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IN THE SUPREME COURT OF THE STATE OF WASHINGTON

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CERTIFICATION FROM THE UNITED STATES DISTRICT COURT,  
WESTERN DISTRICT OF WASHINGTON  
IN RE:

BRETT DURANT, on behalf of  
himself and all other similarly situated,

Plaintiffs,

vs.

STATE FARM MUTUAL AUTOMOBILE INSURANCE  
COMPANY, a foreign automobile insurance company,

Defendant.

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BRIEF OF AMICUS CURIAE  
WASHINGTON STATE ASSOCIATION FOR JUSTICE FOUNDATION

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## **I. IDENTITY AND INTEREST OF AMICUS CURIAE**

The Washington State Association for Justice Foundation (WSAJ Foundation) is a not-for-profit corporation organized under Washington law, and a supporting organization to Washington State Association for Justice. WSAJ Foundation operates an amicus curiae program and has an interest in the rights of persons seeking redress under the civil justice system, including an interest in the proper interpretation and application of Washington Administrative Code § 284-30-395(1).

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

Brett Durant (Durant) brought suit against State Farm Mutual Automobile Insurance Company (State Farm) when State Farm claimed that reaching “maximum medical improvement” justified termination of payment of medical benefits under Durant’s personal injury protection (PIP) coverage. The underlying facts are drawn from the federal court orders and the briefing of the parties. *See Durant v. State Farm Mutual Automobile Ins. Co.*, 2017 WL 950588, at \*1-2 (W.D. Wash. Mar. 9, 2017; Order Re: Class Certification (*Durant 1*)); *Durant v. State Farm Mutual Automobile Ins. Co.*, 2017 WL 2930512, at \*1 (W.D. Wash. July 10, 2017; Order Re: Motion for Reconsideration, Motions to Strike, and Motion to Certify Questions to the Washington Supreme Court (*Durant 2*)); Durant Op. Br. at 2-10; State Farm Resp. Br. at 7-18.

Durant was insured with State Farm when he was injured in an automobile accident in 2013. Durant’s automobile policy included the

following provisions regarding personal injury protection benefits (PIP):

***Personal Injury Protection Benefits*** means accident related:

1. Medical and Hospital Benefits, which are payments for ***reasonable medical expenses*** incurred within three years of the date of the accident.

...

***Reasonable Medical Expenses*** means expenses:

1. that are the lowest one of the following charges:  
[a - d list different methods for calculating medical expenses]
2. incurred for necessary:
  - a. medical, surgical, x-ray, dental, ambulance, hospital, and professional nursing services, and
  - b. pharmaceuticals, eyeglasses, hearing aids and prosthetic devices

that are rendered by or prescribed by a licensed medical provider within the legally authorized scope of the provider's practice and are essential in achieving maximum medical improvement for the bodily injury sustained in the accident.

(State Farm Resp. Br., Exhibit 3; brackets added.)

Durant submitted medical expenses to State Farm for payment under his PIP coverage. State Farm sent Durant its form "Coverage Letter," which explained his PIP coverage as follows:

The policy provides coverage for reasonable and necessary medical expenses that are incurred within three (3) years of the accident. Medical services must also be essential in achieving maximum medical improvement for the injury you sustained in the accident.

Initially, State Farm paid medical expenses, but eventually denied payment for some expenses, explaining "[s]ervices are not covered, as your

provider advised us you previously reached maximum medical improvement.” Durant Op. Br. at 6 (brackets added). Durant advised State Farm that reaching “maximum medical improvement” is not an allowable basis for declining to pay PIP medical expenses, and that pursuant to WAC 284-30-395(1), the only permissible bases for denying PIP medical expense payments are if treatment is not reasonable, necessary, related to the accident, or incurred within three years of the accident.

When State Farm repeated its denial of benefits, Durant filed a class action in King County Superior Court alleging that State Farm violated its duty of good faith, breached the insurance contract, and violated the Insurance Fair Conduct Act and the Consumer Protection Act. After State Farm removed the case to federal court, the federal district court certified a class of plaintiffs to include those State Farm insureds in Washington who were denied PIP benefits based upon State Farm’s determination that its insured had reached “maximum medical improvement,” or that benefits were not “essential in achieving maximum medical improvement for the bodily injury.” *See Durant 1*, 2017 WL 950588, at \*3-7. In a subsequent order, the federal district court judge certified questions of law to this Court. *See Durant 2*, 2017 WL 2930512, at \*2. The certified questions are listed herein as the Issues Presented. *See Part III.*

### **III. ISSUES PRESENTED**

1. Does an insurer violate WAC 284-30-395(1)(a) or (b) if that insurer denies, limits, or terminates an insured’s medical or hospital benefits claim based on a finding of “maximum medical improvement”?

