

NO. 94771-6

IN WASHINGTON STATE SUPREME COURT

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.

FROM THE US DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON

PLAINTIFF'S OPENING BRIEF

Tyler K. Firkins
VAN SICLEN, STOCKS & FIRKINS
721 45th St NE
Auburn, WA 98002
253-859-8899
tfirkins@vansiclen.com

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I. INTRODUCTION

The Washington Administrative Code provides that there are only four reasons for which an insurer may deny, limit or terminate PIP coverage: if treatment is not reasonable, necessary, related to the accident, or incurred within three years of the accident. WAC 284-30-395(1). The regulation unequivocally declares: “these are the *only* grounds for denial, limitation, or termination” of PIP benefits. *Id.* (emphasis added). Yet since 1994, State Farm has adjusted PIP claims based on an additional standard: “treatment must also be essential in achieving maximum medical improvement.” (MMI standard).

The MMI standard is neither permitted by the plain language of WAC 284-30-395, nor is it consistent with the terms “reasonable” and “necessary” as used in the regulation. This Court should answer the District Court’s first certified question in the affirmative and the second in the negative, and hold that State Farm’s MMI standard is unlawful.

II. CERTIFIED QUESTIONS

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)?

III. STATEMENT OF THE CASE

A. Policy Language.

State Farm uses an auto liability policy in the State of Washington that contains the following provisions defining its personal injury protection coverage:

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 mean expenses:

1. That are the lowest one of the following charges:
2. ***Incurred for necessary:***

...

- a. medical, surgical, X-ray, dental, ambulance, hospital, and professional nursing services, and

...

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.***

Declaration of Tyler K. Firkins, Ex. N, Doc. #32.¹ Relying on this policy provision, State Farm has systematically adjusted PIP claims almost exclusively on the MMI standard.

State Farm initially submitted this policy language to the Office of Insurance Commissioner (“OIC”) for approval in 1994. At that time, the OIC approved the language. Three years later, the OIC enacted WAC 284-30-395, which now governs PIP policies in the State of Washington. To date, State Farm has not substantively amended its policy.

B. Brett Durant

Plaintiff Brett Durant is one of thousands of consumers that has been affected by State Farm’s use of the MMI standard. Mr. Durant has been a policy holder with State Farm since 1995. Declaration of Brett Durant, Dkt. #30. He chose to carry \$35,000 in PIP coverage. *Id.* On July 21, 2012, Mr. Durant was injured in a motor vehicle accident when another driver failed to obey a yield sign and struck his vehicle. *Id.* Mr. Durant opened a PIP claim with State Farm. *Id.* State Farm then sent him a form “Coverage Letter” explaining his coverages:

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.*

¹ Record already provided to the Court from the US District Court

(emphasis added). *Id.*

Mr. Durant sought treatment with chiropractor Harold Rasmussen, DC, who diagnosed cervical, thoracic, sacral and bilateral sacroiliac sprain condition with fixation of the right shoulder. Durant Dec, Dkt #30, Ex. Q to Declaration of Tyler Firkins, Dkt. #32. After a shoulder MRI showed a sprain of the middle glenohumeral ligament and a possible small type I SLAP tear, Mr. Durant was referred to an orthopedic surgeon who diagnosed mild bursitis/tendinitis. *Id.* This was treated with physical therapy and cortisone injections. Dkt. #30.

Four months after the accident, State Farm sent Dr. Rasmussen a “Physician Report,” which is a form letter inquiring about the patient’s progress. Durant Dec, Dkt #30, Ex. Q to Declaration of Tyler Firkins, Dkt. #32. The letter was directed towards State Farm’s MMI standard: “Has the patient reached maximum medical improvement?” and, “If the patient has not reached maximum medical improvement, when is your target date?” Notably, the letter did *not* inquire whether Mr. Durant’s treatment was reasonable, necessary, or related to the accident. This form letter, or a variation thereof,² is the same letter that State Farm systematically uses on

² Training material produced by State Farm indicates that his particular form letter contains several pre-approved questions; the adjuster chooses the questions that are applicable. Firkins Dec., Ex. R, Dkt. #32. Thus, the form letters will vary according to the claim.

all of its PIP claims in the State of Washington. Firkins Dec., Ex. C & F, Dkt. #32. Dr. Rasmussen responded that Mr. Durant was not at MMI but his target date was February 2, 2013. Firkins Dec., Ex. Q, Dkt. #32.

Mr. Durant's injuries were not resolved by that date and he continued to receive chiropractic and massage therapy. (Dkt. #30.) State Farm then sent another letter to Dr. Rasmussen, which inquired: "You have treated Brett past his given MMi [sic] date of 2/1/2013. Please explain." Dr. Rasmussen replied, "Patient was not stable and needed treatment to 3/27/2013." *Id.*

While Mr. Durant's injuries may have been "stable" as of the end of March, his injuries had not resolved; he had continued instability throughout the thoracocervical, thoracolumbar, lumbosacral, and bilateral sacroiliac joints as well as instability of the right shoulder due to the SLAP tear. (Dkt. #32, Firkins, Dec. Ex. Q; Rasmussen Dec. ¶ 4) Like many patients, he had temporarily achieved "MMI" by sustained treatment and avoiding activities that would exacerbate his existing injuries—activities that he had been able to engage in before the motor vehicle accident such as playing golf, snowboarding, running, mountain biking, doing yard work, etc. Without the benefit of ongoing treatment, whenever Mr. Durant

However, none of the pre-approved questions deal with whether treatment is reasonable or necessary. Firkins Dec., Ex. F, Dkt. #32.

attempted to return to any of his pre-accident activities, he exacerbated his injuries from the motor vehicle accident. Durant Dec., Dkt. #30.

