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Case Number 27,2023

IN THE SUPREME COURT OF THE STATE OF DELAWARE

EMPLOYERS INSURANCE COMPANY OF WAUSAU; HELMSMAN MANAGEMENT SERVICES, LLC; LIBERTY INSURANCE CORPORATION; LIBERTY MUTUAL FIRE INSURANCE COMPANY; LM INSURANCE CORPORATION; THE FIRST LIBERTY INSURANCE CORPORATION; and WAUSAU UNDERWRITERS INSURANCE COMPANY,	)	No. 27, 2023
Defendants Below, Appellants/Cross-Appellees.	)	On Appeal from the Superior Court of the State of Delaware
v.	)	
FIRST STATE ORTHOPAEDICS, P.A., on behalf of itself and all others similarly situated,	)	C.A. No.: S19C-01-051 CAK
Plaintiffs Below, Appellee/Cross-Appellant,	)	

APPELLEE/CROSS-APPELLANT'S COMBINED ANSWERING BRIEF ON APPEAL AND OPENING BRIEF ON CROSS-APPEAL

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NATURE OF THE PROCEEDINGS

In this proposed class action, the Superior Court found that all prerequisites for class certification under Superior Court Civil Rule 23 were met — and then promptly ***denied*** class certification. This is how that singular result came about.

Plaintiff First State Orthopedics, P.A. ("FSO") is, by all accounts, the largest orthopedic practice in Delaware. On January 31, 2019, it commenced this proposed class action to challenge the defendants' practice of responding to workers'-compensation-related medical bills with a form notice that states:

> THIS SERVICE [IS] NOT AUTHORIZED BY CASE MANAGER. PLEASE CONTACT THE CASE MANAGER FOR FURTHER INFORMATION.[1]

Why did FSO challenge this conduct? Under 19 *Del. C.* § 2322F(e), part of the Delaware Workers' Compensation Act, a carrier's "[d]enial of payment for health care services provided pursuant to this chapter, whether in whole or in part, shall be accompanied with written explanation of reason for denial." The defendants' "not authorized" notices violate this requirement:

[1] The defendants refer to this form wording as "Code x553." As the Court will observe, it is the exact same wording, identified by the exact same code designation, in every coverage denial at issue (whether sent to FSO or to absent class members).

> [Defendants] argue that the response to a claim for payment of medical bills which stated the service was "not authorized by case manager" satisfies the statutory mandate. According to defendants the plain language of the statute allows the tautological response "we deny it because we deny it." I disagree. *** Courts should not rewrite statutes to meet their view of policy. But for me it does not rewrite subsection 2322F(e) by requiring any denial be meaningful. More than "we won't pay because we say so, talk to the manager" is required.[2]

Section 2322F(e) thus requires meaningful explanations. By withholding meaningful explanations, the defendants deprive care providers of any fair chance to contest, or even evaluate, the denial.

Importantly, both FSO's original complaint and its amended complaint sought declaratory relief only — not monetary relief — under Delaware's Declaratory Judgment Act, 10 *Del. C.* § 6501 *et seq*. The distinction is an important one, because (for example) class actions seeking only declaratory relief under Superior Court Civil Rule 23(b)(2) do not require individual notice to absent class members.[3]

In short, FSO sought a fair and lawful claims-handling ***process*** — a process that places care providers in a position to meaningfully assess coverage denials

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[2] *First State Orthopaedics, P.A. v. Emp'rs. Ins. Co. of Wausau*, 2020 WL 2458255, at *2 (Del. Super. Ct. May 12, 2020) (denying motion to dismiss).

[3] *See Wetzel v. Liberty Mut. Ins. Co*., 508 F.2d 239, 254 (3d Cir. 1975), *cert. denied*, 421 U.S. 1011 (1975) (noting that "Rule 23 definitely does not require mandatory notice for (b)(2) actions.")

which (depending on the facts of a particular claim) may or may not be contested, and may or may not be upheld.

