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SUPREME COURT
STATE OF WASHINGTON
8/6/2018 3:48 PM
BY SUSAN L. CARLSON
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No. 954496

SUPREME COURT
OF THE STATE OF WASHINGTON

No. 74600-6-I

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

JOHN STRAUSS and MICHELLE STRAUSS,
Husband and wife, and their marital community,

Appellants,

v.

PREMERA BLUE CROSS,

Respondent.

PREMERA BLUE CROSS'S SUPPLEMENTAL BRIEF

KILPATRICK TOWNSEND
& STOCKTON LLP
GWENDOLYN C. PAYTON
(Washington State Bar No. 26752)
GPayton@kilpatricktownsend.com
JOHN R. NEELEMAN
(Washington State Bar No. 19752)
JNeeleman@kilpatricktownsend.com
Suite 3700, 1420 Fifth Avenue
Seattle, WA 98101
Telephone: 206 467 9600
Facsimile: 206 623 6793

*Attorneys for Respondent
Premera Blue Cross*

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I. INTRODUCTION

In October 2008, petitioner John Strauss was diagnosed with “intermediate if not high-risk” prostate cancer. CP 69. Although his doctors strongly urged him to begin treatment immediately, Strauss waited nearly 16 months to start treatment. CP 115, 127-31. And based on the opinions of his “golf buddies” and his own internet research, Strauss decided to undergo proton beam therapy (“PBT”)—a form of radiation treatment. PBT treatment could be covered under Strauss’s contract with Premera—his medical insurance plan—only if it was “not more costly than an alternative service” and “at least likely to produce equivalent therapeutic or diagnostic results.” CP 274, CP 289.

Strauss rejected the opinions of his radiation oncologist and the three sets of independent medical professionals who reviewed his insurance claim that, while significantly more costly, PBT was no better than other treatments including intensity modulated radiation therapy (“IMRT”). IMRT uses x-rays (rather than protons) to shrink the tumor and kill the cancer cells. After Premera denied coverage of the PBT treatment, Strauss’s claim was reviewed by two external review organizations, whose radiation oncologists concluded that PBT was not medically necessary. Strauss then appealed again, to an independent review organization randomly selected by the Washington State Insurance Commissioner pursuant to Washington law. And *that* radiation oncologist also found that PBT treatment was not medically necessary. Not only did Strauss ignore his doctor and every oncologist who reviewed his claim, his

decision to undergo PBT also ignored the uniform clinic guidelines published by medical organizations and the U.S. Department of Health and Human Services.

The issue before this Court is only whether Strauss met his burden to prove that PBT has fewer side effects than alternate treatments that Premera would have covered. This is a contract dispute. The parties' contract is Strauss's health care insurance plan (the Plan). The Plan provides that it covers only "medically necessary" treatments. The provision of the Plan that matters here is the third-prong of the Plan's definition of "medically necessary"— whether PBT was "not more costly than an alternative service" and "at least as likely to produce equivalent therapeutic or diagnostic results." CP 274, CP 289.

Strauss now asks this Court to overrule the considered and unanimous medical judgments of his doctor, the experienced oncologists who reviewed his insurance claim, and the expert clinical guidelines for addressing prostate cancer that PBT was not "at least as likely to produce equivalent therapeutic or diagnostic results." PBT is significantly more expensive than IMRT, and for purposes of summary judgment the parties agree that they are equally effective as a cancer treatment. Strauss can prevail, therefore, only if he can create a genuine dispute of material fact as to whether PBT leads to fewer side effects than does IMRT.

As both courts below held, there is no such dispute. Against the weight of the judgment of the national medical community, at summary judgment Strauss tendered only the opinion of his PBT provider and an

expert. And their testimony was insufficient. The doctor, when asked whether there was a difference in side effects between PBT and IMRT, testified: “that’s a hard question to answer. There’s data to support, I think, both sides.” CP 683. Strauss’s expert was similarly equivocal, conceding that the difference in side effects between the treatments was only “theoretical.” CP 657. In the absence of any actual *evidence* that PBT resulted in fewer side effects than IMRT, Strauss failed to create a genuine factual dispute, warranting summary judgment for Premera.

