THE WEEK IN TORTS

A Weekly Summary Of The Latest Case Decisions Critical To Those Helping Victims of Negligence

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FLORIDA LAW WEEKLY
VOLUME 40, NUMBER 43
CASES FROM THE WEEK OF OCTOBER 23, 2015

A REFRESHER ON SPECIFIC V. GENERAL JURISDICTION.

Teva Pharmaceutical Industries v. Ruiz, 40 Fla. Law Weekly D2371 (Fla. 2nd DCA October 16, 2015):

In this medical products liability case, the defendant was an Israeli company maintaining it had no connection to Florida and objecting to personal jurisdiction. The court provided a helpful refresher on jurisdictional analysis.

To establish long-arm jurisdiction, a trial court must decide whether (1) there are sufficient jurisdictional facts to bring the acts within the purview of §48.193; and (2) whether the defendant has sufficient minimum contacts with Florida to satisfy constitution due process requirements. That prong requires a consideration of whether the defendant has sufficient minimum contacts with the state so that the exercise of jurisdiction would not offend traditional notions of fair play and substantial justice.

In this case, a man was given a drug manufactured by the defendant during outpatient surgery, which was contaminated with certain toxins and bacteria. The complaint alleged that Teva Pharmaceuticals USA, Inc. (a wholly owned subsidiary of Teva Industries) regularly conducted business in Hillsborough County, and that Teva USA manufactured, distributed, sold or supplied the drug which had caused the injury.

The complaint also alleged that Teva Industries is a publically traded foreign corporation organized, existing and doing business by virtue of the laws of Israel, but that Teva Industries exercised 100% ownership and control over its wholly owned subsidiaries, Teva USA being one of them. The complaint further alleged that the two industries regularly conducted business in Hillsborough County.

The court concluded that the complaint alleged sufficient facts to bring the two industries' actions within the long-arm statute. Once they met this pleading requirement, the burden was then on Teva Industries to file a legally sufficient affidavit or other sworn proof to contest the jurisdictional facts, which it did.

Because that affidavit contained fully disputed jurisdictional allegations, the burden shifted back to the plaintiffs to prove by affidavit or other sworn proof that a basis for long-arm jurisdiction existed. The plaintiff submitted several documents in opposition, as well as testimony. Because of this conflict in the evidence, the trial court was required to hold a limited evidentiary hearing on the topic (the court remanded for one).

However, as to general jurisdiction, the plaintiffs could not establish those requirements. The test for general jurisdiction asks whether according to the U.S. Supreme Court's recent decision in *Daimler v. Bauman*, a foreign corporation's affiliations with the state are so continuous and systematic as to render it essentially at home in the forum state. Because neither Teva USA nor Teva Industries was incorporated in Florida or has its principal place of business here, the court found under *Daimler*, that the court lacked general jurisdiction over the company.

Finally, the appellate court observed that even if the plaintiffs established that the conduct of Teva Industries met the requirements for specific jurisdiction, there must be a demonstration that there are sufficient minimum contacts with Florida to satisfy constitutional and due process. A defendant's suit-related actions must create a substantial connection with the state before that state can exercise jurisdiction consistent with due process. To do that, the relationship must first arise out of contacts that the defendant himself creates with the forum state, and second, the minimum contacts analysis examines the contacts with the state itself (not merely the defendant's contacts with the persons who reside in that state).

Again, with contradictory evidence on the issue in this case, an evidentiary hearing was necessary.

TRIAL COURT PROPERLY GRANTED MOTION TO DISMISS OR STRIKE PLEADINGS FOR FAILURE TO COMPLY WITH DISCOVERY REQUESTS AND FOR DISOBEYING COURT ORDERS.

Sukonik v. Wallack, 40 Fla. Law Weekly D2339 (Fla. 3rd DCA October 14, 2015):

Two sisters in a dispute over the administration of their late mother's estate were involved in heated litigation. One sister repeatedly ignored deadlines, discovery requests, and orders to appear for a deposition.

Ultimately, the court issued a very thorough order noting how the party's deliberate and contumacious disregard of the court's authority and her willful disregard or gross indifference to the orders of the court justified the court's decision to dismiss that party's claim. Because the record supported the trial court's findings, the appellate court found

there was no abuse of discretion and affirmed the decision striking the pleadings.

A TRIAL COURT LACKS JURISDICTION TO REOPEN AND REHEAR A CASE DISMISSED FOR FAILURE TO PROSECUTE.

Sanchez v. Fannie Mae, 40 Fla. Law Weekly D2341 (Fla. 3rd DCA October 14, 2015).

TRIAL COURT ERRED IN AWARDING PIP BENEFITS TO INSURED, BECAUSE THE INSURER DID NOT RECEIVE NOTICE OF THE CLAIM AS THE STATEMENT FOR MEDICAL SERVICES DID NOT COMPLY WITH §627.736(5)(d).

State Farm v. Gonzalez, 40 Fla. Law Weekly D2352 (Fla. 3rd DCA October 14, 2015):

After the insured was in an accident and was transported to a hospital's emergency room, the hospital billed her health carrier but did not bill State Farm. The health carrier paid the bill.

Approximately six months later, the insured's attorney sent a letter of representation to State Farm stating that she was injured in the accident and requesting it to pay the insurance information required by statute, and attaching the police report of the accident indicating transport to the hospital. The letter did not include a bill or statement of the hospital's charges, nor did it demand payment of specific medical services provided to the plaintiff.