A. The Defendants' Improper Removal to District Court

On May 14, 2019, the defendants purported to remove the case to the U.S. District Court for the District of Delaware. But the removal was improper, and on August 29, 2019, the district court granted FSO's motion to remand the case back to Superior Court. In so doing, the district court found that the "true object of the litigation is . . . the value of making informed decisions, not the value of being reimbursed for all of the claims that were denied."[4]

B. The Defendants' Failed Motion to Dismiss

On September 26, 2019, the defendants moved to dismiss the complaint. They argued, as they argue on this appeal, that the statutory requirement that carriers explain their coverage denials does not imply a requirement that the explanations ***actually be meaningful***. As shown above, the Superior Court rejected the argument.

[4] *First State Orthopaedics, P.A. v. Emp'rs Ins. Co. of Wausau*, C.A. No. 1:19-cv-00509-LPS, hearing tr. at 54-55 (D. Del. Aug. 23, 2019) (A184-85). References to the alphanumeric sequence beginning with "A" are to the appendix that accompanied the defendants' opening brief.

C. FSO Amends the Complaint

On November 6, 2020, FSO amended its complaint. The amended complaint sought certification of a proposed class and subclass, as follows:

> **The Proposed Class:**
>
> All persons or entities who, at any time since January 31, 2016, submitted to one or more of the defendants a health care invoice with respect to care provided to a Delaware workers' compensation claimant where (i) the defendant responded to the submission by stating, either verbatim or in substance, that
>
> > THIS SERVICE [IS] NOT AUTHORIZED BY CASE MANAGER. PLEASE CONTACT THE CASE MANAGER FOR FURTHER INFORMATION[,]
>
> and (ii) the defendant neither paid all or any part of the invoice within 30 days of receipt, nor communicated in writing, within 30 days of receipt, any other basis for withholding payment for the invoice.
>
> **The Proposed Subclass:**
>
> All members of the class who have not received from any defendant a revised or corrected explanation in place of, in substitution of, or in supplement to, the putative explanation set forth above (which defendants sometimes refer to as "Code x553").[5]

[5] A372-73.

D. FSO Moves for Class Certification

Following class-certification-related discovery, FSO moved for class certification on April 21, 2021. The defendants sought additional discovery in aid of their opposition, and briefing on FSO's motion was delayed to accommodate that discovery.

E. The Defendants Move for Summary Judgment

Following merits-related discovery, the defendants moved for summary judgment on March 18, 2022.

F. The Superior Court Resolves the Motions

On December 29, 2022, the Superior Court decided both the defendants' summary judgment motion and FSO's motion for class certification, as follows:

i. Because (a) FSO is challenging the offending practice only as to 19 specific coverage denials, each one issued in connection with specific medical bills for specific injured workers, and (b) each such coverage denial falls within the applicable three-year statute of limitations, FSO's claims are not time-barred.

ii. Because (a) the defendants proffered no explanation for their coverage denials until after the complaint was filed, (b) the defendants provided the court with no corrected explanations for the denials, (c) the defendants failed to issue corrections to the deficient denials, either as to FSO or as to absent class members, (d) defendants' conduct has delayed the processing of FSO's medical bills, and (e)

the defendants continue to contest FSO's right to "an actual basis in law or fact for the insurer's position[,]" FSO has standing to prosecute this lawsuit.

iii. Because the defendants continue to actively dispute their obligation to provide meaningful explanations under section 2322F(e), the dispute is not moot.

iv. There is no genuine issue of material fact as to the defendants' obligation to provide meaningful explanations under the statute.

v. The defendants' summary judgment motion was therefore denied.

vi. Consistent with *Stroud v. Grace*, 606 A.2d 75, 81 (Del. 1992) and other authority, it was appropriate to grant summary judgment on the merits to FSO *sua sponte*.

vii. FSO met all four requirements for class certification under Rule 23(a).

viii. Declaratory judgment was appropriate, just as contemplated under Rule 23(b)(2).

ix. Notwithstanding FSO's satisfaction of all requirements for class certification under Rules 23(a) and (b)(2), class certification would be denied because declaratory relief "could be afforded [to FSO] in an individual action."[6]

[6] *First State Orthopaedics, P.A. v. Emp'rs Ins. Co. of Wausau*, 2022 WL 18228287, at *3-10 (Del. Super. Ct. Dec. 29, 2022) (citations omitted).

