. Senatore*, [FN11] the Court dealt for the first time with the issue of specific medical proof submitted by the ***37** plaintiff in opposition to a defendant's threshold motion for summary judgment. When analyzing the plaintiff's physician's affidavit, the Court noted that the "mere repetition of the word 'permanent' in the affidavit of a [plaintiff's] treating physician is insufficient to establish 'serious injury.'" [FN12]

The Court further held that summary judgment should be granted in favor of a defendant "where the plaintiff's evidence is limited to conclusory assertions tailored to meet statutory requirements." [FN13] The Court then held that, when a plaintiff's physician (1) sets forth in his affidavit the type of injuries suffered by the plaintiff and the plaintiff's course of treatment, (2) identifies the limitation of motion in the plaintiff's neck (whereby he could only turn his head 10 degrees to the right or left) and (3) expresses the opinion that there was significant limitation of a body function or system (all supported by exhibits such as office records), such evidence would be sufficient to defeat the defendant's summary judgment motion. [FN14]

*Lopez* has thus come to stand as the guidepost for the type of proof a plaintiff needs to defeat a defendant's threshold motion.

**Subjective Quality of Pain Alone Is Insufficient**

In *Scheer v. Koubek*, [FN15] the Court established the premise that "pain," in and of itself, may not form the basis of serious injury under Insurance Law § 5102(d), rejecting a line of Third Department cases to the contrary. [FN16]

The plaintiff in *Scheer* had suffered only "soft tissue injury," which her own physician had described as "mild." [FN17] According to the appellate court decision, the defendant's physician in *Scheer* had testified that his one and only examination of the plaintiff revealed nothing but subjective complaints of pain; the plaintiff argued that this was sufficient to form the basis for establishing a serious injury. [FN18] Both the trial court and Appellate Division agreed. [FN19] The Court of Appeals reversed, however, citing *Licari*, and stated:

> The subjective quality of plaintiff's transitory pain does not fall within the objective verbal definition of serious injury as contemplated by the No-Fault Insurance Law. [FN20]

From this point on, New York law was clear in holding that proof of a serious injury would have to come from the plaintiff's physician, and not from the plaintiff personally; and this medical proof would have to

demonstrate "objective" signs of injury, as opposed to the plaintiff's "subjective" complaints of pain, in order to raise an issue of fact sufficient to defeat the defendant's motion for summary judgment.

**Plaintiff Must Present "Sworn" Medical Proof**

In *Grasso v. Angerami*, [FN21] the Court further addressed plaintiff's medical proof by stating that the plaintiff's physician must provide his medical opinion by way of "sworn testimony" - *i.e.*, an affirmation or affidavit.

Before *Grasso*, there had been a split in the appellate divisions. The Second Department had accepted the plaintiff's unsworn medical reports and records as sufficient proof to defeat a defendant's motion for summary judgment. [FN22] The First Department, however, had required that the medical proof be in "admissible form." [FN23] The Court of Appeals partially resolved this issue by stating:

> In opposition to defendant's motion for summary judgment pursuant to Insurance Law § 5102(d), plaintiff tendered proof of "serious injury" in inadmissible form, namely an unsworn doctor's report. Inasmuch as plaintiff did not offer any excuse for his failure to provide the medical report in proper form, we need not consider whether proof of serious injury in inadmissible form is sufficient to defeat a motion for summary judgment pursuant to Insurance Law § 5102(d), if an acceptable excuse for the deficiency is offered. [FN24]

In doing so, the Court seems to have followed a long line of cases, most prominently *Zuckerman v. City of New York*, [FN25] which held that a party opposing a motion for summary judgment must present proof in admissible form *or* offer an acceptable excuse for failing to do so. It is now generally accepted that plaintiffs opposing a threshold motion for summary judgment *must* provide either a doctor's affirmation or affidavit if they hope to defeat the motion; unsworn medical reports and records will not suffice.

Nonetheless, a literal reading of *Grasso* leaves open the door that, if the plaintiff can offer a reasonable excuse for his failure to provide a doctor's affirmation or affidavit, *e.g.*, death of the plaintiff's only treating physician, a court could accept from the plaintiff "inadmissible" or "unsworn" medical proof that might be sufficient to defeat a threshold motion.

**Curtailment of Activities Must Be to a "Great Extent"**

A few months later, *Gaddy v. Eyler* [FN26] provided additional standards concerning the plaintiff's proof in opposing***38** a threshold motion for summary judgment. There, the Court was asked to determine whether the plaintiff, who had sustained neck and back injuries, fell under one of three categories set forth in Insurance Law § 5102(d). [FN27]

The Court initially concluded that, because the plaintiff had only a "minor limitation of movement in her neck and back," she had failed to demonstrate a "permanent consequential limitation or use of a body organ or member" or a "significant limitation of use of a body function or system." [FN28] With regard to the "90-out-of-180-day" provision, the Court noted that the plaintiff had missed only two days of work and then returned to most of her daily routine (as a senior court stenographer), and that she submitted no evidence to support her contention that her household and recreational activities had been diminished as a result of her injuries. [FN29]

Because there was no proof that she had been "'curtailed from performing [her] usual activities to a great extent rather than some slight curtailment"' (quoting *Licari*), the Court held that the plaintiff failed to meet the 90/180 day threshold requirement as well. [FN30] In doing so, the Court stressed once again that minor injuries, with insignificant effect on a plaintiff's normal activities, would not qualify as a serious injury. [FN31]

**Expert Opinion Must Be Supported By Factual Foundation**

Three years later, the Court of Appeals dealt once again with the no-fault statute. In *Dufel v. Green*, [FN32] the issue was what specific questions a plaintiff's expert could be asked while testifying at trial concerning the plaintiff's medical condition. The defendant objected to certain questions asked of the plaintiff's experts by her counsel on direct examination. The Court noted:

