

No. 70735-3-I

IN THE COURT OF APPEALS  
OF THE STATE OF WASHINGTON  
DIVISION I

LINDSEY HAYES and MATT ROSSTON, husband and wife;  
JAMES W. BEASLEY II; and all others similarly situated,

Plaintiffs-Appellants,

v.

USAA CASUALTY INSURANCE COMPANY, a foreign insurance  
company doing business in the State of Washington; UNITED SERVICES  
AUTOMOBILE ASSOCIATION, a foreign intransurance exchange  
doing business in the State of Washington; USAA GENERAL  
INDEMNITY COMPANY, a foreign insurance company doing business  
in the State of Washington; GARRISON PROPERTY AND CASUALTY  
INSURANCE COMPANY, a foreign insurance company doing business  
in the State of Washington; JOHN DOES I-XX,

Defendants-Respondents.

BRIEF OF DEFENDANTS-RESPONDENTS

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## I. INTRODUCTION AND SUMMARY OF THE ARGUMENT

Plaintiffs' entire appeal rests on their contention that the trial court "erroneously reformulated and limited" their claims. Plaintiffs repeatedly assert that Judge Yu disregarded the broad scope of the allegations in their Complaint, and instead limited their claims to (1) "computer-generated reductions," made without human involvement, due to (2) "missing" or "inadequate" documentation of the healthcare services for which they sought reimbursement.

Plaintiffs *do not dispute* that their individual claims fail under this purported "reformulation," and that Defendants would be entitled to summary judgment on those claims. Instead, Plaintiffs assert that the trial court "never grasped" the allegations in their Complaint; complain that the court "did not understand" the claims in the Complaint; and even disrespectfully insinuate that the trial court may not have "ever read the Complaint." (*E.g.*, Pls.' Br. at 5, 17, 30.)

Yet *not once* in their 40-page brief do Plaintiffs inform this Court *why* Judge Yu "reformulated" their claims: it was because *Plaintiffs themselves* had "reformulated" and limited their claims in this manner. After Defendants removed the case to federal court based on the broad allegations in the Complaint, Plaintiffs made the strategic decision to narrow the scope of their claims in order to reduce the amount in

controversy and thereby avoid a federal forum.

The federal court accepted Plaintiffs' representations regarding the narrow scope of their Complaint and remanded the case. The court ruled that the "reductions at issue in this case" are only those reductions "*both [1] generated by a computer and [2] attributable to missing documentation.*" (CP 412 (emphasis added).) The court warned, however, that if in state court Plaintiffs "suddenly adopt a position contrary to the one raised in their [remand] motion," the doctrine of judicial estoppel would apply to limit the scope of their claims to the narrow ones they had represented to the federal court. (CP 408, 409 n.3.)

That is precisely what happened here. After remand, Plaintiffs realized that their claims did not fall within the narrow scope of the claims they had asserted in federal court. So they "suddenly adopted" a contrary position before Judge Yu. Plaintiffs argued below (as they now do on appeal) that, based on *broad* reading of their Complaint, their claims are *not* limited to "computerized reductions" for "missing documentation," but rather extend to *human* reviews of the *merits* of the claims, based on documentation that *was* submitted. Now Plaintiffs contend that the reductions purportedly at issue are not limited to those automatically made by computers, without human involvement; rather, any bill that a computer merely "flags" for *human* review is at issue.

But these are the types of reductions that Plaintiffs *denied* were at issue in federal court, and they secured a remand to their chosen forum on that basis. Judge Yu properly held Plaintiffs to their representations about the scope of their own Complaint. Judicial estoppel prohibits parties from securing an advantage by taking one position, but then repudiating that position when it would inure to their detriment. Applying the doctrine of judicial estoppel—a pivotal issue Plaintiffs nowhere even mention in their brief—the trial court granted summary judgment to Defendants. This Court should affirm that judgment in its entirety.

\* \* \*

When Plaintiffs first filed this case in King County Superior Court, their Complaint lodged a broad-based attack on Defendants’ medical bill audit system, making allegations much like those Plaintiffs now assert on appeal. The Complaint broadly challenged the use of a “computer software program *and/or* peer review audit process.” (CP 3, 4 (emphasis added).) Because the breadth of these allegations put more than \$5 million in controversy, Defendants removed the case under the Class Action Fairness Act of 2005 (“CAFA”). Once in federal court, Plaintiffs were determined to get out. They narrowed the scope of their claims alleged in their Complaint to reduce the amount in controversy to less than \$5 million (CAFA’s jurisdictional threshold) and thereby secure a remand.

Accepting Plaintiffs' representations about the scope of their claims, the federal court ruled that the only "reductions at issue in this case" were "those both [1] generated by a computer and [2] attributable to missing documentation." (CP 412.) The court's remand order further clarified the scope of each of these two aspects of Plaintiffs' claims.

The federal court found, and all parties agree, that when Defendants do not reimburse a medical bill in full, they assign a "Reason Code" for that reduction. Plaintiffs admitted, and the federal court found, that the Reason Code applied for reductions for "inadequate" or "missing" documentation is a "DOC" Reason Code—often, a "DOC55" Reason Code.<sup>1</sup> But the court also noted that "DOC" Reason Codes are sometimes generated by a human being, not a computer. Relying on Plaintiffs' representations, the federal court ruled that *only those DOC Reason Codes which were generated by a computer* were at issue in the case. (CP 410.)

Furthermore, because many Reason Codes refer in some way to the "documentation" submitted by insureds and their providers, the federal court—again relying on Plaintiffs' own representations—clarified that only those reductions due to "missing" or "inadequate" documentation

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<sup>1</sup> The explanation for a "DOC 55" Reason Code is as follows: "In order to make a reimbursement decision, documentation is needed to support the medical necessity for continued care or treatment. Documentation must include all records such as patient history, evaluations, test results, progress notes, prescriptions and treatment plans." (CP 408.)

were at issue here—i.e., those reductions attributable to a “DOC” Reason Code. Reductions that were *not* part of the case include Reason Codes which deal with professional or peer reviews—Nurse Review (“NR”) and Professional Review (“PR”)—in other words, reviews by human beings, not computers. These types of Reason Codes are applied when the documentation submitted—although “adequate” to permit a review on the merits of the claim—“*does not substantiate*” the medical necessity of the treatment provided. (CP 401, 408 (emphasis added).)

To remove all doubt, the federal court provided examples of the types of Reason Codes that were and were not put at issue by Plaintiffs:

The following reason code is an example of the conduct that *could* fall under the scope of reductions *challenged by Plaintiffs* in this action:

**DOC55:**        *In order to make a reimbursement decision, documentation is needed* to support the medical necessity for continued care or treatment. . . .

This reason code is clear that denial was based on the fact that *adequate documentation was absent from the insurance* claim form submitted by the primary healthcare provider. *Here, on the other hand, is an example of reductions that Plaintiffs do not challenge:*

**NR 162:**        *Review of the submitted documentation does not substantiate* the medical necessity for passive physical therapy in the absence of active physical therapy at this state in treatment.

*As opposed to DOC55, NR162 explains that denial was based on the fact that the documentation submitted by the primary healthcare provider **did not substantiate** the treatment provided.*

(CP 408-09 (emphasis added).) Indeed, the court’s example of excluded “nurse reviews” was taken from Plaintiffs’ counsel’s own statement at oral argument that “the complaint doesn’t speak to nurse reviews.” (CP 582.)

The court excluded from the amount in controversy all Reason Codes other than “DOC” and, finding that those reductions totaled no more than \$340,000, remanded the case. (CP 412.)

Once in state court, it became clear that none of the named Plaintiffs’ claims satisfied these conditions. Ms. Hayes had no “DOC” Reason Codes *at all*. Instead, some of her medical bills were reduced after a *peer review* (conducted by a physician, *not* a computer) determined that her records “*did not substantiate* the medical necessity” of her treatment—the very type of reduction the federal court ruled was *not* at issue here. As for Mr. Beasley, some of his bills were also denied as a result of a *peer review*—again, not a computer—which concluded that the documentation submitted for certain treatments “[*did*] *not substantiate* the medical necessity” of the treatment. And while some of his bills were denied due to a DOC55 Reason Code, all of these involved *human reviews*, not *computer-generated* reductions. In fact, *three nurses* reviewed his file and concluded that Mr. Beasley and his provider had failed to provide the required prescription and note from the referring physician—despite multiple requests for those records.

Defendants moved for summary judgment on these grounds. Based on Plaintiffs' own reformulation of their claims, and the doctrine of judicial estoppel, the trial court entered judgment for Defendants.

