96561-7

NO. 76448-9
(King County No. 16-2-16112-0 SEA)

IN THE COURT OF APPEALS
OF THE STATE OF WASHINGTON DIV. I

FOLWEILER CHIROPRACTIC, PS, a Washington professional services corporation,

Plaintiff — Appellant,

v.

AMERICAN FAMILY INSURANCE COMPANY,

Defendant - Respondent,

PETITION FOR REVIEW

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I. IDENTIFICATION OF PETITIONER AND COURT OF APPEALS DECISION

American Family Insurance Company petitions for review of the Court of Appeals decision issued on August 27, 2018 and ordered published on October 23, 2018.

II. INTRODUCTION & ISSUE PRESENTED FOR REVIEW

This case presents an important question affecting healthcare providers, insurance companies, and ultimately consumers of healthcare and health insurance in Washington. The Court of Appeals' ruling, if allowed to stand, would make Washington the only state in the nation to reject a tool that has won the approval of regulators and courts across the country because it promotes efficient and fair reimbursement of reasonable healthcare charges. The Court of Appeals has misread the Consumer Protection Act in a way that privileges healthcare providers over consumers, and its ruling undermines efforts to control both insurance and healthcare costs. This Court's review is urgently needed to promote the proper functioning of Washington's healthcare marketplace.

To help manage medical costs, insurance companies rely on databases created by third parties that provide information about the range of charges for specific medical procedures in specific geographic areas. American Family reviews medical bills with the aid of a database operated by FAIR Health, a non-profit organization created in 2009 at the direction

of the New York State Attorney General to ensure accurate and fair medical charge benchmarking. Courts and regulators in Washington and across the country have approved the use of the FAIR Health database in particular, and database-assisted review generally, as a guide to determine whether a healthcare provider's charges are "reasonable," which is a statutory condition of coverage. *See, e.g., St. Louis Park Chiropractic, P.A. v. Fed. Ins. Co.*, 342 F. App'x 809, 813-15 (3d Cir. 2009); *State Farm Mut. Auto. Ins. Co v. Sestile*, 821 So. 2d 1244, 1246 (Fla. Ct. App. 2002); *Nager v. Allstate Ins. Co.*, 83 Cal. App. 4th 284, 292 (2000). Indeed, King County Superior Court judges have repeatedly approved of the use of FAIR Health as a *remedy* for alleged claims-handling abuses. *Chan Healthcare Group, PS v. Liberty Mut. Fire Ins. Co.*, 844 F.3d 1133, 1135, 1143 n.1 (9th Cir. 2017) (discussing King County settlements); *Lebanon Chiropractic Clinic, P.S. v. Liberty Mut. Ins. Co.*, No. 5-15-0111, 2016 WL 546909, at *3 (Ill. App. Feb. 9, 2016) (same).

According to the complaint, American Family reimburses providers in full up to the 80th percentile of charges in the FAIR Health database for the geographic area at issue but does not pay charges above the 80th percentile without further documentation from the provider.[1]

[1] While plaintiff alleges payment at the 80th percentile, American Family's actual practice is to reimburse at the 85th percentile. The distinction is not relevant here.

Plaintiff Folweiler Chiropractic, P.S. (FC), a medical service provider, claims that this practice is "unfair" under the Consumer Protection Act.

The Superior Court granted American Family's motion to dismiss FC's CPA claim. The Court of Appeals reversed. The Court of Appeals ruled that FC's allegations regarding American Family's use of FAIR Health "are sufficient to establish an unfair act in violation of the CPA…." Op. at 8. According to the Court of Appeals, an insurer violates the CPA as a matter of law if its bill review procedures do not in the first instance incorporate factors specific to individual patients and their providers. No other state court has read its consumer protection law in this way.

The question presented is whether the use of a widely-approved medical charge database to review bills for reasonableness is an unfair practice under the CPA as a matter of law.

III. STATEMENT OF THE CASE

A. Medical Billing and Insurance Bill Review

This case concerns American Family's Personal Injury Protection (PIP) policies. American Family's review process begins when providers submit bills for treatment provided to insureds, identifying the treatment by CPT code. Current Procedural Terminology (CPT) codes are part of a system developed by the American Medical Association to foster effective communication within the healthcare system. Am. Med. Ass'n, *Current*

Procedural Terminology 2005 Standard Edition (2004). The five-digit codes cover thousands of services, broken down by the type of procedure or treatment provided and the part of the patient's body involved. Pamela Samuelson, *Questioning Copyrights in Standards*, 47 B.C. L. Rev. 193, 197 (Jan. 2007). CPT codes do not reflect individual patient characteristics – age, weight, health – or provider characteristics – experience, credentials, overhead. The federal government requires Medicare and Medicaid providers to use CPT codes. *Id.* Use of the codes is ubiquitous in the private medical and insurance markets as well.

Washington's PIP statute provides that charges for medical treatment are covered only insofar as they are "reasonable." RCW 48.22.005(7); RCW 48.22.095. This statutory restriction protects PIP insureds, as PIP limits are low (typically $10,000) and easily exhausted by excessive medical expenses.

In order to conform to similar statutory "reasonableness" limitations, insurers across the country employ databases to compare a given provider's charges to others in the marketplace. *See, e.g.*, *Zack v. McLaren Health Advantage, Inc.*, – F. Supp. 3d –, 2018 WL 4501488, at

*11 (collecting authorities).[2] Without such databases, each insurer would need to compile its own set of comparables for each charge, provider, and patient – a far more costly alternative to using third-party data, and a less comprehensive and accurate one to boot.