Additionally, Mr. Durant was working as a Data Center Technician for Motricity where he singlehandedly maintained a 6000 square foot data center. *Id.* This required varying amounts of physical work, which from time to time exacerbated his injuries and he sought chiropractic treatment or massage therapy. *Id.*

When the activities of daily living exacerbate an underlying injury, these exacerbations are legally attributable to the original injury. *Smith v. Northern Pac. R. Co.*, 79 Wash. 448, 140 P. 685 (1914). Since treatment for these exacerbations was reasonable, necessary, and related to the motor vehicle accident, the Plaintiff's providers billed his PIP claim. State Farm denied each bill on the basis that: "Services are not covered, as your provider advised us you previously reached maximum medical improvement." Durant Dec., Dkt. #30.

By this point, Mr. Durant had retained an attorney for his personal injury case. *Id.* His attorney wrote to State Farm asking them to pay the outstanding medical bills. *Id.* The attorney explained that State Farm must use the standard authorized by WAC 284-30-395(1); whether Mr. Durant had reached MMI was irrelevant: unless State Farm had a competent medical opinion that Mr. Durant's treatment was not reasonable, necessary

or related, State Farm must pay the bills. *Id.* The attorney provided State Farm a letter from Dr. Rasmussen explaining that instability throughout the thoracocervical, thoracolumbar, lumbosacral, and bilateral sacroiliac joints as well as instability of the right shoulder due to the labrum tear meant that Mr. Durant would require conservative care on and off for his spinal and pelvic dysfunction and that during periods of exacerbation, Mr. Durant should receive conservative treatment to restore biomechanics and reduce his symptoms of pain.

The State Farm adjuster ignored Dr. Rasmussen's opinion and authored a letter reiterating the previous denial that Mr. Durant had previously reached MMI. Durant Dec., Dkt. 3#0. State Farm did not investigate whether the medical expenses were reasonable, necessary and related to the accident. *Id.* Mr. Durant, through his attorney, responded by letter that the Plaintiff needed medical treatment from time to time due to exacerbations in order to maintain his recovery, and that this treatment should be considered reasonable, necessary and related under WAC 284-30-395(1). *Id.* At this point Mr. Durant had unpaid medical bills of \$1,131.16, which had been denied by State Farm. *Id.* State Farm stood by its decision to deny payment based on the unlawful MMI standard without consideration of the lawful standard in WAC 284-30-395(1). *Id.*

C. Systemic use

Mr. Durant is not the only State Farm insured to have PIP benefits denied on the basis of its MMI standard. Rather, adjustment of PIP claims to the MMI standard is a frequent and systematic occurrence at State Farm. Declaration of Stephen Strzelec, Dkt. #28. State Farm tightly controls every aspect of the PIP claim process by the use of form letters. Declaration of Stephen Strzelec, Dkt. #28. The PIP claim investigation specifically uses form letter with pre-approved questions. The language of these form letters steers the focus of the investigation and almost without exception, these letters focus *solely* on the MMI standard. A transcript of a training broadcast produced by State Farm shows that adjusters are not permitted to deviate from the form letter without permission from a supervisor:

All [IME and UR] referral letters contain pre-drafted questions. These questions are the *only* questions that can be asked of the reviewer. You may need to include more than one of the questions in your letter, but only use questions pertinent to the issue or issues you are investigating. {Stress this}³ If a question listed does not meet your needs, you must have approval from your zone Claim Consultant to use different questions.

Dkt. #32, Firkins Declaration, Exs. P, R.

As an example, in its form Coverage Letter sent out to all PIP claimants, State Farm makes very clear that the MMI standard is *in addition to* the reasonable, necessary and related requirement:

³ Here, the trainer is instructed to “stress” the point that form letters cannot be deviated from without approval.

MEDICAL AND HOSPITAL BENEFITS

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. To assist us in determining what expenses are reasonable and necessary, we may obtain a second opinion from a medical provider. We may also have the treatment reviewed by other medical professionals.

Occasionally there are situations where treatment may not be considered reasonable, necessary, or related to the accident. *Similarly, there may be cases where the services are not essential in achieving maximum medical improvement for the injury sustained in the accident.* In such cases, YOUR PIP COVERAGE MAY NOT PAY FOR ALL OF YOUR EXPENSES.

Dkt. # 32, Firkins Dec., Ex D (emphasis added).

By the use of these form letters, State Farm institutionally assures that PIP claims are systematically adjusted based on the MMI standard. Examination of the claims files produced in discovery confirms not just by design but also in practice, State Farm adjusts PIP claims almost exclusively to the MMI standard. Thousands of Washington consumers have had their PIP benefits denied, terminated or limited due to State Farm's use of the MMI standard.