The Superior Court's analysis of the class certification issue was consistent with its observations at oral argument, where the trial judge clearly signaled that though the Rule 23 criteria had been met, he questioned the "need" for class certification — effectively supplanting the policy decisions on the question of "need" that are embedded within the rule itself:

> THE COURT: And what I'd like to do at this point, because it helps me keep things focused in my mind, and hopefully it will help you understand what my thinking is, is kind of give you my overview of where I think we are.
>
> ***
>
> Those are my comments on the motion for summary judgment. I want to make a few comments on the request to certify the class. And I'm kind of two minds on that issue.
>
> I think that the plaintiffs make a reasonable case that they meet a lot of the elements that we look for under Rule 23. But I have a real fundamental issue with a class in this case. And I asked myself the question, I even wrote it down so I wouldn't forget, why do we even need a class here?
>
> ***
>
> And I have to say, I've gone through those [Rule 23] criteria and it looks pretty good, like you meet those criteria.[7]

[7] A1100, A1106-07, A1244.

SUMMARY OF ARGUMENT

A. Summary of Argument on FSO's Cross-Appeal (Class Certification Issue)

1. Under Delaware law, class certification entails a two-step analysis.[8] The first step requires that the action satisfy the four prerequisites of Rule 23(a).[9] The second step requires the Court to "properly fit the action within the framework provided in subsection (b)."[10]

2. The Superior Court correctly found that FSO had satisfied the four prerequisites to class certification under Rule 23(a). It then proceeded to find (once again, correctly) that declaratory judgment was appropriate, just as contemplated under Rule 23(b)(2) — and appropriate, that is, as to a uniform practice that affects all members of the proposed class uniformly. This analysis should have resulted in a grant of class certification.

3. In a departure from settled law, the Superior Court instead applied a new and unprecedented three-part test for class certification. This three-part test consists of an inquiry into the criteria under Rule 23(a), a second inquiry into the propriety of declaratory judgment as provided under Rule 23(b)(2), and a third

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[8] *Prezant v. De Angelis*, 636 A.2d 915, 920 (Del. 1994) (citing *Nottingham Partners v. Dana*, 564 A.2d 1089, 1094 (Del. 1989)).

[9] *Prezant*, 636 A.2d at 920 (citing *Nottingham Partners* at 1094).

[10] *Prezant*, 636 A.2d at 920 (citing *Nottingham Partners* at 1095).

inquiry into whether a class action is "needed." There is no authority for this third step, which is ill-advised in any event.

4. The relative "need" for class treatment involves policy considerations that have already been made — policy considerations embedded within Rule 23 itself.

5. The Superior Court's "needs" analysis was also internally inconsistent. It relied on *First State Orthopaedics, P.A. v. Liberty Mut. Ins. Co.*, 2020 WL 6875218 (Del. Super. Ct. Nov. 20, 2020) ("*FSO v. Liberty*"), citing that decision for the proposition that "if Defendants continued the practice asserted by Plaintiff, perhaps at that time injunctive relief [or in Superior Court, corresponding declaratory relief] and class certification under Rule 23(b)(2) would be appropriate."[11] But the Superior Court also found that the offending conduct ***is*** continuing, every hour of every day:

> I find that Defendants supplied no explanations of its [Explanation of Benefits] denials until after the Complaint was filed. Nor have Defendants provided me with the corrected explanations, or corrected the incorrect denials that it sent to patients over the years, including the 19 patients as to which Plaintiff claims to be an assignee.
>
> ***

[11] *First State Orthopaedics, P.A. v. Emp'rs Ins. Co. of Wausau*, 2022 WL 18228287, at *3 (Del. Super. Ct. Dec. 29, 2022) (citing *FSO v. Liberty* at *13) (internal quotation omitted).