2. Is the term “maximum medical improvement” consistent with the definition of “reasonable” or “necessary” as those terms appear in WAC 284-30-395(1)?

#### IV. SUMMARY OF ARGUMENT

This Court applies a two-part test to determine whether insurance policy provisions limiting benefits comply with coverage mandated by the Legislature: 1) Whether the policy language that limits benefits is inconsistent with the express language of a statute or regulation; 2) Whether the policy language that limits benefits is inconsistent with the statute or regulation’s declared public policy. Policy language limiting benefits will be upheld only if both questions are answered in the negative.

State Farm’s PIP policy conflicts with the express language of WAC 284-30-395(1), which provides that medical services may be denied *only* if not reasonable, not necessary, not related to the accident, or not incurred within three years of the accident. State Farm’s policy excludes expenses not “essential in achieving maximum medical improvement,” imposing an additional exclusion not permitted by the text of the WAC.

State Farm’s policy also conflicts with the declared public policy underlying the PIP statutes and regulation, which seek to ensure full compensation under PIP coverage for those injured in automobile accidents. State Farm’s PIP policy provision limiting payment of medical services to those services “essential in achieving maximum medical improvement” is inconsistent with Washington’s declared public policy regarding PIP coverage to “make whole” those injured in automobile accidents.

Unlike the Industrial Insurance Act, in which maximum medical improvement may be said to facilitate the “grand compromise” reflected in that unique statutory scheme, maximum medical improvement is wholly inconsistent with the language and policies underlying PIP coverage in Washington State.

## V. ARGUMENT

### A. **Overview Of The Washington Statutes and Regulations That Define What Medical Services Must Be Provided Under PIP Coverage.**

“Insurance contracts are required to contain minimum protections depending on the particular kind of insurance. RCW 48.18.130(1). No insurance contract can contain an inconsistent or contradictory term to any mandated, standard provision unless it is more favorable to the insured. RCW 48.18.130(2).” *Kroeber v. GEICO Ins. Co.*, 184 Wn.2d 925, 929-30, 366 P.3d 1237 (2016).

PIP coverage is regulated pursuant to RCW 48.22.085-.105. RCW 48.22.085 requires automobile insurers to offer PIP coverage, .090 sets forth the allowed exclusions to PIP coverage, and .095-.100 set forth required PIP benefit limits, including limits for medical and hospital benefits. “Medical and hospital benefits” for PIP coverage are defined as:

[P]ayments 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 healthcare 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.

RCW 48.22.005(7) (brackets added); *see also* RCW 48.22.005(12). RCW 48.22.105 provides that the Insurance Commissioner may adopt such rules as are necessary to implement RCW 48.22.005 and 48.22.085-.100.

By enacting RCW 48.30.010(2), the Legislature granted the Commissioner the authority to identify unfair acts in the business of insurance. *See Federated Am. Ins. Co. v. Marquardt*, 108 Wn.2d 651, 654, 741 P.2d 18 (1987), *overruled by statute as stated in Neah Bay Chamber of Commerce v. Dep't of Fisheries*, 119 Wn.2d 464, 832 P.2d 1310 (1992). WAC 284-30-395 was adopted pursuant to this authority, and defines unfair acts or practices in the business of insurance specifically applicable to PIP coverage. WAC 284-30-395(1) provides in pertinent part as follows:

[I]n every case prior to denying, limiting, or terminating an insured's medical and hospital benefits, an insurer shall provide an insured with a written explanation of the coverage provided by the policy, including a notice that the insurer may deny, limit, or terminate benefits if the insurer determines that the medical and hospital services:

- (a) Are not reasonable;
- (b) Are not necessary;
- (c) Are not related to the accident; or
- (d) Are not incurred within three years of the automobile accident.

These are the only grounds for denial, limitation, or termination of medical and hospital services permitted pursuant to RCW 48.22.005(7), 48.22.095 or 48.22.100.

(Brackets added.)

Coverage mandated by statute is part of an insurance policy. *See*

*Kyrkos v. State Farm*, 121 Wn.2d 669, 672, 852 P.2d 1078 (1993); *Touchette v. Northwestern Mut. Ins. Co.*, 80 Wn.2d 327, 328, 494 P.2d 479 (1972). Exclusions that deny statutorily mandated coverage are void. *See Kyrkos*, 121 Wn.2d at 672; *Britton v. Safeco Ins. Co. of Am.*, 104 Wn.2d 518, 526-27, 707 P.2d 125 (1985). Insurers cannot diminish statutorily mandated insurance coverage through language in a policy. *See Liberty Mut. Ins. Co. v. Tripp*, 144 Wn.2d 1, 12, 25 P.3d 997 (2001).