> To establish that plaintiff had sustained a serious injury, plaintiff's two physicians were asked, in words tracking the statutory language, whether plaintiff sustained "a permanent consequential limitation" and "a significant limitation" of the use of a body member, function, organ or system. Over defendant's objection both answered that she had. The doctors were also asked in nonstatutory language whether plaintiff had sustained a permanent injury and both answered that she had.
>
> At the conclusion of the trial, the court asked the jury to determine whether plaintiff had sustained (1) permanent loss of a body organ, member, function or system; (2) permanent consequential limitation of use of a body function or system; (3) significant limitation of use of a body function or system; or (4) a medically determined injury preventing normal activities for 90 out of the 180 days following the accident. The jury returned a verdict finding in plaintiff's favor on questions 2, 3 and 4 and awarded her damages. [FN33]

The defendants claimed that the questions the plaintiff's counsel posed to the two physicians were improper because they were the same questions posed to the jury in the interrogatories contained in the verdict sheet. The Court held that whether an injury is "permanent" or a limitation is "significant" or "consequential" is a medical question beyond the knowledge of the average juror and thus requires the benefit of an expert's specialized knowledge. [FN34] Therefore, the opinion of the two physicians, even though framed in the precise statutory language, which also was the language in the interrogatories submitted to the jury, was proper, but the jury must still determine whether the objective medical evidence supported the expert's conclusion.

Furthermore, the Court noted that the expert's opinion must be supported by a "factual foundation," which gives the defendant the ability to cross-examine the expert and call into question his opinions. [FN35] The defendants could also call their own medical expert witnesses to rebut the plaintiff's experts, and the jury would still have to weigh the testimony of all of these witnesses in determining whether the plaintiff sustained a serious injury. [FN36]

Based on this ruling, most plaintiffs' counsel in automobile accident cases will now ask their medical experts the precise questions posed of the plaintiff's experts in *Dufel*. The Court in *Dufel*, however, did caution that there may be instances where particular questions posed in "statutory form are unduly prejudicial" and should, therefore, not be permitted, although the Court did not elaborate on this point. [FN37]

**Permanent "Loss of Use" Must Be Total**

In 2001, *Oberly v. Bangs Ambulance Inc.* [FN38] presented the issue of whether a plaintiff who maintained

that he sustained a "permanent loss of use of a body organ, member, function or system" had to prove a "total loss" as opposed to only a "partial loss" of use.

The plaintiff, a dentist, alleged a "serious injury" to his right arm as a result of an automobile accident. He complained of "pain and cramping" in the arm and alleged that the pain limited "his ability to practice as a dentist." [FN39] Apparently, the injury did not prevent him from practicing dentistry, but in some way limited his ability to do his job fully (although the decision does not specify to what extent).

The defendant moved for summary judgment based on lack of a serious injury and the plaintiff decided to abandon all the serious injury provisions, except for his alleged "permanent loss of use" - *i.e.*, the injury to his right arm. [FN40] The plaintiff argued that the permanent loss need not be significant or total but that even a partial loss would qualify. [FN41]

***39** The Court, interpreting legislative intent, first noted that if the Legislature had meant "permanent loss" to include "partial" loss of use, it would have qualified the phrase "permanent loss" accordingly. [FN42] Second, the Court said that the permanent loss standard was contained in the original 1973 version of the statute, and had survived the 1977 amendment to the statute, which added the categories of "permanent consequential limitation of use of a body organ or member" and "significant limitation of use of a body function or system." [FN43] The Court reasoned that these two categories relate to partial losses and, had the Legislature considered "permanent loss of use" to already include partial losses, there would have been no reason to add these categories to the statute. [FN44]

Many in the insurance industry believed that *Oberly* would result in a drastic increase in dismissal of threshold cases. It is apparent, however, from a close reading of *Oberly* that this requirement of *total* "permanent loss of use" pertains only to *that* category of injury and does not apply to the other categories such as "permanent consequential limitation of use of a body organ or member" or "significant limitation of use of a body function or system," both of which, according to the Court, require only a partial, not a total, limitation.

As such, the impact of *Oberly* apparently is on only one of the (essentially) four categories of injury, and a plaintiff can still rely on a *partial*, rather than *total*, "permanent consequential limitation of use" or "significant limitation of use."

**Expert's Opinion May Be Either "Qualitative" or "Quantitative"**

The most recent Court of Appeals threshold decision is *Toure v. Avis Rent-A-Car Systems*, [FN45] in which a trio of cases (*Toure, Manzano v. O'Neil* and *Nitti v. Cierrico*) were decided jointly in one opinion. As Judge Graffeo noted in the opening sentence of her opinion: "These three cases examine the nature and extent of qualitative, objective medical proof necessary for a plaintiff to meet the 'serious injury' threshold under the No-Fault Law." [FN46]

Initially, the Court noted that a plaintiff's expert *can* establish a plaintiff's physical limitation by giving a "numeric percentage" of the plaintiff's loss of range of motion to substantiate his or her claim. [FN47] This would be, for example, where a plaintiff's physician either testifies or states in his affirmation or affidavit that the plaintiff has a "20%" or "30-degree" loss of rotation in his cervical or lumbosacral spine. This would constitute a "quantitative" designation of the plaintiff's physical limitation.

The Court then went on to hold, however, that an expert's qualitative assessment of a plaintiff's physical limitations, when supported by objective evidence, is sufficient to create an issue of fact regarding serious injury as well. The qualitative assessment involves comparing the plaintiff's limitations to his "normal function, purpose and use of the affected body organ, member, function or system." [FN48] When this qualitative assessment is supported by objective evidence, a defendant can test the findings both through cross-examination as well as by way of his own expert. [FN49] If, however, the qualitative assessment is unsupported by objective evidence, it could be "wholly speculative" and defeat the purpose of the no-fault law, which is to eliminate "insignificant injuries." [FN50] Therefore, the court must determine whether this qualitative assessment meets certain criteria.