II. STATEMENT OF THE CASE

A. Strauss’s medical insurance plan covered treatments “not more costly than an alternative service” and “at least as likely to produce equivalent therapeutic or diagnostic results.”

The contract at issue in this case—Premera’s Heritage Preferred Plus 20 Plan (the Plan)—covers radiation therapy services, CP 186, but only if the services provided are, in “our [Premera’s] judgment,” “medically necessary.” CP 177 (“it must be, in our judgment, medically necessary, and must be furnished in a medically necessary setting”). But Premera’s judgment in determining medical necessity is restricted. The Plan contains an extensive definition of “medically necessary,” and in making the determination, Premera follows a Corporate Medical Policy that is based on peer-reviewed medical literature, national guidelines, and local standards and that is published on the Internet. CP 212; CP 216-22.

The Plan defines “medically necessary” as those “covered services ... that a physician, exercising prudent clinical judgment, would provide to a patient” for the treatment of a disease, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service ... at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the view of physicians practicing in the relevant clinical areas and any other relevant factors.

CP 212.

Only part of this definition is relevant in this case. For purposes of this appeal, there is no dispute that PBT is a "generally accepted standard of medical practice." But there is a dispute about the definition's third-prong—i.e., whether PBT was "not more costly than an alternative service" and "at least as likely to produce equivalent therapeutic or diagnostic results." CP 274, CP 289.

Premera uses its Corporate Medical Policy #8.01.10 to evaluate medical necessity based on peer-reviewed medical literature, national guidelines, and local standards. CP 216-22. The Corporate Medical Policy states that PBT is not medically necessary "because the outcomes have not shown to be superior to other approaches including intensity modulated radiation therapy (IMRT), ... yet proton beam therapy is generally more costly than these alternatives." CP 217.

The Medical Policy was updated twice during the relevant period. A January 2010 update stated that “a systematic review of published peer-reviewed literature reported previously and updated here is devoid of any clinical data demonstrating benefit in terms of survival, tumor control, or toxicity in comparison with best conventional treatment for ... prostate cancer.” CP 224-30. An April 2010 update cited the lack of “randomized trials of charged particle radiation therapy for cancer.” CP 232-39.

B. Strauss ignored his doctor’s advice and chose PBT instead of IMRT.

Strauss was diagnosed with intermediate risk prostate cancer in October 2008. CP 69. Upon diagnosis, Strauss’s urologist, Dr. Lin, discussed treatment options with him, including “radiation and surgical management of the disease.” *Id.* Strauss told Dr. Lin that he was particularly interested in radiation due to the positive experience of some of his “golf buddies” and other friends, and that he had heard about PBT treatment at the Loma Linda University Medical Center in Southern California. *Id.*; CP 94 (Strauss Dep. at 28); CP 110 (Lin Dep. at 44). Dr. Lin, however, did not recommend PBT over any other radiation treatment option. CP 84, 110 (Lin Dep. at 44, 64); CP 94 (Strauss Dep. at 27).

Dr. Lin referred Strauss to Dr. Russell, a radiation oncologist, to review radiation treatment options. CP 72; CP 88 (Russell Dep. at 31); CP 94 (Strauss Dep. at 28). Even before he saw Dr. Russell, Strauss was “leaning pretty heavily toward” PBT based on the advice of his friends, his own internet research, and the fact that his winter home was only 45

minutes away from Loma Linda. CP 94 (Strauss Dep. at 28-29); CP 1020. Dr. Russell, Strauss’s own radiation oncologist, did not recommend PBT. CP 88 (Russell Dep. at 32-33). Dr. Russell told Strauss of the “lack of clear, long-term evidence showing improved side effect profile for patients who undergo proton therapy versus [IMRT] therapy.” CP 1020. Still, Strauss told Dr. Russell that he was “most interested in seeking proton therapy since [Loma Linda] is near his family.” *Id.*

Contrary to his doctor’s recommendation, Strauss delayed any treatment. Indeed, more than six months after Strauss’s diagnosis, Dr. Lin—having heard nothing from Strauss—called and again encouraged him “strongly” to undergo treatment. CP 96. But Strauss waited, and waited, ultimately beginning PBT treatment at Loma Linda in February 2010—more than 16 months after his cancer diagnosis. CP 115, 127-31.