Astonishingly, Plaintiffs' brief recounts *none of this*. Nowhere do they disclose their own representations to the federal court; the fact that those representations formed the basis for the federal court's remand order; their continued representations in state court regarding the limited scope of their claims (until they realized that their claims did not satisfy their own formulation); or Judge Yu's decision based on the doctrine of judicial estoppel. It was as if it never happened.

Instead, Plaintiffs proceed as if Judge Yu arbitrarily "reformulated" their claims. Remarkably, Plaintiffs now contend that "every bill" satisfies the "computer-generated" requirement—because a computer was somehow involved—and that their claims are based on the mere fact that a computer "flagged" or "auto-moved" a bill for (1) a "sham" professional review to determine (2) whether the documentation "*substantiated*" the treatment. But if those types of claims were at issue, this case would still be in federal court. Those are *precisely* the reductions the federal court—based on Plaintiffs' representations—held were *not* at issue. As Judge Yu ruled, "[n]on-payment of claims for other reasons are not part of this lawsuit." (CP 2061.)

The judgment below should be affirmed for several reasons.

First, this Court should not consider Plaintiffs' arguments that Judge Yu improperly "reformulated" their claims, because Plaintiffs failed to preserve that issue on appeal. As appellants, Plaintiffs have an obligation to fairly present the record below, including the trial court's ruling, and to explain, with citations to legal authorities and the record, why the trial court erred. As officers of the Court, Plaintiffs' counsel also have a duty of candor to the Court.

Plaintiffs do not fairly present Judge Yu's decision. Indeed, their opening brief fails to address the legal basis for Judge Yu's summary judgment decision: judicial estoppel. Plaintiffs' failure to address this legal issue in their opening brief, and their related material omissions regarding the record below, constitute a waiver of the argument on appeal.

Second, even if the Court were to consider the merits of Plaintiffs' "reformulation" argument, Judge Yu's decision should be affirmed. Having succeeded in obtaining a remand from federal court to their chosen forum by virtue of their representations about the scope of their claims, Plaintiffs are judicially estopped from changing their theories of the case, either before the trial court or on appeal. As Judge Yu aptly put it: "plaintiffs should be estopped from continuously shifting what the case is about." (8/30/13 RP at 42.) Plaintiffs *do not dispute* that Defendants are

entitled to summary judgment on all of Plaintiffs' claims under Judge Yu's "reformulation." That should end this appeal.

The trial court's judgment may also be affirmed on additional grounds. For example, the trial court correctly ruled that Plaintiffs did not have a cognizable legal injury. Plaintiffs themselves represented to the federal court that cognizable damages consist of those out-of-pocket expenses for which insureds were "balance-billed" by their providers. But Plaintiffs did not allege in their Complaint that they themselves were balance-billed at all, and they provided no evidence that they paid anything out-of-pocket to their providers on the types of claims that are at issue in this case: computerized reductions for inadequate documentation.

Moreover, Plaintiffs not only failed to preserve for appeal their cursory argument that the trial court erred by dismissing Defendants with whom Plaintiffs did not have a contract, but Plaintiffs are simply wrong on the merits of their "juridical link" argument. Plaintiffs neither alleged nor provided evidence of the extraordinary circumstances that could justify holding one corporation liable for the alleged actions of an affiliate.

Finally, Plaintiffs devote much of their brief to arguing the supposed procedural "unfairness" of the proceedings below. They assert, for example, that the trial court should have converted Defendants' CR 12(b)(6) motion to a summary judgment motion (an argument they never

made to Judge Yu in their several reconsideration motions). In fact, the trial court had no such obligation; regardless, the argument is irrelevant, because Defendants later filed a summary judgment motion that Judge Yu granted. And although Plaintiffs complain about being ordered to provide evidence of “injury,” that evidence was entirely within Plaintiffs’ possession, and required no discovery from Defendants.

Judge Yu bent over backwards to accommodate Plaintiffs. When Plaintiffs failed to respond to Defendants’ motion to dismiss, the court could have granted the motion outright; instead, the court considered Plaintiffs’ arguments. Plaintiffs also deliberately chose not to try to amend their Complaint to correct its numerous deficiencies— because, as Plaintiffs’ counsel admitted, they did not want to risk having an amendment precipitate another removal to federal court.

Plaintiffs made a number of deliberate, strategic decisions, all designed to avoid a federal forum. They now must live with the consequences of those decisions. There is no basis for reversing the trial court’s judgment, and it should be affirmed in its entirety.

## **II. STATEMENT OF THE CASE**

### **A. Plaintiffs’ Complaint and the Initial Formulation of Their Claims in State Court**

On May 16, 2012, Plaintiffs filed this action in King County Superior Court on behalf of themselves and a putative class of Washington

auto insureds against United Services Automobile Association (“United Services”), USAA Casualty Insurance Company (“CIC”), USAA General Indemnity Company (“GIC”), and Garrison Property and Casualty Insurance (“Garrison”). (CP 1-32.) Plaintiffs alleged that they were insured under auto policies issued by “the USAA Defendants” and that Defendants improperly denied their claims for reimbursement of medical expenses submitted under their first-party medical benefits coverages (Personal Injury Protection (“PIP”) or MedPay). (*E.g.*, CP 5, 15-18.)

The Complaint did not specify which Defendant insured which Plaintiffs, or what actions each Defendant allegedly took regarding each Plaintiff. Instead, the Complaint lumped together all Defendants as “USAA.” (CP 6.) Nevertheless, Defendants demonstrated, and Plaintiffs later conceded, that Plaintiff Hayes was insured only under a CIC auto policy, and Plaintiff Beasley was insured only under a United Services policy. (CP 474; Pls.’ Br. at 6.) It is undisputed that neither Plaintiff had an insurance contract with Defendants GIC or Garrison. (CP 474.)

Plaintiff’s Complaint broadly attacked Defendants’ medical bill audit system, by which Defendants, assisted by a third-party vendor (Auto Injury Solutions, or “AIS”), review healthcare bills submitted under their auto policies. Defendants’ auto policies, and Washington law, obligate them to pay only those medical expenses that are “reasonable and

necessary” for treatment to injuries caused by a covered auto accident. (CP 503; RCW 48.22.005.) According to the Complaint, Defendants allegedly engaged in an improper “cost containment program” consisting of a “computer software program and/or peer review audit practice.” (CP 3, 21.) Among other things, Plaintiffs initially challenged two practices: (1) the alleged use of a computer software program to deny claims due to “inadequate documentation” of the medical treatments, and (2) the use of purported “sham” peer reviews of insureds’ medical records, conducted by healthcare professionals retained by AIS, to determine whether the treatment was medically necessary and appropriate. (CP 7-11, 22, 27.)

The Complaint contained six Counts. Count I alleged that Defendants were “unjustly enriched” by not reimbursing insureds’ medical expenses. (CP 27.) Count II was for breach of the insurance policies. (CP 28.) Count III was for “bad faith” and breach of the covenant of good faith, and also alleged that Defendants had violated various statutes and regulations, including RCW 48.30.015, WAC 284-30-330, and WAC 284-30-395. (CP 28-29.) Count IV sought declaratory and injunctive relief precluding Defendants from continuing their medical bill review practices. (CP 29.) Count V alleged violations of the Washington Consumer Protection Act (“CPA”). (CP 29-30.) Count VI alleged violations of the Insurance Fair Conduct Act (“IFCA”), RCW 48.30.015. (CP 30.)

Significantly, although Plaintiffs complained that Defendants did not pay their providers' bills in full, the Complaint did *not* allege that Plaintiffs *themselves* had paid any of the unreimbursed expenses or even that their providers had billed them for the unreimbursed amounts (a practice referred to as "balance-billing"). (CP 472 n.3.) Thus, the Complaint did not allege that either Plaintiff sustained any direct, out-of-pocket losses as a result of the alleged practices being challenged.

**B. The Federal Court Proceedings**

**1. Plaintiffs' Narrowing of Their Claims**

Relying on the broad allegations in the Complaint, Defendants removed this action to federal court on the ground that CAFA's \$5 million jurisdictional minimum was satisfied. (CP 37-45; Fed. Doc. 1.)<sup>2</sup> The case was assigned to Judge James L. Robart.

Quoting from Plaintiffs' interrogatory responses, Defendants contended that the claims at issue involved "two disputed practices":

In their Complaint, Plaintiffs allege two disputed practices. The first is that USAA fails to pay PIP claims based on a *lack of adequate documentation*. . . .