***Toure Case*** In *Toure*, the plaintiff's physician, in his affirmation opposing the defendant's threshold motion, did *not* ascribe a specific percentage to the loss of range of motion in the plaintiff's spine. He did, however, set forth the "qualitative nature" of the plaintiff's limitations.

For instance, while Dr. Waltz did not indicate that the plaintiff had a 50% or 30-degree loss of range of motion in flexion in his lumbosacral spine, he did state that the plaintiff's CT scan and MRI showed herniated and bulging discs and that plaintiff had both muscle spasms and a "'decreased range of motion'" in his lumbosacral spine. [FN51] Furthermore, the physician related his findings to the "plaintiff's complaints of difficulty in sitting, standing and walking for extended periods of time and plaintiff's inability to lift heavy objects at work." [FN52] The plaintiff's physician concluded that "these limitations are a natural and expected medical consequence of his [plaintiff's] injuries." [FN53] The Court then noted:

> We cannot say that the alleged limitations of plaintiff's back and neck are so "minor, mild or slight" as to be considered insignificant within the meaning of Insurance Law § 5102(d). As our case law further requires, Dr. Waltz's opinion is supported by objective medical evidence, including MRI and CT scan tests and reports, paired with his observations of muscle spasms during his physical examination of plaintiff. Considered in the light most favorable to plaintiff, this evidence was sufficient to defeat defendant's motion for summary judgment. [FN54]

***40** In doing so, the Court has apparently overruled prior appellate division case law, which consistently held that the plaintiff's physician must "specifically quantify" the alleged restriction of motion in plaintiff's cervical or lumbosacral spine by either "percentages" or "degrees." [FN55] According to *Toure*, the physician can now describe the limitation in terms of the daily routine activities (both work related and non-work related) that were affected by the injuries. There must, however, be sufficient "objective medical proof," *e.g.*, MRI or CT scan tests or reports, along with the doctor's own clinical findings during physical examination of the plaintiff, to support the physician's opinion. In the absence of the same, the qualitative assessment will be insufficient to defeat the defendant's motion.

***Manzano Case*** *Manzano* involved a trial in which the defendant moved to set aside the jury's verdict of $70,000 in damages, based on the plaintiff's failure to establish a serious injury as a matter of law. The Court initially noted:

> In this case, plaintiff presented the testimony of her treating physician, Dr. Cambareri, who opined that plaintiff suffered two herniated cervical discs as a result of the automobile accident. His conclusion was supported by objective evidence introduced at trial, namely, the MRI films that he interpreted. Although this medical expert did not assign a quantitative percentage to the loss of range of motion in plaintiff's neck or back, he described the qualitative nature of plaintiff's limitations based on the normal function, purpose and use of her body parts. In particular, Dr. Cambareri correlated plaintiff's herniated

discs with her inability to perform certain normal, daily tasks. These limitations are not so insignificant as to bar plaintiff's recovery under the No-Fault Law. [FN56]

Again, the Court relied upon the qualitative nature of the plaintiff's injury and her inability to perform certain normal daily tasks, such as heavy lifting, shoveling the driveway, cleaning the house and picking up the children. [FN57] The plaintiff's physician was again able to connect the "herniated discs," as demonstrated on MRI films of the plaintiff's spine which the physician had personally reviewed, to plaintiff's inability to carry out these tasks. Based on the same, the jury's finding of "serious injury" was upheld by the Court.

***Nitti Case*** The last opinion in this trio of decisions, *Nitti*, involved a trial in which the plaintiff presented the testimony of a chiropractor who apparently had examined the plaintiff only twice before trial. These exams were six months apart. The chiropractor, Dr. Patriarco, also reviewed an MRI report of the plaintiff's spine that was not introduced into evidence at trial. [FN58] Nonetheless, Dr. Patriarco testified that the plaintiff "'sustained an L4-5 intervertebral disk disorder with associated neuritis, which was further complicated by a congenital anomaly,'" which would prevent the plaintiff from exercising and engaging in certain activities. [FN59] Dr. Patriarco also testified that he detected a muscle spasm in the plaintiff's right cervical spine that radiated into her shoulders and he also found restriction of motion in her neck and back. [FN60]

Based on this testimony, the jury found that the plaintiff sustained a serious injury under the 90/180 day category but not under the "significant limitation" category. The Court disagreed:

> Although medical testimony concerning observations of a spasm can constitute objective evidence in support of a serious injury, the spasm must be objectively ascertained. This requirement was not satisfied by the testimony of plaintiff's expert that he detected a spasm, where he did not, for example, indicate what test, if any, he performed to induce the spasm. Furthermore, Dr. Patriarco testified on cross-examination that the tests he administered to reach his conclusion regarding plaintiff's limitation of motion were subjective in nature as they relied on plaintiff's complaints of pain. Nor did the MRI report he mentioned constitute objective proof. *Toure* and *Manzano* recognize that an expert's conclusion based on a review of MRI films and reports can provide objective evidence of a serious injury. In this case, however, the witness merely mentioned an MRI report without testifying as to the findings in the report. Moreover, the MRI report was not introduced into evidence, thus foreclosing cross-examination. Nor did Dr. Patriarco testify that the underlying MRI film supported his diagnosis of an "L4-5 intervertebral disk disorder." Given the inadequacy of the objective medical proof supporting the opinion of plaintiff's expert, defendants' motion to set aside the verdict should have been granted. [FN61]

In *Nitti*, there was an absence of "objective proof" to support Dr. Patriarco's opinion that the plaintiff suffered from an "L4-5 intervertebral disk disorder with associated neuritis." Based on the same, the plaintiff failed to prove the existence of a serious injury. Perhaps the most significant statement in this opinion, however, is the following: "*Toure* and *Manzano* recognize that an expert's conclusion based on a review of MRI films and *reports* can provide objective evidence of a serious injury." [FN62] Is the Court now maintaining that a plaintiff's treating physician can rely upon "unsworn" MRI reports as a basis for his opinion that the plaintiff has sustained a serious injury under Insurance Law § 5102(d)?