D. Class action

Mr. Durant filed this action in King County Superior Court in 2015, alleging that State Farm's use of the MMI standard violates its duty of good faith, breaches the insurance contract, violates the Insurance Fair Conduct Act,

and violates the Consumer Protection Act. (Compl., Dkt 1.) State Farm removed to federal court under the Class Action Fairness Act. Dkt. #1, Notice of Removal. The United States District Court certified a class of plaintiffs as

All insured as defined in the medical payments coverage portions of State Farm’s policies, and all third-party beneficiaries of such coverage, under any State Farm insurance policy issued in the state of Washington with respect to whom State Farm terminated, or limited benefits, based upon its determination that its insured had reach “maximum medical improvement” or that such benefits were not “essential in achieving maximum medical improvement for the bodily injury.

Dkt. #50, Order Granting Plaintiff’s Motion to Certify Class.

State Farm moved for reconsideration. In denying the motion for reconsideration, the District Court also certified the following two questions to this Court:

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. ARGUMENT

A. Standard of review.

“Certified questions from federal court are questions of law that this court reviews de novo.” *Brady v. Autozone Stores, Inc.*, 397 P.3d 120, 122

(2017). This Court’s review is based not in the abstract but based on the certified record provided by the federal court. *Carlsen v. Glob. Client Sols., LLC*, 171 Wn.2d 486, 493, 256 P.3d 321 (2011).

In this case, the District Court has certified two related questions concerning State Farm’s unlawful use of an insurance adjustment standard, maximum medical improvement (MMI). The first question essentially deals with the construction of the regulation at issue in this case, WAC 280-30-395. This question will be examined in the initial section of this brief. The second question asks this Court to decide whether the MMI standard is “consistent” with two terms, reasonable and necessary, used in the actual regulation.

B. An insurer violates WAC 284-30-395 when it denies, limits, or terminates an insured’s medical or hospital benefits claim based on a finding of “maximum medical improvement.”

The central issue in this litigation is whether an insurer may deny, limit, or terminate PIP benefits for reasons other than those listed in WAC 284-30-395, such as the MMI standard. Thus, the District Court asks whether an insurer violates 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.” The answer to this question is specifically addressed in the regulation itself. WAC 284-30-395 states:

(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.

WAC 284-30-395 (emphasis added). The final sentence of this regulation is unambiguous: no other reasons for denying PIP benefits are permitted.

The meaning of a statute is a question of law reviewed de novo. *State v. Breazeale*, 144 Wn.2d 829, 837, 31 P.3d 1155 (2001); *State v. J.M.*, 144 Wn.2d 472, 480, 28 P.3d 720 (2001). The court's fundamental objective is to ascertain and carry out the legislature's intent, and if the statute's meaning is plain on its face, then the court must give effect to that plain meaning as an expression of legislative intent. *J.M.*, 144 Wn.2d at 480. These rules of statutory construction apply equally to administrative rules and regulations, particularly where, as here, they are passed pursuant to

statutory authority. *City of Kent v. Beigh*, 145 Wn.2d 33, 45, 32 P.3d 258 (2001) (quoting *State v. Burke*, 92 Wn.2d 474, 478, 598 P.2d 395 (1979)).

Here the regulation is clear when it states that “[T]hese are the only grounds for denial, limitation, or termination of medical and hospital services” WAC 284-30-395. An insurer violates the regulation when it employs different grounds, such as “essential in achieving maximum medical improvement.”

State Farm has argued that its use of the term maximum medical improvement is merely another definition of reasonable and necessary, as those terms are used in the regulation. This argument fails for a variety of reasons. First, the regulation states clearly that insurers can only employ the grounds or standards for denial set forth in the regulation. The regulation does not permit substitution of terminology, even if the new term or element is similar. The regulation unequivocally states that “[T]hese are the *only* grounds for denial, limitation, or termination of medical and hospital services.” *Id.* (emphasis added.)

Second, State Farm’s MMI standard is not a definition, but rather an *additional* criteria that treatment must meet in order to be covered. The proposition that MMI is a definition of reasonable and necessary is a recent invention by State Farm to defend this litigation. State Farm’s argument is contradicted by its own representations to its insured. In every instance,

after an insured opens PIP claim, WAC 284-30-395 requires the insurer to provide a written explanation of the coverage. Pursuant to this regulation, State Farm sends its insured a form “Coverage Letter.” This letter makes clear that the MMI standard is *in addition to* the reasonable, necessary and related requirement. Dkt. #32, Declaration of Tyler K. Firkins, Ex. D.

MEDICAL AND HOSPITAL BENEFITS

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. To assist us in determining what expenses are reasonable and necessary, we may obtain a second opinion from a medical provider. We may also have the treatment reviewed by other medical professionals.

Dkt. #30, Declaration of Brett Durant; Dkt. #32, Declaration of Tyler K. Firkins, Ex. D. (italics added.)

Later in the Coverage Letter, State Farm tells its insured a *second time* that the MMI standard is in addition to the reasonable, necessary and related requirement.

Occasionally there are situations where treatment may not be considered reasonable, necessary, or related to the accident. *Similarly, there may be cases where the services are not essential in achieving maximum medical improvement for the injury sustained in the accident.* In such cases, YOUR PIP COVERAGE MAY NOT PAY FOR ALL OF YOUR EXPENSES.

Id. (italics added.) Nowhere does State Farm treat the MMI standard as a definition. Thus, it strains credibility for State Farm to contend that the MMI standard is merely a definition of reasonable or necessary.