The second disputed practice in the Complaint is that USAA uses a *medical review by a third-party health care provider* or professional to deny payment of reasonable and necessary medical expenses based on the

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<sup>2</sup> Portions of the federal court record are contained in a CD-ROM, which is also part of the record before this Court as Exhibit FE 9. (CP 434-435.) Citations to the federal docket are to "Fed. Doc. \_\_\_."

*treatment either not being related to the covered accident  
and/or the treatment not being necessary.*

(Fed. Doc. 45 at 7 (emphasis added).) Thus, the Complaint challenged reductions resulting from either (1) inadequate documentation, or (2) peer reviews of insureds' records to determine medical necessity.

Plaintiffs moved to remand, representing to the federal court that their claims were actually much narrower than those described in their interrogatory responses, and that Defendants had read the allegations of their Complaint too broadly. (Fed. Doc. 41 at 2.)

First, Plaintiffs asserted that the “fundamental factual predicate” of the Complaint was that they were challenging “*computer-generated reductions*”—*not* reductions due to human review of medical records. According to Plaintiffs, the reductions at issue in the Complaint were “defined by the fact that they only exist” because

“a computer *generated a reduction* for ‘inadequate documentation’ *without human involvement*”

and

“the *reductions* at issue are only those which are *generated by a computer not a human being.*”

(CP 577, 1568 (underlining in original; italics added).)

Thus, according to Plaintiffs' own characterization of their claims, the “reductions” must have been generated by a *computer*, “not a human being.” In contrast to the Complaint—which challenged human reviews

in and of themselves—Plaintiffs now asserted that human or peer reviews were relevant to their claims only if a computer had *already reduced* the provider’s bill; under Plaintiffs’ reformulation of their claims, the human review must have come *after* a computer-generated reduction and served merely to “substantiate” the reduction already made by a computer. Plaintiffs therefore represented to the federal court that this suit involves only those reductions resulting when *both* of these conditions are present—an initial, computer-generated *reduction*, followed by a “sham” peer review that “substantiated” or confirmed the *computerized reduction*:

[T]here are two defining factual predicates of the claims and reductions at issue as alleged by Plaintiffs: (1) the *reduction* is based on a computer generated reduction, not a reduction generated by a claims adjuster; and (2) that the *computer generated reductions* for “inadequate documentation” are allegedly *substantiated* by a “sham” physician review that does not reflect an actual or honest evaluation of the documentation submitted by the provider.

(CP 468, 596 (underlining in original; italics added).)

Second, Plaintiffs further limited their claims by specifying that the computerized reductions must have been for “*inadequate documentation*.” Plaintiffs distinguished between two types of reductions that refer to “documentation”: (1) computerized reductions because “inadequate” or no documentation was submitted to support the treatment, and (2) reductions due to a healthcare professional’s finding that the submitted

documentation, although “adequate” to permit consideration of the merits of the claim, “did not substantiate” that the treatment was medically reasonable, necessary, and related to a covered auto accident. (CP 470.)

Plaintiffs argued that this case involved only the first practice—computerized reductions for “*inadequate*” or “missing” documentation—and did *not* involve reductions due to the failure of the submitted documentation to “*substantiate*” the medical necessity of the treatment. (CP 470, 595-96.) Under Defendants’ medical bill audit system, either a computer or a healthcare professional may make a determination regarding “inadequacy” or lack of documentation, although determinations that documentation does not “substantiate” the medical necessity of the treatment, or that the injuries were related to a covered auto accident, are made by nurses or other health care professionals. (CP 408-09.)

Third, Plaintiffs further represented to the federal court that only a very limited set of “Reason Codes” were at issue. Reimbursements of healthcare charges are reflected on Explanation of Reimbursement forms (“EORs”) and Adjustment forms (“ADJs”), which Defendants mail to the insured, the insured’s providers, and the insured’s attorney. If a charge cannot be reimbursed in full, the EOR or ADJ reflects a “Reason Code” that explains why not. (CP 1774.)

For example, a “DOC” Reason Code indicates that the charge is

not reimbursed because no documentation was submitted at all, or because the submitted documentation was “inadequate” to permit consideration of the merits of the claim: “*In order to make a reimbursement decision, documentation is needed to support* the medical necessity for continued care or treatment.” (CP 596, 1774 (emphasis added).) Plaintiffs admitted that “the code used by [Defendants] for alleged lack of adequate documentation is called ‘Doc 55.’ ” (CP 2445 n.10.)

On the other hand, an “NR” (Nurse Review) Reason Code like NR162 is used when the documentation submitted—while “adequate” to permit consideration of the claim—does not “substantiate” the medical necessity of the treatment: “*Review of the submitted documentation does not substantiate* the medical necessity . . . .” (CR 596-97 (emphasis added).) Likewise, a “PR” (Professional Review by physicians) Reason Code like PR49 is used when the submitted documentation does not “substantiate” the medical necessity of the treatment: “[R]eview of *the submitted documentation does not substantiate the medical necessity* of the physical therapy provided.” (CP 1994 (emphasis added).)

Plaintiffs told the federal court that it “should look at ‘DOC’ ” Reason Codes, and “should *not* look,” for example, at “NR [Codes], because, among other things, *the complaint doesn’t speak to nurse reviews.*” (CP 582 (emphasis added).)

Thus, in order to reduce the amount in controversy, and secure a remand, Plaintiffs asserted that their claims were only for (1) “computer-generated reductions” for (2) “lack of adequate documentation.”

## **2. Plaintiffs’ Arguments in Federal Court for the Narrow Scope of Legally Cognizable “Injury”**

Plaintiffs also argued to the federal court that Defendants had overstated the amount in controversy because Plaintiffs’ legally cognizable damages were limited to the amounts “*actually paid* by any of the class members.” (CP 473 (emphasis added).)

Contending that “all reductions are not going to be actual damages in this case,” Plaintiffs admitted that providers may write off unreimbursed charges, and also that the insurer may pay a bill when the provider threatens to “balance bill” the insured. (CP 572.) Plaintiffs argued that Defendants’ estimate of the amount in controversy was “not a reliable statement of the amount of class damages because it is *not* the amount *in fact* paid by the class members and overstates the potential debt owed by class members to providers because it includes reductions that were *written off* by providers.” (Fed. Doc. 41 at 2 (emphasis in original).) According to Plaintiffs, “actual damages” are “the amount that *the class member insured actually paid providers*”—the amount by which the insured was “balance-billed.” (Fed. Doc. 50 at 6 (emphasis added).)

### 3. The Federal Court's Remand Ruling

The federal court determined that CAFA's \$5 million jurisdictional minimum was not satisfied, and federal jurisdiction did not exist, because of Plaintiffs' representations regarding the narrow scope of their claims. (CP 407-08.) Although the court agreed with Defendants that the Complaint, "read literally, is ambiguous" (CP 409 n.2), it agreed with Plaintiffs that they were challenging only a small subset of the reductions put at issue in the Complaint.

First, quoting the selection from Plaintiffs' brief, the court ruled that the only reductions at issue were those "*both* generated by a computer and attributable to missing documentation." (CP 408 (emphasis added).)

Second, relying on Plaintiffs' representations, the court ruled that not all reductions about "documentation" were at issue—only computer-generated reductions due to documentation that was "inadequate" or absent entirely. (CP 408-09.) Following Plaintiffs' representations, the court distinguished between (1) reductions due to *inadequate* or complete lack of documentation—which *could* be at issue in the case—and (2) reductions due to a healthcare professional's finding that the submitted documentation "*does not substantiate*" that the treatment was medically reasonable—which were *not* at issue. (CP 409 (emphasis added).)

Third, relying on Plaintiffs' representations, the court limited

Plaintiffs' claims to certain Reason Codes. The court ruled that the claims "could" involve DOC Reason Codes (for "inadequate documentation"), but not other Reason Codes, like NR/Nurse Review, which reflect a healthcare professional's determination that the submitted documentation did not "substantiate" medical reasonableness.

The federal court then excluded all Reason Codes other than those attributable to a DOC Reason Code, and found that those DOC reductions were no more than \$340,000. (CP 410, 412.) All other Reason Codes were "*unchallenged reductions.*" (CP 413 (emphasis added).)

The court further found that not even all DOC Reason Codes were implicated in this action. (CP 410 n.5.) As Plaintiffs acknowledged, some DOC Reason Codes are generated by a human review, not a computer, and therefore were outside the scope of Plaintiffs' claims. (CP 582.)