If so, is this consistent with the Court's prior holding in *Grasso v. Angerami*, [FN63] that an unsworn doctor's report is inadmissible and thus insufficient to defeat a defendant's motion for summary judgment based on the no-fault "threshold"? Or does it simply mean that, in the plaintiff's physician's sworn affirmation or affidavit, he may rely, in part, on an unsworn MRI report, provided it is the type of report a physician would reasonably rely ***41** upon in coming to his diagnosis? This seems more likely, although it is probable that we may need to

wait and see whether the Court of Appeals provides further clarification on this issue in future decisions.

What seems clear from *Toure* is that courts no longer need to find that the plaintiff's medical expert quantified the plaintiff's alleged limitation of motion, in terms of percentages or degrees, but the physician can also qualify the restriction in terms of the plaintiff's daily activities, provided the plaintiff supplies an "objective" medical basis for the restrictions. This will no doubt dramatically affect the way both plaintiff's and defense counsel approach "threshold" motions in the future, as well as the way courts decide these motions.

[FNa1]. **ANTHONY J. CENTONE** practices in the area of automobile insurance defense as a trial and appellate attorney. He is also an adjunct professor of law at Pace University School of Law, where he teaches civil practice. A graduate of Villanova University, he received his J.D. from Pace University School of Law.

[FN1]. Now known as the "Comprehensive Motor Vehicle Insurance Act," as amended effective September 1, 1984.

[FN2]. *Toure v. Avis Rent-A-Car Sys.*, 98 N.Y.2d 345, 746 N.Y.S.2d 865 (2002).

[FN3]. 57 N.Y.2d 230, 455 N.Y.S.2d 570 (1982).

[FN4]. Insurance Law § 5102(d) provides:

> "Serious injury" means a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment.

[FN5]. 57 N.Y.2d 230.

[FN6]. *Id.* at 236.

[FN7]. *Id.*

[FN8]. *Id.* at 238.

[FN9]. *Id.* at 238-39.

[FN10]. *Id.* at 238.

[FN11]. 65 N.Y.2d 1017, 494 N.Y.S.2d 101 (1985).

[FN12]. *Id.* at 1019.

[FN13]. *Id.*

[FN14]. *Id.* at 1020.

[FN15]. 70 N.Y.2d 678, 518 N.Y.S.2d 309 (1987).

[FN16]. *Scheer v. Koubek*, 126 A.D.2d 922, 511 N.Y.S.2d 435 (3d Dep't 1987); *Butchino v. Bush*, 109 A.D.2d 1001, 486 N.Y.S.2d 478 (3d Dep't 1985).

[FN17]. 70 N.Y.2d at 679.

[FN18]. 126 A.D.2d at 923-24.

[FN19]. *Id.* at 924.

[FN20]. 70 N.Y.2d at 679.

[FN21]. 79 N.Y.2d 813, 580 N.Y.S.2d 178 (1991).

[FN22]. *Palmer v. Amaker*, 141 A.D.2d 622, 529 N.Y.S.2d 536 (2d Dep't 1988).

[FN23]. *McLoyrd v. Pennypacker*, 178 A.D.2d 227, 577 N.Y.S.2d 272 (1st Dep't 1991).

[FN24]. *Grasso*, 79 N.Y.2d at 814-15.

[FN25]. 49 N.Y.2d 557, 562, 427 N.Y.S.2d 595 (1980).

[FN26]. 79 N.Y.2d 955, 582 N.Y.S.2d 990 (1992).

[FN27]. *Id.* at 957.

[FN28]. *Id.*

[FN29]. *Id.* at 958.

[FN30]. *Id.*

[FN31]. *Id.*

[FN32]. 84 N.Y.2d 795, 622 N.Y.S.2d 900 (1995).

[FN33]. *Id.* at 797.

[FN34]. *Id.* at 798.

[FN35]. *Id.*

[FN36]. *Id.*

[FN37]. *Id.* at 799.

[FN38]. 96 N.Y.2d 295, 727 N.Y.S.2d 378 (2001).

[FN39]. *Id.* at 297.

[FN40]. *Id.*

[FN41]. *Id.*

[FN42]. *Id.* at 298-99.

[FN43]. *Id.* at 299.

[FN44]. *Id.*

[FN45]. 98 N.Y.2d 345, 746 N.Y.S.2d 865 (2002).

[FN46]. *Id.* at 350.

[FN47]. *Id.*

[FN48]. *Id.*

[FN49]. *Id.* at 351.

[FN50]. *Id.*

[FN51]. *Id.* at 352.

[FN52]. *Id.*

[FN53]. *Id.*

[FN54]. *Id.* at 353 (citations omitted).

[FN55]. *Forte v. Vaccaro*, 175 A.D.2d 153, 572 N.Y.S.2d 241 (2d Dep't 1991); *Philpotts v. Petrovic*, 160 A.D.2d 856, 554 N.Y.S.2d 289 (2d Dep't 1990).

[FN56]. 98 N.Y.2d at 355 (citation omitted).

[FN57]. *Id.* at 354.

[FN58]. *Id.* at 356.

[FN59]. *Id.*

[FN60]. *Id.*

[FN61]. *Id.* at 357-58.

[FN62]. *Id.* at 358 (emphasis added).