State Farm's contention is also contradicted by its own policy language. The term MMI is found in State Farm's definition of reasonable expenses:

Reasonable Medical Expenses mean expenses:

3. That are the lowest one of the following charges:

4. Incurred for necessary:

...

b. medical, surgical, X-ray, dental, ambulance, hospital, and professional nursing services, and

...

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.*

Dkt. #7, Declaration of Tyler K. Firkins, Ex. A. Because State Farm used the word "and," a reading of the plain language of the policy makes it unambiguous that the "essential in achieving maximum medical improvement is *conjunctive* to the "incurred for necessary" medical treatment requirement. Plainly, the MMI standard is *not* a definition of necessary; it is an additional criteria that must be met in order for treatment to be covered under the PIP policy.

Therefore, answering the first question certified to this Court is straightforward. For the reasons stated above, an insurer does “violate WAC 284-30-395(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.’ ” This is so because the regulation unambiguously does not permit the use of additional or substitute grounds or standards.

To allow for grounds to be substituted, even if the grounds were similar, would render the words of the statute superfluous. It is a basic legal principle that just as courts “cannot add words or clauses to an unambiguous statute when the legislature has chosen not to include that language,” *State v. Delgado*, 148 Wn.2d 723, 727, 63 P.3d 792 (2003); courts may not delete language from an unambiguous statute: “ ‘Statutes must be interpreted and construed so that all the language used is given effect, with no portion rendered meaningless or superfluous.’ ” *Davis v. Dep’t of Licensing*, 137 Wn.2d 957, 963, 977 P.2d 554 (1999) (quoting *Whatcom County v. City of Bellingham*, 128 Wn.2d 537, 546, 909 P.2d 1303 (1996)). Therefore, when the regulations states that “[T]hese 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.” this Court cannot render these words meaningless by allowing substitutions such as “essential in achieving maximum medical improvement.”

Even if courts could delete language from regulations, and even if State Farm specifically stated in its policy and in its communications to its insured that its maximum medical improvement standard is just another way of applying the reasonable and necessary standard in the regulation, the statement would be untrue.⁴ The maximum medical improvement standard is more restrictive than the regulatory standard of reasonable and necessary. An analysis of the meaning of reasonable and necessary versus maximum medical improvement demonstrates that those terms are inconsistent.

C. The meaning of reasonable and necessary in Washington and under WAC 284-30-395.

The second question posed by the District Court is whether “maximum medical improvement is consistent with the definition of ‘reasonable’ or ‘necessary’ as those terms appear in WAC 284-30-305.” These terms are not defined by either statute or regulation. *See* RCW 48.22.005 and WAC 284-30-395. However, the Court should assume that the legislature understood how those terms are understood in other areas of law. *Hangman Ridge Training Stables, Inc. v. Safeco Title Ins. Co.*, 105 Wn.2d 778,789, 719 P. 2d 531 (“We presume the Legislature is familiar with past judicial interpretations of its enactments.”)

⁴ In neither its policy nor its communications to its insureds does State Farm ever equate “necessary” and “maximum medical improvement.”

The terms “reasonable” and “necessary” are used in the context of tort litigation, and specifically are addressed in the Washington Pattern Instructions. WPI 30.07.01. While the comments to the instruction do contain a significant list of cases, none of the cases directly addresses the definition of both terms.

Washington cases have addressed the meaning of the term “reasonable” in the context of tort litigation. The cases hold that reasonable means the medical bills actually incurred, together with testimony that the amounts incurred were reasonable, i.e., that the cost of the medical bills was reasonable. *Carr v. Martin*, 35 Wn.2d 753, 762, 215 P.2d 411, 416 (1950); *Trudeau v. Snohomish Auto Freight Co.*, 1 Wn.2d 574, 585–86, 96 P.2d 599, 604 (1939); *Patterson v. Horton*, 84 Wn. App. 531, 543, 929 P.2d 1125, 1130–31 (1997).

Given the definition of reasonable as discussed in the above cases, maximum medical improvement has no relationship to the term as used in the context of tort litigation. In answer to the District Court’s certified question, MMI is not consistent with the definition of reasonable because it does not address issues related to the cost of medical treatments and

services. The next issue presented is whether the MMI standard is “consistent” with the term “necessary” as used in the PIP regulation.⁵

The term “necessary” has not been adequately defined in the context of the WPI on damages, or in the context of PIP insurance regulations. It seems clear that the PIP regulation adopted the reasonable and necessary terms from cases involving tort litigation. Yet, Washington courts have not specifically defined the meaning of the term “necessary” in the context of either tort litigation or PIP regulations.

Certainly, Washington cases are clear that a medical provider must testify that past economic medical charges are “necessary” in a general sense. But the term has not been further explored in our courts. Logic suggests there must be some relationship between the services and the injury producing incident. Medical treatments that do not treat a condition caused by the car crash are not necessary—at least to treat the crash related injuries as required by WAC 284-30-395. To further understand how “necessary” is defined in Washington, an understanding of underlying tort principles is necessary.

⁵ It is not strictly necessary to define the term “necessary” in order to resolve the issues in this case. As discussed in section D *infra*, State Farm’s MMI standard is not consistent with the term “necessary” under any reasonable definition of the word. This Court may, in the exercise of judicial restraint, leave it to the legislature to decide upon a definition.

