

No. 65322-9-I

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

FARMERS INSURANCE COMPANY OF WASHINGTON,

Appellant,

v.

TARYN BARQUEST, on behalf of herself and all others similarly
situated,

Respondent.

APPELLANT'S REPLY BRIEF – REDACTED VERSION

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I. INTRODUCTION

Respondent tries to divert review from the trial court's clear legal errors by making sweeping mischaracterizations about insurance companies, *e.g.*, that "every dollar paid toward a claim is a dollar the insurer does not get to keep," that "[t]he first-party insured is exquisitely vulnerable," and that the insurer must be "prevent[ed] from toeing the line of the law while undermining the interests of the insured." Brief of Respondent ("Resp. Br.") at 1. Her attempt to inflame this Court with such statements is simply a futile effort to avoid the record, which demonstrates that Farmers rarely requests Independent Medical Examinations ("IMEs"), does so when it has reasonable, legitimate questions about a claim, and clearly cannot be found to have acted in bad faith on this record on summary judgment. *See* Commissioner's Ruling Granting Discretionary Review ("Commissioner's Ruling") at 5 ("the record on summary judgment does not reflect that Farmers always or often lacked a good faith reason to engage in additional investigations of the individual PIP claims of the class members. To the contrary, the record on summary judgment includes specific instances of a good faith basis ...").

Respondent wholly ignores evidence demonstrating that IMEs are the exception and not the rule. During the class period, Farmers

processed over 45,000 separate PIP claims and paid over \$182,000,000, while requesting IMEs in less than 6% of the claims. *See* CP 1240 at ¶ 10. In fact, Farmers paid Respondent for all of her treatment for nearly three months after her accident. *See id.* at 1257-1259. Respondent even concedes that Farmers acted in good faith in a number of instances. For the reasons discussed below, the Court should reject Respondent's erroneous view of the law and her disregard of the factual record, and restore Farmers' right to demonstrate at trial that it acted in good faith by requesting IMEs in specific cases.

First, Respondent simply cannot avoid the inevitable conclusion that the trial court relied principally upon a statute which, on its face, does not apply to the challenged conduct. WAC 284-30-395 provides conditions for an insurer's decision to "deny, limit, or terminate" medical benefits and states that it "applies only where the insurer relies on the medical opinion of healthcare professionals to deny, limit, or terminate medical and hospital benefit claims." WAC 284-30-395 (emphasis added). Because it is undisputed that Respondent challenges Farmers' conduct before it receives such medical opinions, through IMEs, WAC 284-30-395 does not apply. Respondent's weak defense that there was an "invited error" is unsubstantiated, as Farmers has consistently argued that WAC 284-30-395 does not preclude its continued investigation of certain

claims. In fact, Respondent's argument only underscores the trial court's error. The trial court's interpretation of WAC 284-30-395 conflicts with WAC 284-30-380, which explicitly provides standards when an insurer needs to continue investigating and requires notice – not payment – under such circumstances. Farmers has fully complied with WAC 284-30-395 and WAC 284-30-380.

Respondent tries to salvage her claim by arguing that the trial court relied upon WAC 284-30-330. This is contrary to the record, which shows that the trial court relied principally on WAC 284-30-395 and not WAC 284-30-330. *See* RP 4/2/2010 at 70:11-22; 71:1-2. Moreover, Farmers did not violate WAC 284-30-330, which prohibits “refusing to pay claims without conducting a reasonable investigation.” *See* WAC 284-30-330(4). The record demonstrates that Farmers did not “refus[e]” payment when requesting IMEs. To the contrary, the record is undisputed that Farmers paid a significant amount of PIP benefits on behalf of class members, including Respondent herself, for a long period of time before requesting an IME. The record is also undisputed that, following an IME, Farmers paid any suspended benefits if there was evidence that any portion of the treatment was “reasonable” and “necessary.”

