

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 REPLY BRIEF

Tyler K. Firkins
David Nauheim
721 45th St NE
Auburn, WA 98002
253-859-8899
tfirkins@vansiclen.com

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I. INTRODUCTION

State Farm's arguments are centered around a number of false premises. First, throughout its Brief, State Farm argues that "essential in achieving maximum medical improvement is part of the definition of "necessary" in the insuring agreement. In fact, the insuring agreement does not contain a definition of "necessary." The MMI provision in question is part of the definition of "***Reasonable medical expenses.***" (Dkt. 39-1, p24; Ex. 3 (emphasis in original).) It is therefore untrue, as repeatedly argued, that "State Farm's Personal Injury Protection 'PIP' coverage in Washington defines 'necessary' medical expenses to include 'treatment essential to achieving maximum medical improvement.'" (Opp'n Br. 1.)

But even if the MMI standard was a definition of necessary, that misses the point: the certified question is whether the MMI standard violates WAC 284-30-395. It is no defense to say, as State Farm seems to argue, that the unlawful provision is found in its contract.

Second, throughout its Brief, State Farm argues that the Office of the Insurance Commissioner (OIC) has approved Policy Form 9847A. While this statement is true, it is a meaningless fact and implies a false premise. Countless insuring agreements have been approved by the OIC that include unlawful provisions. To address this reality, the Washington legislature enacted RCW 48.18.510, which provides that if a portion of an

insuring agreement is determined to be unlawful, then the offending provision will simply be construed in a manner consistent with the insurance code. This statute has been repeatedly employed over the years when courts have found insuring agreements out of compliance with the insurance code, as in this case. Therefore, the simple fact of approving an insurance policy form in no way establishes the lawfulness of the provisions, otherwise RCW 48.18.510 would be unnecessary.

Third, much of State Farm's Brief argues that the OIC agrees with State Farm because (1) the OIC approved its form, and (2) a draft legal memorandum by an OIC staff attorney approved the MMI standard even though the OIC memorandum was never adopted or released. These arguments are significantly flawed for a variety of reasons, but most importantly because it ignores the fact that this Court is the final arbiter, not only of the legality of any insuring agreement, but also whether an insurer's conduct violates insurance regulations.

Finally, State Farm utterly fails to answer the foundational premise of Plaintiff's argument: that WAC 284-30-395 unambiguously prohibits any other standards for denying PIP claims other than those set out in the regulation. Since the MMI standard is inconsistent the exclusive bases permitted in the regulation, the Court should answer the Certified Question (1) YES, and Certified Question (2) NO.

II. ARGUMENT

State Farm begins its argument by claiming that the term necessary is defined in its insuring agreement when it clearly is not. State Farm then extensively argues, in effect, that since the OIC approved its form, it must be legal. These arguments fail for a variety of reasons that will be explained in the analysis that follows.

A. State Farm's Insuring Agreement does not define the term necessary.

Contrary to its contention, State Farm's insuring agreement never defines the term necessary or even "necessary medical expenses." State Farm's policy *does* define the term "reasonable medical expenses." And while it is true that the word necessary appears within the definition of reasonable medical expenses, the MMI provision is not a definition of the term "necessary."

The portion of the contract that State Farm relies on is found in the agreement entitled "additional definitions." When defining a term, the agreement states the term and then it is immediately followed by the word "means," and then the definition. For example, the agreement states:

Insured means:

1. You;
2. Resident relatives; and
3. Any other person:
 - a. While occupying with your permission; or

- b. Struck as a pedestrian by your car or a newly acquired car.

(Dkt. 39-1, Ex. 3 at 7 (emphasis in original).)

Of note, each time a term is defined in the policy it is bolded. The term “necessary” is not in bold; nor does the word “means” follow the word necessary. It is therefore plain that the policy does not define the term necessary. Rather, the MMI provision is just one of four requirements that a medical expense must meet in order to be consider a “reasonable medical expense.” The provision is attached as Appendix A. Read in its entirety, the definition of “reasonable medical expenses,” contains four elements; for a medical expense to meet the definition, it must be:

- (1) the lowest of (a), (b), (c) or (d);
- (2) incurred for necessary medical, surgical, X-ray, [etc.] services;
- (3) rendered or prescribed by a licensed medical provider within their scope of practice;
- “and”
- (4) are essential in achieving maximum medical improvement for the bodily injury sustained in the accident.