[FN63]. 79 N.Y.2d 813, 580 N.Y.S.2d 178 (1991).
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# V. Seminar Participants' Curricula Vitae and Resumes

**Hon. Leonard B. Austin**

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|---|---|
| **Judicial Offices** | Justice of the Supreme Court - 1999 to present<br><br>▪ Dedicated Matrimonial Part - 1999 to 2000<br>▪ Commercial Division - 2000 to 2009<br><br>Associate Justice of the Appellate Division, Second Department - 2009 to present |
| **Other Professional Experience** | Adjunct Professor of Law, Hofstra University School of Law - Fall 2002 to present<br><br>Associate Counsel to the Speaker of the New York State Assembly - 1980 to 1981<br>▪ Counsel to the Agriculture and Commerce and Industry Committees<br><br>Private practice of law:<br>▪ Leonard B. Austin, P.C. - 1990 to 1998<br>▪ Wolfson, Grossman & Austin - 1988 to 1990<br>▪ Stillman, Herz & Austin - 1980 to 1988<br>▪ Stillman & Austin - 1979 - 1980<br>▪ Solo practice - 1978 to 1979<br><br>Assistant Law Librarian, Hofstra University School of Law - 1978 to 1979 |
| **Admission to the Bar** | New York; Florida, United States Court of Appeals, Second Circuit; United States District Court for the Eastern, Southern and Northern Districts of New York. Also admitted pro hac vice in Texas, New Jersey and Pennsylvania and the United States Bankruptcy Courts for the Eastern District of Massachusetts and the District of North Carolina |
| **Education** | Hofstra University School of Law - J.D. - 1977<br>Georgetown University - B.A. - 1974<br>Jewish Theological Seminary - Summer 1973 |
| **Publications & Leading Cases** | Publications:<br><br>NYSBA Family Law Review, View From the Bench, Fall/Winter 2001<br><br>Banking Law Journal, The Impact of New York Supreme Court's Commercial Division on Bank Litigation, October, 2001.<br><br>Physicians Management Magazine, Divorce Battleground: What is Your Medical |

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| | License Worth Today? September 1989<br><br>Crains NY Business, Punish Illegal Peddlers, Not Innocent Parties; June 1, 1987<br><br>American Medical News, License Status in M.D. Divorces; (Two Parts) May 8 and 15, 1987<br><br>Leading Cases:<br><br>Lipco Electrical Corp. v. ASG Consulting Corp., NYLJ p. 20, col. 3 (8/26/04)<br><br>Sodexho Management Inc. v. Nassau Health Corp., NYLJ p. 19 col. 3 (10/6/04), affd., 23 A.D.3d 370 (2nd Dept. 2005)<br><br>Yemini v. Goldberg, 12 Misc.3d 1141 (2006)<br><br>Brown v. DeGrace, 193 Misc.2d 391, affd., 298 A.D.2d 526 (2nd Dept. 2002)<br><br>Anonymous v. Peters, 189 Misc.2d 203 (2001)<br><br>Eredics v. Chase Manhattan Bank, 186 Misc. 2d 19 (2000), affd., 292 A.D.2d 338 (2nd Dept. 2002), affd., 98 N.Y.2d 606 (2003).<br><br>Beverage Marketing USA, Inc. v. South Beach Beverage Co., Inc., 15 Misc.3d 1124(A) (2007), affd., 58 A.D.3d 657 (2nd Dept. 2009)<br><br>Cohen v. Nassau Educators Federal Credit Union, 12 Misc.3d 1164(A), affd., 37 A.D.3d 751 (2nd Dept. 2007)<br><br>Wisell v. Indo-Med Commodities, Inc., 11 Misc.3d 1089(A) (2006), on reargument, 14 Misc.3d 1209(A) (2006)<br><br>Fuchs v. Wachovia Mortgage Corp., 9 Misc.3d 1129(A) (2005), affd., 41 A.D.3d 424 (2nd Dept. 2007)<br><br>Tal Tours (1996) Inc. v. Goldstein, 9 Misc.3d 1117(A) (2005), affd., 34 A.D.3d 786 (2nd Dept. 2006)<br><br>Gallimore v. Wing, NYLJ, p. 24, col. 1 (9/25/02)<br><br>Oliver V. v. Kelly V., 224 N.Y.L.J. 101, p. 37, col. 6 (11/27/00)<br><br>Tunga v. Tunga, 223 N.Y.L.J. 83, p. 36, col. 5 (5/1/00) |

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|---|---|
| **Professional & Civic Activities** | American Bar Association<br><br>New York State Bar Association (Member of the House of Delegates and Past Presiding Member of the Judicial Section)<br><br>Florida Bar Association<br><br>Nassau County Bar Association<br><br>Jewish Lawyers Association of Nassau County (Board of Directors)<br><br>New York Bar Foundation (Life Fellow)<br><br>American College of Business Court Judges (President and Chair of the By-laws Committee)<br><br>Theodore Roosevelt Inn of Court (Past President)<br><br>Association of Justices of the Supreme Court<br><br>Pattern Jury Instructions Committee<br><br>Commercial Division Rules Revision Committee<br><br>Unified Court System Matrimonial Practice Committee<br><br>Unified Court System Commercial Division Curriculum Committee<br><br>Nassau County Courts Quarantine Team<br><br>Volunteer Judge in various mock trial and moot court competitions sponsored by the New York State Bar Association, Nassau County Bar Association, Hofstra University School of Law and St. John's Law School, 1999 to present<br><br>Temple Beth Torah (Executive Board and Past President) |

# Donnalynn Darling

**Law Practice**

Donnalynn Darling is the Chair of Meyer, Suozzi, English & Klein, P.C.'s Personal Injury and Medical Malpractice groups, and Chair of the firm's Education Law practice. Ms. Darling's practice specializes in plaintiff's personal injury trial work, as well as trials of catastrophic tort and wrongful deaths. Her use of a creative approach to the issue of proximate cause in a prominent wrongful death suit resulted in a homeowner being held responsible for the death of a pedestrian who was struck by a motor vehicle. In creating the firm's Education Law practice, Ms. Darling responded to increasing requests by parents of learning disabled children for assistance in securing timely educational evaluations, services and accommodations for their children in public and private school settings under federal and state regulations.