Second, the undisputed record on Respondent's own motion demonstrates that Farmers acted reasonably, based on legitimate concerns, when it continued its investigation of certain claims before paying. Respondent has completely failed to present any evidence that Farmers acted unreasonably to the class. In fact, she has acknowledged that, in several cases about which Farmers presented evidence in the record, Farmers acted in good faith. *See* Resp. Br. at 38 (claiming that Farmers' adjusters acted on "suspicion" and in bad faith "with the exception of one case in which the adjuster had physician evidence that the claim was likely not reasonable and necessary" and "one claim in which the insured had failed to cooperate"). The trial court's ruling improperly holds Farmers in bad faith to all class members – including situations where Respondent admits Farmers acted in good faith and where Farmers had a reasonable basis for further investigation. Washington law is clear that where an insurer has a reasonable basis to question a claim, as Farmers did here, it does not act in bad faith. *See Ki Sin Kim v. Allstate Ins. Co.*, 153 Wn. App. 339, 356 n.3 (2009) ("Reasonableness of an insurer's actions is a complete defense to any bad faith claim by an insured."). At a minimum, Respondent's admission underscores the numerous factual issues that must be resolved at trial before any finding that Farmers acted in bad faith to any class member. Summary judgment therefore was improper.

Third, the trial court's ruling represents a drastic departure from Washington law, which permits PIP insurers to conduct investigations of claims and which has rejected coverage by estoppel in first-party claims. Even the cases Respondent cites recognize that "consideration of the opinions of an independent physician" constitutes a "reasonable and adequate investigation." *See* Resp. Br. at 26. The trial court's ruling improperly requires Farmers to pay all claims despite the undisputed record demonstrating that Farmers has reasonable bases for questioning some claims. Respondent attempts to justify this erroneous conclusion by claiming that Farmers is "wrong" in over 80 percent of the cases where it requests IMEs. *See* Resp. Br. at 32. This misconstrues the statistical evidence in the record, which shows that over 30 percent of the time, IME reports conclude that different treatment is needed; almost 20 percent of the time, prior treatment is not needed; and almost half of the time, no further treatment is needed. CP 1128 at ¶28. By accepting Respondent's simplistic and one-sided view of the record, the trial court's ruling destroyed the insurers' established right to continue investigating claims which raise legitimate red flags and should be reversed.

Finally, the trial court erred in denying Farmer's motion for partial summary judgment on Respondent's bad faith claim. Under Washington law, an insurer acts in bad faith only when it takes a position that is

“unreasonable, frivolous, or untenable.” *Liberty Mut. Ins. Co. v. Tripp*, 144 Wn.2d 1, 23 (2001). Because Washington law permits Farmers to continue its investigation before making certain payments, Farmers’ conduct cannot possibly be viewed as an “unreasonable” position as a matter of law. The trial court’s ruling should be reversed.

II. ARGUMENT

A. The Trial Court’s Ruling Misinterprets Washington Law and Incorrectly Requires a PIP Insurer to Pay Claims Before Completing its Investigation.

1. The Trial Court Improperly Relied Upon WAC 284-30-395 As the Basis For Its Ruling.

The trial court’s reliance on WAC 284-30-395 for its summary judgment ruling constitutes clear error warranting reversal. WAC 284-30-395 explicitly states that it “applies only where the insurer relies on the medical opinion of healthcare professionals to deny, limit, or terminate medical and hospital benefit claims.” WAC 284-30-395 (emphasis added). It is undisputed that Respondent is challenging Farmers’ conduct before it receives these medical opinions. *See* Resp. Br. at 7; Commissioner’s Ruling 7 (“WAC 284-30-395 does not apply to the practices complained of by the class members.”). Indeed, Respondent herself admits that “[n]one of [her] filings for summary judgment asserted that WAC 284-30-395 controls this case.” Resp. Br. at 42.

Faced with the inevitable conclusion that WAC 395-30-395 does not apply to the challenged conduct, Respondent struggles to argue that the trial court did not actually rely on WAC 395-30-395, but instead discussed it simply for interpretive value, relying instead upon WAC 284-30-330. *See* Resp. Br. at 41-42. However, the record does not support Respondent's argument. On the exact page Respondent cites for this proposition, the trial court stated:

whether this is a violation of the WACs, the trial court is required to look at the WACs . . . The WACs state that the insurer may deny, limit or terminate benefits if the insurer determines the medical services are not reasonable or not necessary, not related to the accident or not incurred within three years, and those are the only grounds for denial, limitation or termination.