Appendix A.

Significantly, the word “and” before the MMI provision makes the MMI provision conjunctive, i.e., a separate and additional requirement. The MMI standard is a separate and distinct requirement, *not* a definition of necessary. This is consistent with what State Farm tells its insured in its coverage letter:

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.*

(Dkt. 30 at 24 (emphasis added.)) The idea that the MMI provision is a definition of necessary is a recent invention by State Farm made to defend this litigation.

Ignoring the plain language of the policy, State Farm argues, “Here, the clear and unambiguous provision of State Farm’s policy show that MMI is a component of the definition of “necessary” and not a separate and standalone requirement as Plaintiff claims.” (Opp’n Br. 20.) Remarkably, State Farm goes a step further and underlines the term “necessary” and the clause “and are essential to achieving maximum medical improvement that are contained in different paragraphs to try to create the appearance of a definition. This creative effort fails because clauses or words do not follow the other conventions used in the policy to define terms, such as bolding the term being defined, and using the word “means.” Nowhere in the policy does it say:

Necessary means medical services that are necessary and essential in achieving maximum medical improvement.

Nor would it make sense of an insuring agreement to define a term by restating the term. To be consistent with State Farm’s argument the policy

would actually have to read:

Necessary means:

1. Only those medical services that are essential to achieving maximum medical improvement.

Instead, the policy is silent as to the definition of the term necessary. This is important because it means that State Farm's interpretation of its policy is not consistent with either the plain language of its own policy or, and more importantly, the plain language of WAC 284-30-395.

Even if the policy did include such a definition it would still violate WAC 284-30-395 because it defines the term necessary in a manner that does not comport with the term necessary. This is so because the concept of maximum medical improvement is in no way implied by the term "necessary." Thus, the MMI standard is in violation of the plain language of the regulation.

B. The MMI standard is inconsistent with the lawful standard in WAC 284-30-395

WAC 284-30-395(1) is unambiguous. It 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).

State Farm argues that WAC 284-30-395(1) is only a notice regulation. It is true that part of WAC 284-30-395 could be considered a notice regulation in part, i.e., it tells insurers what notice they must give to their insured.¹ However the sentence, “These are the only grounds for denial for denial, limitation, or termination of medical and hospital services . . . ,” is not part of the notice requirement. It is an unambiguous statement of law. It makes clear that if an insurer uses any other standard to adjust PIP claims, it violates WAC 284-30-395.

State Farm ignores this sentence in its brief. Yet it still argues that its MMI provision does not violate WAC 284-30-395 because its insuring agreement defines the MMI standard to be equivalent to the term necessary. This argument fails, however, because even if *arguendo* the MMI provision the policy’s definition of necessary, it would still be impermissible because it is more restrictive and narrows the treatment that would be allowed under the lawful standard. State Farm cannot evade WAC 284-30-395 by using a definition of necessary that expands the bases for denial beyond those allowed in the regulation.

1. The term essential is more restrictive than necessary.

State Farm argues that essential means the same thing as necessary

¹ The coverage letter is sent by State Farm at the initiation of every PIP claim in compliance with WAC 284-30-395.

according to the internet dictionaries. However, the courts that have considered the term necessary have found that the word necessary has a wide range of meanings. The court in *Miskofsky v. Ohio Cas. Ins. Co.* reasoned, the term necessary includes “absolute physical necessity,” but also “that which is useful convenient, appropriate, suitable, proper or conducive to the end sought.” 203 N.J. Super. 400, 413, 497 A.2d 223 (Law Div. 1984) (quoting *Kay County Excise Board v. Atchison, T. & S.F.R. Co.*, 185 Okl. 327, 91 P.2d 1087 (Sup. Ct. 1939)).² The court in *U.S. v. Horn* 955 F.Supp 1141, 1147 (D. Ct. Minn. 1997) reached a similar conclusion. see also *State ex rel. Banking Commission v. Avery County Bank*, 14 NCApp. 283, 188 SE2d 9 cert. denied, 281 NC 514, 189 SE2d 35 (1972).