> The challenged conduct and the dispute over it are ongoing. Defendants have not proffered a global effort to withdraw their explanations, or to correct them with new explanations. Even if Defendants have corrected the explanations for Plaintiff's patients, the challenged claim denials remain the operative explanations for other numerous patient claims in Delaware. Defendants' designee would not concede that claim denials must communicate an actual basis in fact or law for the insurer's position. Thus, there remains an ongoing dispute between the parties.[12]

In other words, the Superior Court found that the defendants failed to supply proof that they had corrected the deficient denials that were sent to FSO; had made no effort to correct the deficient denials sent to absent class members; and were continuing to insist that their claim denials need not identify any basis in fact or law for their refusal to pay — and for these reasons, the offending conduct was continuing in nature. It then concluded that class certification would only be appropriate if the offending conduct proved to be continuing in nature; and it cited that proposition as a reason for denying class certification. This self-contradictory analysis was error.

6. The Superior Court's "needs" analysis effectively repeals Rule 23. Specifically, the court concluded that a class action was not needed because relief could be afforded on an individual basis.[13] But relief can be afforded on an

[12] *First State Orthopaedics, P.A. v. Emp'rs Ins. Co. of Wausau*, 2022 WL 18228287, at *6-7 (Del. Super. Ct. Dec. 29, 2022).

[13] *Id.* at *3 (citations omitted).

individual basis in ***every*** proposed class action. If the availability of individual relief determines the propriety of class certification, no class should ever be certified in any case, either under Superior Court Civil Rule 23 or Chancery Court Rule 23.

7. Class actions are a widely recognized means of empowering individuals and small businesses to seek justice in cases that, as a practical matter, could not otherwise be pursued. The Superior Court's decision to deny class certification in a case where all criteria for class certification were met will lead lawyers to insist on hourly fee arrangements in cases that (like this one) involve nonmonetary relief only, or that involve only modest economic harm. That will have the effect of disempowering individuals and small businesses, and permitting powerful commercial actors to act with impunity.

8. Class actions are also widely recognized as a means of incentivizing lawyers to pursue cases on a representative basis, under contingency fee arrangements. This has historically been seen as a positive good; for as noted above, class actions redress wrongs that would otherwise go unchallenged. But why would any private practitioner prosecute a proposed class action in a jurisdiction where, even if the named plaintiff satisfies all the prerequisites for class certification under Rules 23(a) and (b), class certification will ***still*** be denied — and denied for a reason (the availability of individual relief) that applies in

every case? Unless the Superior Court's analysis is reversed, it cannot be expected that lawyers will accept such assignments in the future, at least in Superior Court (and perhaps also in Chancery Court).

B. Summary of Argument on Defendants' Appeal (Summary Judgment Issues)

1. Denied. The Superior Court correctly found that FSO has standing to sue, because:

a. The defendants supplied FSO with no explanation of the offending claim denials at any time prior to the filing of the complaint;

b. The defendants failed to show that they had cured the tautological "explanations" for the denials they sent to FSO, thereby depriving FSO of important contractual and statutory rights and delaying the processing of FSO's bills on an ongoing basis;

c. The defendants admitted in discovery that they have made no effort to cure the deficient denials sent to other Delaware care providers, thereby creating uncertainty regarding the rights of all such providers (including FSO) to receive meaningful explanations of claim denials now and in in the future;

d. The defendants continue to deny that their workers'-compensation-related claim denials must identify any actual basis in law or fact for the denial, and this likewise creates uncertainty as to FSO's rights now and in the future; and

e. These circumstances establish that FSO continues to suffer an injury in fact — an injury that is directly traceable to the defendants' conduct, and one that would be redressed by an outcome favorable to FSO on the merits.[14]

f. Meanwhile, though the defendants argued below that the parties' dispute was moot, they have abandoned the mootness argument on appeal. This leaves them in the odd position of conceding the existence of a live and actual controversy touching on important rights — rights important enough to be guaranteed by the General Assembly — while simultaneously arguing that the holder of those rights has no standing to sue.