RP 4/2/2010 at 70:11-22. This is a direct citation of the standards in WAC 284-30-395(1)(a)-(d).¹ Because WAC 284-30-395 applies only where an insurer "relies on the medical opinion of healthcare professionals" (*i.e.*, based on IME results), and not to an insurer's conduct before the IME, the trial court's ruling was improper.²

¹ The trial court again referenced WAC 284-30-395 when it stated "paragraph 1 requires them to only deny, limit, or terminate benefits for one of those reasons." RP 4/2/2010 at 71:1-2.

² In fact, given that Respondent admits that she does not allege that Farmers violated WAC 284-30-395, *see* RP 4/2/2010 at 38:15-18, the trial court's focus on this regulation at oral argument in itself justifies reversal, because Farmers did not have an opportunity to highlight the obvious problems with its direct application here. *See Fountain v. Filson*, 336 U.S. 681, 683, 69 S. Ct. 754 (1949) (summary judgment "could not be given"

Farmers' conduct is permitted by WAC 284-30-380, which recognizes that an insurer's initial investigation may not provide it with sufficient information and allows the insurer to conduct additional investigation in such cases. The regulation states: "If the insurer needs more time to determine whether a first party claim should be accepted or denied, it must notify the first party claimant within fifteen working days after receipt of the **proofs** of loss giving the reasons more time is needed." WAC 284-30-380 (emphasis added). Respondent tries to minimize the import WAC 284-30-380 and avoid its devastating impact on the trial court's ruling by stating, with no support whatsoever, that "the proof of loss is the initial PIP application -- not each individual medical bill." Resp. Br. at 45. This is plainly wrong. As an initial matter, WAC 284-30-380 refers to "proofs," in the plural. The plural form belies Respondent's contention that the statute is triggered only by an insured's single, initial PIP application in the PIP context. *See* WAC 284-30-380. Farmers' PIP policy uses similar terms. CP 140 (requiring insureds to "[p]rovide any written proofs of loss we require.").

"The object of the proofs is to furnish the company with the particulars of the loss and all data necessary to determine its liability and

in favor of a party that had not moved for relief on that issue because, by ruling "on a new issue," the court gives the other party "no opportunity to present a defense").

the amount thereof.” *Pagni v. New York Life Ins. Co.*, 173 Wash. 322, 346-347 (1933). In the PIP context, where an insured seeks reimbursement of multiple medical expense payments for treatment over a period of time, the “proofs of loss” are each medical bill indicating the medical service and the amount of the expense. These medical bills, and not the initial PIP application, provide the insurer with requisite information to determine the amount payable under PIP coverage. *See Fox v. Bankers Life & Cas. Co.*, 61 Wn.2d 636, 640 (1963) (finding that insured’s medical bills were sufficient proofs of loss of medical expenses and medical testimony was not required). The medical bills submitted to an insurer trigger the notification requirements of WAC 284-30-380, and so long as the insurer promptly notifies the insured that it requires additional information, the insurer is authorized to continue its investigation. *See* WAC 284-30-380.

Farmers has fully complied with WAC 284-30-380, and Respondent has never alleged otherwise. For example, when Farmers determined that it needed more information about some medical bills submitted by class member [REDACTED], Farmers sent her a letter stating that her bills were “being held pending the outcome of our investigation” because she was continuing treatment for several months

after a minor vehicle accident. *See* CP 1699-1705; CP 1716-1717. This is exactly what WAC 284-30-380 contemplates.