C. Premera denied coverage, and three independent radiation oncologists determined that PBT was not medically necessary.

Relying on Premera’s Medical Policy, one of Premera’s assistant medical directors, Dr. Kaneshiro, denied the request for pre-authorization of PBT as not “medically necessary” because PBT has “not been shown to be superior to other approaches including intensity modulated radiation therapy (IMRT) . . . yet [PBT] is generally more costly than these alternatives.” *Id.*; CP 1366 (Kaneshiro Dep. at 35).

The appeals process for Strauss’s health plan was regulated by Washington law and provided two levels of internal appeals and then an external review by an Independent Review Organization (“IRO”). Strauss

filed a Level I Appeal on December 30, 2009. CP 247-52. Strauss included a half-page letter from Dr. Stewart, his *cardiologist*—not his urologist or his radiation oncologist—asking that Strauss be approved for PBT. CP 253. However, Dr. Stewart admitted that “[c]omparative studies are not yet available,” but he nonetheless opined that “there is strong preliminary evidence that the side effects associated with [PBT] are significantly lower.” *Id.* Dr. Stewart was hesitant to write the letter because he knew there was no evidence that PBT was superior to IMRT. CP 260 (Stewart Dep. at 111-13). Dr. Stewart admitted that he wrote the letter for Strauss based on the “hope” that PBT had fewer side effects. *Id.*

Premera referred the Appeal to Medical Review Institute of America (“MRIoA”), an external review organization, for a “Same Specialty Review” by an external radiation oncologist. CP 272-73. On January 8, 2010, MRIoA’s radiation oncologist upheld Premera’s initial coverage decision. In finding that PBT was not “medically necessary,” the reviewer first quoted the relevant Plan language: “The plan language defines medically necessary procedures as those which have scientific evidence to allow a conclusion regarding health outcomes *and which are the least costly of otherwise equivalent medical alternatives for treatment of a certain condition.*” CP 273 (emphasis added). The reviewer observed that “there is no evidence in the recent peer-reviewed literature of improved efficacy or reduced toxicity with the use of protons compared to photons.” CP 274. Thus, the reviewer concluded that PBT was not medically necessary because it was “significantly more expensive” than

IMRT: “As protons are significantly more expensive, the treatment is defined as not medically necessary in this particular case according to the plan language.” CP 274. Based on MRIOA’s independent review, Premera denied Strauss’s Level I Appeal on February 1, 2010. CP 277-78.

Strauss filed a Level II Appeal on March 2, 2010. CP 280-81. Premera’s three-person appeal panel denied the Level II Appeal. The Panel emphasized the “medically necessary” definition’s third-prong— i.e., whether PBT was “not more costly than an alternative service” and “at least likely to produce equivalent therapeutic or diagnostic results.” CP 289. The panel relied on a second MRIOA report, which reiterated: “Medical necessity is not met in that alternative treatments are available with similar efficacy and toxicity, but at a significant reduction in cost” and that “there is no evidence in the recent peer-reviewed medical literature of improved efficacy or reduced toxicity with the use of protons compared to photons.” CP 289. Therefore, “[a]s protons are significantly more expensive, the treatment is defined as not medically necessary in this particular case according to the plan language.” CP 289. The panel informed Strauss that if he thought Premera was wrong he could request review by an IRO “for a coverage decision that will be binding on us.” CP 290.

Strauss requested external review of the Level II Appeal decision by an IRO. CP 297. As required by Washington law, *see* W.A.C. 284-43A *et seq.*, Premera submitted the IRO request to the Office of the

Insurance Commissioner (“OIC”) to randomly select an IRO. OIC assigned Managing Care Managing Claims (“MCMC”). CP 302-06. On August 3, 2010, MCMC’s reviewer, also an experienced radiation oncologist,¹ upheld Premera’s denial. CP 308-13.