Washington has long followed the basic rule of liability stated in Restatement (Second) of Torts §457 (1965) making the original tortfeasor responsible for all damages resulting from her negligence, including any additional harm

allegedly caused by persons rendering aid—like treating physicians:

If the negligent actor is liable for another's bodily injury, he is also subject to liability for any additional bodily harm resulting from normal efforts of third persons in rendering aid which the other's injury reasonably requires, irrespective of whether such acts are done in a proper or a negligent manner.

Lindquist v. Dengel, 92 Wn.2d 257,262 (1979) (citing *Adams v. Allstate Ins. Co.*, 58 Wn.2d 659, 669, 364 P.2d 804 (1961)); *Martin v. Cunningham*, 93 Wash. 517, 518, 161 P. 355 (1916); *see also Whitaker v. Kruse*, 495 N.E.2d 223, 225-226 (Ind.App. 1986) (“The rationale for permitting recovery under this rule is that the tortfeasor created the necessity for medical care in the first instance. So long as the individual seeking medical care makes a reasonable choice of physicians, he is entitled to recover for all damages resulting from any aggravation of his original injury caused by a physician’s misdiagnosis or mistreatment.”) This rule is consistent with the recognition that plaintiff will not be deemed to be at fault for following the treatment recommendations of his physicians:

It is not a part of the duties of a patient to distrust his

physician, or to set his judgment against that of the expert whom he has employed to treat him, or to appeal to other physicians to ascertain if the physician is performing his duty properly. The very relation assumes trust and confidence on the part of the patient in the capacity and skill of the physician; and it would indeed require an unusual state of facts to render a person who is possessed of no medical skill guilty of contributory negligence because he accepts the word of his physician and trusts in the efficacy of the treatment prescribed by him. A patient has the right to rely on the professional skill of his physician, without calling others in to determine whether he really possesses such skill or not. The patient is not bound to call in other physicians, unless he becomes fully aware that the physician has not been, and is not, giving proper treatment.

Kelly v. Carroll, 36 Wn.2d 482, 501 (1950).

The Indiana Supreme Court looked closely at the “necessity” component of the “reasonable and necessary” standard in *Sibbing v. Cave*, 92 N.E. 2d 549 (2010). After a thorough analysis of Restatement (2d) of Torts §457, the *Sibbing* court held treatment is “necessary” when it “proximately resulted from the wrongful conduct of another.” 92 N.E.2d at 604. For this reason, a defendant cannot dispute the necessity of medical expenses by challenging the judgment of plaintiff’s doctors in prescribing, or not prescribing, treatment. “[T]he defendant disputes the medical judgment of the plaintiff’s medical providers in choosing to administer the questioned studies and treatment. This he may not do.” *Id.*

The *Sibbing* court reasoned that the “scope of liability” rule of proximate cause precludes a defendant from challenging the “necessity” of

medical treatment and bills by disagreeing with the professional judgment of the treating doctors because even negligent treatment is reasonably foreseeable. The court finally held:

[W]e hold that the phrase "reasonable and necessary," as a qualification for the damages recoverable by an injured party, means (1) that the amount of medical expense claimed must be reasonable, (2) that the nature and extent of the treatment claimed must be necessary in the sense that it proximately resulted from the wrongful conduct of another, and (3) the rule in *Whitaker* is a correct application of the "scope of liability" component of proximate cause.

Sibbing, 922 N.E.2d at 604. Cf. *Hillebrandt v. Holsum Bakeries, Inc.*, 267 So.2d 608, 610 (La.App. 1972) ("The blameless tort victim should not bear the expense of litigating with his doctor and should certainly not bear the risk of having to pay tort-caused charges the tortfeasor escapes, since neither item is attributable to the victim's fault.").

While the public policies underlying tort litigation and PIP insurance are somewhat different, the policy prohibiting a third party from interfering with medical decisions made between an injured person and their physician is universal, and of a constitutional dimension. *Matter of Guardianship of Ingram*, 102 Wn.2d 827, 836, 689 P.2d 1363 (1984). Courts should not create a policy whereby third parties, such as insurance companies, can interfere with the medical decision making between an injured party and their physician. For example, the fact that an insurance

company can come up with different reasoning that would involve less or different treatment cannot serve as a basis to challenge the necessity of treatment. Such conduct would significantly interfere with a patient's personal rights of bodily integrity and personal liberty. *See, e.g., Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 123, 170 P.3d 1151 (2007).

Further, the concept underlying insurance "is to make an insured whole in the event that a covered peril occurs." *Keenan v. Industrial Indem. Ins. Co.*, 108 Wn.2d 314, 323, 738 P.2d 270 (1987) (concurring opinion). An insured is only "made whole" in terms of treatment, if he or she is returned to pre-accident condition. However, when that is not possible, because the injury is permanent, or will exacerbate from time to time, then the insured is not made whole unless she can maintain her pre-accident function over time.

Therefore, the term "necessary" in Washington in both the PIP and tort litigation context should be given the following definition:

Necessary medical treatment or services are those treatments or services that are related to the injury producing event, and deemed necessary by the injured party's licensed medical provider, and such treatment or services are within the standard of care for such licensed providers.

Because this proposed definition involves licensed providers, issues regarding inappropriate treatment can be addressed through professional licensing agencies, rather than interfering with the physician-patient

relationship, or compelling courts to become involved in medical decision-making. Creating a policy whereby third parties are allowed to retrospectively quibble over whether a particular treatment is necessary even though such treatment is within the standard of care will simply open the floodgates of litigation, and inject courthouses into healthcare decision-making.