Finally, the federal court, again following Plaintiffs' representations, further narrowed Plaintiffs' claims by ruling that not even a "computer-generated reduction" for "inadequate documentation" was necessarily at issue. According to the court, such reductions would not necessarily represent an insured's "actual damages," because the insured may not have been "balance-billed" for the unreimbursed amount:

*Additionally, the reductions taken by USAA do not necessarily constitute actual damages. As made clear in the record by several depositions of primary healthcare providers, when an*

insurance company does not pay an insurance claim in full, it is not necessarily the practice of primary healthcare providers to simply pass along the balance of the bill to its patients. . . . Sometimes, for example, the primary healthcare provider writes-off a portion of the bill. . . . As such, *just because USAA applies reductions to an insurance claim does not mean that a policyholder suffers actual monetary damages in an amount equivalent to the total of those reductions.*

(CP 410-11 (emphasis added).)

**C. Judicial Estoppel and the Scope of Plaintiffs' Claims on Remand to State Court**

Defendants argued to the federal court that Plaintiffs were mischaracterizing their Complaint to avoid federal jurisdiction, while leaving open the possibility of seeking more than \$5 million as soon as the case was remanded to state court. (CP 409 n.3.) The federal court acknowledged that “strict construction” of federal jurisdiction “creates the potential for manipulation of the jurisdictional rules by plaintiffs who may plead for damages below the jurisdictional amount in state court with the knowledge that the claim is actually worth more, but also with the knowledge that they may be able to evade federal jurisdiction by virtue of the pleading.” (CP 409 n.3 (quotations omitted).)

But the court ruled that Defendants were not without remedy if, following remand to state court, Plaintiffs “suddenly adopt[ed] a position contrary to the one raised in their motion” and attempted to expand the scope of their claims. If they did, they would be barred from doing so by

the doctrine of judicial estoppel:

*Nevertheless, if Plaintiffs do indeed suddenly adopt a position contrary to the one raised in their motion, then USAA will certainly have at its disposal the defense of judicial estoppel: “Judicial estoppel precludes a party from gaining an advantage by taking one position and then seeking a second advantage by taking an incompatible position in a subsequent action.” Johnson v. Si-Cor Inc., 906, 28 P.3d 832, 834 (Wash. Ct. App. 2001).*

(CP 409 n.3 (emphasis added).)

#### **D. The Proceedings in State Court After Remand**

##### **1. The Individual Claims of the Named Plaintiffs**

Thus, with the federal court’s remand, Plaintiffs’ claims were limited to (1) “computerized reductions,” without human involvement, because (2) the documentation submitted in support of the bills was “inadequate” or missing entirely. Indeed, Plaintiffs initially represented to the state court that this was, in fact, the scope of their claims. (CP 746, 959 (“Plaintiffs filed this lawsuit as a class action on behalf of all Washington insureds of USAA whose PIP claims were denied due to a computer generated denial for lack of adequate documentation.”).) But when it became apparent that Plaintiffs’ own claims did not satisfy these two conditions, Plaintiffs attempted to recharacterize their claims and reassert the broad claims alleged in their Complaint. The record in this case is uncontradicted, and Plaintiffs do not dispute that their claims do not satisfy these two threshold conditions.

**a. Hayes and Rosston**

Ms. Hayes was injured in a December 7, 2010 accident and made a claim under a CIC policy. (CP 1774.) According to records her providers submitted, between December 8, 2010 and April 11, 2012, Ms. Hayes received chiropractic treatments (51 visits), massage therapy treatments (27 visits), physical therapy treatments (20 visits), and acupuncture therapy treatments (12 visits); had one visit to a physiatrist; and had one electrodiagnostic visit. CIC received bills for these treatments totaling \$18,314.79 and paid \$9,818.99 of those. (CP 1775.)

For bills not paid in full, charges were not reimbursed for the following reasons: (a) many charges were duplicates (“DUP” Reason Codes); (b) some were for treatments that were not separately identifiable services (“CR” (Code Review) Reason Codes); (c) certain charges exceeded a reasonable fee (“RF\_1” Reason Codes); (d) certain charges were apportioned to a previous accident; and (e) certain treatments were found to be not medically necessary, after a peer review concluded that the documentation submitted “[*did*] not substantiate the medical necessity” of the treatment (“PR,” “NR,” or “SR” Reason Codes). (CP 1775.)

Thus, *none* of these charges was denied or reduced based on a *computer-generated* finding of inadequate documentation; and none had a “DOC” or DOC55 Reason Code. (CP 1775.) The only reductions for

“documentation” issues of any kind were the result of a healthcare professional’s determination that the submitted documentation did not “substantiate” the medical necessity of the treatment—the very type of “documentation” reduction the federal court, at Plaintiffs’ insistence, had ruled was *not* part of this case. (CP 1775, 1781-82, 1793, 1798, 1809, 1812, 1815, 1818, 1821, 1824, 1827-28.)<sup>3</sup>

**b. Beasley**

Mr. Beasley was injured in a December 16, 2010 accident and submitted a PIP claim to United Services for reimbursement of his medical bills. Between December 2010 and September 2012, Mr. Beasley received 30 massage therapy treatments and other treatments. United Services received bills for these treatments totaling \$14,866.43 and paid \$8,570.14 of those charges. (CP 1776.)

Of those bills not paid in full, charges were not reimbursed because (a) many charges were duplicates (“DUP” Reason Codes) (CP 1776); (b) some exceeded the reasonable fee (“RF\_1” Reason Codes) (CP 1776); (c) certain treatments were found to be not medically necessary after a peer review concluded that the documentation “[*did*] *not substantiate* the medical necessity” of the treatment (CP 1776) (“PR” Reason Codes); (d)

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<sup>3</sup> Rosston was the named insured on the CIC auto policy under which Hayes submitted her PIP claim, but he did not submit a PIP claim in his own right. (CP 1775.) Plaintiffs do not contend that he has a valid claim. (Pls.’ Br. at 6.)

certain charges were reduced due to payment from a collateral source (CP 1833); and (e) certain charges were reimbursed pursuant to an agreed Preferred Provider Organization rate (“PPO” Reason Codes) (CP 1776).

The only reductions that reflected a Reason Code for “inadequate documentation” (DOC 55) were for 11 massage therapy treatments totaling \$3,050. (CP 1776-77.) But these “DOC55” reductions were made following a determination *by a nurse—not* a computer—that a referring provider’s note and prescription were missing. (CP 1777.) United Services then issued an EOR with a DOC55 Reason Code, which included a note from the reviewing nurse stating: “Need referring provider note and prescription from Dr. Hoang Thuy Lien.” (CP 1777.)

After the EOR was issued for the 11 massage therapy treatments, United Services followed up by sending Mr. Beasley and the massage therapist a number of ADJs and “Documentation Request” forms reiterating that the documentation was inadequate. (CP 1777.) Also, on two separate occasions different nurses reviewed the file and confirmed that the referring doctor’s prescription was still missing. (CP 1777.)

Thus, Mr. Beasley’s claim did not involve a “computer-generated” determination that the submitted documentation was inadequate. The only “inadequate documentation” finding—the DOC Reason Codes relating to the 11 massage therapy treatments—was *not* by a computer, but by human

beings (*three separate nurses*). (CP 1777-78.)

## **2. The Trial Court's Rulings on Defendants' Motion to Dismiss**

Following remand, Defendants filed a motion to dismiss on January 23, 2013. Defendants argued (1) that Plaintiffs alleged no cognizable injury because they did not assert that they had made out-of-pocket payments to their providers for unreimbursed medical bills; (2) that Plaintiffs' CPA claim failed to allege a cognizable injury to "business or property," because the CPA does not encompass claims for medical expenses associated with personal injuries; (3) that Plaintiffs improperly brought claims against Defendants with whom they had no contractual relationship or privity; (4) that Plaintiffs' unjust enrichment claim was invalid because Plaintiffs' claims were predicated on the existence of a valid written contract; (5) that the Complaint failed to plead fraud with the particularity required by CR 9(b); (6) that Plaintiffs' IFCA claim failed to allege compliance with the statute's presuit notice requirement; and (7) that the claims for declaratory and injunctive relief fell with the dismissal of Plaintiffs' substantive claims. (CP 471-79.) Hearing on the motion was originally scheduled for March 8, 2013, but was reset to March 22 at Plaintiffs' request. (CP 1146.)