**Professional Profile**

In 1978, Ms. Darling began her career as an Assistant District Attorney under Bronx D.A. Mario Merola. As part of her exhausting caseload, she was in charge of prosecuting sex crimes involving children. In many instances, these victims were unable to verbally communicate their abuse, be it for reasons of trauma, infancy or difficulty with language. Under Ms. Darling's leadership, the Bronx D.A.'s office pioneered the use of anatomically-correct cloth dolls of all races, ages and genders. The use of these dolls enabled the alleged victims to act out the offenses perpetrated upon them in front of the Grand Jury, when they lacked the verbal skills to do so, in order that indictments could be obtained. This trail-blazing method of testimony was upheld by the courts and is widely used today. After leaving the District Attortney's Office, Ms. Darling has focused her career in the area of plaintiff's personal injury trial work, representing seriously injured plaintiffs in auto, premises, Labor Law, municipal and professional liability matters.

**Community Involvement**

Ms. Darling serves on the Board of Directors of Variety Child Learning Center, a center-based special education pre-school. She was appointed by then Nassau County Department of Health Commissioner David M. Ackman, M.D., as a member of the County's Local Early Intervention Coordinating Council whose purpose it is to advise the County regarding the planning, delivery and evolution of services to special needs children from birth to age three.

**Recognition**

In April 2005, Ms. Darling received a "Voice For All Children Award" from the Coalition Against Child Abuse & Neglect. In May 2005 and again in May 2009, she was honored as one of

"Long Island's Top 50 Professional Women" by Long Island Business News. Additionally, Ms. Darling is rated "AV" by Martindale-Hubbell, the highest level in professional excellence and ethics.

**Professional Affiliations**

Ms. Darling is a member of the Nassau County Bar Association, a founding member of the Committee of Attorneys and Accountants, and a member of the New York State Trial Lawyers Association. She is also a member of the New York State Bar Association and is a frequent lecturer on trial evidence, special education law and other topics.

**Ellen H. Greiper**
*Of Counsel*

Ellen Greiper has over 24 years experience in construction litigation, handling claims involving complex construction defects, large property loss, labor law and toxic exposures. She also has an extensive background in the defense of large personal injury claims arising from premises liability, and construction accidents. Prior to joining the firm, Mrs. Greiper was the managing partner of a New York City firm where she litigated, through trial, numerous claims on behalf of property owners, design professionals and building contractors in the New York and New Jersey areas.

Mrs. Greiper is a certified Mediator and Arbitrator for the State and District courts in Nassau County for trial ready matters and attorney fee disputes. She is a member of the Theodore Roosevelt Inn of Court, and several other professional associations where she frequently teaches and lectures on various risk management and legal topics.

Mrs. Greiper received her Juris Doctorate from Brooklyn Law School. She is admitted to practice in the Courts of the State of New York and New Jersey; the United States District Courts for the Southern, Eastern and Northern District of New York; and The United States Supreme Court.

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**Education**

Georgetown University Law Center, JD Degree
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**Professional Experience**

2004-present Law Office of James J. Keefe, P.C.
Solo Practice concentrating in personal injury and civil rights (plaintiff and defense) estate administration and litigation, real estate, business formation and litigation

1980-2004 Montfort, Healy, McGuire and Salley
1140 Franklin Avenue
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Senior Partner 1990-2004
Partner 1985-1989
Associate 1980-1984

1979-1980 O'Brien and Keefe
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1976-1978 James M. O'Brien
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Associate

1970-1976 District Attorney, New York County
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Assistant District Attorney

**Military Service**

1971-1972 First Lieutenant USAF

**Admitted to Practice**

New York 1971 USDC Southern & Eastern Districts 1974 USCA Second Circuit 1974
Florida 1975 USDC Southern District of Florida 2009
New Jersey 1985 USDC District of New Jersey 1985
United States Supreme Court 1999

**Languages**

French, German, some Russian

**Professional Organizations**

New York State Bar Association
Member, Tort Reparations Committee 1992-2000
Member, Torts, Insurance and Compensation Law Section
Executive Committee 2000-present
Member, Trial Law Section

Nassau County Bar Association
Annual Dinner Committee, 1980
Defendants' Round Table, 2000
Supreme Court Committee, 2000

Trial Lawyers' Section of Nassau and Suffolk County Bar Associations
Board Member 1987-present

Treasurer 1995-6; Secretary 1996-7;
3rd Vice Chair 1997-8; 2nd Vice Chair 1998-99; 1st Vice Chair 1999-2000
Chairman 2000-2001

The Florida Bar

New Jersey Bar Association

American Board of Trial Advocates (Rank of Advocate)

Catholic Lawyers' Guild Diocese of Rockville Centre [Nassau and Suffolk Counties]
Board Member 1996-1999

Theodore Roosevelt American Inn of Court (Nassau County, NY) 2004 – present
Pupillage Group presentation February 2008 – Electronically Stored Documents and Privilege

**Professional Service**

Lecturer, Queens County Bar Association, *How to try a Police Liability Case* February 1999

Lecturer, Nassau County Medical Center, Department of Anesthesia, *How to Survive a Medical Malpractice Suit*

Lecturer, New York State Bar Association, *Litigating for Municipalities* April 1993

Co-Presenter, *Handling a Personal Injury Case in Federal Court* August 2003

**Community Service**

Garden City Centennial Soccer League
Volunteer Coach, Girls' and Boys' Soccer 1982-1991
Board Member 1985-1989

Saint Anne's R.C. Church, Garden City, NY
Promoter, 75th Anniversary Campaign
Member, Liturgy Committee 2001-present
Member, Pastoral Council 1987-1999
Lector
Member, Communications Committee