Because WAC 284-30-395 does not apply and because WAC 284-30-330 authorizes Farmers' conduct,³ Respondent is left to argue that Farmers somehow "invited" the trial court's error. *See* Resp. Br. at 42-44. This argument is wholly misplaced. The invited error doctrine precludes a party from arguing in support of one proposition in the trial court, and then articulating the opposite position on appeal. For example, in *City of Bellevue v. Kravik*, 69 Wn. App. 735, 739, 850 P.2d 559 (1993), which Respondent cites, the Court rejected the appellant's challenge to the trial court's admission of certain evidence because the appellant had already argued in favor of the admission of related evidence in the trial court. *See* Resp. Br. at 42. Respondent also relies on *In Re Estate of Stevens*, 94 Wn. App. 20, 31, 971 P.2d 58 (1999), where the appellant had filed a motion to vacate an order of default under a particular rule, and then challenged the trial court's denial by claiming that the same rule under which it filed its own motion did not apply. *See also Deaconness Med. Center v. The Dep't of Revenue*, 58 Wn App. 783, 785 (1990) (noting that "[a] more perfect example of invited error cannot be imagined" where party took a "new" and opposite position on appeal).

³ *See* discussion *infra* at 11-14.

In contrast, Farmers has consistently argued that its conduct does not violate WAC 284-30-395, which has relevance only after an insurer obtains a medical professional's opinion and also permits, rather than precludes, Farmers' procedure. As Farmers explicitly stated in its opposition to Respondent's summary judgment motion, "[n]othing in the statute mandating PIP coverage' or in WAC 284-30-395, requires an insurer to 'pre-approve or prepay treatment expenses' before the PIP insurer's investigation by way of an IME was complete." See CP 1567. Farmers discussed WAC 284-30-395 below to highlight that it allows an insurer to rely upon the opinion of a medical professional when making a decision to "deny, limit, or terminate" medical benefits, but in no way dictates an insurer's duties prior to such IME – the conduct at issue here. CP 1566-1568. Respondent's argument that Farmers invited the trial court's contrary – and erroneous – construction of WAC 284-30-395 must be rejected.

2. WAC 284-30-330 Does Not Prohibit Farmers From Continuing Its Investigation Before Making Certain Payments.

In order to shoehorn her claims into WAC 284-30-330(4), Respondent unsuccessfully tries to characterize Farmers' request for an IME before continuing to pay certain claims as an outright "refusal" to

pay. There is simply no legal or record basis to support this mischaracterization of Farmers' challenged conduct.

WAC 284-30-330(4) provides that an insurer may not "refus[e] to pay claims without conducting a reasonable investigation." (Emphasis added.) However, the suspension of payments pending an additional investigation is not akin to a "refusal . . . without" an investigation. Washington's insurance regulations define an "investigation" to include "all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or an insurance contract." WAC 284-30-320(6). An IME is one tool, among many, Farmers uses to gather additional information as part of this permissible investigation. Respondent's statement that "at least 84.9 percent of the time Farmers sends such denial letters to insureds," is misleading. *See* Resp. Br. at 8. The record demonstrates that Farmers' claims representatives request IMEs in only a small percentage of PIP claims and only where legitimate questions arise regarding coverage eligibility. *See* CP 1240 at ¶ 10 (less than 6% of claims during class period resulted in a request for an IME). Moreover, as Respondent herself admits, "[t]he most common phrasing" in the letters that Farmers sends to class members when it determines an IME is necessary is that Farmers is "withholding payment of these bills and all future bills'

pending the results of the IME.” Resp. Br. at 13 (emphasis added). Nowhere in these letters does Farmers “deny” or “refuse” the claim outright.

Respondent also disregards the record showing that by the time an IME is considered, Farmers has paid significant PIP benefits on behalf of class members. For example, before Respondent attended an IME, Farmers had paid for all of her treatment for nearly three months after the accident. *See* CP 1257-1259. Additionally, where the IME indicates that any portion of treatment is reasonable and necessary, Farmers pays for that portion. *See* CP 1129 at ¶ 30. This refutes Respondent’s argument that Farmers’ request for an IME is a “denial.”