**B. Limiting Payment Of PIP Medical Benefits To Medical Services “Essential In Achieving Maximum Medical Improvement” Is Inconsistent With WAC 284-30-395(1).**

The Legislature defined the circumstances in which PIP coverage must be offered to insureds, and authorized the Insurance Commissioner to adopt rules to implement PIP coverage. WAC 284-30-395(1) sets forth the only allowable bases for an insurer to deny, limit or terminate payment of medical benefit claims, including if the insurer determines the medical benefits (a) are not reasonable, or (b) are not necessary. “Reasonable” and “necessary” are not defined in WAC 284-30-395 or in RCW 48.22.005, the statute setting forth definitions for Ch. 48.22 RCW, Casualty Insurance, which includes the statutes regulating PIP coverage.

State Farm argues that medical services “essential in achieving maximum medical improvement” defines “necessary” medical services in its PIP policy, consistent with the statutory and regulatory requirement to provide coverage for reasonable and necessary medical services.

In the context of UIM coverage, the Washington Supreme Court has

applied a two-part test to determine whether a policy exclusion is permissible under the statutory scheme: (1) Is the exclusion inconsistent with the express language of the statute?; and, if not, (2) Is the exclusion inconsistent with the statute's declared public policy? *See Kyrkos*, 121 Wn.2d at 673-74; *see also Bohme v. PEMCO Mut. Ins. Co.*, 127 Wn.2d 409, 412, 899 P.2d 787 (1995). Application of this test should be appropriate in the context of PIP coverage, as both UIM and PIP are coverages that every insurer writing automobile policies in Washington must, by law, offer to insureds, and thus "are both creatures of public policy." *Sherry v. Fin. Indem. Co.*, 160 Wn.2d 611, 620, 160 P.3d 31 (2007).

1. **Limiting payment of PIP medical benefits to medical services "essential in achieving maximum medical improvement" is inconsistent with the express language of WAC 284-30-395(1).**

Applying the first part of the *Kyrkos* test, *i.e.*, whether the policy conflicts with the express language of the statute, requires statutory construction because the terms "necessary" and "reasonable" are undefined in the PIP statutes and regulation. This Court interprets both statutes and administrative regulations using rules of statutory construction. *Columbia Riverkeeper v. Port of Vancouver USA*, 188 Wn.2d 80, 90, 392 P.3d 1025 (2017). The meaning of a statute is a question of law, and the "fundamental objective is to ascertain and carry out the Legislature's intent." *Dep't of Ecology v. Campbell & Gwynn, LLC*, 146 Wn.2d 1, 9, 43 P.3d 4 (2002). "Ultimately, in resolving a question of statutory construction, this Court will adopt the interpretation which best advances the legislative purpose."

*Bennett v. Hardy*, 113 Wn.2d 912, 928, 784 P.2d 1258 (1990). “When a statutory term is undefined, the words of a statute are given their ordinary meaning.” *State v. Gonzalez*, 168 Wn.2d 256, 263, 26 P.3d 131 (2010). The Supreme Court has adopted a broad, contextual “plain language” rule which discerns legislative intent from the language of the statute at issue, related statutes, the statutory scheme as a whole, and facts of which the court may take judicial notice. *See Dep’t of Ecology*, 146 Wn.2d at 10-12.

The Court may examine statutory terms using dictionary definitions. *Cregan v. Fourth Memorial Church*, 175 Wn.2d 279, 285, 285 P.3d 860 (2012). Black’s Law Dictionary (10<sup>th</sup> ed. 2014) defines the adjective “reasonable” as “1. Fair, proper, or moderate under the circumstances; sensible. 2. According to reason.” The adjective “necessary” is defined as “1. That is needed for some purpose or reason; essential. 2. That must exist or happen and cannot be avoided; inevitable.” An earlier edition of Black’s contains a more expansive definition of “necessary”:

This word must be considered in the connection in which it is used, as it is a word susceptible of various meanings.... It is an adjective expressing degrees, and may express mere convenience or that which is indispensable or an absolute physical necessity. It may mean something which in the accomplishment of a given object cannot be dispensed with, or it may mean something reasonably useful and proper, and of greater or lesser benefit or convenience, and its force and meaning must be determined with relation to the particular object sought.

Black’s Law Dictionary 1181 (4th ed. 1968).

This latter definition best comports with the concept of “necessary” medical services. Whether any particular medical services are necessary will

vary from patient to patient, and will vary in the same patient depending upon the degree of the patient's injury at any given time. The above definitions of "reasonable" and "necessary" demonstrate that those terms cannot usually be defined in a way that can be broadly applied to determine the general appropriateness of a particular form of medical treatment in all situations. Whether medical treatment is reasonable depends upon the circumstances, and depending upon those circumstances, whether the treatment is necessary could mean it is either essential or useful and proper. Whether medical services are reasonable and necessary usually will be determined on a case-by-case basis.