MCMC’s reviewer concluded that “the Proton therapy is not medically necessary in this case.” The IRO did not address the comparative cost of the procedures, as Premera had done. CP 312. But he agreed that there was no evidence that PBT is superior to IMRT. The IRO identified its “main conclusions” as follows:

- “No, the health plan should not cover the requested proton therapy.”
- “Even though there are positive data available from Loma Linda and other centers for this technology in prostate cancer, other more established alternative treatments such as brachytherapy either with LDR or HDR, IMRT and prostatectomy, have longer followup time and experience available and better known outcomes in terms of efficacy, toxicities and effects on quality of life.”

¹ The reviewer’s identity was confidential but his experience was extensive: “I am board certified in Radiation Oncology. My areas of expertise include breast cancer, prostate cancer, lung cancer, prostate seed implant, gamma knife stereotactic radiosurgery, linac based stereotactic radiosurgery, radiation therapy, and high dose brachytherapy. I am published in the peer reviewed medical literature and member of the American Society for Therapeutic Radiology and Oncology, American Society of Clinical Oncology, American College of Radiology, and the American College of Radiation Oncology.” CP 310.

- “Per NCCN [National Comprehensive Cancer Network], the recommended radiation therapy treatments for Prostate Cancer include 3D conformal therapy, IMRT and brachytherapy. There is no consensus or mentioning of Proton therapy.”
- “A search in clinicaltrials.gov supports that this type of treatment is currently undergoing several phase II studies.”

CP 309.

D. Procedural History.

Strauss sued Premera, asserting claims for breach of contract, bad faith, and violation of the Consumer Protection Act. CP 3-9. Premera moved for summary judgment. CP 18-43. The trial court granted Premera’s motion, and dismissed all of Strauss’s claims as a matter of law. CP 1467-68. Strauss appealed, and the Court of Appeals affirmed. 408 P.3d 699 (2017).

III. ARGUMENT

A. Strauss needed to offer evidence that PBT was “medically necessary” under the Plan because PBT leads to fewer side effects.

The Plan provided coverage only for “medically necessary” treatments. Strauss admitted that PBT is more expensive than and no more effective at treating the cancer as other treatments that Premera would have covered. Therefore, Strauss needed to show that PBT would have led to fewer side effects.

Courts “construe insurance policies as contracts.” *Quadrant Corp. v. Am. States Ins. Co.*, 154 Wn. 2d 165, 171, 110 P.3d 733, 737 (2005).

“The criteria for interpreting insurance contracts in Washington are well settled.” *Id.* “Most importantly, if the policy language is clear and unambiguous,” the Court “must enforce it as written; we may not modify it or create ambiguity where none exists.” *Id.*

Moreover, under Washington law, Strauss bears the burden to show that his PBT treatment was medically necessary. “The burden first falls on the insured to show its loss is within the scope of the policy’s insured losses.” *Overton v. Consol. Ins. Co.*, 145 Wn. 2d 417, 431-32, 38 P.3d 322, 329 (2002); *see also Pleasant v. Regence Blue Shield*, 181 Wn. App. 252, 261-62, 325 P.3d 237, 243 (2014) (same); *Baxter v. MBA Group Ins. Trust Health and Welfare Plan*, 958 F. Supp. 2d 1223, 1233 (W.D. Wash. 2013) (applying a de novo standard and holding that “Plaintiff bears the burden of showing proton therapy is ‘not more costly than an alternative service or sequence of services or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease’”). Therefore, Strauss, who is claiming insurance benefits, must prove that “the coverage he seeks is medically necessary.”

Finally, this is a summary judgment case. “An issue of material fact is genuine if the evidence is sufficient for a reasonable jury to return a verdict for the nonmoving party.” *Keck v. Collins*, 184 Wn. 2d 358, 370, 357 P.3d 1080, 1086 (2015). In other words, there is a genuine factual dispute “where reasonable minds could differ on the facts controlling the

outcome of the litigation.” *Ranger Ins. Co. v. Pierce Cty.*, 164 Wn. 2d 545, 552, 192 P.3d 886, 889 (2008).