B. The FAIR Health Database

American Family has used the FAIR Health database to evaluate the reasonableness of medical charges since 2011. CP 9-10, 24. FAIR Health and its database were created in 2009 pursuant to settlements between the New York Attorney General and major insurers after problems with an earlier database called Ingenix had come to light.[3] Use of the FAIR Health database has been approved or required by legislatures or regulators in Alaska, California, Connecticut, New Jersey and New York.[4] Courts, too, have long endorsed the use of medical charge

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[2] These databases are used both in reviewing claims made under PIP policies and in reviewing claims made under health insurance policies that limit reimbursement for out-of-network services to reasonable or "usual and customary" charges. *See id.*

[3] Press Release, New York State Office of the Attorney General, *Attorney General Cuomo Announces Historic Nationwide Reform of Consumer Reimbursement System for Out-Of-Network Health Care Charges* (Oct. 27, 2009); *see also, e.g.*, *Keeping it Simple: Health Plan Benefit Standardization and Regulatory Choice Under the Affordable Care Act*, 74 Alb. L. Rev. 241, 277 (2010).

[4] 10 N.Y.C.R.R.R. § 69-10.21(a); Cal. Health & Safety Code § 127452(b); http://regs.cqstatetrack.com/info/get_text?action_id=762209&text_id=211591&type=full_text ("FAIR Health was selected to provide medical billing data" for Alaska's Worker's Compensation Medical Fee Schedule); https://www.prnewswire.com/news-releases/connecticut-consumer-protection-law-designates-fair-health-data-out-of-network-reimbursement-reference-point-300294308.html ("FAIR Health is the only organization specified by the Commissioner as qualifying as an official data source" for Connecticut's Benchmark Database Public Act); NJ Admin. Code § 11:3-29.4(e)(1)

benchmarking generally as an efficient means of bill review. *Supra* at 2.

Within Washington, courts have repeatedly approved the use of FAIR Health data. In multiple cases, King County Superior Court judges have approved class-action settlements in which the parties agreed that the insurer would use FAIR Health data to remedy alleged claims-handling abuses. *Chan*, 844 F.3d at 1135, 1143 n.1 (discussing King County settlements). The parties to these settlements have agreed, and courts have ordered, that the FAIR Health database "'does not, in and of itself, breach any duty or obligation under any applicable law or contract requiring [the insurer] to pay or reimburse 'usual or customary'" or 'reasonable' charges.'" *Id.* at 1135. The practice approved in at least one of the settlements was payment at the 85th percentile of the FAIR Health database. *Lebanon Chiropractic Clinic*, 2016 WL 546909 at *3 (discussing King County settlement).

C. FC's Claim and Lower Court Rulings

Records attached to the complaint show that FC provided services under CPT codes including 98942 – for chiropractic manipulative treatments involving five spinal regions – and 98943 – for extraspinal chiropractic manipulative treatments. CP 21, 48. FC listed a single

("National databases of fees, such as those published by FAIR Health . . . are evidence of the reasonableness of fees for the provider's geographic region or ZIP code").

charge for each patient who received these treatments – $95 for CPT 98942 and $60 for CPT 98943. The charges did not vary by patient. *Id.*

American Family reviewed FC's charges by comparing them to other charges for the same CPT-coded treatment in FC's "geo-zip" (the area covered by the first three digits of FC's zip code). Op. at 3. With respect to the charges at issue in this case – each of which exceeded the 80th percentile – American Family sent FC (1) a check for payment at the 80th percentile, and (2) an Explanation of Remittance stating American Family would consider paying charges above the 80th percentile upon the submission of supporting documentation. CP 24, 27, 29.

In a complaint filed in July 2016, FC asserted a single claim under the CPA, alleging that American Family's use of FAIR Health is an unfair trade practice. CP 16-18. American Family moved to dismiss, drawing on the history and broad acceptance of FAIR Health. Judge Ramsdell granted American Family's motion on December 19, 2016. CP 1030-31.

The Court of Appeals reversed. The Court of Appeals did not acknowledge the approval of the FAIR Health database by the courts and regulators cited above. Nor did the court cite any authority, in Washington or elsewhere, suggesting that use of the database is improper or that insurers must engage in a subjective inquiry of each charge. Indeed, the court cited no decision related to medical bill review at all.

Instead, the Court of Appeals relied on the fact that the PIP statute covers reasonable expenses incurred by "the insured." Op. at 8. The Court of Appeals held that the statutory reference to "the insured" requires an insurer to consider personal characteristics of both the patient and the provider at all stages of its bill review. *Id.*

Based solely on this purported violation of the PIP statute, the Court of Appeals concluded that American Family's bill review process is an unfair practice under the CPA. Op. at 8. It so ruled despite having previously recognized that healthcare providers such as FC lack standing to assert an unfair act based solely on the violation of an insurance statute. Op. at 6. This is because the CPA protects consumers, not providers who charge high-end rates. American Family moved for reconsideration.

In addition to the legal errors discussed below, American Family moved on the basis of a factual error in the Court of Appeals' decision. In describing the purportedly unfair conduct, the Court of Appeals erroneously stated that American Family pays only 80% of the average charge in the database, which would mean that every provider is reimbursed at a rate 20% below the average charge. *See* Op. at 8. But FC did not allege and could not have alleged any such conduct. It is undisputed that American Family paid in full both average fees and all other fees up to the 80th percentile. CP 4 at ¶¶3.12-13. American

Family's actual practice of paying charges in full up to the 80th percentile bears little resemblance to what the Court of Appeals described – starting with the average charge and then discounting that average charge by 20%.

The Court of Appeals denied American Family's motion without written analysis on October 23, 2018 and granted FC's motion to publish the same day. American Family now seeks this Court's review.