The need for a case-by-case determination of "reasonable and necessary" does not make the meaning of these terms in WAC 284-30-395(1) ambiguous. The ordinary meaning of "reasonable" or "necessary" medical services as those terms are used in that regulation is not consistent with limiting medical services to only those services "essential in achieving maximum medical improvement." Rather than defining "reasonable" or "necessary," limiting medical services to those "essential in achieving maximum medical improvement" narrows the ordinary meaning and conflicts with the broad use of the terms "reasonable" and "necessary" medical services in WAC 284-30-395(1).

After application of the plain meaning rule, if a statute remains reasonably susceptible to more than one meaning, it is ambiguous and the Court will turn to rules of statutory construction. "Washington insurance

statutes are to be liberally construed for the benefit of the public.” *Kroeber*, 184 Wn.2d at 933. When Washington law requires insurers to include provisions in their policies, and terms in the required provisions are not defined in the statute and are subject to more than one reasonable interpretation, the terms are ambiguous and will be construed against the insurance company and in favor of the insured. *See Reliable Credit Ass’n, Inc. v. Progressive Direct Ins. Co.*, 171 Wn. App. 630, 633, 639-42, 287 P.3d 698 (2012).

Here, if the use of the terms “reasonable” and “necessary” in WAC 284-30-395(1) is determined to be ambiguous, a liberal construction of the regulation for the benefit of the public results in a meaning that is not narrowed to include only those medical services “essential in achieving maximum medical improvement.” The practice of medicine is not limited to services “essential in achieving maximum medical improvement,” but also includes advising and prescribing for treatment of pain. *See* RCW 18.71.011. Palliative care has been defined as care that “focuses on providing relief from symptoms, pain, and stress for the patient.” *Dependency of Lee*, 200 Wn. App. 414, 424 n.5, 404 P.3d 575 (2017). Treatment prescribed for relief from pain and symptoms may not be “essential in achieving maximum medical improvement,” but nonetheless is necessary to treat injuries from automobile accidents.<sup>1</sup>

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<sup>1</sup> *See, e.g., Douglas v. Allstate Ins. Co.*, 821 N.W.2d 472 (Mich. 2012). The Supreme Court of Michigan applied a plain language analysis to determine what medical expenses were allowable under Michigan's PIP statute, which requires that allowable expenses must be "for an injured person's care, recovery, or rehabilitation." 821 N.W.2d at 477. The Court held

State Farm's limitation on payment of PIP benefits for medical services "essential in achieving maximum medical improvement" is directly contrary to the language in WAC 284-30-395(1), which provides the only bases for an insurer to limit PIP medical services are if those services are not reasonable, are not necessary, are not related to the accident, or are not incurred within three years of the accident.

**2. Limiting payment of medical benefits to medical services "essential in achieving maximum medical improvement" is inconsistent with the PIP statutes and regulation's declared public policy.**

After application of the first part of the *Kyrkos* test, if the Court finds State Farm's limitation of payment of medical services does not conflict with the express language of WAC 284-30-395(1), the Court applies the second part of the test and examines the public policies underlying the PIP statute. *See Kyrkos*, 121 Wn.2d at 673. Under this prong, the relevant inquiry is whether the policy conflicts not with the express language, but with its declared public policies. *See id.* at 673-74.

In RCW 48.01.030, the Legislature defines "[t]he business of insurance" as "one affected by the public interest." (Brackets added.) The Washington Supreme Court has stated:

Both courts and the legislature have recognized that insurance contracts are imbued with public policy concerns.... Indeed,

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that expenses for "recovery" or "rehabilitation" are "costs expended in order to bring an insured to a condition of health or ability sufficient to resume his preinjury life," while expenses for "care" must have a meaning that "is broader than 'recovery' and 'rehabilitation' because it may encompass expenses for... services... that are necessary because of the accident but that may not restore a person to his preinjury state." 821 N.W.2d at 483-84 (citation omitted).

[i]nsurance contracts are unique in nature and purpose. An insured does not enter an insurance contract seeking profit, but instead seeks security and peace of mind through protection against calamity. The bargained-for peace of mind comes from the assurance that the insured will receive prompt payment of money in times of need.

*National Sur. Corp. v. Immunex Corp.*, 176 Wn.2d 872, 878, 297 P.3d 688 (2013) (quoting *Love v. Fire Ins. Exch.*, 271 Cal. Rptr. 246 (1990) (citations omitted)).

PIP coverage has been described as “essentially no-fault coverage for medical expenses arising from bodily injuries sustained in an automobile accident.” *Van Noy v. State Farm*, 142 Wn.2d 784, 787, 16 P.3d 574 (2001). PIP benefits are not fault based; people purchase PIP coverage to pay for the immediate costs of an accident, such as medical expenses and loss of income. *Sherry*, 160 Wn.2d at 624.