According to Respondent, “[a]n insured is entitled to expect that a claim examination will include, as part of a reasonable and adequate investigation . . . consideration of the opinions of an independent physician from the appropriate specialty before deciding to terminate benefits on the basis of a medical conclusion.” Resp. Br. at 26 (emphasis added). By requesting an IME, Farmers’ claims representatives are doing exactly that – seeking additional “information and expertise” from an “independent physician.”⁴ All of the cases Respondent cites are

⁴ For this reason, Respondent’s contentions regarding the alleged violation of WAC 284-30-330(13) are also misplaced. *See* Resp. Br. at 28-30. When Farmers issues a “denial of a claim,” it is undisputed that it promptly provides an explanation of the basis by

inapposite. For example, in *Aecon Bldgs., Inc. v. Zurich North Amer.*, 572 F. Supp. 2d 1227, 1239 (W.D. Wash. 2008), the court found that the insurer violated WAC 284-30-330 because the claims adjuster “conducted no investigation at all” of whether plaintiff was covered as an “Additional Insured” under a liability policy, including failure to examine documents submitted by the claimant. *See id.* at 1231. Here, in contrast, Farmers’ claims representatives reviewed the facts relating to a claimant and, rather than denying the claim outright, requested additional information from an independent medical professional. *See* CP 1578-1585 at ¶¶ 11-13, 25-28, CP 1639-1647 at ¶¶ 14-18, 28-32.⁵ None of the cases Respondent cites provide any support whatsoever for her claim that “refusing to pay a claim” should include a temporary suspension of benefits pending an IME.⁶

sending a letter to the insured with the IME report, detailing the basis for the denial and instructing the insured where to direct questions regarding the coverage decision. *See e.g.*, CP 1699-1705 at ¶ 23 and CP 1734-1736. Accordingly, Farmers’ conduct fully complies with WAC 284-30-330(13).

⁵ Respondent’s citation to *Revelation Indus. Inc. v. St. Paul Fire & Marine Ins. Co.*, 206 P.3d 919 (Mont. 2009), is also unavailing. *See* Resp. Br. at 24. The case involved the question of whether an insurer could look exclusively at the allegations in the complaint filed by an insured when assessing its duty to defend. *See Revelation*, 206 P.3d at 922-923. Similarly, her reliance on *Ivanov v. Farmers Ins. Co. of Oregon*, 185 P.3d 417 (Or. 2008), and *Strawn v. Farmers Ins. Co. of Oregon*, 209 P.3d 357 (Or. Ct. App. 2009), is misplaced, as these cases involved an Oregon presumption that claims for medical expense benefits are presumed to be “reasonable and necessary.” As discussed below, however, there is no equivalent presumption in Washington.

⁶ Respondent’s reliance on *Paul Revere Life Ins. Co. v. DiBari*, 2010 WL 918084, slip op. at *4 (D. Conn. 2010), also fails to further her claim and, indeed, supports Farmers’ conduct here. *See* Resp. Br. at 24. The Court in *Paul Revere* interpreted a Connecticut

B. The Record Demonstrates That Farmers Acted Reasonably and In Good Faith When it Requested IMEs and Suspended Benefits and Plaintiff Has Failed to Present Any Evidence to the Contrary.

As Farmers established in its opening brief, the trial court erred in granting summary judgment in favor of the entire class because the record demonstrates that Farmers had legitimate, reasonable bases to request IMEs and suspend benefits for some class members. “Most significantly, the abusive and bad faith use of IMEs alleged by the class members is not reflected in the facts considered on summary judgment.” Commissioner’s Ruling at 7 (emphasis added). On her own motion, Respondent failed to present any evidence that Farmers breached its duty of good faith as to any class member.⁷ This failure was fatal to her motion. *See Aecon Buildings, Inc. v. Zurich North Amer.*, 572 F. Supp. 2d 1227, 1234 (W.D. Wash. 2008) (where “the moving party will have the burden of proof at trial, it must affirmatively demonstrate that no

statute that precluded insurers from “refusing to pay claims without conducting a reasonable investigation” as requiring an insurer to consider “the relevant opinions of the treating physician where a medical issue is unclear or controverted, or consideration of the opinions of an independent physician from the appropriate specialty before deciding to terminate benefits.” *Paul Revere*, 2010 WL 918084, slip op. at *4 (emphasis added).