In contrast, essential, is more restrictive than necessary, meaning something that is “*absolutely* necessary.” For this reason alone, State Farm’s “essential in achieving MMI” standard is more restrictive than the lawful standard of WAC 284-30-395, making the provision unlawful.

However, the MMI provision is unlawful for a second reason: maximum medical improvement is not consistent with the concept of necessary medical treatment.

² State Farm argues that New Jersey has subsequently re-written its PIP statute because of “overutilization” in New Jersey. That may be, but it is irrelevant. Washington has *not* re-written its PIP statute and still uses the reasonable and necessary standard that is equivalent of what the *Miskofsky* court analyzed.

2. Maximum Medical Improvement is not consistent with necessary.

Every court that has ever considered the question has held that MMI is not consistent with reasonable and necessary. *See, e.g., Perun v. Utica Mut. Ins. Co.*, 280 N.J. Super. 280, 655 A.2d 99 (N.J. Law Div. 1994) (“[a]fter treatment to effectuate a cure or rehabilitation has ended and a patient’s condition has plateaued, medical expenses for palliative treatment may continue, but only to the extent that such expenses are deemed reasonable and necessary.”); *Victum v. Martin*, 367 Mass. 404, 326 N.E.2d 12 (Sup.Jud.Ct. 1975) (necessary requires a showing that the treatment was rendered by a competent medical doctor and were a “bonafide effort to alleviate and ameliorate the injury.”); *Group Hospitalization, Inc. v. Levin*, 305 A.2d 248 (D.C. 1973) (necessary does not require that treatment be “indispensable” or “essential”); *Di Giorgio Fruit Corp. v. Pittman*, 49 So.2d 600 (Fla. 1950) (holding that treatment for periodic flare-ups of an injury, was reasonable).³

In other words, the term “maximum medical improvement” is a phrase that limits what treatment may be needed. It answers the question,

³ The Plaintiff has not found a single case that is contrary to this principle. Notably, State Farm does not cite any cases to the contrary.³ *Matter of Gaul*, 268 A.D.2d 816, 818 (2000), cited by State Farm, does not address this question whatsoever. This issue in that case was only whether the arbitrator committed misconduct. The MMI issue was neither raised by the parties nor considered by the court.

“Necessary to accomplish what?” Every court that has examined this issue has concluded that the term necessary does not mean only treatments that are meant to accomplish maximum medical improvements. Instead, courts have universally concluded necessary treatment includes treatment that restores function or reduces ongoing pain.

Additionally, State Farm’s MMI standard is more restrictive for another reason: because of the phrase, “in achieving.” Some treatments are not intended to effectuate a cure of the condition. Some treatments are solely meant to achieve reductions in pain; pain that did not exist before the injury. Such treatments would not be covered by State Farm’s restrictive definition. Further, once maximum medical improvement is achieved, some patients may require treatment to maintain that status. ((Dkt. 32, Ex. Q ¶ 3.) While such treatment is necessary, it is not necessary in *achieving* MMI. It is only necessary in *maintaining* MMI. Maintaining MMI is just as reasonable and necessary, as is achieving MMI. Therefore, State Farm’s definition is more restrictive and therefore unlawful.

Mr. Durant’s case is instructive on this point. Mr. Durant’s chiropractor, at the request of State Farm, gave an MMI date for Mr. Durant. However, the doctor also said that although Mr. Durant was at MMI, he was not cured. Mr. Durant still had reoccurring dysfunction in his spine and would need conservative treatment from time to time for exacerbations.

(Dkt. 32, Ex. Q at 6, 7.) In other words, he would need care that was not geared to achieving MMI, but to maintaining MMI.