IV. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED

Review is appropriate here both because the Court of Appeals' decision is in sharp conflict with this Court's CPA jurisprudence and because the decision substantially and detrimentally affects the public interest. RAP 13.4(b)(1), (4).

The Court of Appeals' decision leaves insurers in Washington under a cloud of confusion regarding their ability to evaluate and manage healthcare costs. It suggests that Washington will be an outlier among states, the only one whose healthcare marketplace must operate without the benefit of the bill review mechanisms at issue here.

The government-approved practice of reviewing bills with the aid of the FAIR Health database curtails unreasonable healthcare costs in a way that is fair to all parties. Database-assisted bill review efficiently reimburses providers and protects patients and consumers. The Court of Appeals' decision threatens to eliminate that practice. The decision also

badly distorts this state's CPA jurisprudence by branding as inherently unfair a practice American Family had every reason to believe complied with its obligations under Washington law.

A. The Court of Appeals' Decision Conflicts With This Court's CPA Jurisprudence.

A court and regulator-approved practice is not "unfair." Under the CPA, plaintiffs have the burden to plead and prove an unfair or deceptive act or practice. *Hangman Ridge Training Stables, Inc. v. Safeco Title Ins. Co.*, 105 Wn. 2d 778, 780 (1986). Some CPA plaintiffs may prove a per se unfair act by establishing that the challenged practice contravenes a specifically designated statute. *Id.* at 786. But only insureds may assert a per se CPA claim for the violation of an insurance statute. *Tank v. State Farm Fire & Cas. Co.*, 105 Wn. 2d 381, 393 (1986); *Pain Diagnostics & Rehab. Assoc. v. Brockman*, 97 Wn. App. 691, 698 (1999). As the Court of Appeals recognized, FC, which is not an insured, has no standing to assert a per se claim. Op. at 6-7. As a provider, FC has to plead and prove *more* than the violation of a statute. FC must show that the challenged practice is inherently unfair. And what is deemed unfair must "evolve through a gradual process of judicial inclusion and exclusion." *Saunders v. Lloyd's of London*, 113 Wn. 2d 330, 344 (1989) (internal quotation marks and citations omitted).

That gradual process means that "[a]cts performed in good faith under an arguable interpretation of existing law do not constitute unfair conduct violative of the consumer protection law." *Leingang v. Pierce County Medical Bureau, Inc.*, 131 Wn. 2d 133, 155 (1997). A CPA claim fails as a matter of law where a challenged practice is not "flatly inconsistent" with a statute, is not prohibited by an appellate decision, and is consistent with trial court rulings. *E.g., Watkins v. Peterson Enterprises, Inc.*, 57 F. Supp. 2d 1102, 1110-11 (E.D. Wash. 1999) (applying *Leingang*). In the insurance context in particular, "a denial of coverage . . . based on reasonable conduct of the insurer does not constitute an unfair trade practice." *Leingang*, 131 Wn. 2d at 155.

The Court of Appeals' ruling cannot be reconciled with *Saunders* or *Leingang*. Regulatory authorities across the country have recognized the appropriateness of reviewing medical bills for reasonableness by means of the FAIR Health database. *Supra* at 5-6 & n. 3-4. Courts have done the same – both with respect to FAIR Health in particular and with respect to medical charge benchmarking generally. *Supra* at 2.

Closer to home, King County Superior Court judges have repeatedly approved settlements in which the parties agree insurers will use the FAIR Health database to assess reasonableness. *Id.* In one such settlement, the insurer was required to adopt the exact practice the Court

of Appeals deemed unfair in this case – paying at the 85th percentile of charges for each provider's geographical area. *Id.* As part of these settlements, courts have explicitly determined that use of the FAIR Health database is *not* a violation of any law. *Chan*, 844 F.3d at 1135, 1143 n.1.

All of this establishes that American Family's practice was lawful: It comported with court-approved practices in this state as well as statutory and regulatory standards across the country. At a minimum, American Family's conduct was consistent with an "arguable interpretation of existing law." *Leingang*, 131 Wn. 2d at 155. Indeed, an insurer seeking to conform its conduct to Washington law could scarcely do better than to consult the judicially-sanctioned King County settlements. The Court of Appeals' refusal even to consider those settlements – or the national body of law approving the use of FAIR Health – contravenes *Leingang* and *Saunders.*

The Court of Appeals improperly permitted FC to assert a per se claim and then misinterpreted the PIP statute. The Court of Appeals' decision also runs roughshod over the important distinction between per se and non-per se CPA claims. As a provider, FC is not one of the intended beneficiaries of consumer protection or insurance statutes, and so cannot establish an unfair act solely by reference to the purported violation of insurance statutes or regulations. *See Pain Diagnostics*, 97 Wn. App. at

698; *Tank*, 105 Wn. 2d at 393. But after acknowledging this law, the Court of Appeals disregarded it. The court concluded that FC adequately pled a CPA violation based *exclusively* on purported violations of Washington insurance statutes. Op. at 8-9. This is no different from the per se claim FC is barred from asserting.

Not only did the Court of Appeals incorrectly apply this Court's CPA jurisprudence, it also misinterpreted the PIP statute itself. The statute requires "payments for all reasonable and necessary expenses incurred by or on behalf of the insured . . . for health care services." RCW 48.22.005(7); Op. at 7. In interpreting the term "reasonable," the Court of Appeals emphasized the term "insured," and read it to mean that the *only* way to determine whether a charge is "reasonable" is to consider the individual circumstances of each "insured." Op. at 8. Under the Court of Appeals' interpretation, even delaying such consideration until after an initial review through a database that automatically pays charges up to the 80th percentile could violate the purported statutory command. *See id.*

The statute does not support that reading. Under long-established law, the term "reasonable," whether used by the legislature or a court, denotes an objective standard. *E.g.*, *State v. Linville*, 191 Wn. 2d 513, 518 (2018); *Wash. State Physicians Ins. Exch. v. Fisons Corp*., 122 Wn. 2d 299, 343 (1993); *Cowell v. Good Samaritan Cmty. Health Care*, 153 Wn.