UIM and PIP insurance are both “creatures of public policy.” *Sherry*, 160 Wn.2d at 620. Because the Legislature requires every insurer writing automobile policies to offer UIM and PIP, public policy is implicated and exclusions that are valid in other forms of insurance may be void and unenforceable in UIM and PIP. *Id.*<sup>2</sup> As insurance contracts are generally

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<sup>2</sup> In *Touchette*, the Court discussed the public policy declared by the statutory requirement in RCW 48.22.30 that UIM coverage shall be offered: “[The statute] is but one of many regulatory measures designed to protect the public from the ravages of the negligent and reckless driver. It was enacted to expand insurance protection for the public in using the streets, highways and walkways and at the same time cut down the incidence and consequences of risk from the careless and insolvent drivers. The statute is both a public safety and a financial security measure. Recognizing the inevitable drain upon the public treasury through accidents caused by insolvent motor vehicle drivers who will not or cannot provide financial recompense for those whom they have negligently injured, and

private contracts between parties, the insurer is ordinarily permitted to limit its liability unless to do so would be inconsistent with statute and the underlying public policies. See *Mendoza v. Rivera-Chavez*, 140 Wn.2d 659, 662, 999 P.2d 29 (2000); *Brown v. Snohomish County Physicians Corp.*, 120 Wn.2d 747, 753, 845 P.2d 334 (1993); *Mut. of Enumclaw Ins. Co. v. Wiscomb*, 95 Wn.2d 373, 381, 622 P.2d 1234 (1980), *adhered to on rehearing*, 97 Wn.2d 203, 643 P.2d 441 (1982).

The legislatures and the courts have long been concerned with the use, operation and regulation of automobiles on public highways. *State Farm Gen. Ins. Co. v. Emerson*, 102 Wn.2d 477, 483, 687 P.2d 1139 (1984). “Washington State has long favored full compensation for those injured in automobile accidents. ‘This rule embodies a policy deemed socially desirable in this state, in that it fosters the adequate indemnification of innocent automobile accident victims.’” *Sherry*, 160 Wn.2d at 620-21 (quoting *Thiringer v. Am. Motors Ins. Co.*, 91 Wn.2d 215, 220, 588 P.2d 191 (1978) (citation omitted)); see also *Mendoza*, 140 Wn.2d at 665 (the financial responsibility act (ch. 46.29 RCW), and the mandatory liability insurance act (ch. 46.30 RCW) “express a strong public policy in favor of compensating the victims of road accidents”).

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contemplating the correlated financial distress following in the wake of automobile accidents and the financial loss suffered personally by the people of this state, the legislature for many sound reasons and in the exercise of the police power took this action to increase and broaden generally the public's protection against automobile accidents." 80 Wn.2d at 332 (brackets added).

In *Thiringer*, the insured sought benefits under his PIP policy after settling the underlying claim with the tortfeasor. The insurer, relying upon the reimbursement and subrogation rights in the policy, claimed the settlement should be first allocated to the special damages covered under the PIP policy. The Supreme Court held the settlement proceeds should be applied first to the insured's general damages, and then, only if any excess remained, to the special damages covered under the PIP provision. 91 Wn.2d at 219-20. The Court's opinion was "guided by the principle that a party suffering compensable injury is entitled to be made whole." *Id.* at 220.<sup>3</sup>

In *Brown*, the Court held that public policy was violated by health care service contract provisions that excluded coverage to the extent that benefits were available to the insured through UIM coverage. *See Brown*, 120 Wn.2d at 754. Relying upon *Thiringer*, the Court held that the provisions in the health care service contract violated the public policy in Washington favoring adequate indemnification of innocent automobile accident victims. *See id.* at 754-55. The Court rejected the insurer's argument that the holding in *Thiringer* was limited to subrogation principles, stating "[t]he public policy favoring full compensation of innocent automobile accident victims does not arise only in situations involving subrogation." *Id.* at 756. In *Sherry*, the Court discussed its opinion in *Brown*, and stated it "implicitly rejected a

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<sup>3</sup> In *Thiringer*, 91 Wn.2d at 220, the Court relied upon *Cammel v. State Farm Mut. Auto. Co. Ins.*, 86 Wn.2d 264, 543 P.2d 634 (1975), *overruled by statute as stated in Millers Cas. Co. v. Briggs*, 100 Wn.2d 1, 665 P.2d 891 (1983), which noted the "apparent statutory policy" of adequate indemnification of innocent automobile accident victims. 86 Wn.2d at 267 (citation omitted).

narrow interpretation of full compensation,” despite the fact that it “was not confronted with a subrogation, reimbursement, set-off, or offset provision.” 160 Wn.2d at 623. Instead, the Court noted that it “dealt with a medical insurance exclusion, but the principle is the same.” *Id.* That principle is that insureds are entitled to full compensation, and “insureds are fully compensated when they have made a complete recovery of the actual losses suffered as a result of an automobile accident.” *Id.* at 614.