To establish a genuine issue of material fact, therefore, Strauss must offer evidence that PBT is “medically necessary,” as required by the Plan. Here, the Court of Appeals explained that the parties agree (for purposes of summary judgment) on application to the record facts of all elements of the “medically necessary” definition except for whether IMRT and PBT provided “equivalent therapeutic ... results”: “Strauss does not dispute that PBT is more costly than IMRT or that PBT and IMRT are equally effective in treating prostate cancer. Therefore, Strauss concedes he must show PBT results in superior or fewer side effects than IMRT.” 408 P.3d at 710; *see also* CP 827 (Laramore Depo. at 247) (Strauss’s expert acknowledges that “[f]or Mr. Strauss, the proton beam treatment cost” was “[h]igher than with IMRT”).

The superior court determined, and the Court of Appeals agreed, that there was no “genuine issue” as to whether PBT leads to fewer side effects and, accordingly, that Premera was “entitled to a judgment as a matter of law.” CR 56(c). As explained below, based on the summary judgment record, “reasonable minds” could arrive at only one conclusion—nothing but impermissible speculation and conjecture supported Strauss’s argument that PBT resulted in fewer sides effects than IMRT.

B. There is no clinic evidence that PBT results in fewer side effects than IMRT.

It is undisputed that no randomized trials demonstrate that PBT causes fewer side effects than does IMRT. CP 780 (Laramore Depo. at 65). As Strauss's expert and PBT doctor admitted, such trials represent the "gold standard," CP 660 (Laramore Dep. at 147), and the only "definitive data," CP 902 (Bush Dep. at 55), for comparing different treatment options. CP 424; CP 901-03; CP 657. In addition, the summary judgment record contains abundant evidence that contradicts Strauss's claim in this case.

To begin with, Strauss's own doctor—his radiation oncologist—told him that PBT did not result in fewer side effects. CP 88 (Russell Dep. at 32-33); CP 1020. Moreover, Premera's Corporate Medical Policy explained that PBT is not medically necessary "because the outcomes have not shown to be superior to other approaches including intensity modulated radiation therapy (IMRT) ... yet proton beam therapy is generally more costly than these alternatives." CP 217. A 2010 update to that policy indicated that "systemic review of published peer-reviewed literature ... is devoid of any clinical data demonstrating benefit" of PBT compared with other treatments. CP 224-30. And, as explained above (pp. 6-10), independent radiation oncologists at external organizations conducted the Level I Appeal, the Level II Appeal, and an IRO review—and *all* concluded that PBT was not medically necessary.

Because there is no medical evidence showing that PBT is superior, the medical community uniformly considers IMRT to be the

standard of care for radiation therapy to treat prostate cancer. Indeed, no recognized national association of radiologists or oncologists recommends PBT. CP 416 (Beer Report); CP 827 (Laramore Dep. at 248-49); CP 439-40, 940 (Bush Dep. at 185-86, 202-05); CP 663 (Russell Dep. at 30).

The National Comprehensive Cancer Network (“NCCN”) is an alliance of the leading cancer centers that drafts guidelines for the treatment of cancer. CP 416-18, 420. Its “guidelines are developed based on testing, and evidence through panels of expert physicians in the field of cancer treatments and reflect a consensus reached by these physicians on current approaches and standards for the treatment of cancer. These guidelines are the standard of care for the treatment of cancer.” *Lucas v. Texas Intern. Life Ins. Co.*, 2012 WL 6000306, at *2 (E.D. Okla. Nov. 30, 2012); *see also Zeneca Inc v. Eli Lilly & Co.*, 1999 WL 509471, at *23 (S.D.N.Y. July 19, 1999) (NCCN is “an expert body in the field of clinical oncology” and its guidelines “are authoritative in the field”). NCCN’s Clinical Practice Guidelines in Oncology for Prostate Cancer conclude, based on peer-reviewed studies and trials, that “there is no clear evidence supporting a benefit or decrement to proton therapy over IMRT for either treatment efficacy or long-term toxicity.” CP 368. NCCN’s guidelines for patients similarly explains, “[t]o date, research hasn’t shown that proton treatment is any better or worse for treating cancer or causing side effects.” CP 482. Indeed, when Strauss considered options for radiation therapy to treat his prostate cancer, and later appealed Premera’s coverage

decision, the NCCN Guidelines did not even *mention* PBT. CP 554-99 (2009 guidelines); CP 601-24 (2010 guidelines).