App. 911, 925 (2009). The phrase "incurred by or on behalf of the insured" does not change the meaning of "reasonable." It merely identifies the *charge* that should be reviewed for reasonableness. The requirement that charges be "reasonable" and the requirement that they be "incurred by or on behalf of the insured" are two *separate* conditions for PIP coverage. *See Durant v. State Farm Mut. Auto. Ins. Co.*, 191 Wn. 2d 1, *8-9 (2018) (discussing WAC provision implementing PIP statute). The statutory reference to "the insured" does not convert the reasonableness condition into a subjective standard, nor suggest that objectively *un*reasonable charges are covered. The Court of Appeals' interpretation of "reasonable" in the PIP statute is as erroneous as its application of "unfair" under the CPA.[5]

These are not merely technical errors. Allowing FC to claim that American Family's bill review process is "unfair" under the CPA based on a purported violation of the PIP statute excludes the interests of insureds from the application of both statutes. American Family's bill review practices *benefit* insureds. Insureds benefit from a reasonable and fair

[5] After identifying a new statutory duty to conduct a patient and provider-specific assessment of reasonableness in the first instance, the Court of Appeals interpreted two WAC provisions cited by FC "consistent[ly] with [that] statutory duty." Op. at 9. The court thus concluded that the term "investigation" in WAC 284-30-330(3) and (4) "unequivocally" means that an insurer must assess reasonableness with respect to individual patient and provider characteristics. *Id.* The Court of Appeals' regulatory analysis is derivative of its statutory analysis and therefore falls with it.

method for preventing excess charges from eroding coverage limits, just as insureds benefit from a tool that keeps soaring healthcare costs from raising the price of insurance – as regulators and courts have recognized elsewhere. Yet here, the Court of Appeals failed even to consider the effect of its decision on the real subjects of consumer protection law. As explained below, the Court of Appeals' decision promotes providers' interests at the expense of consumers. That turns the law on its head. The CPA, like the federal statute on which it is based, was designed to protect consumers, not to sacrifice their interests to those of other businesses.[6]

B. The Court of Appeals' Decision Detrimentally Affects Issues of Substantial Public Interest.

The Court of Appeals' decision elevates providers' interests over those of consumers. The Court of Appeals' decision involves an issue of substantial public interest, and resolves that issue to the public detriment. If the Court of Appeals' decision is permitted to stand, the process of medical bill review in this state will depart dramatically from processes already approved by Washington courts and by other by courts and legislatures throughout the country. Rather than using medical charge databases to evaluate and control costs, insurers will be required, for every

[6] *See, e.g., Boggs v. Whitaker*, 56 Wn. App. 583, 587 (1990) (1938 amendment to the FTC Act "'makes the consumer, who may be injured by an unfair trade practice, of equal concern, before the law, with the merchant . . . .'") (quoting legislative history).

procedure billed to them, either to investigate the individual circumstances surrounding each visit or to abandon reasonableness review altogether. This novel and untested regime will produce unfavorable results for multiple stakeholders in medical and insurance markets, patients not least among them. Such a model would ill serve the interests reflected in both the PIP statute and the CPA.

Any requirement of up-front individualized consideration of a *patient's* individual characteristics as part of medical bill review is inconsistent with the realities of medical billing. Under the CPT codes, the treatment provided to a patient is categorized, documented and billed without regard to individual patient characteristics. *Supra* at 6-7. FC's own charges illustrate this clearly: FC charges the same amount for all patients who receive the same CPT-code designated treatment. *Id.* The Court of Appeals' novel notion of patient-specific bill review (and its corollary, pricing based on any number of individual factors regarding each patient and provider) is not the law and is inconsistent with practices developed by the medical establishment decades ago and used for billing and coverage purposes by government and private insurers ever since.[7]

[7] *See, e.g.*, Samuelson, *Questioning Copyrights in Standards*, 47 B.C. L. Rev. 193, 197 ("The stated purpose of the CPT is 'to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians, and other healthcare providers, patients and third parties'") (quoting AMA source material).

The Court of Appeals' directive that insurers consider *provider* characteristics in reviewing reasonableness in the first instance is equally misguided. American Family's bill review process already makes allowance for differences among providers. American Family's reasonableness review can be contrasted with Medicare, Medicaid, and health insurance covering treatments by in-network providers, which generally fix a single reimbursement rate for each CPT code in each geographic area. Rather than constraining providers in this way, American Family pays a range of charges for each treatment in each geographic area. American Family pays 100% of all charges up to the 80th percentile, and never pays providers who charge in excess of the 80th percentile any less than the 80th percentile charge. This system permits full recovery of charges to a broad range of providers who believe that they are entitled by virtue of experience or other factors to charge amounts above the rate charged by most of their peers. It is undisputed, moreover, that American Family restricts charges to the 80th percentile *only in the first instance*. Providers whose charges are reduced to the 80th percentile may submit documentation supporting charges above the 80th percentile. CP 24, 27, 29. If they do so, provider-specific review can occur.

The Court of Appeals' decision requires something quite different. It requires claims reviewers to analyze, in the first instance, and for each

of the multiple treatments administered during a visit, whether the provider's experience, credentials, overhead or other factors justify charges at various points along the cost spectrum. The result of this labor-intensive practice will be to raise costs for both insurers and insureds, with no discernible public benefit.