Here, Washington statutes mandate that insurers writing automobile insurance offer PIP coverage, which includes coverage for payment of “all reasonable and necessary expenses incurred... for injuries sustained as a result of an automobile accident.” *See* RCW 48.22.005(7); RCW 48.22.085, .095, .100. The statutory requirement to offer PIP coverage implicates public policy. *See Sherry*, 160 Wn.2d at 620. WAC 284-30-395(1) provides that the only permissible bases for denying PIP medical expense payments are if treatment is not reasonable, not necessary, not related to the accident, or not incurred within three years of the accident. These statutes and the regulation reflect strong public policy in favor of the full compensation of medical benefits for victims of road accidents.

State Farm’s policy limits payment of PIP medical benefits to services “essential in achieving maximum medical improvement.” Whether called an exclusion or a definition of “necessary expenses,” this limitation denies Durant his PIP medical benefits necessary to return him to his preinjury state. Excluding payment for palliative care from the reasonable

and necessary medical expenses that are required to be paid under PIP coverage violates the public policy reflected in the statutory and regulatory scheme underlying PIP coverage, which is to fully compensate insureds for their actual damages from automobile accidents.

**C. The “Maximum Medical Improvement” Doctrine Plays A Central Role In The Context Of The Workers’ Compensation System, But Is Inapplicable And Contrary To The Statutory Requirement To Pay For “Reasonable” And “Necessary” PIP Medical Services.**

State Farm cites a WAC regulation promulgated pursuant to Title 51 RCW, Industrial Insurance, that states “[o]nce a worker’s condition has reached maximum medical improvement, treatment that results only in temporary or transient changes is not proper and necessary,” suggesting that this regulatory limitation of payment for health care services by the Department of Labor and Industries supports State Farm’s argument that medical services after an insured reaches maximum medical improvement are not “necessary” services under its PIP policy or WAC 284-30-395(1). State Farm Resp. Br. at 33-34 (quoting WAC 296-20-01002). This is an inapt comparison, as the purposes in regulating medical services provided to injured workers under Title 51 RCW and in regulating medical services an insurer is required to pay in PIP coverage under Title 48 are wholly different.

Washington’s public system of workers’ compensation is not the equivalent of insurance. *See Washington Ins. Guar. Ass’n v. Dep’t of Labor and Indus.*, 122 Wn.2d 527, 532-33, 859 P.2d 592 (1993). The Industrial Insurance Act “was the product of a grand compromise in 1911. Injured

workers were given a swift, no-fault compensation system for injuries on the job. Employers were given immunity from civil suits by workers.” *Birklid v. Boeing Co.*, 127 Wn.2d 853, 858, 904 P.2d 278 (1995) (quoting *Stertz v. Industrial Ins. Comm'n*, 91 Wash. 588, 590–91, 158 P. 256 (1916)). This compromise ensures the worker receives speedy relief, while granting employers immunity from the full extent of liability under the civil justice system. See *Meyer v. Burger King Corp.*, 144 Wn.2d 160, 164, 26 P.3d 925 (2001). “As a result, employees may receive less than full tort damages in exchange for the expense and uncertainty of litigation.” *Minton v. Ralston Purina Co.*, 146 Wn.2d 385, 390, 47 P.3d 556 (2002).

Maximum medical improvement in Title 51 RCW is related to the concept of “fixed impairment,” which plays a central role in the “grand compromise” reflected in the IIA. “Maximum medical improvement may be present though there may be fluctuations in levels of pain and function.... ‘Maximum medical improvement’ is equivalent to ‘fixed and stable.’” WAC 296-20-01002 ((3), definition of “proper and necessary”).<sup>4</sup> An injured worker is entitled to receive “proper and necessary” medical services, but once “maximum medical improvement” has been reached the Department may consider the worker’s condition “fixed and stable” and close the claim, at which point the worker may be eligible for an award of permanent

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<sup>4</sup> The regulation also appears to limit the types of medical services considered “proper and necessary” under the IIA. “In distinguishing curative and rehabilitative treatment from merely palliative treatment, WAC 296-20-01002 states ‘[c]urative and rehabilitative care produce long-term changes.’” 6A Wash. Prac., Wash. Pattern Jury Instr. Civ., WPI 155.31, COMMENT (6<sup>th</sup> ed.)

disability, among other benefits. *See Boyd v. City of Olympia*, 1 Wn. App.2d 17, 27-28, 403 P.3d 956 (2017); *Zavala v. Twin City Foods*, 185 Wn. App. 838, 872, 343 P.3d 761 (2015).