Plaintiffs did not respond to the motion to dismiss. Instead, on

February 19, Plaintiffs moved to strike the motion to dismiss and sought CR 11 sanctions. (CP 740-56.) Before Plaintiff filed the CR 11 motion, Defendants' counsel told Plaintiffs' counsel that if Plaintiffs believed they had valid claims, they should amend their Complaint to include important missing factual allegations. (CP 1146.) Plaintiffs' counsel declined, stating that he would not amend the Complaint because he was concerned that doing so *could invite another removal to federal court*. (CP 1146.)

The trial court, Judge Mary I. Yu, denied Plaintiffs' motion to strike, ruling that the court would “decide the Motion to Dismiss on the merits when it is noted to be heard”—March 22. (CP 1296.) But when the time came for Plaintiffs' response, Plaintiffs neither filed an opposition brief nor attempted to amend their Complaint to remedy the multiple deficiencies noted in Defendants' motion. After Defendants noted Plaintiffs' failure to file a response, Plaintiffs belatedly asked the court to “rely on” their CR 11 motion as their response brief. (CP 1423.)

On March 25, 2013, the Court granted Defendants' motion to dismiss: “Without an insurance policy that connects a specific Plaintiff to a specific Defendant, Plaintiff cannot assert a claim or liability pursuant to an insurance policy when there is no privity.” (CP 1437.)

### **3. Plaintiffs' Multiple Requests for Reconsideration, and Their Attempts to Expand the Scope of Their Claims**

#### **a. Plaintiffs' Reconsideration Motions**

On March 27, Plaintiffs moved for “clarification and/or reconsideration” of the March 25 Order (CP 1440-45), and on March 29 filed a “motion for reconsideration” of the dismissal of the two Defendants (United Services and CIC) who insured Plaintiffs (CP 1462-71).

The court denied the latter motion on the “very narrow issue” it raised, but agreed to reconsider the issues in the first motion. (CP 1492-95.) On reconsideration, the court clarified that, as to the contract claims, it was dismissing only the claims against the companies with whom neither Plaintiff had a contract (GIC and Garrison): “The confusion lies in Plaintiffs’ insistence on clustering alleged related insurance companies for purposes of finding a contractual relationship.” (CP 1534-35.)

The court stated that it would reconsider dismissal of the remaining claims “if Plaintiffs can actually show injury to their business or property *caused by each Defendant.*” (CP 1535 (emphasis in original).) The court posed the following questions: “Did the Plaintiffs actually pay providers for any charges not paid by the insurer? Are there ‘out-of-pocket’ expenses that Plaintiffs might not have incurred but for the alleged injury?” (CP 1536-37.) The court noted that these were “legal questions”

on which Plaintiffs bore the burden of proof. (CP 1537.) The court allowed Plaintiffs “to note a motion” with evidence of legally cognizable injury within 60 days. (CP 1537.)

Plaintiffs did not do so. Instead, on June 17, 2013—well after the May 23 deadline for motions for reconsideration—Plaintiffs filed a *third* motion for reconsideration, asking the trial court to reconsider all its prior rulings. (CP 1907-20.) And to try to establish legally cognizable “injury,” Plaintiffs claimed that they had paid out-of-pocket certain unreimbursed medical expenses. (CP 1911.)

In response, Defendants showed that Plaintiffs’ “evidence” of out-of-pocket expenses did not relate to the limited claims Plaintiffs had put in issue: “computerized reductions” for “inadequate documentation.” (CP 1974.) For example, the \$987.18 that Hayes claimed to have paid a provider (CP 1933) was for treatment found to be not medically necessary after a *physician’s* review of the medical records—not a computerized reduction for inadequate documentation. (CP 1775.) Hayes also asserted that she had paid \$1,000 to Ballard Back Pain Relief Clinic on February 14, 2013 for expenses “submitted to and not paid by USAA.” (CP 1933.) But no such bill was ever submitted to Defendants, and therefore no computer-generated reduction for inadequate documentation was ever taken on it. (CP 1781-1829.)

With respect to Mr. Beasley, the payments he reportedly made to a massage therapist (Ricardo Saldia) were for charges that (a) were reduced due to payment from a collateral source (CP 1776, 1833); (b) exceeded the reasonable fee (CP 1776, 1866-67); or (c) followed a nurse's determination (not a computer's) that a referring provider note and prescription were missing (CP 1776, 1835, 1838). Thus, as with Hayes, the amount Beasley asserted that he had paid related to reimbursement decisions that Plaintiffs were *not* challenging in this case. (CP 1776.)

**b. Plaintiffs' Expansion of Their Claims**

Plaintiffs *did not dispute* that their "out-of-pocket" payments were *not* for computerized reductions for inadequate documentation. Instead, in an attempt to salvage their claims, Plaintiffs began to retreat from, and ultimately repudiate, the numerous representations they had made to the federal court, and to Judge Yu, regarding the scope of their claims.

First, Plaintiffs asserted that "*all* bills submitted by Washington providers . . . are sent electronically" to AIS, and therefore "*every bill* is subject to a computer review." (CP 1993 (emphasis in original).) Thus, Plaintiffs were expanding their claims from computerized "reductions" to the mere involvement of a computer in the process.

Second, Plaintiffs expanded the nature of the "documentation" reductions they claimed were at issue. Although Plaintiffs argued to the

federal court that only reductions for “inadequate” or “missing” documentation were at issue, Plaintiffs now argued that “inadequacy of documentation as a basis for denying payment of a provider’s bill . . . occurs in a number of expressions, e.g., the documentation *does not support the necessity for the treatment.*” (CP 1993-94 (emphasis added).)

Third, despite explicitly telling the federal court that “nurse reviews” were not at issue because “the complaint doesn’t speak to nurse reviews,” *see supra* p. 6, Plaintiffs now asserted that nurse and other professional reviews *were* at issue. Plaintiffs cited three examples of Reason Codes they now contended were at issue:

- PR49, “**review of the submitted documentation does not substantiate** the medical necessity of the physical therapy provided”;
- PR172, “**review of the submitted documentation does not substantiate** that the **treatment** provided is medically necessary”; and
- PR176, “**review of the submitted documentation does not substantiate** the treatment **provided** is related to the loss.” (Reply at 1-3 & nn.2, 3 (emphasis added).)

(CP 1994, 1995 & nn.2, 3 (emphasis added).)

*All* of these Reason Codes, of course, had been *excluded* from the scope of Plaintiffs’ claims by the federal court, which held, based on Plaintiffs’ representations, that Reason Codes using the phrase “review of the submitted documentation *does not substantiate* the treatment provided” were *not* part of this case. (CP 407-10.)

Defendants argued that, as the federal court had ruled in its remand order, Plaintiffs' attempt to broaden their claims was barred by the doctrine of judicial estoppel. (CP 1973-74.) In response, Plaintiffs contended that they had *no obligation to abide by their representations to the federal court*—even calling any such notion “baseless.” (CP 1996.)

On July 12, 2013, the trial court denied Plaintiffs' third motion for reconsideration. The court rejected Plaintiffs' attempt to broaden their claims beyond those defined by the federal court based on Plaintiffs' prior representations, and confirmed the narrow scope of Plaintiffs' claims:

The sole issue was whether Plaintiffs could show injury from Defendants' alleged practice of denying insurance claims based upon an automated or computer review. *Non-payment of claims for other reasons are not part of this lawsuit.*

(CP 2061 (emphasis added).)

The court also noted that it had “accepted” Plaintiffs' assertions that their claims were “based upon an alleged practice of reviewing and denying insurance claims by a computer (without human review).” (CP 2061.) The court ruled that Plaintiffs had not established that their claims were denied on that basis and, therefore, that they had suffered injury as a result of that practice:

The court afforded Plaintiffs with an additional opportunity to provide the court with such evidence of injury as a result of this practice, but *Plaintiffs have not done so in their*

*latest pleading and barrage of paper.* Rather than focus on this narrow issue, Plaintiffs have instead opted to disregard the court's order and filed an untimely Motion for Reconsideration of the court's entire order without asking leave to do so (See CR 59 setting a ten day timeline).

(CR 2061 (emphasis added).)

#### **4. The Trial Court's Ruling on Defendants' Summary Judgment Motion**

While the parties were briefing Plaintiffs' various motions for reconsideration, Defendants filed a motion for summary judgment on the grounds that none of Plaintiffs' claims was reduced or denied due to a "computer-generated reduction" for "inadequate documentation." (CP 1729-38.) In response, Plaintiffs admitted that "the code used by [Defendants] for alleged lack of adequate documentation is called 'Doc 55.'" (CP 2445 n.10.) Plaintiffs did not dispute that no DOC55 reduction was taken on Hayes' claim, or that the DOC55 reductions on Beasley's claims were not "computer generated," but the result of reviews by three nurses. Instead, Plaintiffs actually asserted that they were *not bound* by the representations they had made in federal and state court regarding the narrow scope of their claims, and that they were free to assert broader claims. (CP 1996.)