Nassau County Republican Committee 1984-present
Campaign Coordinator [Garden City Area] State Senator John Dunne 1986
Alternate Delegate, Judicial Nominating Convention 1988
Chairman, Annual Fundraiser, Garden City Republican Committee 1990-2000

Chaminade High School (Mineola, NY) Alumni Association
Co-chair, 25th Reunion, Class of 1963
Board Member 1988-1992
President's Council 1993-present
Alumni Telethons 1990-present
Class Representative 1988-present

Georgetown University Alumni Association
Alumni Admissions Program Interviewer 1985-2007
Alumni Admissions Recruitment Member 1990-2007
Law Alumni 30th Reunion Planning Committee 1999-2000

# Barbara A. Lukeman

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## Practice

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Products: Class Action. Trade & Industry Representation
Class Actions & Aggregate Litigation
Consumer Products
Automotive, Trucking & Fuel Systems

## Experience

Barbara Lukeman practices primarily in the areas of product liability, mass tort defense, and complex business disputes. She has defended and counseled clients in many tort actions in federal and state courts, nationwide, and in the New York area, with regard to pharmaceuticals, medical devices, chemicals, lead paint, tools, and food products, as well as aircraft and automobiles. Ms. Lukeman was a member of the trial team that secured a directed verdict on behalf of a major automotive manufacturer in a case involving allegations of design defect and personal injury. She has successfully argued motions before both state and federal courts, prepared numerous appellate briefs, authored several articles, and has been a frequent guest speaker and lecturer for continuing legal education programs and seminars.

Ms. Lukeman is a Special Professor of Law at Hofstra University School of Law where she teaches a course in products liability. In addition, Ms. Lukeman has taught several skills-based and substantive law courses, including sexual orientation and the law, research and writing, and appellate advocacy. She has also instructed law students on negotiation skills and deposition techniques for the National Institute of Trial Advocacy (2004).

Ms. Lukeman has served as coach for several Hofstra Moot Court teams including the Rendigs Product Liability, and the Williams Institute Moot Court Competition on Sexual Orientation and Gender Identity teams. She coached moot court teams to first-place finishes in the 2004, 2005, and 2006 Nassau Academy of Law competitions. In 2007, to acknowledge her contribution to Hofstra's moot court program, the student-run Moot Court Association instituted an award, in her name, to be presented each year to an outstanding law student who advances the goals of the Moot Court Association. Most recently, Hofstra Law School's Alumni Board presented Ms. Lukeman with its Emerging Leader Award.

## Admissions

Ms. Lukeman is admitted to practice in New York and before the United States District Courts for the Eastern and Southern Districts of New York, as well as the Second Circuit Court of Appeals, the United States Supreme Court, and the District of Columbia.

## Education

Columbia University School of Law, LL.M. (Harlan Fiske Stone Scholar)
Hofstra University School of Law, J.D. (with distinction, Law Review)
Hofstra University, B.A. (*summa cum laude*, Phi Beta Kappa)

## Publications and Presentations

- "The Reluctance to Certify a Mass Class Under CAFA," *Product Liability Law 360*, November, 2009. (Author with John J. Weinholtz)
- "Gatekeeper's New Tool: Heightened Pleading Standards," *Product Liability Law 360*, October, 2009. (Author with James W. Weller)
- "The Expanding World of the Products Liability Litigator," *New York Law Journal*, August 2009. (Author with Joseph J. Ortego)
- "Winning on Appeal: Writing an Effective Appellate Brief," *National Business Institute*, August 2009. (Author and Presenter)
- "Legal Research on the Internet: Navigating Federal, State, and Local Rules," National Business Institute, August 14, 2009. (Author & Presenter)
- "Women Inspiring Women," Hofstra Law School, March 30, 2009. (Panelist)
- "The Consumer Product Safety Improvement Act of 2008: Transparency in the Age of Information," *In-House Defense Quarterly*, Spring 2009. (Author with James W. Weller)
- "Some Rules Are Not Meant to Be Broken, Strategic Use of Discovery in Complex Litigation," *National Business Institute*, February 2009. (Author and Presenter)
- "Consumer Product Safety Action Alert: Federal Judge Holds Phthalates Ban is Retroactive," *Nixon Peabody*, February 2009. (Author with James W. Weller)
- "Consumer Product Safety Action Alert: CPSC Announces Latest Enforcement Policy," *Nixon Peabody*, February 2009. (Author with Kelly B. Kramer)
- "Passive Restraint Systems and the Crashworthiness Doctrine: A Case Study," *Published for ACI Automotive Conference*, Spring 2008. (Author with Joseph J. Ortego)
- "The Defense of Federal Preemption in Automotive Product Liability Cases: Recent Developments," *New York State Bar Association*–Published for NYSBA CLE Conference on Crashworthiness Litigation, Spring 2007. (Author with Samuel Goldblatt)
- "Style and Substance of the Appellate Brief," *National Business Institute;* Published for NBI Seminar, February 2007. (Author & Presenter)

## Affiliations

Ms. Lukeman is a member of the American Bar Association, New York City Bar Association, and a founding member of Hofstra Law School's Moot Court Association. She is also a member of the Theodore Roosevelt American Inn of Court and the Defense Research Institute.

Colleen Baktis
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## EDUCATION

**Touro College Jacob D. Fuchsberg Law Center,** Central Islip, NY
Juris Doctor Candidate, May 2012
**Class Rank:** Top 2.6%
**GPA:** 4.0
**Awards:** CALI Award for Academic Excellence in Torts
**Activities:** Criminal Law Society
Women's Bar Association
Volunteer Income Tax Assistance Program
Suffolk County Bar Association, Student Member

**Hofstra University,** Hempstead, NY
Bachelor of Business Administration, *summa cum laude*, December 2008
(Concentrating in Legal Studies in Business )
**Honors**: Provost's List (All Semesters)

## EXPERIENCE

**Geisler & Gabriele, LLP** Garden City, NY
**Paralegal** December 2007 – August 2009

Retrieved pertinent materials for trial preparation including medical records, expert materials, and discovery materials. Maintained case files. Assisted in trial preparation and preparing legal documents such as motions, subpoenas and discovery demands. Scheduled client and expert meetings and examinations before trial of plaintiffs, co-defendants and nonparty witness. Trained new paralegals. Assisted in developing paralegal procedures.