NCCN is not alone. The American Society for Radiation Oncology (“ASTRO”) publishes a model policy on PBT. CP 626-44. As it relates to the treatment for prostate cancer, ASTRO concludes: “There is no clear evidence that proton beam therapy for prostate cancer offers any clinical advantage over other forms of definitive radiation therapy.” CP 642. ASTRO recommends PBT serve as a primary treatment for prostate cancer “only ... within the context of a prospective clinical trial or registry.” *Id.*

Finally, the Agency for Healthcare Research and Quality (“AHRQ”), part of the U.S. Department of Health and Human Services, likewise publishes guidelines on PBT for cancer treatment. CP 646-50. The guidelines—which are a “synthesis of currently accepted approaches to management, derived from a review of relevant scientific literature”—state: “Members of the working group do not currently recommend that patients with prostate cancer ... be referred for proton beam radiotherapy, due to an insufficient evidence base.” CP 648.

C. The evidence that Strauss submitted does not create a “genuine issue” whether PBT results in fewer side effects than IMRT.

In response to this mountain of evidence, at summary judgment Strauss relied on two, and only two, things: the testimony of his expert Dr. Laramore and his PBT provider Dr. Bush. The testimony of neither witness creates a “genuine” factual dispute.

Strauss contends that “Dr. Bush recommended PBT over IMRT ... because PBR risks fewer side effects.” Pet. Rev. 3. But Dr. Bush’s deposition testimony was far more equivocal. He was asked, “As between IMRT and proton beam therapy, is it your opinion that there is a difference in these side effects?” CP 905 (Bush Dep. at 68). He responded, “That’s—that’s a hard question to answer. There’s data to support, I think, both sides.” Further, Dr. Bush opined, “To show that the side effects are, in a scientific way, right, that proves that side effects are substantially less with proton, I would say the evidence as of today is not as strong as we would like to see.” *Id.* 905 (Bush Dep. at 68-69). Such equivocal testimony is insufficient to forestall summary judgment. *See Bickoff v. Wells Fargo Bank, N.A.*, 705 F. App’x 616, 618 (9th Cir. 2017) (“equivocal and speculative statements” are insufficient to defeat a summary judgment motion).

Likewise with Dr. Laramore, Strauss’s expert. Dr. Laramore acknowledged that “there have been no randomized trials at this stage.” CP 780 (Laramore Depo. at 62). So his opinion was based on comparisons of *different* studies with different patient groups. *Id.* He admitted that this requires the assumption—one supported by no evidence whatever—that “the patient groups are basically equivalent” in the different studies. *Id.* And he conceded that his conclusion that PBT has fewer side effects is solely “theoretical,” and based on “assumptions” and

“inferences” drawn from the literature.² CP 657, 778-79, 787 (Laramore Depo. at 57-58, 62-64, 93); *see also* CP 691 (Laramore Report: “there have not been direct randomized trials ... but rather one must review the literature to infer the advantages and disadvantages”). In short, this evidence represents little more than impermissible “speculation, conjecture, or mere possibility.” *Reese v. Stroh*, 128 Wn. 2d 300, 309, 907 P.2d 282, 287 (1995); *see also Meyer v. Univ. of Washington*, 105 Wn. 2d 847, 852, 719 P.2d 98, 102 (1986) (“nonmoving party in a summary judgment may not rely on speculation [or] argumentative assertions that unresolved factual issues remain”); *Kyreacos v. Smith*, 89 Wn. 2d 425, 429, 572 P.2d 723, 725 (1977) (“Facing a motion for summary judgment, a party cannot rely upon speculation and allegations to meet contrary facts.”).

Moreover, Dr. Laramore also expressly *agreed* with the ASTRO policy, discussed above, which states that PBT “should only be performed within the context of a prospective clinical trial or registry.” CP 827 (Laramore Depo. at 248). It is undisputed that Strauss did not receive PBT treatment as part of a clinical trial or registry, and that the Plan itself expressly excludes coverage for medical care provided as a part of a clinical trial. CP 192.