State Farm argues that it paid for Mr. Durant's shoulder injection after the MMI date as proof that it will pay for treatment after MMI. However, this is inaccurate. State Farm determined that Mr. Durant was at MMI for chiropractic and chiropractic-referred treatment. It never determined that he was at MMI for his shoulder. Thus, paying for his shoulder treatment is not evidence that State Farm will pay for treatment after an MMI date. State Farm never paid for chiropractic or chiropractic-referred treatment after the MMI date.

State Farm argues that the MMI standard "in practice" would not be used to deny palliative care, or care that was necessary to sustain life, not necessary to achieving maximum medical improvement. However, this is rebutted by State Farm's conduct in Mr. Durant's case. This is also rebutted by what occurred in many of the claims files that were produced in discovery. (*See* Dkt. 29 ¶¶2-5.)

State Farm next argues that because the OIC approved its form, it must be legal and in compliance with the insurance code.

C. The OIC has not opined on the whether the MMI standard violates WAC 284-30-395.

State Farm argues that this Court should give deference to the OIC's

interpretation of WAC 284-30-395, citing *Brady v. Autozone Stores, Inc.*, 188 Wn.2d 576, 397 P.3d 120 (2017). This argument is misleading at best—the OIC has *never* opined on the issue before this Court: whether State Farm’s MMI standard violates WAC 284-30-395(1).

State Farm asserts that the OIC has “repeatedly approved” its policy form, and that the Court should defer to the OIC’s expertise on this issue. (Opp. Br. 19, 49.) First, there is no judicial deference to an agency’s approval of a policy form. On the contrary, instead of deference to OIC’s approval of a form, the legislature has provided that an unlawful provision in an insurance policy should be read as if the offending provision had been *stricken* and only the lawful provisions remained:

Any insurance policy, rider, or endorsement hereafter issued and otherwise valid, which contains any condition or provision not in compliance with the requirements of this code, shall not be rendered invalid thereby, but shall be construed and applied in accordance with such conditions and provisions as would have applied had such policy, rider, or endorsement been in full compliance with this code.

RCW 48.18.510 (“Validity of nonconforming forms”); *see also* RCW 48.18.110 (the OIC shall withdraw approval of forms that violate statute or regulation). Clearly, the legislature recognized that from time to time, the OIC would err in approving a policy form.

Further, OIC’s approval State Farm’s Form 9847A was in 1994, *prior* to the promulgation of WAC 284-30-395(1) and thus has no bearing

on whether the MMI provision violates the insurance code that was not promulgated until 1997.

State Farm argues that, while WAC 284-30-395 did not exist in 1994, RCW 48.22.005(7) did, and therefore the OIC's approval in 1994 somehow contemplated WAC 284-30-395. However, RCW 48.22.005(7) does not define reasonable or necessary, it defines "medical and hospital benefits." Nor does it limit the bases for denial as does the later regulation. The statute does not "echo" WAC 284-30-395 in any substantive way. Thus, State Farm's contention that the 1994 approval somehow relates to WAC 284-30-395 is not credible.

And while it is true that the OIC approved Form 9847A again in 2006, a letter from the OIC to State Farm about the renewal, demonstrates that during that process the OIC did *not* consider the issue of whether the MMI provision violates WAC 284-30-395. (Opp. Br. Ex. 4 (listing the issues that *were* considered).) In short, the OIC has never affirmatively considered whether the MMI provision violates WAC 284-30-395 and opined on that issue.

The OIC's failure to raise concern about the MMI provision in Form 9847A is not proof that the OIC approved of the provision. There countless reasons why the OIC might have failed to raise the issue: the most obvious reason being—it was overlooked. The American Family form that was

approved, despite the fact that it violated WAC 284-30-395, is a perfect example that policy forms can be erroneously approved. (Dkt. 32-2 at 2-3.) But the bottom line is that in 2006, the OIC did not affirmatively consider whether the MMI provision violated WAC 284-30-395 or opine on the matter.