After receiving the letter of representation, State Farm corresponded with plaintiff's counsel numerous times, asking for information regarding treatment as a result of the accident. The attorney failed to respond, and State Farm did not receive any information for two years.

After plaintiff's repeated failure to provide State Farm with the requested information and nearly five years after the accident, the plaintiff then filed an action against State Farm seeking to collect UM benefits. The case was settled and a month later plaintiff's attorney demanded State Farm pay an additional $10,000 in med-pay and PIP benefits, which State Farm refused to do.

State Farm moved for summary judgment asserting it did not owe benefits for the ER's charges because State Farm did not receive a statement of charges as required under §627.736(5)(d). The trial court though denied that motion because State Farm had not challenged the reasonableness, relatedness or necessity of those charges. The trial court entered a final judgment awarding the plaintiff $685 in PIP and med-pay benefits for the treatment rendered.

State Farm maintained on appeal that it was not furnished with requisite notice of the PIP claim, and because of that, the benefits never became due. The Third District agreed.

Because it was undisputed that the statement State Farm received for the hospital's medical services did not comply with the statute (it was not submitted on one of the required forms and did not identify each medical procedure by the physician's current procedural terminology), the benefits were not overdue.

Additionally, although §627.736(4)(b) provides that PIP benefits shall be overdue if not paid within 30 days after the insurer is furnished with notice of the fact of a covered loss

and amount, (5)(d) provides that for the purposes of that paragraph, the insurer shall not be considered to have been furnished with notice of the amount of covered loss or medical bills, unless the statement or bills comply with the paragraph in the statute. Because the statement for medical services rendered by the hospital did not comply with that section, State Farm did not receive notice of the claim. Therefore, the PIP benefits never became due.

As State Farm's policy specifically provides that if the PIP benefits are not payable the med-pay benefits are not payable either (because med-pay is essentially excess coverage), there was no obligation to pay the med-pay either.

WHERE AN EMERGENCY SERVICE PROVIDER SUBMITS ITS CLAIMS WITHIN THE STATUTORY 30-DAY RESERVE PERIOD UNDER PIP, THOSE CLAIMS WILL BE PRIORITIZED FOR PAYMENT, BUT STILL SUBJECT TO ANY DEDUCTIBLES THAT EXIST IN THE INSURANCE CONTRACT BETWEEN THE INSURED AND THE INSURER.

Mercury Insurance Co. v. Emergency Physicians of Central, 40 Fla. Law Weekly D2364 (Fla. 5th DCA October 16, 2015):

An insurance company filed a petition seeking a writ of certiorari of an order affirming a county court judge's conclusion that under PIP, a provider for emergency services which submits bills in accordance with §627.736(4)(c), is entitled to have the bills paid, regardless of the existence of a deductible in the insured's insurance contract.

The case involved the interplay between §627.736(4)(c) and §627.739(2). The former requires the insurer upon being notified of an accident to reserve $5,000 in PIP benefits for 30 days for payment to certain emergency providers.

The latter states that the named insured may elect a deductible in various amounts, which must be applied to 100% of the expenses and losses described in §627.736. It states that after the deductible is met each insured is eligible to receive up to $10,000 in total benefits as described in this section.

The issue was whether a PIP insurer could apply the insured's contractually selected deductible to all bills received in the order they are received, including a bill submitted by an emergency service provider within the 30-day reserve period. The circuit court affirmed the judgment of the county court, which had ruled that the legislature had intended to give priority to emergency providers, and therefore did not intend to have the deductible applied to them if the bills were submitted pursuant to §(4)(c). The circuit court affirmed, holding it was only when the deductible is met by **other** bills that the emergency service provider's bill is to be paid in full.

The Fifth District disagreed. The insured in the case had been involved in an accident, and had a policy with Mercury that provided $10,000 in PIP benefits and a $500 deductible. She received a $191 bill by the emergency room physicians and submitted it within 30 days from the date Mercury received notice of the accident (it was the only one submitted within that time frame). Mercury then applied the $191 bill to the plaintiff's $500 deductible, and did not receive another bill until more than 30 days after being notified of the accident. Mercury did not receive sufficient notice to cover the deductible until more than 60 days after being notified. The provider sued Mercury stating that it could not apply its bills to the deductible.

The court concluded that when reading the two sections together, there is an inescapable conclusion that **deductibles are to be applied to bills even for emergency providers and hospitals**. The plain language of the two sections is not in conflict, and provides that where an emergency services provider submits its claim within the 30-day reserve period provided in §627.736(4)(c), those claims will be prioritized for payment. However, any such payment will be subject to the deductible that exists in the insurance contract between the insured and the insurer, making it clear that the deductible provision does apply.

ERROR TO DISMISS COMPLAINT WITHOUT PREJUDICE FOR FAILURE TO APPEAR FOR CASE MANAGEMENT CONFERENCE WITHOUT FINDING THAT PLAINTIFF'S ACTIONS WERE WILLFUL, FLAGRANT, DELIBERATE, OR OTHERWISE AGRRAVATED.

Perkins v. Jacksonville Housing Authority, 40 Fla. Law Weekly D2377 (Fla. 1st DCA October 20, 2015).

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