⁷ The trial court struck eight declarations Respondent submitted because she made none of the declarants available for depositions after repeated requests. The only other evidence Respondent submitted consisted of inadmissible, self-serving attorney declarations that contained rank hearsay and broad, almost identical generalizations about Farmers and unnamed “clients,” and a declaration from a Farmers’ employee/insured who appears discontent primarily with the doctor who performed the IME and whose declaration only underscores the factual issues here. *See* Resp. Br. at 17-18; CP 256-261 at ¶¶ 6, 11.

reasonable trier of fact could find other than for the moving party”) (emphasis added); *see also Rizzuti v. Basin Travel Serv.*, 125 Wn. App. 602, 616 (2005) (“To prevail on a claim of bad faith denial of coverage, the insured must come forward with evidence that the insurer acted unreasonably.”).

Respondent not only fails to cite to any record evidence that Farmers acted in bad faith as to any class member, but admits, with respect to certain class members, that Farmers’ request for an IME before paying was reasonable. *See* Resp. Br. at 9 (emphasis added). Specifically, Respondent references “one case in which the adjuster had physician evidence that the claim was likely not reasonable and necessary (██████████, *see* CP 1638-1697), and one claim in which the insured had failed to cooperate (██████████, *see* CP 1577-1637).” Resp. Br. at 38. Respondent concedes that in those two instances Farmers relied on “pre-IME evidence that amounts to more than a suspicion or conjecture” but maintains that on other cases Farmers’ “adjusters were operating from hunches, suspicions, or rules of thumb.” *Id.* (emphasis added).

As Respondent recognizes, Farmers had a legitimate basis to request that ██████████ attend an IME, as her own treating doctors questioned the validity of her subjective complaints and in fact, recommended an IME even before Farmers did so. *See* CP 1639-1647 at

¶¶ 12, 14, 15, 21. Similarly, Farmers acted reasonably when requesting that class member ██████████ attend an IME after his doctor refused to complete a medical form sent by Farmers and because he was continuing to receive significant chiropractic treatment despite his doctor's indication that such treatment should be reduced. *See* CP 1578-1585 at ¶ 11. The factual record contains additional similar examples that Farmers acted in good faith. *See, e.g.*, CP 1699-1705 at ¶ 9 (explaining that class member ██████████ was asked to attend an IME because she was receiving significant treatment for several months after a minor motor vehicle accident); CP 1639-1647 at ¶¶ 26-28 (requesting IME of class member ██████████ to ascertain if different treatment was required because she had been receiving chiropractic and massage therapy treatment multiple times weekly for more than one year without being referred for any MRI or CT scans).

The trial court disregarded this evidence in the record, and held that Farmers acted in bad faith as to all class members, including those who Respondent herself admits were sent for IMEs based on legitimate reasons. This was error. “[R]easonableness of an insured’s actions is a complete defense to any bad faith claim. . . .” *Ki Sin Kim*, 153 Wn. App. at 356 n.3. The trial court’s sweeping ruling deprived Farmers of the reasonableness defense as to all class members – even in cases where, as

Respondent herself concedes, Farmers acted reasonable.⁸ See Commissioner's Ruling at 1 (“[t]he trial court ruling broadly extends to situations where the insurer has a good faith and reasonable basis to question whether ongoing treatments are reasonable, necessary, or related to the accident.”).

Respondent cannot minimize the record evidence presented by Farmers by claiming that the evidence “lack[s] statistical validity”. See Resp. Br. at 9.⁹ At the summary judgment stage affidavits are admissible to determine whether there are “material issues creating a genuine issue for trial,” if “those facts [would] be admissible in evidence at trial.” *Grimwood v. University of Puget Sound, Inc.*, 110 Wn.2d 355, 359 (1988). “The ‘facts’ required by CR 56(e) to defeat a summary judgment motion are evidentiary in nature. . . . A fact is an event, an occurrence, or something that exists in reality.” *Id.* The factual affidavits submitted by Farmers’ claims representatives detail the particular reasons that led them to request an IME. Thus, the affidavits contain facts that clearly satisfy

⁸ Respondent’s acknowledgement also underscores why class certification is inappropriate because an individual investigation of each claim is necessary to determine whether Farmers breached its duty of good faith as to any class member.