Brady v. Autozone Stores, Inc., No. 93564-5 (Wash. June 29, 2017), is instructive. The plaintiffs' in *Brady* alleged that Autozone had violated Washington labor regulations by withholding wages during meal breaks. Like here, the district court certified two questions to this Court. Like here, the dispute centered on whether Autozone had violated an administrative regulation. However, unlike here, the state agency had actually interpreted the regulation. In *Brady*, this Court gave a "high level of deference" to the agency's own interpretation of its regulation."

Here, the OIC has not issued any guidance on the MMI issue. If it had, that guidance would be entitled to a high level of deference, but the Court would still not be bound by the agency's interpretation. *Overton v. Washington State Econ. Assistance Auth.*, 96 Wash.2d 552, 555, 637 P.2d 652 (1981) However here, the OIC has not issued any guidance on the issue.

State Farm argues that the OIC's legal department "issued a memorandum concluding that State Farm's MMI language did *not* violate WAC 284-30-395. (Opp. Br. 17.) This is a misrepresentation; the OIC legal

department has never “issued a memorandum” on this issue.

Per the request of Deputy Commissioner Mollie Nollete, OIC Legal Department attorney Marcia Stickler submitted a *draft* advisory opinion to her on whether the MMI provision violated WAC 284-30-395(1). (Dkt 74, Ex A.) Deputy Commission Nollete rejected the opinion:

Is this the final version? This is a change from the historical agency position. We ask for reconsideration. From [Deputy Commissioner Alan Hudina] with my agreement:

WAC 284-30-395(1) is very clear when it states, “These are the only (emphasis added) grounds (R&F editorial comment: not reasonable, not necessary, not related to the accident, or not within three years of the automobile accident) for denial, limitation, or termination of medical and hospital services permitted pursuant to RCW 48.22.005(7)...”

The company expanded the grounds for denial by including the phrase, “are essential in achieving maximum medical improvement.” The Legal opinion informs us this definition from Labor and Industries means, “when no fundamental or marked change in an accepted condition can be expected with or without treatment” and is equivalent to “fixed and stable.” I think this expansion goes beyond the “only grounds” in the regulation. I don’t see it as being unreasonable or unnecessary to provide treatment that may fall short of providing “fundamental or marked change.” Indeed, the regulation provides for reasonable treatment and while that treatment may fall short of providing “fundamental or marked change,” it nonetheless may be providing relief and it would certainly be considered “reasonable” to provide such relief. The regulation does not provide for cessation when the treatment is not curative or rehabilitative as in the memo from Legal. If the treatment is “palliative only” (Webster’s - to make less intense or severe), the treatment is beneficial to the consumer and would certainly be considered reasonable under the regulation.

(Dkt 74, Ex B.) Mollie Nollete is the Deputy Insurance Commissioner for the Rates and Forms Department, the division of the OIC that is responsible for approval of policy forms like Form 9847A. (*Id.*) Not only did the OIC never adopt the internal draft memorandum, but there was considerable internal skepticism about the draft opinion.

What is more, the draft advisory opinion was never “issued,” as State Farm claims, it was only circulated internally. Issued means, “the act of publishing or officially giving out or making available.” <https://www.merriam-webster.com/dictionary/issue>. The draft memorandum State Farm cites was never made public and was never adopted as a regulatory interpretation by the OIC. The only reason the parties discovered it was through a Public Records Request by the Plaintiff. It is misleading for State Farm to claim that the OIC Legal Department “issued” a memorandum approving of the MMI language.

Thus, the only advisory opinion by the OIC is that found in the published letter disapproving American Family Insurance’s similar language in 2010.

What is more, examining the argument in the OIC legal department draft memorandum reveals its flaws.

D. The use of MMI in Workers Compensation and Maritime claims is irrelevant to the Certified Question.

Both State Farm and the draft memorandum argue that the MMI standard has been adopted in the context of Washington's Worker's Compensation system and therefore is equivalent to the definition of necessary in the insurance code. (Opp'n Br. 33.) This argument fails for several reasons.