The same is true of the alternative FC has proposed throughout this litigation, which is that insurers simply pay all costs, without regard to reasonableness. That option cannot be squared with the PIP statute, which requires reimbursement only of "reasonable" charges. RCW 48.22.005(7). The policy embodied in the PIP statute takes precedence over – and is plainly better than – FC's preferred result. Under FC's system, all insureds would subsidize the above-market fees that providers at the far end of the spectrum elect to charge. Meanwhile, those insureds actually treated by the above-market providers would see their policy limits imperiled – a significant detriment given typical limits of $10,000.[8]

The Court of Appeals' decision incentivizes inequitable billing practices. The harmful consequences of the Court of Appeals' novel

[8] Courts in other states have rejected providers' argument that insurers should pay *all* expenses for similar reasons. *E.g., Advocacy Org. for Patients & Providers v. Auto Club Ins. Assoc*., 257 Mich. App. 365, 378 (2003) ("It is to be recalled that the public policy of this state is that the existence of no-fault insurance shall not increase the cost of health care. . . . not only should an insurer audit and challenge the reasonableness of bills submitted by health care providers, but the providers should expect no less").

policy are magnified when viewed within the larger medical and insurance markets. Healthcare providers generally operate with two distinct fee schedules. "[W]ith regard to medical services, different patients (or more accurately different insurers) pay dramatically different prices for the same medical care." George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 Baylor L. Rev. 425, 431-32 (Spring 2013). Providers list one set of fees for insurers with whom they have "in network" contracts and a second set of much higher "chargemaster" fees for all other payers – uninsured patients, automobile insurers, medical insurers with respect to whom they are out of network. "Discounts from chargemaster prices given to insurers . . . average about 62%, but in specific cases can be 80% or even more." *Id.* at 431. Providers thus charge automobile insurers and health insurers with whom they lack network relationships two to three times what they charge government and other private insurers. *Id.* Indeed, the two sets of fee schedules may vary so widely that providers are incentivized to *avoid* payment from health insurers that pay negotiated, in-network rates, in an effort to capture the much higher rates they can charge to auto insurers.[9]

[9] Michael K. Beard & Dylan H. Marsh, *Arbitrary Healthcare Pricing and the Misuse of Hospital Lien Statutes by Healthcare Providers*, 38 Am. J. Trial Advoc. 255, 257-58 (2014) (identifying nationwide trend in which "[p]roviders who believe the patient may

Under these circumstances, an insurer's ability to review medical charges for reasonableness is of paramount importance. FAIR Health and other medical charge databases were created to establish a fair method for evaluating and controlling excessive costs, ultimately to the benefit of patients and insureds. The Court of Appeals' decision bars Washington insurers from using this critical tool and thereby contravenes the public interest. This Court should accept review in order to bring Washington law back into line with the law of the many states that have approved the use of medical benchmarking to balance the interests of all constituencies in medical and insurance markets. If left to stand, the Court of Appeals' decision can only contribute to the national healthcare crisis by depriving insurers of an effective control on ever-rising medical costs.

V. CONCLUSION

The Court should grant American Family's petition for review.

Respectfully submitted November 26, 2018.

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pursue a personal injury claim may refuse to file a claim with the patient's health insurer or government sponsored plan, preferring instead to gamble on the possibility of much greater reimbursement by filing a lien on the patient's tort recovery").

CERTIFICATION

I hereby certify that on November 26, 2018, I caused a copy of the document to which this certification is attached to be filed electronically with:

Clerk of the Court
Court of Appeals, Division I
600 University Street
One Union Square
Seattle, WA 98101-1176

I further certify that I caused a true and correct copy of the same to be delivered by email to:

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APPENDIX A

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

FOLWEILER CHIROPRACTIC, PS, a Washington professional services corporation, Appellant, v. AMERICAN FAMILY INSURANCE COMPANY, Respondent.	No. 76448-9-I DIVISION ONE UNPUBLISHED OPINION FILED: August 27, 2018

MANN, A.C.J. — Folweiler Chiropractic, PS (Folweiler) filed a class action complaint against American Family Insurance Company (American Family) for violating Washington's Consumer Protection Act (CPA).[1] Folweiler alleged that American Family's practice of using a computer database to assess whether medical provider bills were reasonable was an unfair practice under the CPA. Folweiler appeals the trial court's decision dismissing its action under CR 12(b)(6). Because Folweiler's complaint

[1] Chapter 19.86 RCW.

sufficiently alleged that American Family's conduct violated the CPA, we reverse and remand for further proceedings.[2]

FACTS

Folweiler is a professional services corporation that provides chiropractic care and massage therapy in King County. American Family is an insurance company that sells and underwrites automobile insurance policies in Washington. Insurance policies sold or underwritten by American Family included personal injury protection (PIP) covering medical expenses incurred by a covered person arising from a covered automobile accident.

On July 8, 2016, Folweiler filed a class action complaint against American Family on behalf of a class of at least 900 similarly situated medical providers. Folweiler's complaint alleged: (1) between July 2012 and July 2016 Folweiler treated patients who had PIP coverage under an automobile insurance policy issued or underwritten by American Family, (2) American Family, as part of its general policy and practice in Washington, directed Folweiler to bill American Family directly for treatment rather than the patient, (3) American Family accepted Folweiler's bills as claims for payment of reasonable and necessary medical expenses under the patient's PIP coverage, (4) American Family had a policy and practice of relying on a computer database to determine payment of all medical expense bills submitted by Washington providers, (5) the computer database was created by Fair Health and was utilized to compare the amount billed by the provider for each procedure with the amount represented by the

[2] Folweiler asked that we take judicial notice of certain documents outside of the pleadings. We decline to do so and deny Folweiler's motion.