⁹ Respondent’s focus upon the alleged flaws in Farmers’ evidence is misplaced. It is only “where the nonmoving party will bear the burden of proof at trial, [that] the moving party can prevail merely by pointing out . . . that there is an absence of evidence to support the non-moving party’s case.” *Aecon Bldgs*, 572 F. Supp. 2d at 1234. Here, the burden shifts to Farmers only after Respondent “affirmatively demonstrates” that “no reasonable trier of fact could find other than for” her, a showing she failed to make. *Id.*

this evidentiary standard.¹⁰ *See also Weston v. Emerald City Pizza, LLC*, 137 Wn. App. 164, 171-173 (2007) (considering several employee questionnaires as evidence of company’s practices and denying certification because plaintiff’s claims were not typical). Moreover, at summary judgment, “[t]he trial court. . . must keep in mind that ‘credibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from facts are jury functions, not those of a judge. . . . The evidence of the nonmovant is to be believed, and all justifiable inferences are to be drawn in his favor.’” *United Steelworkers of Amer. v. Phelps Dodge Corp.*, 865 F.2d 1539, 1542 (9th Cir. 1989).

The record demonstrates, at a minimum, that Farmers acted reasonably and in good faith by requesting IMEs and suspended payment in some cases. The trial court was not free to disregard this evidence by granting summary judgment on the bad faith claim to the entire class, and should be reversed.

¹⁰ Respondent also incorrectly asserts that this evidence is irrelevant because an insurer’s conduct is “judged by what the insurer knows at the time, not what the insurer learns after conducting the investigation.” *See* Resp. Br. at 38. These affidavits show exactly that – what the claims representative knew at the time that they requested IMEs and why they made such decisions.

and begun paying on the claim and paying medical bills.”).¹¹ This would transform PIP insurance into a blank check¹² and is unsupported by Washington law. Good faith does not require an insurer “to pay claims which are not covered by the contract. *See Coventry Assoc.*, 136 Wn.2d at 280.

To create estoppel, contrary to Washington law, Respondent relies upon an Oregon presumption that has no Washington counterpart. She argues that medical treatments are presumed to be reasonable and necessary because “otherwise, the treatment provider would violate [the] professional code by providing the treatment.” *See Resp. Br.* at 26. The sole support she offers for this spurious proposition is that Washington’s Department of Health prohibits misrepresentation by licensed providers. *See id.* Yet, the Washington Supreme Court has flatly rejected this position. *See Ambach v. French*, 167 Wn.2d 167, 178 n.5 (2009) (recognizing that medical professionals in a fee-for-service practice have economic incentives to provide a high volume of services for patients,

¹¹ Respondent argues the ruling that Farmers could have permissibly denied the entire claim outright within fifteen days after receiving notice of the claim. *See Resp. Br.* at 45. This would render WAC 284-30-380, which explicitly allows insurers to continue investigating certain claims after the 15-day deadline, meaningless.

¹² PIP coverage is not health insurance that provides comprehensive health coverage. PIP is far narrower and only covers claims which are reasonable, necessary, and related to the automobile accident. *See Sadler*, 2008 U.S. Dist. LEXIS 71665 at *31 (W.D. Wash. 2009), *aff’d* 2009 U.S. App. LEXIS 24316 (9th Cir. 2009) (rejecting the “implied contention that PIP benefits offer the same type of guaranteed coverage generally provided by health insurance”).

C. By Preventing Farmers From Investigating Claims and Mandating Payment of All Claims, Including Ineligible Ones, The Trial Court Created PIP Coverage By Estoppel Contrary to Washington Law.

The practical effect of the trial court's ruling, which prohibits a PIP insurer from suspending questionable bills while investigating them through IMEs, is that insurers must pay 100 percent of pre-IME bills, despite evidence that legitimate questions often arise regarding certain treatments, and evidence that many of these bills represent ineligible claims. This ruling necessarily creates coverage by estoppel for ineligible claims, contrary to settled Washington law that rejects this remedy in first-party cases. *See Coventry Assoc. v. Amer. States Ins. Co.*, 136 Wn.2d 269, 284 (1998). Respondent's attempt to avoid the import of *Coventry* here by claiming that "[t]he trial court herein made no ruling on damages, only on duty and breach," *see* Resp. Br. at 44, confuses damages with estoppel, an equitable remedy. By requiring Farmers to pay all pre-IME bills, the trial court estopped Farmers from denying payments for claims ineligible for PIP.