First, unlike either RCW 48.22.005 or WAC 284-30-395, WAC 296-20-01002, governing the worker's compensation system, very specifically defines what treatment is proper and necessary.⁴ The regulation goes on to state that the Department of Labor & Industries will not pay for treatment incurred after the injured worker reaches MMI. *Id.*

Had the OIC intended to restrict "necessary" treatment using the MMI standard, it clearly had the language to do so, and could have

⁴ WAC 296-20-01002 states in relevant part:

- (a) Reflective of accepted standards of good practice, within the scope of practice of the provider's license or certification;
- (b) Curative or rehabilitative. Care must be of a type to cure the effects of a work-related injury or illness, or it must be rehabilitative. Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of an accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Curative and rehabilitative care produce long-term changes;
- (c) Not delivered primarily for the convenience of the claimant, the claimant's attending doctor, or any other provider; and
- (d) Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition.

incorporated the language from WAC 296-20-01002 into WAC 284-30-395. It also could have used the term “necessary and proper” rather than reasonable and necessary. *Louthan v. King Cy.*, 94 Wn.2d 422, 429, 617 P.2d 977 (1980) (“legislative bodies . . . are presumed to have full knowledge of existing statutes affecting the matter upon which they are legislating).

There is significance to the fact that the OIC chose not to use the MMI language from the Worker’s Compensation legislative scheme. That it did not use this language is reflective of a deliberate choice not to employ the worker’s compensation standard in the context of PIP coverages.

The purposes of worker’s compensation represent a compromise between employers and employees, who, in exchange for speedy and certain relief, expect that their recovery will be less than what they otherwise could have recovered under the common law. *Flanigan v. Dep’t of Labor & Indus.*, 123 Wn.2d 418, 422-23, 869 P.2d 14 (1994).

Notably, a finding of MMI in the realm of worker’s compensation does not foreclose the injured employee from receiving benefits. Once an employee has reached MMI, he or she is then eligible for a permanent partial disability (PPD) award, depending on the nature of the injury.⁵ WAC

⁵ *Tomlinson v. Puget Sound Freight Lines, Inc.*, 166 Wn.2d 105, 115, 206 P.3d 657 (2009), cited by State Farm, discusses the PPD award. The Court did not make a wholesale

296-26-19000. Additionally, worker's compensation claims may be reopened if the employee suffers an aggravation of the injury. *Loushin v. ITT Rayonier*, 84 Wn. App. 113, 117, 924 P.2d 953 (1996). Importantly, neither of these things are possible under State Farm's "essential in achieving maximum medical improvement" standard: once an insured reaches MMI, there is no provision for any ongoing pain or disability, and State Farm will not re-open the claim because MMI has been "achieved."

In contrast to the workers compensation scheme, the purpose of the PIP mandate is "to remedy the long recognized and serious problem of the tort system's inability to rapidly, *adequately, and fairly* compensate victims of automobile accidents." *Wood v. Mut. of Enumclaw Ins. Co.*, 97 Wn. App. 721, 726, 986 P.2d 833 (1999) (emphasis added). PIP policies take no account of the insured's level of disability, provide no long-term benefits, and generally cannot be reopened for exacerbations. As a result, application of the MMI standard to PIP would result in less protection and a greater denial of benefits than the worker's compensation system. This is borne out in State Farm's policy, which states that it will only provide benefits that are necessary and "*essential to achieving* maximum medical improvement."

endorsement of the MMI standard; it merely discussed its relation to PPD. Furthermore, the MMI standard was used to *approve* benefits in that case, not to deny them.

(emphasis added).⁶ This runs contrary to the purpose of PIP in providing *adequate and fair* compensation to injured crash victims, and is more restrictive even than the Washington workers compensation system.