80th percentile of charges in the Fair Health database for the same procedure in the same zip code defined geographical area, (6) when the computer review found the provider's bill amount was greater than the 80th percentile amount, the computer would limit the "payment amount" to the 80th percentile and would show the reason for the reduction as an explanatory code P0041,[3] (7) The computer created an Explanation of Review (EOR) that set out the original "charged amount" and the reduced "payment amount," and provided the following explanation for the reduction from the amount charged:

> For Dates of Service 5/31/11 and prior, the amount allowed is based on benchmark data provided by Ingenix. For Dates of Service 6/1/11 and greater, the amount allowed was reviewed using the FH (Fair Health) RV Benchmark Database. Medical providers are asked to accept the reasonable amount as full payment for health care services and not bill the patient for additional charges. We require supporting documentation to reconsider charges for additional payment.

Folweiler alleged that based on the P0041 reduction, American Family paid Folweiler's claims between July 2012 and July 2016 at the reduced payment amount.

Folweiler's complaint alleged further that: (1) no one at American Family determined that a provider's billed amount was a reasonable amount for that provider in that provider's geographic area, (2) no one at American Family investigated or knew the identity, background, credentials, experience or any personal characteristics of the individual providers used as comparators in arriving at the 80th percentile amount, (3) no one at American Family independently investigated whether the amount billed was a

[3] Folweiler's complaint alleged that American Family reduced charges to the "80th percentile," but in its later pleadings to the trial court and in its briefs to this court FC represented that the reduction is to the 85th percentile—not the "80th percentile." The difference is irrelevant to the resolution of this appeal. We use the 80th percentile alleged in the complaint.

reasonable amount for that provider to charge for that procedure in that provider's city, and (4) no one at American Family knew whether the amount billed was a reasonable amount for that provider to charge based on the provider's background, credentials, usual and customary fee, the amount paid by other auto insurers, or any other individualized characteristics or factors.

Folweiler's complaint alleged that American Family's practice violated the PIP statute, RCW 48.22.005(7) and RCW 48.22.095, and the regulations defining unfair claims settlement practices in WAC 284-30-330. Folweiler also alleged that American Family's claims settlement practice was an unfair practice that violated the CPA.

American Family moved to dismiss Folweiler's complaint under CR 12(b)(6). It argued that its practices complied with WAC 284-30-330 and chapter 48.22 RCW. The trial court granted American Family's motion to dismiss. The trial court denied Folweiler's motion for reconsideration. Folweiler appeals.

ANALYSIS

We review CR 12(b)(6) dismissals de novo. FutureSelect Portfolio Mgmt., Inc. v. Tremont Grp. Holdings, Inc., 180 Wn.2d 954, 962, 331 P.3d 29 (2014). "A dismissal for failure to state a claim under CR 12(b)(6) is appropriate only if "it appears beyond doubt that the plaintiff can prove no set of facts, consistent with the complaint, which would entitle the plaintiff to relief." Bravo v. Dolsen Cos., 125 Wn.2d 745, 750, 888 P.2d 147 (1995) (internal quotations omitted). "Therefore, a complaint survives a CR 12(b)(6) motion if any set of facts could exist that would justify recovery." FutureSelect, 180 Wn.2d at 963. A CR 12(b)(6) motion should be granted only "sparingly and with care." Bravo, 125 Wn.2d at 750 (citation and internal quotations omitted).

"Washington is a notice pleading state and merely requires a simple concise statement of the claim and the relief sought." Pac. Nw. Shooting Park Ass'n v. City of Sequim, 158 Wn.2d 342, 352, 144 P.3d 276 (2006); CR 8(a).

Washington's CPA

The CPA prohibits "[u]nfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce." RCW 19.86.020. The CPA authorizes a private cause of action: "'[a]ny person who is injured in his or her business or property' by a violation of the act may bring a civil suit for injunctive relief, damages, attorney fees and costs, and treble damages." Panag v. Farmers Ins. Co. of Washington, 166 Wn.2d 27, 37, 204 P.3d 885 (2009) (alteration in original) (quoting RCW 19.86.090). To prevail on a CPA claim, a plaintiff must show (1) an unfair or deceptive act or practice, (2) that act or practice occurs in trade or commerce, (3) a public interest impact, (4) injury to the plaintiff in his or her business or property, and (5) a causal link between the unfair or deceptive act and the injury. Hangman Ridge Training Stables, Inc. v. Safeco Title Ins. Co., 105 Wn.2d 778, 780, 719 P.2d 531 (1986).

This appeal puts elements one and three at issue.

A. Unfair or deceptive act

American Family asserts that Folweiler's complaint failed to allege American Family had engaged in an unfair or deceptive practice. We disagree.

Whether a particular act is unfair or deceptive is a question of law. Panag, 166 Wn.2d at 47. "A defendant's act or practice is per se unfair or deceptive if the plaintiff shows that it violates a statute declaring the conduct to be an unfair or deceptive act or

practice in trade or commerce." Rush v. Blackburn, 190 Wn. App. 945, 961-62, 361 P.3d 217 (2015); Hangman Ridge, 105 Wn.2d at 786.

While Folweiler's complaint alleged a per se CPA violation by claiming American Family's claims settlement process violates RCW 48.22.005(7) and WAC 284-30-330, this claim fails as a matter of law. It is well established that "only an insured may bring a per se action" for violations of the CPA. Tank v. State Farms, 105 Wn.2d 381, 394, 715 P.2d 1133 (1986); Pain Diagnostics & Rehabilitation Assocs. v. Brockman, 97 Wn. App. 691, 698, 988 P.2d 972 (1999) (dismissing provider's per se CPA action for violation of PIP statute). Because Folweiler was not an insured, it cannot assert a per se violation of the CPA against American Family.