Such a definition does not permit a third party or insurance carrier to simply cut off treatment because it found a physician who is willing to say in a report that she would have used a different or less expensive treatment process; or more simply that the treatment was not necessary. In other words, so long as the medical provider's recommendations are within the standard of care, then the recommendations cannot be challenged as unnecessary. However, the proposed definition still permits challenges to treatment that is unrelated to the injury producing event, or treatment that is outside the standard of care, or treatment that is unreasonable in terms of cost.

Further support for such a policy is found in WPI 105.08 and the comments thereto. According to the instruction, a physician cannot be held liable for exercising professional judgment in deciding between two or more treatments or diagnoses as long as she acts within the standard of care. As the comments note, "medicine is an inexact science where the desired

results cannot be guaranteed, and where professional judgment may reasonably differ as to what constitutes proper treatment.” Comment, quoting, *Watson v. Hockett*, 107 Wn.2d 158, 727 P.2d 669 (1986).

Other courts have agreed with such a construction in the context of PIP insurance. For example, in *Thermographic Diagnostics, Inc. v. Allstate Ins. Co.*, the court held:

Under the New Jersey No Fault Act, the “necessity” of a medical expense must be decided by the treating physician, the one most qualified to make such a judgment. It should not be the province of the Judiciary to decide, in the face of conflicting expert medical testimony, highly complex questions of medicine and science. Surely the Legislature could not have intended for the Judiciary to sit in the capacity of a medical board of review. Therefore, this court holds that “need” is shown if the treating physician orders a thermographic test based upon the physician's sincere belief that the procedure will further the diagnosis and treatment of his patient. Of course, abuses of this judgment by the physician, where it can be shown that multiple tests are ordered or tests not warranted by the circumstances are ordered, can receive individual scrutiny and review by a court.

219 N.J. Super. 208, 227–28, 530 A.2d 56 (1987); *see also Victum v. Martin*, 367 Mass. 404, 407, 326 N.E.2d 12 (1975) (necessary if the treatment rendered by a competent medical doctor was a bona fide effort to alleviate and ameliorate the injury).

Washington should not create and encourage retrospective reviews of treatment so that third parties can avoid paying benefits by finding an

expert that simply disagrees with the professional judgment of a licensed treating provider exercising their professional judgment within the standard of care. What is “necessary” is ultimately a decision best left to the treating provider, and this Court’s definition of the word should reflect such a policy.

D. Any reasonable definition of necessary does not include State Farm’s MMI standard.

State Farm contends that its requirement of “maximum medical improvement” is equivalent to the regulatory term, necessary. However, regardless of the definition of “necessary” adopted by this Court, the MMI standard is not equivalent to any reasonable definition of necessary that can be applied to that term.

To begin, as shown in section B, *supra*, State Farm does not simply use the term maximum medical improvement. Instead, it requires that the treatment is both necessary *and* “essential” in achieving maximum medical improvement. The standard “essential” is more restrictive than is the term necessary without also adding the further requirement that the treatment or services also relates to achieving maximum medical improvement. The word necessary has a wide range of meanings.

As the Appellate Court of New Jersey reasoned, the term necessary includes not only “absolute physical necessity,” but also “that which is useful convenient, appropriate, suitable, proper or conducive to the end

sought.” *Miskofsky v. Ohio Cas. Ins. Co.*, 203 N.J. Super. 400, 413, 497 A.2d 223 (Law Div. 1984), *overruled on other grounds*, 225 N.J. Super. 606, 543 A.2d 110 (App.Div. 1988) (quoting *Kay County Excise Board v. Atchison, T. & S.F.R. Co.*, 185 Okl. 327, 91 P.2d 1087 (Sup. Ct. 1939)). The court explained:

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 or proper and of greater or lesser benefit or convenience and its force and meaning must be determined with relation to the particular object sought and as a relative and comparative term, depending upon its application to the object sought.

Id.

In contrast, State Farm’s terminology, essential, is more restrictive, meaning something that is “absolutely necessary.” OXFORD ENGLISH DICTIONARY, <https://en.oxforddictionaries.com/definition/essential>. Thus, under State Farm’s definition, something must be more than necessary; it must be “absolutely necessary.” This alone means the MMI standard is not “consistent” with necessary.

But State Farm’s MMI standard is also more restrictive in that treatment must not only be essential, but also aligned only to curing the condition, as the term maximum medical improvement denotes. Stated a different way, only treatment that will lead to a cure of the condition or is curative is necessary under State Farm’s standard. There is no support for

such a restrictive definition of the term necessary in the context of tort litigation or PIP regulations. Indeed, such a limitation makes no sense when considering some of the injuries that people sustain in car crashes.

For instance, in many unfortunate cases, motor vehicle collision injuries cause permanent injury or impairment, which cannot be cured by surgery or other means—the pain can only be managed, for example by periodic steroid injections or radiofrequency neurotomy. Such treatment is not essential in achieving maximum medical improvement, as the patient’s injury by its permanent nature cannot be further improved. However, the treatment *is* medically necessary, and if related to the accident and reasonable in cost, should be covered under WAC 284-30-395. State Farm’s more restrictive standard would not cover this treatment.