On August 30, 2013, the trial court heard argument on the summary judgment motion. (8/30/13 RP.) In an oral ruling, the court granted Defendants' motion. Judge Yu expressed frustration with

Plaintiffs’ “continuously shifting what the case is about.” The court ruled that Plaintiffs were bound by the doctrine of judicial estoppel to the representations they had made—first to the federal court, and then in state court—regarding the scope of their claims:

THE COURT: You know, I feel very familiar with this record. *I can't tell you how many times I've gone back and have read the record, reviewed the record, tried to comprehend all of the pleadings that have been submitted, including what came from Judge Robart on a remand,* and I am granting the summary judgment today.

I go back even to my own order that was entered on July 12th of this past year and, for the second time, trying to also clearly indicate what was the scope of this particular case.

*I said it more than once. I asked about it each time, and then again even asserted it specifically, and the pleadings that came back always were different.*

It seemed to be a refinement, and it was an attempt to really be very clear about what this case was.

*I agree completely, frankly, with defense counsel's argument today in terms of what came back from Judge Robart, what the remand was, what my decisions have been, and what the pleadings have been, and it's consistently changed.*

And I do believe that — ***that plaintiffs should be estopped from continuously shifting what the case is about.***

I'm granting the motion.

(8/30/13 RP at 41-42 (emphasis added).)

The court also rejected Plaintiffs’ arguments to expand their claims to those involving computer “flagging” or “auto-moving.” The court held

that computer flagging is not a “denial” or “reduction,” but “simply shifts” consideration of the issue into another review process—here, reviews by healthcare professionals, *not computers*. (8/30/13 RP at 43.) The court’s ruling was confirmed in an Order dated September 6, 2013. (CP 2643.)

### **III. ARGUMENT**

#### **A. The Trial Court’s Decision Granting Summary Judgment to Defendants Should Be Affirmed.**

##### **1. Plaintiffs Waived Their Argument that the Trial Court Erred in “Reformulating” Their Claims.**

Although Plaintiffs’ entire appeal hinges on their contention that Judge Yu improperly “reformulated” their claims, they nowhere even *mention* the bases for her ruling: Plaintiffs’ repeated representations to both the federal and state courts limiting their claims, and the resulting application of judicial estoppel to preclude Plaintiffs from repudiating those representations in state court. This Court should not even consider Plaintiffs’ arguments that Judge Yu improperly “reformulated” their claims, because Plaintiffs failed to preserve that issue on appeal.

As appellants, Plaintiffs have an obligation to fairly present the record below, including the trial court’s ruling, and to explain, with citations to legal authorities and the record, why the trial court erred. R. App. P. 10.3(a)(5) (appellant’s brief must contain “a fair statement of the facts and procedure relevant to the issues presented for review”).

Moreover, as officers of the Court, Plaintiffs' counsel have a duty of "candor and fairness," and may not present a "misleading" picture of the record below. *In re Kennedy*, 80 Wn.2d 222, 232, 235, 492 P.2d 1364, 1370 (1972); *see In re Boucher*, 837 F.2d 869, 871 (9th Cir. 1988) (attorneys must "state clearly, candidly, and accurately the record").

Finally, issues not argued or discussed in an appellant's opening brief "are deemed abandoned and are not open to consideration on their merits." *In re Kennedy*, 80 Wn. 2d at 236, 492 P.2d at 1371; *e.g., Hall v. Feigenbaum*, 178 Wn. App. 811, 817, 319 P.3d 61, 64 (2014); R. App. P. 10.3(a)(4) (opening brief must contain a "separate concise statement of each error . . . together with the issues pertaining to the assignments of error"); *see also Brownfield v. City of Yakima*, \_\_\_ Wn. App. \_\_\_, 316 P.3d 520, 534 (2014) ("Passing treatment of an issue or lack of reasoned argument is insufficient to merit judicial consideration.").

Plaintiffs do not fairly present Judge Yu's decision or explain why it is allegedly wrong. Indeed, their opening brief does not even mention the legal basis for Judge Yu's summary judgment decision—the doctrine of judicial estoppel—or the factual bases for that decision—Plaintiffs' repeated representations to the federal court regarding the scope of their claims, and the federal court's ruling on that issue. Plaintiffs provide no analysis of judicial estoppel or precedent addressing that issue, much less

an explanation of why the decision below was allegedly incorrect. Plaintiffs therefore necessarily fail to demonstrate, with supporting authorities and references to the record, how Judge Yu allegedly erred in applying the doctrine of judicial estoppel. More than that, Plaintiffs mischaracterize the trial court's ruling by repeatedly suggesting that Judge Yu arbitrarily, and with no good reason, "reformulated" their claims. Plaintiffs' failure to address the judicial estoppel issue and related material omissions of the record go to the very heart of their appeal.

By failing to address the factual and legal bases underlying Judge Yu's ruling, Plaintiffs have waived any claim on appeal that Judge Yu improperly "reformulated" their claims, and may not dispute Judge Yu's application of judicial estoppel. Because Plaintiffs do not dispute that all their claims fail under Judge Yu's "formulation" of those claims,<sup>4</sup> the judgment below should be affirmed for this reason alone.

**2. The Trial Court Correctly Ruled That Plaintiffs Were Judicially Estopped from Expanding the Scope of Their Claims.**

Wholly apart from Plaintiffs' waiver of the issue on appeal, the

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<sup>4</sup> Although Plaintiffs assign as error (No. 4) the trial court's summary judgment ruling on their breach-of-contract claims (the only claims remaining after the rulings on the motion to dismiss and Plaintiffs' reconsideration motions), the issue of the scope of their claims applies to all. Judge Yu addressed the "formulation" of Plaintiffs' claims in her ruling on their motion for reconsideration of the dismissal order (CP 1534-35), and the "reformulation" of the claims applies equally to all claims, regardless of cause of action.

trial court's decision regarding the scope of Plaintiffs' claims, and the application of judicial estoppel, should be affirmed because it is correct.

Plaintiffs *do not dispute* that their claims fail to satisfy the two threshold elements that Plaintiffs repeatedly represented to the federal and state courts: (1) "computerized reductions," without human involvement, (2) due to "inadequate documentation." Under well-established principles of judicial estoppel, Plaintiffs are bound by their representations and cannot now attempt to expand the scope of their claims.

As the federal court correctly ruled: " 'Judicial estoppel precludes a party from gaining an advantage by taking one position and then seeking a second advantage by taking an incompatible position in a subsequent action.' " (CP 409 n.3 (quoting *Johnson v. Si-Cor Inc.*, 107 Wn. App. 902, 906, 28 P.3d 832, 834 (2001)); *e.g.*, *Skinner v. Holgate*, 141 Wn. App. 840, 847, 173 P.3d 300, 303 (2007) (applying judicial estoppel when plaintiff who took inconsistent position in prior federal proceeding); *Cunningham v. Reliable Concrete Pumping, Inc.*, 126 Wn. App. 222, 225, 108 P.3d 147, 148 (2005) (same); *Peck v. Cingular Wireless, LLC*, No. C09-106Z, 2009 WL 775385 at \*1 (W.D. Wash. Mar. 20, 2009) (plaintiffs judicially estopped from contradicting representations made in prior removal regarding scope of complaint).) Judicial estoppel serves to preserve respect for judicial proceedings and to prevent inconsistency and

duplicity in parties' conduct before courts. *Skinner*, 141 Wn. App. at 847, 173 P.3d at 303; *Cunningham*, 126 Wn. App. at 225, 108 P.3d at 148.

Here, to convince the federal court that the \$5 million jurisdictional minimum was not satisfied, Plaintiffs significantly narrowed the allegations of their Complaint. The federal court accepted those representations; remanded the case based on them; but noted that Plaintiffs would be bound by their representations in state court. Having successfully obtained a remand to their chosen forum as a result of those representations, Plaintiffs cannot now renege on them.

Plaintiffs do not even mention the judicial estoppel issue before this Court, and therefore have waived any argument that Judge Yu improperly "reformulated" their claims. But in the trial court, Plaintiffs argued that they were not bound by their representations to the federal court. (CP 1996.) Plaintiffs contended that under *Standard Fire Insurance Co. v. Knowles*, \_\_\_ U.S. \_\_\_, 133 S. Ct. 1345, 185 L. Ed. 2d 439 (2013), Plaintiffs' representations were "not binding on the *class* claims" they wished to pursue because, under *Knowles*, named plaintiffs could not "bind" class members to the scope of their claims before class certification. (CP 1996 (emphasis added).) *Knowles* said no such thing.