**Panera Bread** Rockville Centre, NY
**Shift Supervisor** September 2006 – November 2007

Managed and trained 30 employees. Maintained store cleanliness and safety procedures. Responded to guest complaints. Prepared deposits for daily shifts. Responsible for cash safe and security measures. Ordered necessary products for given shift. Accountable for opening and closing procedures and labor and sales tracking.

**Associate Trainer / Corporate Trainer** November 2003 – September 2006

Interacted with customer by taking orders and prepared food orders. Maintained sandwich line standards, rules and procedures and ensured all employees were following proper standards. Trained new employees in all areas of the Bakery/Café. Assisted with opening and staff development in new Bakery/Cafes.

**New Line Cinema** New York, NY
**Publicity Intern** January 2006 – May 2006

Responsible for reading newspapers and magazines for mentions of upcoming releases. Created memos related to said articles. Developed promotional ideas for releases. Helped in organizing press events and promotional events. Held press preview screenings. Answered phones, emails, general questions, and sent direct mail and announcements

## OTHER

**Interests:** Music, running, baseball

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## Education

**Touro College Jacob D. Fuchsberg Law Center**, Central Islip, NY
Juris Doctor Candidate, May 2012
*Activities:* Criminal Law Society, ADR Society, VITA

**State University of New York College at Oneonta**, Oneonta, NY
Bachelor of Science, Accounting, May 2006
*Honors:* Dean's List- Spring 2006
*Activities:* NCAA Lacrosse, Accounting Club

## Experience

**Marcum LLP,** Melville, NY
*Audit Senior* September 2006- August 2009
**Alternative Investment Group:** Provide assurance, accounting, and business advisory services to hedge funds including offshore funds and master-feeder structures, investment management companies, fund of funds, and private equity funds. Clients range in size from $5 million to approximately $1 billion under management. Assigned to engagements requiring the valuation of difficult to value investments such as illiquid investments for Private Investment in Public Equity funds, futures, and options. Designed and implemented excel based schedules for hedge fund accounting service clients. Involved in client relations including, but not limited to addressing client concerns during engagements and client meetings. Contributed to the preparation and presentation of Financial Statements based on GAAP and International Financial Reporting Standards.
**Commercial Group:** Provide assurance services to public and private clients in the restaurant, telecommunication, e-commerce, manufacturing, retail, and financial services industries. Clients range in size from start-up companies to firms with assets in excess of $750 million. Responsible for all levels of engagements from planning to final report issuance; including fieldwork, training of new staff on engagements, technical research, and drafting financial statements and footnote disclosures. Participated in preparing training materials and training new recruits to the firm. Assisted in research and implementation of new risk assessment standards.

**National Network of Accountants**, Bohemia, NY
*Office Assistant* December 2005- May 2006
Developed and maintained a database of clients to be used for networking. Designed and dispensed promotional material for networking events. Involved in client relations and promotional events.

**Kehoe & Merzig, P.C.**, Oneonta, NY
*Intern* January 2006- May 2006
Shadowed town attorney in town ordinance and trusts and estates matters.

**Wolfsohn Financial Services, Inc.,** Lynbrook, NY
*Intern* June 2005- August 2005
Performed accounting service and tax preparation duties for assigned accounts. Assisted clients preparing for IRS audits and financial statement audits. Responsible for responding to IRS Inquiries.

## Other

*Licenses:* New York State licensed Certified Public Accountant
*Affiliations:* New York State Society of Certified Public Accountants
American Institute of Certified Public Accountants
American Bar Association, student member

# William D. Melofchik

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## EDUCATION

**Touro College Jacob D. Fuchsberg Law Center,** Central Islip, NY
Juris Doctor Candidate, May 2012
*Activities:* Arts, Entertainment and Sports Law Society Member. Real Estate Law Society Member. Participant in Suffolk County Bar and Courts Foreclosure Pro Bono Project

**University of Connecticut,** Storrs, CT
Bachelor of Arts in English, July 2008
*Minor:* Political Science
*GPA:* 3.0
*Honors:* All Big East Student Athlete Honor Roll 5 semesters
*Activities:* Cross Country (Captain Junior and Senior years), 1st Team All-Northeast 2005
Indoor Track & Field – Member of 2006 Big East Championship Team
Outdoor Track & Field – Competed in multiple Big East Championships
Big Brother Mentor for other student athletes
*Study Abroad:* Florence, Italy (Spring 2008)
Studied Italian, Renaissance Art and European Union Evolution/Operation

## WORK EXPERIENCE

**Shore Runner Inc., Long Branch, NJ**
*Training Consultant/Sales Delegate* August 2008-August 2009
Advise endurance athletes as to proper training techniques, equipment use and injury treatment/avoidance. Supervise daily functions of multiple stores; including inventory management, sending/receiving shipments, and overall store processes.

**University Catering Service, Storrs, CT**
*Catering Assistant* Summer 2008
Oversaw the set-up, delivery and breakdown of catering services for an extensive variety of upscale political, academic and athletic events.

**Elberon Bathing Club, Elberon, NJ**
*Manager/Lifeguard* Summer 2005-2007
Responsible for daily opening and closing operations. Maintained staff payroll. Directed staff scheduling. Administered environmental safety tests. Upheld a perfect safety record for entire employment history.

## OTHER

*Interests:* Endurance sports; photography; guitar; literature
*Volunteer:* Assist and teach at local religious education program (2000-Present)