Or for instance, if a patient sustains a traumatic brain injury in a car crash, therapies to improve the patient’s functioning and ability to perform activities of daily living (ADL) are not curative or strictly essential. However, the treatment might allow the patient to reach or maintain a certain level of functioning, while not being “cured” or restored to pre-accident functionality. However, if the treatments are discontinued, the patient’s functioning could regress. Thus, the treatments are necessary to maintain function.

As another example, if a person was involved in a crash, and was left in a vegetative state, no treatments or services rendered would cure the insured's condition. Such treatments therefore would not be "essential in achieving maximum medical improvement." Rather, the treatments are simply being used to maintain the limited function of the patient. The treatment and services do not cure but allow the patient to survive. The patient does not improve, she simply preserves the function she is left with.

In this case, Mr. Durant's medical provider noted in writing that he continued to need occasional conservative treatment so that he could maintain his function. Dkt. 32, Declaration of Tyler Firkins, Ex. Q. The medical provider opined that such treatment was necessary to maintain function, that would deteriorate in the absence of such treatment. State Farm denied further benefits indicating that Mr. Durant had previously reached MMI. Dkt. 32, Declaration of Tyler Firkins, Ex. Q.

As can be seen from the above examples, the proposed treatment is necessary to maintain function and the ability to perform ADLs, but does not effectuate a further improvement or cure of the condition. Therefore, the MMI standard is not only more restrictive than is the term necessary, it precludes necessary treatment. It is therefore inconsistent with the term necessary.

Other courts have rejected similar language. In *Hobby v. CNA Ins. Co.*, 267 A.D.2d 1084, 1085 (N.Y. 1999), an insurer sought to discontinue the plaintiff's no-fault medical coverage under her auto policy on the grounds she had reached "maximum medical improvement." New York insurance regulations required the insurer to pay "[a]ll necessary expenses" for medical treatment and "any other professional health services; all without limitation as to time, provided that within one year after the date of the accident causing the injury it is ascertainable that further expenses may be incurred as a result of the injury." In a one paragraph opinion, the court upheld summary judgment in favor of the plaintiff, ruling that there was no authority under state regulation for using an MMI standard to discontinue benefits.

While there is no Washington case construing the meaning of reasonable and necessary medical treatment in the context of WAC 284-30-395, the insurance commissioner has weighed in on the subject. Prior to 2010, American Family Insurance had a PIP policy which read, "Services will only be provided until recovery has reached a plateau or improvement in the bodily injury has slowed or ceased entirely." Dkt. #7, *Nauheim Dec. Ex. 1*. While, like here, the policy was approved by the insurance commissioner, once the offending language was brought to his attention, he found that it was in violation of WAC 284-30-395(1). *Id.* He ordered

American Family Insurance to apply the correct standard to all of its insurance contracts and further ordered American Family to file a revised form in compliance with WAC 284-30-395. *Id.*

Similarly, this Court should rule that the MMI standard is not consistent with the reasonable and necessary standard.

E. The distinction between palliative care and curative care is irrelevant

State Farm attempts to create a false debate between palliative and curative care in defending its unlawful standard. But treatment that permits a patient to continue to function is not palliative. But even if the erroneous debate is accepted, palliative care can be necessary care.

The PIP regulations do not distinguish between palliative care and curative care. The legislative branch has demonstrated an ability to create a specific distinction between curative and palliative care in the context of worker's compensation but did not do so with respect to PIP regulations.⁶ If the OIC intended to permit a PIP insurer to terminate treatment based on a finding that further treatment is palliative or that an insured had reached MMI, it would have included this in WAC 284-30-395. *State v. Delgado*, 63 P.3d 792, 729, 63 P.2d 792 (2003) (expressio unius est exclusio alterius, to express one thing implies the exclusion of the other).

⁶ WAC 296-20-01002

Palliative care is legitimate, necessary care. There are several kinds of treatment that are considered necessary in the medical community.

Medical treatment is given to preserve life *and* relieve the patient as much as possible from pain and disability whether physical or mental. It may encompass providing an amalgam of services or benefits to an injured patient, if “medically necessary to [plaintiff’s] existence.” Included within the definition is “treatment which is for palliative relief of symptoms, although not designed to effectuate a cure”

Cavagnaro v. Hanover, 236 N.J. Super. 287, 291, 565 A. 2d 728 (NJ Sup.Ct., Law Div. 1989) (emphasis added).

Indeed, defining medical necessity as “essential in achieving maximum medical improvement” is inconsistent with the definition of the practice of medicine, which is defined as anyone who “undertakes to diagnose, cure, advise, or prescribe for any human disease, ailment, injury, *infirmity*, deformity, *pain or other condition*, physical or mental, real or imaginary, by any means or instrumentality.” *Morelli v. Ehsan*, 110 Wn.2d 555, 558, 756 P. 2d 129 (1988) (quoting RCW 18.71.011(1)) (emphasis added).

Similarly, WAC 182-500-0070 defines medical necessity as:

a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, *alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain*, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client

requesting the service. For the purposes of this section, 'course of treatment' may include mere observation or, where appropriate, no medical treatment at all.

WAC 182-500-0070 ("definitions of words and phrases used in rules for medical assistance and other health care programs") (emphasis added).

This WAC regulation would clearly permit the type of treatment that State Farm denied coverage for Mr. Durant under the MMI standard.