E. State Farm’s reliance on cases involving the interpretation of insuring agreements is misplaced.

State Farm next deliberately misconstrues the Plaintiff’s argument claiming that he is attempting to use extrinsic evidence to reform the insurance contract or to interpret the contract. (Opp’n Br. 22.) The Plaintiff is not asking the Court to rely on extrinsic evidence to reform the contract. Instead, the Plaintiff is asking the Court to hold that the MMI standard violates an insurance regulation. The Certified Questions before this Court are not issues of contract interpretation. The Court is called upon to construe an insurance regulation; the “context rule” is inapplicable. State Farm’s argument is simply inapposite.⁷

The coverage letter that is called extrinsic evidence by State Farm, is its effort to comply with WAC 284-30-395(1) which requires insurers to send out an explanation of PIP coverages before any denial takes place. This letter, which is sent systematically to State Farm insureds, demonstrates that

⁶ It should also be noted that under the LNI standard the Department pays until MMI is reached. But State Farm may deny claims before MMI is reached if the treatment is not “essential in achieving maximum medical improvement.”

⁷ It is ironic that State Farm urges the Court not to consider its coverage letter to its insureds because it is “extrinsic evidence,” but puts forward the OIC’s letters surrounding the 1994 and 2006 approval of Form 9847A as admissible evidence.

even State Farm does not believe that its policy defines necessary in the same way that the insurance code does. Instead, State Farm adds an additional requirement. Not only must the treatment be reasonable and necessary, and within three years,⁸ but also “essential to achieving maximum medical improvement.” The letter states:

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 . . .

(Dkt 32.) Far from defining the term necessary, State Farm accurately states to its insureds that it is adding an additional requirement as a potential basis for denial in contravention of WAC 284-30-395.

State Farm claims the Plaintiff is asserting that the coverage letter language contradicts the policy language. This is not so. The Plaintiff contends that the language in the coverage letter accurately interprets the unlawful policy language, and must therefore be disregarded in accordance with RCW 48.18.510. The clear terms of the regulation express the only basis for denial of claims.

State Farm next makes a laborious argument that the Plaintiff’s reading of WAC 284-30-395 renders an entire subsection of the regulation

⁸ The requirements of WAC 284-30-395.

meaningless. (Opp'n Br. 25.) State Farm seems to argue that subsection 1 applies only before "payment decisions" are made, while subsection 2 governs entirely and exclusively to issues pertaining to payment decisions. It further argues that if the only bases for denial are whether the bills are reasonable and necessary, then subsection 2 becomes meaningless.

State Farm reaches this conclusion by pointing out that an insurer must do more than simply state that a bill is denied or limited simply because it is not reasonable or not necessary as an example. (Opp'n Br. 25 (*citing* WAC 284-30-395(2))). While it is true that an insurer must provide an explanation as to the true basis for denial as provided in the IME, subsection 2 does not render subsection 1 superfluous.

State Farm is conflating *definition* with *explanation*. The regulation requires State Farm to explain *why* it decided that treatment is not reasonable, necessary or related, i.e., it cannot simply say, we determined that treatment is not necessary. It must explain why this determination was made.

Harmonized, it means that the only basis for denial is that a claim is not reasonable, not necessary or not related or not incurred within three years. And when explaining the basis for making a denial in accordance with subsection 1, the insurer must provide some plain language explanation. As an example, an insurer would say that a bill was not

reasonable because the bill costs more than similar providers charge in the community. Or an insurer would say that the IME physician concluded that the injury was not related to the car crash, but was instead a preexisting condition that was symptomatic prior to the car crash.

Nothing in subsection 2 of the regulation renders the words used in subsection 1 to be inapplicable to subsection 2. Instead, subsection 1 expressly explains that the only basis for denial is whether the treatment is not necessary, not reasonable, and not related. The regulation unequivocally states “These are the only grounds for denial, limitation, or termination of medical and hospital services permitted”

The Defendant next erroneously argues that the Plaintiff cites no law to support his theory.

F. The Plaintiff cites a law that mandates that unlawful terms be excluded from the policy

The Defendant argues that the Plaintiff cites no law to override the express terms of the policy. (Opp’n Br. 26.) This assertion by State Farm is patently false. The Plaintiff has repeatedly cited RCW 48.18.510. Nor has the Plaintiff argued that public policy should be a basis for ignoring unlawful provisions in an insuring agreement.⁹

⁹ State Farm extensively cites cases discussing invalidating policy provisions that violate public policy. The cases are irrelevant because the plaintiff has never made the argument.