Folweiler's complaint also alleged that American Family's claim settlement process is an unfair practice that violated the CPA. "If a defendant's act is not per se unfair or deceptive, then the plaintiff must show the conduct is "unfair" or "deceptive" under a case-specific analysis of those terms." Rush, 190 Wn. App. at 962; Hangman Ridge, 105 Wn.2d at 786. "Because the act does not define 'unfair' or 'deceptive,' this court has allowed the definitions to evolve through a 'gradual process of judicial inclusion and exclusion." Saunders v. Lloyd's of London, 113 Wn.2d 259, 330, 344, 779 P.2d 249 (1989) (quoting State v. Reader's Digest Ass'n, 81 Wn.2d 259, 275, 501 P.2d 290 (1972)).

An act may be considered unfair and a violation of the CPA if the unfair act or practice is "not regulated by statute but in violation of public interest." Klem v. Wash. Mut. Bank, 176 Wn.2d 771, 787, 295 P.3d 1179 (2013). This can include considering

> whether the practice, without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the common law or otherwise—whether, in other words, it is within at least the penumbra of some common-law, statutory, or other established concept of unfairness.

Magney v. Lincoln Mut. Sav. Bank, 34 Wn. App. 45, 57, 659 P.2d 537 (1983) (quoting Fed. Trade Comm'n v. Sperry & Hutchinson Co., 405 U.S. 233, 244 n.5, 92 S. Ct. 898, 31 L. Ed. 2d 170 (1972)).

Consequently, while Folweiler may not maintain a CPA action for a per se violation of the PIP statute and trade practice regulations, the statute and regulations may nonetheless guide our consideration of whether American Family's claim settlement practice is unfair and violates the public interest.

Folweiler's complaint alleged that American Family's practice of relying on the Fair Health database and to reduce payment amounts to 80 percent of the geographic region is an unfair act in violation of the public interest established by RCW 48.22.095 as defined by RCW 48.22.005(7). RCW 48.22.095 establishes minimum PIP coverage limits for automobile insurers. Relevant here, RCW 48.22.095(1)(a) requires insurers to offer automobile insurance policies that provide minimum PIP coverage of $10,000 for "medical and hospital benefits." "Medical and hospital benefits" are defined by RCW 48.22.005(7) as:

> payments for all reasonable and necessary expenses incurred by or on behalf of the insured for injuries sustained as a result of an automobile accident for health care services provided by persons licensed under Title 18 RCW, including pharmaceuticals, prosthetic devices and eyeglasses, and necessary ambulance, hospital, and professional nursing service. Medical and hospital benefits are payable for expenses incurred within three years from the date of the automobile accident.

On its face, RCW 48.22.095(1)(a) and RCW 48.22.005(7) require payment of "all reasonable and necessary expenses incurred by or on behalf of the insured." The statutes necessarily impose a duty to look at each claim individually in order to determine the reasonable and necessary expenses for the insured. The law requires an individualized assessment rather than substituting a formulaic approach that pays only 80 percent of the average charge for a large geographic area. Folweiler's complaint alleged American Family's claim settlement process violates the duty to conduct an individualize assessment by failing to consider and independently evaluate the identity, background, credentials, experience or any personal characteristic of the individual provider or whether the amount charged was reasonable for the individual treatment provided. The allegations in Folweiler's complaint are sufficient to establish an unfair act in violation of the CPA based on a violation of the public interest embodied in RCW 48.22.095(1)(a) and RCW 48.22.005(7).

Folweiler's complaint also alleged that American Family's claim settlement process is an unfair and contrary to WAC 284-30-330. Chapter 284-30 WAC defines "certain minimum standards which, if violated with such frequency as to indicate a general business practice, will be deemed to constitute unfair claims settlement practices." WAC 284-30-300. WAC 284-30-330 identifies specific unfair claims settlement practices and includes: "[f]ailing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies," and "[r]efusing to pay claims without conducting a reasonable investigation." WAC 284-30-330(3) and (4).

Consistent with the statutory duty discussed above, reading WAC 284-30-330(3) and (4) together unequivocally establishes a duty to actually investigate and conduct a reasonable investigation of claims. Again, this requires an individualized assessment and not simply applying a geographic based formula to each claim regardless of the individual circumstances. The allegations in Folweiler's complaint are sufficient to establish an unfair act in violation of the CPA based on a violation of the public interest embodied in WAC 284-30-300.

2. Injury

The injury element under the CPA is broadly defined. It is met "upon proof the plaintiff's property interest or money is diminished because of the unlawful conduct even if the expenses caused by the statutory violation are minimal." Panag, 166 Wn.2d at 57. Out-of-pocket expenses and pecuniary losses "occasioned by inconvenience" are injury. Panag, 166 Wn.2d at 57. Monetary damages are not necessary to establish injury, a mere delay in use of property or receiving payment is an injury under the CPA. Sorrel v. Eagle Healthcare, Inc. 110 Wn. App. 290, 298, 38 P.3d 1024 (2002) (injury exists where the claimant's monetary refund was delayed two weeks).

Folweiler pleaded that it suffered injury: "[d]uring the period from July 8, 2012 to July 8, 2016, Folweiler suffered injury and damage to its business as a direct and proximate result of American Family's practice of making P0041 reductions to Washington provider bills in the manner described above." The complaint further alleged that class members "sustained injury to their business caused by American Family's practice in the form of reduced payments, delay in payment of reasonable

medical expenses, out of pocket administrative costs or added expenses, business interruption or inconvenience." Folweiler sufficiently pleaded injury under the CPA.

Because Folweiler sufficiently pleaded the required CPA elements, the trial court erred in dismissing its case for failure to state a claim under CR 12(b)(6).