According to Respondent's flawed theory, once Farmers pays a single bill submitted under a PIP claim, it must continue to pay all bills, despite evidence that a medical treatment is ineligible for PIP coverage. *See* Resp. Br. at 44 ("Here, Farmers has already accepted the proof of loss

“some of which may not be necessary,” and some of which “often . . . lie in the gray area”) (emphasis added); *Sadler*, 2008 U.S. Dist. LEXIS 71665 at *31-32 (finding no “presumption” that emergent surgery was eligible for PIP despite neurosurgeon’s recommendation, and holding that an insured bears the cost of treatment until an insurer makes a decision on a claim).

Respondent repeatedly argues that Farmers acted in bad faith because its requests for IMEs are, “in retrospect,” wrong 82.8 percent of the time. *See* Resp. Br. at 6, 8, 9, 16, 32, 40. This assertion oversimplifies and distorts the key conclusions revealed by the statistical analysis, as the Commissioner also recognized. *See* Commissioner’s Ruling 6. Farmers’ expert statistician, Sydney Firestone, analyzed a statistically valid sample of PIP claims which involved IMEs and found that, in over 30 percent of cases, the IME physician or medical professional recommended that the PIP claimant continue with different treatment; almost 20 percent of the time, prior treatment was not needed; and almost 50 percent of the time, no further treatment was needed. *See* CP 808. This confirms that the red flags, which led claims representatives to question whether a treatment is reasonable, necessary, and related to an accident, are legitimate. Respondent oversimplifies and

disports the statistical evidence regarding the IME conclusions by ignoring these overall conclusions.

Respondent's view of the statistical evidence in the record is also inconsistent. She relies upon the statistical analysis of the IME conclusions to argue, "in retrospect," that Farmers was "wrong," but at the same time insists that "the later-conducted IMEs cannot retroactively establish that Farmers was reasonable to deny claims before the IME." *See* Resp. Br. at 8, 32. Respondent cannot have it both ways. If Farmers cannot retroactively accept the conclusions in the IME reports to validate that claims representatives had legitimate reasons to request IMEs in the first place, Respondent cannot retroactively attack these conclusions in the IME reports to create PIP coverage for ineligible claims.

D. The Court Should Reverse the Denial of and Grant Farmers' Motion for Partial Summary Judgment Because Farmers Complied With Washington Law.

For these same reasons, the trial court improperly denied Farmers' motion for partial summary judgment on Respondent's bad faith claim. *See* CP 1068-1070 at ¶ 2. Nothing in Washington's insurance regulations require a PIP insurer to pay for treatments before completing its investigation. Rather, an insurer is permitted to continue its investigation if it "needs more time to determine whether a first party claim should be accepted or denied." WAC 284-30-380. Washington courts have also

permitted insurers to “suspend” benefits while continuing these investigations. *See Albee v. Farmers Ins. Co.*, 92 Wn. App. 866, 874 (1998) (affirming summary judgment where Farmers had a “reasonable basis” to “suspend” benefits pending an IME). Because Washington’s insurance regulations and courts have recognized insurers’ rights to continue investigating, Farmers’ conduct cannot be found to be “unreasonable, frivolous or untenable” – as required for bad faith. *Liberty*, 144 Wn.2d at 23. Farmers’ motion for summary judgment should have been granted.

III. CONCLUSION

Accordingly, the trial court’s ruling should be reversed.

DATED: March 17, 2011.

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CERTIFICATE OF SERVICE

I certify that I caused the foregoing, APPELLANT'S REPLY BRIEF – REDACTED VERSION, to be filed with the Court of Appeals (original and one copy); a copy was also sent via pdf/email to said opposing counsel and via U. S. Mail:

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