Maximum medical improvement thus appears to function in two complementary ways in the worker's compensation system. First, it establishes that an injured worker has a "fixed and stable" impairment, thereby triggering disability benefits. *See Boyd*, 1 Wn. App.2d at 28; *see also* WAC 296-20-200(4). The disability benefits awarded constitute compensation for the value of the injured worker's permanent loss of function. *See* WAC 296-20-19000; *see also Tomlinson v. Puget Sound Freight Lines, Inc.*, 166 Wn.2d 105, 111, 206 P.3d 657 (2009). Second, establishing MMI terminates the responsibility of the self-insured employer or Department to provide ongoing medical expenses. *See Shafer v. Dep't of Labor and Indus.*, 166 Wn.2d 710, 716-17, 213 P.3d 591 (2009) (closure of claim proper when injured worker's condition has become fixed and stable).

In sum, by establishing an impairment as fixed and stable, a finding of maximum medical improvement serves a critical role in determining the relative rights and remedies available under the IIA, facilitating the "compromise" reflected in that unique statutory scheme.<sup>5</sup>

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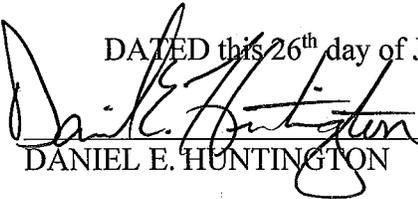
<sup>5</sup> Maximum medical improvement in workers' compensation under state law is closely related to the concept of "cure" in the "maintenance and cure" doctrine applicable to injured seamen under federal maritime law. *See Miller v. Arctic Alaska Fisheries Corp.*, 133 Wn.2d 250, 268, 944 P.2d 1005 (1997) (recognizing that "[m]aintenance and cure is the maritime analog to land-based industrial insurance paying an injured seaman's medical expenses (cure) and compensation in lieu of wages (maintenance) for injuries incurred in service of a ship" (brackets added)); *see also Dean v. Fishing Co. of Alaska*, 177 Wn.2d 399, 406, 300 P.3d 815 (2013) (noting that a "shipowner's duty to pay maintenance and cure continues until the seaman ... reaches the point of maximum medical recovery" (internal quotations

The restrictive limitation on the definition of “proper and necessary” medical care set forth in the IIA WAC regulation is not present in the statutes or regulation governing PIP coverage. A reviewing court will not add language to an unambiguous statute. *See Qwest Corp. v. City of Kent*, 157 Wn.2d 545, 553, 139 P.3d 1091 (2006); *Kilian v. Atkinson*, 147 Wn.2d 16, 20, 50 P.3d 638 (2002). WAC 284-30-395(1) provides that an insurer may deny, limit or terminate benefits if it determines medical services are not reasonable or necessary, *without* limiting the meaning of reasonable or necessary to services “essential in achieving maximum medical improvement.” The failure to so narrow “reasonable” or “necessary” services underscores that the Insurance Commissioner’s regulation did not adopt the IIA’s restrictive definition of “proper and reasonable” medical services.

## VI. CONCLUSION

The Court should adopt the analysis advanced in this brief in the course of resolving the certified questions.

DATED this 26<sup>th</sup> day of January, 2018.

  
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On Behalf of WSAJ Foundation

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and citations omitted)). State Farm agrees that the “maximum medical cure” standard in maritime law is the equivalent of “maximum medical improvement,” and states that “[u]nder the ‘maximum medical cure’ standard, a ship owner’s obligation to pay an injured seaman’s medical bills ends when he or she has reached a point where ‘future treatment *will merely relieve pain and suffering but not otherwise improve the seaman’s physical condition.*’” State Farm Resp. Br. at 34-35 (quoting *Lee v. Metson Marine Servs., Inc.*, 2012 WL 5381803 (D. Haw. Oct. 31, 2012) (emphasis added)). Nothing in Washington’s PIP statutes and regulation, or the underlying public policy, suggests that required payment for medical services will **not** include treatment that “will merely relieve pain and suffering but not otherwise improve a patient’s physical condition.”

## CERTIFICATE OF SERVICE

I hereby certify that on the 26<sup>th</sup> day of January, 2018, I electronically filed the foregoing document with the Clerk of the Court using the Washington State Appellate Courts Portal which will send notification of such filing to all counsel of record herein.