² Likewise, the studies on which Laramore relied addressed PBT’s effectiveness based on models, dosimetric studies (studies that compare treatment plans), and cross-study comparisons. CP 419 (Beer Report).

In short, the determination of “medically necessary” under the Plan must be based on “credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinic areas and any other relevant factors.” CP 212. In light of Strauss’s radiation oncologist’s advice, Premera’s Corporate Medical Policy, the three independent reviewers, and the unanimous view of medical community guidelines, the equivocal and speculative assertions of Strauss’s two witnesses would not permit “a reasonable jury to return a verdict for the nonmoving party.” *Keck*, 184 Wn. 2d at 370, 357 P.3d at 1086. The summary judgment for Premera, therefore, should be affirmed.

D. *Baxter* supports the summary judgment in this case.

The Western District of Washington has addressed the exact same issue, involving the *same* definition of medically necessary, in *Baxter v. MBA Group Ins. Trust Health & Welfare Plan*, 958 F. Supp. 2d 1223 (W.D. Wash. 2013). Like Strauss, the plaintiff in *Baxter* concluded that receiving PBT at Loma Linda was “the best option” for him, and like here, his claim, internal appeals, and IRO were denied on the basis of the plan’s “medically necessary” term—specifically because the “clinical outcomes with this treatment have not been shown to be superior to other approaches including intensity modulated radiation therapy (IMRT).” *Id.* at 1225-26. Notably, like Strauss, the *Baxter* plaintiff submitted letters from his treating physician at Loma Linda and Dr. Laramore—the same expert who

testified for Strauss in this case—extolling the supposed superiority of PBT to IMRT. *Id.* at 1226.

The federal district court granted summary judgment to the plan, concluding as a matter of law that PBT was not “medically necessary” under the plan. The court held: “Based on the applicable [de novo] standard of review, Plaintiff has not met his burden to show that there is a genuine issue of material fact whether proton therapy is superior to IMRT. The current non-randomized observational studies demonstrate that proton therapy provides equivalent treatment to IMRT in terms of cancer control and side-effects.” *Id.* at 1237. In reaching its conclusion, the court held that “inconsistencies in the current observational studies [cross-study comparisons] comparing proton therapy with other modalities of treatment for prostate cancer are consistent with NCCN’s conclusion that ... clinical trials have not yet yielded data that demonstrates superiority to, or equivalence of, proton beam and conventional external beam for treatment of prostate cancer.” *Id.* at 1234, 1237-38. In short, the court found that “[n]o study cited by either party provides statistically significant evidence that one therapy is superior to the other.” *Id.*

The *Baxter* decision—which is based on the same medical evidence presented in this case, from the same clinic that treated Strauss and from the same expert that Strauss presents, and applied the same plan definition of “medically necessary” at issue here—is persuasive authority in this case.

IV. CONCLUSION

This Court should affirm the judgment of the Court of Appeals,
Division 1.

DATED: August 6, 2018

Respectfully submitted,

KILPATRICK TOWNSEND &
STOCKTON LLP

By: /s/ Gwendolyn C. Payton
GWENDOLYN C. PAYTON
JOHN R. NEELEMAN
Attorneys for Respondent
Premera Blue Cross

CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury of the laws of the State of Washington that on the 6th day of August, 2018, I caused to be served a copy of the foregoing on the following person(s) in the manner indicated below at the following address(es):

Howard M. Goodfriend
Victoria E. Ainsworth
SMITH GOODFRIEND, P.S.
1619 8th Avenue North
Seattle, WA 98109
howard@washingtonappeals.com
tori@washingtonappeals.com

Patrick A. Trudell
KORNFELD TRUDELL BOWEN &
LINGENBRINK, PLLC
3724 Lake Washington Blvd NE
Kirkland WA 98033-7802
patrick@ktblaw.com

First Class United States Mail and electronic mail.

By:

/s/ Gwendolyn C. Payton

GWENDOLYN C. PAYTON

KILPATRICK TOWNSEND & STOCKTON LLP

August 06, 2018 - 3:48 PM

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Appellate Court Case Title: John Strauss and Michelle Strauss v. Premera Blue Cross
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