First, as Plaintiffs acknowledge, the most that *Knowles* addresses are the "*class claims*" of the putative class members. It does *not* address

the *named plaintiffs' own claims*. *Knowles* simply put a stop to some attorneys' tactics (including Plaintiffs' counsel here (CP 409 n.3)) of purporting to “stipulate” for the putative class to an amount less than the federal jurisdictional minimum to remain in state court. 133 S. Ct. at 1350-51. The Court in *Knowles* held that putative class members were not bound by limitation regarding the amounts that could be awarded them at trial, because the named plaintiff could not “legally bind members of the proposed class before the class is certified.” *Id.* at 1348-49.

Of course, *Knowles* did not say that named plaintiffs could not bind *themselves*—regarding their *own, individual claims*—by their representations to a federal court. *E.g., Guy v. State Farm Auto. Ins. Co.*, No. 3:13CV00229 JLH, 2013 WL 6511927 at \*2-3 (E.D. Ark. Dec. 12, 2013). Yet that is precisely what Plaintiffs are arguing here. Nor did *Knowles* change longstanding law that plaintiffs may structure the *type* of claims—rather than the amount of damages—they are bringing on behalf of the putative class. *See, e.g., Deaver v. BBVA Compass Consulting & Benefits, Inc.*, 946 F. Supp. 2d 982, 991-92 (N.D. Cal. 2013); *Curts v. Waggin' Train, LLC*, No. 13-0252-CV-W-ODS, 2013 WL 2319358 at \*1-2 (W.D. Mo. May 28, 2013) (*Knowles* does not prohibit named plaintiffs from narrowing scope of claims and class definition).

Thus, the entirety of Plaintiffs' argument on appeal—that the trial

court ignored the fact that their *Complaint* broadly challenges reductions other than “computerized reductions” for “inadequate documentation”—is simply irrelevant. *Plaintiffs* made their *Complaint* irrelevant when they narrowed the scope of their allegations to avoid federal court.

Also irrelevant are *Plaintiffs*’ assertions that “*every bill* is subject to a computer review” (CP 1993), and that the “initial step” for *every bill* is a “computer review” that “flags” the bill for additional—human—review (Pls.’ Br. at 17). If *Plaintiffs*’ claims were that broad, this case would still be in federal court: as *Plaintiffs* themselves admitted, every one of the reductions *Defendants* included in the amount in controversy was “initiated” with a “computer “review.” (CP 1993.)

Likewise irrelevant are *Plaintiffs*’ attempts to recast and broaden their claims to include bills that were merely “flagged” or “auto-moved” by a computer for *human* review. (Pls.’ Br. at 19.) *Plaintiffs* succeeded in obtaining a remand in part because they narrowed their claims to computer-generated *reductions*, “without human involvement.” But as Judge Yu correctly determined, a computer “flag” for further human review is the *antithesis* of a computer “denial,” because a flag or auto-move merely sends the determination to a *human being* for review: “Computer flagging is not a denial. It simply shifts [the determination] into a whole other review process.” (8/30/13 RP at 43.)

**B. The Trial Court Correctly Held that Plaintiffs Had Not Sustained a Legally Cognizable Injury.**

The trial court also correctly ruled that Plaintiffs had neither alleged nor established a cognizable injury. (CP 2061.) None of Plaintiffs' purported "out-of-pocket" payments were for the limited types of reductions Plaintiffs were challenging. As the trial court correctly concluded, Plaintiffs failed to provide "evidence of injury" resulting from the challenged practices, but instead simply "barraged" the court with paper and a third (untimely) motion for reconsideration.

On appeal, Plaintiffs *do not dispute* that their Complaint failed to allege that they made *any* out-of-pocket payments. (CP 1968.) And although they assert that they submitted evidence of payment of *some* medical bills themselves, they *do not dispute* that these payments were for reductions other than "computerized reductions" for "inadequate documentation." Instead, they assert that a legally cognizable "injury" does not require allegations or proof of "monetary loss." (Pl.'s Br. at 20.) This argument fails as a matter of law.

First, Plaintiffs are judicially estopped from arguing that evidence of actual, monetary loss is not required. Plaintiffs argued to the federal court that actual, monetary loss in the form of out-of-pocket payments to providers was required to state a valid claim, and that Defendants'

amount-in-controversy estimate was overstated because it included reductions that were not “balance-billed.” The federal court agreed, and therefore remanded the case. Plaintiffs are judicially estopped from repudiating the position they had taken in federal court to secure a remand.

Second, Plaintiffs are wrong as a matter of Washington law. Plaintiffs rely on an *Oregon* case, *Strawn v. Farmers Ins. Co.*, 209 P.3d 357, 366-67 (Or. Ct. App. 2009), for the proposition that, in order to obtain damages, plaintiffs need show only that the insurer’s practices left them *potentially liable* to pay their providers for the unreimbursed amounts. (Pls.’ Br. at 21-22.) But the Oregon statute does not govern here.<sup>5</sup> Washington law still requires evidence of *actual* “injury to business or property.” RCW 19.86.090. Here, Plaintiffs submitted *no evidence* of *any* type of injury—even a nonmonetary CPA injury that might be cognizable under *Panag v. Farmers Ins. Co.*, 166 Wn. 2d 27, 57, 204 P.3d 886, 900 (2009), *see* Pls.’ Br. at 20—other than the out-of-pocket payments they made for reductions *that are not part of this case*.

Finally, Plaintiffs’ claims about nonreimbursement of their medical expenses are not injuries to “business or property” under the CPA, but are noncognizable “personal” injuries. Although the trial court ruled against

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<sup>5</sup> Other jurisdictions limit an insured’s compensable injuries to their “balance-billed” payments. *McGill v. Auto. Ass’n*, 207 Mich. App. 402, 407, 526 N.W.2d 12, 14 (1994); *Allstate Indem. Co. v. Forth*, 204 S.W.3d 795, 796 (Tex. 2006).

Defendants on this issue (CP 1535), this Court nevertheless may affirm the judgment below on this ground. *E.g.*, *McGowan v. State*, 148 Wn.2d 278, 287-88, 60 P.3d 67, 72 (2002).

In *Ambach v. French*, 167 Wn. 2d 167, 175, 216 P.3d 405, 409 (2009), the Supreme Court held that “payment for medical treatment . . . does not transform medical expenses into business or property harm.” The “statutory exclusion of recovery for personal injuries prevents a plaintiff from claiming *expenses* for personal injuries as a qualifying injury.” *Id.* at 176; *see, e.g.*, *Association of Wash. Pub. Hosp. Dists. v. Philip Morris Inc.*, 241 F.3d 696, 705 (9th Cir. 2001) (“Expenses for personal injuries are not injuries to business or property under the CPA.”).

Accordingly, courts have held that PIP and MedPay claims for reimbursement of unpaid medical expenses do not constitute valid CPA claims. For example, in *Dees v. Allstate Ins. Co.*, 933 F. Supp. 2d 1299 (W.D. Wash. 2013), the court dismissed an insured’s CPA claim seeking reimbursement of medical bills under PIP, holding that those injuries “are derivative of [the insured’s] personal injuries. Personal injuries are not compensable damages under the CPA and do not constitute an injury to business or property.” *Id.* at 1310. Other courts have done the same. *See, e.g.*, *Haley v. Allstate Ins. Co.*, No. C09-1494 RSM, 2010 WL 4052935 at \*8 (W.D. Wash. Oct. 13, 2010), *reconsideration granted on other*

*grounds*, 2010 WL 5224132 (Dec. 14, 2010) (no CPA claim against insurer for medical expenses incurred from denial of MedPay benefits); *Braden v. Tornier, Inc.*, No. C09-5529RJB, 2009 WL 3188075 at \*4 (W.D. Wash. Sept. 30, 2009) (medical expenses are personal injury damages not within scope of CPA); *Sadler v. State Farm Mut. Auto. Ins. Co.*, No. C07-995Z, 2008 WL 4371661 at \*9 (W.D. Wash. Sept. 22, 2008) (claim that insurer improperly processed PIP claim “is not cognizable under the CPA”), *aff’d*, 351 F. App’x 234 (9th Cir. 2009).