We reverse and remand to the trial court for further proceedings.

Mann, A.C.J.

WE CONCUR:

Leach, J.

Dwyer, J.

APPENDIX B

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

FOLWEILER CHIROPRACTIC, PS, a Washington professional services corporation, Appellant, v. AMERICAN FAMILY INSURANCE COMPANY, Respondent.	)	No. 76448-9-I DIVISION ONE ORDER DENYING MOTION FOR RECONSIDERATION

Respondent American Family Insurance Company has filed a motion for reconsideration of the court's opinion filed on August 27, 2018. Appellant Folweiler Chiropractic has filed an answer. The panel has determined that the motion for reconsideration should be denied.

Therefore, it is

ORDERED that the motion for reconsideration is denied.

FOR THE PANEL:

Mann, A.C.J.

APPENDIX C

RCW 48.22.005

Definitions.

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Automobile" means a passenger car as defined in RCW 46.04.382 registered or principally garaged in this state other than:

(a) A farm-type tractor or other self-propelled equipment designed for use principally off public roads;

(b) A vehicle operated on rails or crawler-treads;

(c) A vehicle located for use as a residence;

(d) A motor home as defined in RCW 46.04.305; or

(e) A moped as defined in RCW 46.04.304.

(2) "Bodily injury" means bodily injury, sickness, or disease, including death at any time resulting from the injury, sickness, or disease.

(3) "Income continuation benefits" means payments for the insured's loss of income from work, because of bodily injury sustained by the insured in an automobile accident, less income earned during the benefit payment period. The combined weekly payment an insured may receive under personal injury protection coverage, worker's compensation, disability insurance, or other income continuation benefits may not exceed eighty-five percent of the insured's weekly income from work. The benefit payment period begins fourteen days after the date of the automobile accident and ends at the earliest of the following:

(a) The date on which the insured is reasonably able to perform the duties of his or her usual occupation;

(b) Fifty-four weeks from the date of the automobile accident; or

(c) The date of the insured's death.

(4) "Insured automobile" means an automobile described on the declarations page of the policy.

(5) "Insured" means:

(a) The named insured or a person who is a resident of the named insured's household and is either related to the named insured by blood, marriage, or adoption, or is the named insured's ward, foster child, or stepchild; or

(b) A person who sustains bodily injury caused by accident while: (i) Occupying or using the insured automobile with the permission of the named insured; or (ii) a pedestrian accidentally struck by the insured automobile.

(6) "Loss of services benefits" means reimbursement for payment to others, not members of the insured's household, for expenses reasonably incurred for services in lieu of those the insured would usually have performed for his or her household without compensation, provided the services are actually rendered. The maximum benefit is forty dollars per day. Reimbursement for loss of services ends the earliest of the following:

(a) The date on which the insured person is reasonably able to perform those services;

(b) Fifty-two weeks from the date of the automobile accident; or

(c) The date of the insured's death.

(7) "Medical and hospital benefits" means payments for all reasonable and necessary expenses incurred by or on behalf of the insured for injuries sustained as a result of an automobile accident for health care services provided by persons licensed under Title 18 RCW, including pharmaceuticals, prosthetic devices and eyeglasses, and necessary

ambulance, hospital, and professional nursing service. Medical and hospital benefits are payable for expenses incurred within three years from the date of the automobile accident.

(8) "Automobile liability insurance policy" means a policy insuring against loss resulting from liability imposed by law for bodily injury, death, or property damage suffered by any person and arising out of the ownership, maintenance, or use of an insured automobile. An automobile liability policy does not include:

(a) Vendors single interest or collateral protection coverage;

(b) General liability insurance; or

(c) Excess liability insurance, commonly known as an umbrella policy, where coverage applies only as excess to an underlying automobile policy.

(9) "Named insured" means the individual named in the declarations of the policy and includes his or her spouse if a resident of the same household.

(10) "Occupying" means in or upon or entering into or alighting from.

(11) "Pedestrian" means a natural person not occupying a motor vehicle as defined in RCW **46.04.320**.

(12) "Personal injury protection" means the benefits described in this section and RCW **48.22.085** through **48.22.100**. Payments made under personal injury protection coverage are limited to the actual amount of loss or expense incurred.

[**2003 c 115 § 1; 1993 c 242 § 1.**]

NOTES:

Severability—1993 c 242: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [**1993 c 242 § 7.**]

Effective date—1993 c 242: "Sections 1 through 5 of this act shall take effect July 1, 1994." [**1993 c 242 § 8.**]

RCW 48.22.095

Automobile insurance policies—Minimum personal injury protection coverage.

(1) Insurers providing automobile insurance policies must offer minimum personal injury protection coverage for each insured with benefit limits as follows:

(a) Medical and hospital benefits of ten thousand dollars;

(b) A funeral expense benefit of two thousand dollars;

(c) Income continuation benefits of ten thousand dollars, subject to a limit of two hundred dollars per week; and

(d) Loss of services benefits of five thousand dollars, subject to a limit of two hundred dollars per week.

(2) The coverage under this section may be excluded as provided for under RCW 48.177.010(6).

[2015 c 236 § 9; 2003 c 115 § 4; 1993 c 242 § 4.]

NOTES:

Severability—Effective date—1993 c 242: See notes following RCW 48.22.005.

SIDLEY AUSTIN LLP

November 26, 2018 - 3:39 PM

Transmittal Information

Filed with Court:	Court of Appeals Division I
Appellate Court Case Number:	76448-9
Appellate Court Case Title:	Folweiler Chiropractic, PS, Appellant v. American Family Insurance Company, Respondent
Superior Court Case Number:	16-2-16112-0

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