While no Washington court has specifically addressed palliative versus curative care in the context of tort litigation, or PIP regulations, numerous other courts have. In *Sebroski v. United States*, 111 F. Supp.2d 681 (D. Md. 1999), the plaintiff sought future medical expenses for chiropractic care for chronic pain. The defendant argued that there should be no recovery for chiropractic care that is merely palliative. The court rejected this distinction, stating:

However, the Court is also convinced that reasonable medical expenses need not be limited to only curative treatment. The fact that care is only palliative cannot mean that such medical care is never recoverable. This Court can find no reasoned distinction between long term prescription of pain medications and long term prescription of chiropractic treatments.

Id. at 684-685.

Similarly, in *Miskofsky v. Ohio Cas. Ins. Co.*, the defendant insurer terminated coverage for PIP benefits after it found that its insured's treatment had hit a plateau and that further treatment was only "palliative."

203 N.J. Super. 400, 497 A.2d 223 (Law Div. 1984), *overruled on other grounds*, 225 N.J. Super. 606, 543 A.2d 110 (App.Div. 1988). The issue was whether N.J.S.A. 39:6A-4(a) required a PIP insurer to pay medical expenses proximately caused by an automobile accident that are both reasonable and necessary and if so, whether “necessary medical expenses” was limited to treatment intended to “effect a cure of the injured party,” or whether, once the insured’s recovery hit a plateau, it also included treatment that was only “palliative in nature.” *Id.* at 404. First the court found that the statute did require payment of medical expenses that were both reasonable, necessary, and related to the accident. *Id.* 409. Thus, the statute construed by the court imposed the same duty as WAC 284-30-395(1).

Next the court construed the meaning of “necessary treatment.” Like here, the defendant contended that necessary medical expenses should be limited to treatment that effectuates a “cure” for the injuries sustained in the automobile accident. *Id.* at 413. Once a plateau in recovery has been reached, the defendant argued, further treatment is not “necessary” because it is palliative and only brings temporary relief of symptoms. *Id.* The court rejected the defendant’s restrictive interpretation, holding that treatment that is designed to relieve pain, although not “designated to effectuate a cure, are within the legislative contemplation of [reasonable and necessary] medical treatment.” *Id.* 231. *See also Victum v. Martin*, 367 Mass. 404, 326

N.E.2d 12 (Sup.Jud.Ct. 1975); *Group Hospitalization, Inc. v. Levin*, 305 A.2d 248 (D.C. 1973).

Even in maritime cases where only treatment intended to effect maximum cure is permitted, numerous courts have allowed palliative treatment that permits increased function. *Hedges v. Foss Mar. Co.*, 3:10-CV-05046 RBL, 2015 WL 3451347, at 5 (W.D. Wash. 2015); *Lee v. Metson Marine Servs.*, 2012 U.S. Dist. LEXIS 155957, *3, 2012 WL 5381803 (D.Haw.2012) (denying shipowner's motion to terminate benefits where SCS implant was recommended) (quoting *Messier v. Bouchard Transp.*, 756 F.Supp.2d 475, 481 (S.D.N.Y.2010) ("The obligation to 'cure' a seaman includes the obligation to provide him with medications and medical devices that will improve his ability to function, even if they do not improve his actual condition")); *Kuithe v. Gulf Caribe Maritime, Inc.*, 2010 U.S. Dist. LEXIS 89661, *4, 2010 WL 3419998 (S.D.Ala. 2010) ("treatment that improves condition by allowing remunerative activity previously precluded by pain does constitute cure"); *Mabrey v. Wizard Fisheries, Inc.*, 2008 U.S. Dist. LEXIS 9985, 13–14, 2008 WL 110500 (W.D.Wa. 2008) (concluding that the need for pain medication was "more than palliative" because it would help improve the seaman's condition).

In sum, the term necessary as stated in WAC 284-30-395 is not consistent with an additional requirement that treatment must also be

“essential in achieving maximum medical improvement.” Further, the term necessary is also not consistent with the term maximum medical improvement. This is necessarily so because maximum medical improvement denotes curative treatment, as opposed to treatment that may prevent a condition from worsening. The PIP regulation at issue here is more broadly written, and must be broadly construed. The term “necessary” is not consistent with State Farm’s MMI standard.

V. CONCLUSION

Pursuant to WAC 284-30-395, a PIP insurer may only limit hospital and medical benefits if the treatment provided was not reasonable, necessary, related to the accident, or incurred within three years. State Farm’s policy adds an additional limitation: that treatment must be essential in achieving maximum medical improvement. Because an insurer may not add additional restrictions other than those listed in WAC 284-30-395, State Farm’s use of the MMI standard to deny, limit, or terminate PIP benefits is unlawful. This Court should answer the first question in the affirmative.

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Further, State Farm's restrictive standard is not consistent with either reasonable or necessary as those terms are intended to mean under WAC 284-30-395. The MMI standard is more restrictive on its face. Therefore, this Court should answer the second question in the negative and hold that the MMI standard is not "consistent" with the terms reasonable and necessary.

DATED this 18th day of September, 2017.

VAN SICLEN, STOCKS & FIRKINS

/s/ Tyler K. Firkins

Tyler K. Firkins, WSBA #20964
David Nauheim, WSBA #41880
Attorneys for Plaintiff Brett Durant and all
other similarly situated people.
721 45th Street N.E.
Auburn, WA 98002
Tfirkins@vansiclen.com
(253)859-8899

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