**C. The Trial Court’s Rulings Regarding “Affiliates” Issues Should Be Affirmed.**

Plaintiffs do not assign as error the trial court’s holdings regarding the doctrine of privity and its application to what Plaintiffs term the “affiliates” issue. Instead, in a one-paragraph, conclusory argument, they claim that the trial court’s dismissal of “affiliated companies” (those with whom Plaintiffs had no insurance contract) was error because the trial court allegedly did not consider Plaintiffs’ arguments regarding “juridical link” and “joint enterprise” liability. (Pl.’s Br. at 26; *see id.* at 5 (Assignment of Error 1(d)).) The trial court committed no error.

**1. Plaintiffs Waived Appellate Review of This Issue.**

As an initial matter, Plaintiffs have waived appellate review of this issue. First, Plaintiffs did not properly present these issues to the trial

court. They filed no response to the motion to dismiss, and their CR 11 motion (which they belatedly told the court to consider as their response to the motion to dismiss) did not mention this argument. (CP 740-56.) Instead, as Plaintiffs acknowledge (Pls.' Br. at 27 n.40), they did not present these arguments until their *third* reconsideration motion. (CP 2061, 1907-20.) That motion was untimely and did not preserve the argument. *E.g.*, CR 59(b); *Schaefco, Inc. v. Columbia River Gorge Comm'n*, 121 Wn. 2d 366, 367-68, 849 P.2d 1225, 1226 (1993).

Plaintiffs' failure to fairly present this argument to the trial court is compounded by their cursory, one-paragraph treatment of the issues in their appellate brief, with an attempt—in a footnote—to incorporate by reference a filing in the trial court. (Pls.' Br. at 26-27 n.40.) This argument is not sufficiently preserved, and is therefore waived for this reason as well. *E.g.*, *In re Guardianship of Lamb*, 173 Wn.2d 173, 183 n.8, 265 P.3d 876, 882 (2011); *St. Joseph Gen. Hosp. v. Department of Revenue*, 158 Wn. App. 450, 472, 242 P.3d 897, 908 (2010).

## **2. Plaintiffs' Argument Is Wrong as a Matter of Law.**

Plaintiffs' "juridical link" and "joint enterprise" arguments are also wrong on the merits. The doctrines simply do not apply here.

Plaintiffs' attempt to satisfy these doctrines consists solely of

allegations that Defendants use the “same practices” and that all claims adjusters are United Services employees. (Pls.’ Br. at 26.) Courts consistently *decline* to apply these doctrines under these circumstances. For example, in *Hovenkotter v. Safeco Corp.*, the court rejected the claim that a plaintiff had standing to sue his insurer and two affiliated companies because of the “centralized process” of insurance claims handling. No. C09-218JLR, 2009 WL 6698629 at \*2 (W.D. Wash. Aug. 3, 2009). The court “decline[d] to endorse the notion that related companies may be sued by one plaintiff have claims against only one company based on a theory that the defendants are all engaged in the same activity.” *Id.*

Likewise, in *Shin v. Esurance*, the plaintiff claimed that her insurer and affiliates were “juridically linked” and formed a single enterprise because of common claims handling. No. C8-5626 RBL, 2009 WL 688586 at \*1 (W.D. Wash. Mar. 13, 2009). The court found that this was insufficient to create standing: “The Court refuses to embrace the notion that all related companies may be haled into court for the actions of one (or in this case two) of those inter-related, but distinct, companies merely because they have agreed on common practices.” *Id.* at \*5. For the juridical link doctrine to apply, the plaintiff at least would have to show that the companies were “so intricately linked that ‘the separateness of the corporation has ceased to exist.’ ” *Id.* Plaintiffs have alleged no such

extraordinary facts that might justify application of this doctrine.<sup>6</sup>

**D. The Trial Court Committed No Procedural Error.**

Plaintiffs' arguments regarding the supposed unfairness of the proceedings below are likewise without merit.

Plaintiffs argue, for example, that the trial court improperly failed explicitly to convert Defendants' Rule 12(b)(6) motion into a summary judgment motion. (Pls.' Br. at 12.) But that argument is irrelevant, because the trial court granted Defendants' summary judgment motion based on Plaintiffs' own formulation of their claims. In any event, the court was under no obligation to convert the CR 12(b)(6) motion, because the "beyond the pleadings" evidence the court entertained was, in fact, properly considered on a CR 12(b)(6) motion. The court considered Plaintiffs' insurance policies, the federal court remand order, and the transcript of arguments before the federal court. (3/22/13 RP at 13-14; CP 1436-37.) The policies were properly considered on a CR 12(b)(6)

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<sup>6</sup> The cases Plaintiffs cite are inapposite. In *Doe v. Spokane & Inland Empire Blood Bank*, 55 Wn. App. 106, 115, 780 P.2d 853, 859 (1989), the court actually declined to apply the juridical link doctrine, noting that it normally applies in cases against "government officials required by law or policy to act in a particular manner." *Washington Educators Association v. Shelton School District* dealt with allegations of systemic sex discrimination and did not specifically address the doctrine. 93 Wn. 2d 783, 790-91 613 P.2d 769, 774 (1980). In *Fallick v. Nationwide Mutual Insurance Co.*, the issue was the scope of the claims, not the identity of the defendants. 162 F.3d 410, 412 (6th Cir. 1998). And *Chipman v. Northwest Healthcare Corp.* explicitly based its holding on express allegations of a "concerted scheme" among the defendants, an allegation not made here. 288 P.3d 193, 205 (Mont. 2012).

motion, given that Plaintiffs' claims were based on them. *E.g.*, *Birnbaum v. Pierce Cnty.*, 167 Wn. App. 728, 732, 274 P.3d 1070, 1072 (2012); *Rodriguez v. Loudeye Corp.*, 144 Wn. App. 709, 726, 189 P.3d 168, 176 (2008). Likewise, the court certainly was entitled to consider and take judicial notice of the federal court proceedings in this very case. *See, e.g.*, *State v. Myers*, 47 Wn. 2d 840, 843-44, 290 P.2d 253, 255 (1955); *State v. Duran-Davila*, 77 Wn. App. 701, 705, 892 P.2d 1125, 1127 (1995).

Plaintiffs' repeated suggestions of procedural errors by the trial court are also unfounded. By all rights, the trial court could have granted Defendants' motion to dismiss due to Plaintiffs' failure to file an opposition brief. *See* King Cty. LCR 7(b)(4)(D). But the trial agreed to consider their arguments on the merits.

Nor did the trial court's decisions deprive Plaintiffs of the opportunity to fully and fairly present their claims. In the months before and after Defendants' summary judgment was filed, Plaintiffs had ample opportunity to pursue discovery. For example, Plaintiff pursued vigorous written discovery, and took the depositions of three claims adjusters, as well as the CR 30(b)(6) deposition of AIS. (CP 2212-13.) But the basis on which the trial court dismissed Plaintiffs' claims—their failure to fall within the scope of their own claims, and their lack of evidence of any legally cognizable injury—was due to evidence that was in Plaintiffs'

exclusive possession. They submitted multiple declarations attempting to establish “injury” (CR 1921-22, 1932-33, 1981-82, 1990-91), but none showed that their claims, or any balance-billed payments, were for “computerized reductions” for “inadequate documentation.”

Finally, Plaintiffs had ample opportunity to attempt to amend their Complaint. But they once again made a strategic decision based on their desire to maintain a state court forum and avoid federal court: Plaintiffs’ counsel admitted that he did not want to amend their pleading because he was worried that doing so could create another opportunity for Defendants to remove the case to federal court. *See supra* p. 10. Plaintiffs have no one to blame but themselves for their inability to state a valid claim.

#### **IV. CONCLUSION**

Defendants respectfully request that the Court affirm the judgment of the trial court dismissing Plaintiffs’ claims with prejudice.

DATED: April 9, 2014

Respectfully submitted,

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**CERTIFICATE OF SERVICE**

The undersigned hereby certifies as follows:

1. I am employed at Corr Cronin Michelson Baumgardner & Preece LLP, attorneys for Defendants-Respondents herein.

2. On this 9<sup>th</sup> day of April, 2014, I caused the document to which this certificate is attached, Brief of Defendants-Respondents, to be filed with the Clerk of the Court of Appeals, Division I, of the State of Washington, and served upon the following in the manner indicated below:

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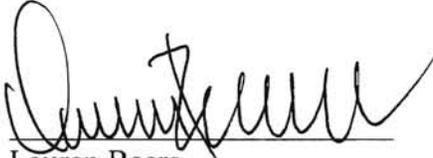
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I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

DATED this 9<sup>th</sup> day of April, 2014 at Seattle, Washington.

  
Lauren Beers