Only in a footnote does State Farm acknowledge the Plaintiff's primary argument. (Opp'n Br. 27 n.11.) In that footnote State Farm argues that "this Court" rarely overrides express policy terms pursuant to RCW 48.18.510. This argument is beside the point, and ignores all the other courts that have used the statute to "override" policy language.

To begin, the frequency with which this Court applies a statute is entirely irrelevant to the question of whether this Court should apply a statute when asked to do so. Thus, State Farm cited no instances in which this Court refused to apply RCW 48.18.510 when asked to do so. Nor does State Farm make any coherent argument why the statute should not be applied in this case.

Further, State Farm's limitation relating to the last time "this Court" applied the statute ignores the plethora of other courts that have recently applied the statute. *See e.g., Murray v. Anderson Bjornstad Kane Jacobs, Inc.*, No. C10-484 RSL, 2011 WL 617384, at *4 (W.D. Wash. 2011); *Seattle-First Nat. Bank v. Washington Ins. Guar. Ass'n*, 94 Wash. App. 744, 753, 972 P.2d 1282, 1288 (1999); *Treves v. Union Sec. Ins. Co., LLC*, No. C12-1337RAJ, 2014 WL 325149, at *3 (W.D. Wash. 2014) (Honorable Richard Jones, who certified these questions, applied the statute).

This Court should therefore ignore arguments not made by the Plaintiff, and instead examine the arguments actually asserted and the relevant authority regarding those arguments.

G. The Plaintiff's proposed definition of necessary is appropriate.

State Farm makes various arguments against the Plaintiff's proposed definition of "necessary." State Farm does not actually propose definition, except to contend that dictionary definitions are consistent with its own policy language, which is false.

Demonstrating the fallacy of its own arguments, State Farm argues that the Plaintiff's definition is inappropriate because it "adds words to subsection 1(b)." (Opp'n Br. 37.) And yet, State Farm has added an entire phrase to the regulation, while claiming that its addition is entirely appropriate. State Farm added the phrase "and essential to achieving maximum medical improvement" to the term necessary. State Farm is correct that its addition of words to subsection 1(b) is unlawful.

DATED this 16th day of October, 2017.

/s/ Tyler K. Firkins

Tyler K. Firkins, WSBA #20964
David Nauheim, WSBA #41880
Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I certify that I served a copy of the forgoing documents on the following individuals specified below on October 16, 2017. Service was made by the means specified below.

Gregory Worden Laura Hawes Young Lewis Brisbois Bisgaard & Smith 2101 Fourth Ave., Ste. 700 Seattle, WA 98121	[X] Via ECF
Frank Falzetta Jennifer Hoffman David Dworsky Sheppard Mullin Richter & Hampton 333 S. Hope St., 43 rd Floor Los Angeles, CA 90071 ffalzetta@sheppardmullin.com jhoffman@sheppardmullin.com ddworsky@sheppardmullin.com	[X] Via ECF

s/Diana M. Butler

Diana M. Butler, Paralegal

APPENDIX A

Reasonable Medical Expenses mean expenses:

1. that are the lowest one of the following charges:
 - a. The usual and customary fees charged by a majority of healthcare providers who provide similar medical services in the geographical area in which the charges were incurred;
 - b. The fee specified in any fee schedule:
 - (1) applicable to medical payments coverage, no-fault coverage, or personal injury protection coverage included in motor vehicle liability policies issued in the state where *medical services* are provided; and
 - (2) as prescribed or authorized by the law of the state where *medical services* are provided;
 - c. The fees agreed to by both the *insured's* healthcare provider and *us*; or
 - d. The fees agreed upon between the *insured's* healthcare provider and a third party when *we* have a contract with such third party.
2. incurred for necessary:
 - a. medical, surgical, X-ray, dental, ambulance, hospital, and professional nursing services, and
 - b. pharmaceuticals, eyeglasses, hearing aids, and prosthetic devicesthat 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.

Subject to 1. and 2. above, semi-private room charges are the most *we* will pay unless intensive care is medically required.

VAN SICLEN STOCKS & FIRKINS

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