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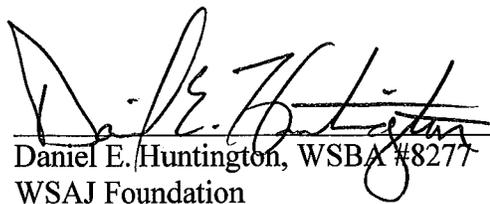
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# APPENDIX

**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.]

## WAC 284-30-395

### Standards for prompt, fair and equitable settlements applicable to automobile personal injury protection insurance.

The commissioner finds that some insurers limit, terminate, or deny coverage for personal injury protection insurance without adequate disclosure to insureds of their bases for such actions. To eliminate unfair acts or practices in accord with RCW 48.30.010, the following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance specifically applicable to automobile personal injury protection insurance. The following standards apply to an insurer's consultation with health care professionals when reviewing the reasonableness or necessity of treatment of the insured claiming benefits under his or her automobile personal injury protection benefits in an automobile insurance policy, as those terms are defined in RCW 48.22.005 (1), (7), and (8), and as prescribed at RCW 48.22.085 through 48.22.100. This section applies only where the insurer relies on the medical opinion of health care professionals to deny, limit, or terminate medical and hospital benefit claims. When used in this section, the term "medical or health care professional" does not include an insurer's claim representatives, adjusters, or managers or any health care professional in the direct employ of the insurer.

(1) Within a reasonable time after receipt of actual notice of an insured's intent to file a personal injury protection medical and hospital benefits claim, and in every case prior to denying, limiting, or terminating an insured's medical and hospital benefits, an insurer shall provide an insured with a written explanation of the coverage provided by the policy, including a notice that the insurer may deny, limit, or terminate benefits if the insurer determines that the medical and hospital services:

- (a) Are not reasonable;
- (b) Are not necessary;
- (c) Are not related to the accident; or
- (d) Are not incurred within three years of the automobile accident.

These are the only grounds for denial, limitation, or termination of medical and hospital services permitted pursuant to RCW 48.22.005(7), 48.22.095, or 48.22.100.

The written explanation responsive to an insured's intent to file a personal injury protection medical and hospital benefits claim must also include contact information for the office of the Washington state insurance commissioner's consumer protection services, including the consumer protection division's hotline phone number and the agency's web site address, and a statement that the consumer may contact the office of the insurance commissioner for assistance with questions or complaints.

(2) Within a reasonable time after an insurer concludes that it intends to deny, limit, or terminate an insured's medical and hospital benefits, the insurer shall provide an insured with a written explanation that describes the reasons for its action and copies of pertinent documents, if any, upon request of the insured. The insurer shall include the true and actual reason for its action as provided to the insurer by the medical or health care professional with whom the insurer consulted in clear and simple language, so that the insured will not need to resort to additional research to understand the reason for the action. A simple statement, for example, that the services are "not reasonable or necessary" is insufficient.

(3)(a) Health care professionals with whom the insurer will consult regarding its decision to deny, limit, or terminate an insured's medical and hospital benefits shall be currently licensed, certified, or registered to practice in the same health field or specialty as the health care professional that treated the insured.

(b) If the insured is being treated by more than one health care professional, the review shall be completed by a professional licensed, certified, or registered to practice in the same health field or specialty as the principal prescribing or diagnosing provider, unless otherwise agreed to by the insured and the insurer. This does not prohibit the insurer from providing additional reviews of other categories of professionals.

(4) To assist in any examination by the commissioner or the commissioner's delegatee, the insurer shall maintain in the insured's claim file sufficient information to verify the credentials of the health care professional with whom it consulted.

(5) An insurer shall not refuse to pay expenses related to a covered property damage loss arising out of an automobile accident solely because an insured failed to attend, or chose not to participate in, an independent medical examination requested under the insured's personal injury protection coverage.

(6) If an automobile liability insurance policy includes an arbitration provision, it shall conform to the following standards:

(a) The arbitration shall commence within a reasonable period of time after it is requested by an insured.

(b) The arbitration shall take place in the county in which the insured resides or the county where the insured resided at the time of the accident, unless the parties agree to another location.

(c) Relaxed rules of evidence shall apply, unless other rules of evidence are agreed to by the parties.

(d) The arbitration shall be conducted pursuant to arbitration rules similar to those of the American Arbitration Association, the Center for Public Resources, the Judicial Arbitration and Mediation Service, Washington Arbitration and Mediation Service, chapter 7.04 RCW, or any other rules of arbitration agreed to by the parties.

[Statutory Authority: RCW 48.02.060 and 48.22.105. WSR 12-19-081 (Matter No. R 2012-13), § 284-30-395, filed 9/18/12, effective 4/1/13. Statutory Authority: RCW 48.02.060, 48.22.105 and 48.30.010. WSR 97-13-005 (Matter No. R 96-6), § 284-30-395, filed 6/5/97, effective 7/6/97.]

**RICHTER-WIMBERLEY, P.S.**

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