2. Denied. The Superior Court correctly rejected the defendants' statute of limitations argument. This lawsuit does not arise from some vague abstractions, free-floating in the ether. Rather, it arises from specific transactions — specific medical bills submitted to the defendants under specific insurance contracts with respect to specific injured workers. Each and every claim denial that forms the basis of this lawsuit relates to just such a medical bill; and each was issued by the defendants within the applicable three-year statute of limitations. The fact that the defendants issued similarly deficient claim denials for other, older medical bills for

[14] *See Dover Hist. Soc. v. City of Dover Plan. Comm'n*, 838 A.2d 1103, 1110 (Del. 2003) (setting forth the requirements for standing).

other injured workers is irrelevant. Indeed, if the defendants' odd take on the statute of limitations is upheld, then every Delaware care provider will be forced to sue on every disputed medical bill under the theory that if the same insurer issues a similar denial on some other patient ten years down the road, the later-occurring claim will be time-barred. But the applicable statutes of limitations (for actions based on a promise and actions based on a statute) do not apply to a defendants' corporate "practices"; they instead apply to specific transactions — specific breaches of contract and specific statutory violations. Here, those transactions occurred within the applicable limitations period, and FSO's claim for declaratory judgment is not time-barred.

3. Denied. The defendants' contention that the explanations required under section 2322F(e) need not be meaningful — that they may instead be meaning***less*** — is absurd. An explanation that explains nothing is no explanation at all, be it in writing or no. Nor did the General Assembly enact section 2322F(e) out of some affinity for "writings"; rather, it enacted the provision so that care providers and injured workers would be meaningfully informed of a carrier's position, and able to make informed judgments as to whether and how to contest that position.

Further, the fact that FSO's Rule 30(b)(6) designee struggled to understand what the defendants' form denials mean — offering that they may refer to preauthorization of benefits — is not a feather in the defendants' cap. The literal

meaning of Code x553, which cannot be denied with anything like intellectual honesty, is *We're not paying because we say so*. And as the defendants' own 30(b)(6) designee admitted, the code says absolutely nothing about preauthorization.

In other words, the defendants have managed to thoroughly confuse Delaware's health care professionals, leaving them to guess at whatever the carrier's tautological nonsense is supposed to mean. Though the defendants claim this as a triumph, it is better described as a continuing disaster — if not for the defendants, then for care providers and injured workers. Claim denials are supposed to inform, not confuse; and they cannot properly be interpreted to mean something (here, something about "preauthorization") that they nowhere state.

STATEMENT OF FACTS

A. The Parties

Plaintiff First State Orthopaedics is an orthopedic practice. It proceeds in this case both in its own right and as assignee of its patient-assignors.[15]

Under settled law, injured workers are third-party beneficiaries of workers' compensation insurance contracts.[16] This means that, by virtue of its patient assignments, FSO has the standing of a third-party beneficiary under the insurance policies issued by the defendants. Nor is there any dispute that the defendants have responded to FSO's workers'-compensation-related invoices by sending the form notices described above — proof that they recognize FSO's standing to bill the carrier directly.

The defendants are members of the Liberty Mutual group. With the exception of defendant Helmsman Management Services, LLC, each defendant regularly sells contracts of workers' compensation insurance in Delaware. Helmsman, for its part, is believed to be a wholly owned subsidiary of Liberty Mutual Holding Company, Inc. It provides claims administration services to members of the Liberty Mutual group.

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[15] Amended complaint at ¶3 (A367).

[16] *Pierce v. Int'l Ins. Co. of Ill.*, 671 A.2d 1361, 1365-66 (Del. 1996) (injured worker is third-party beneficiary under workers' compensation insurance contract).

B. The Statutory Scheme

Prompt payment of medical expenses is a core objective of Delaware's workers' compensation scheme. In *Histed v. E.I. duPont de Nemours & Co.*, 621 A.2d 340 (Del. 1993), this Court observed that "[t]he philosophy of the [Workers' Compensation] Act is to obviate the need for litigation and to give an injured employee, irrespective of fault, prompt compensation."[17] Consistent with this philosophy, the Workers' Compensation Act imposes a 30-day deadline for payment of covered medical expenses — not merely once, but in two separate provisions of the Act.[18] Meanwhile, under 19 *Del. C.* § 2322F(e), "Denial of payment for health care services provided pursuant to this chapter, whether in whole or in part, shall be accompanied with written explanation of reason for denial."

C. The Defendants' Wrongful Conduct

The defendants routinely purport to satisfy the requirements of section 2322F(e) by sending the form Explanation of Benefits (or "EOB") referenced above. Again, these EOBs state, verbatim or in substance, that

> THIS SERVICE [IS] NOT AUTHORIZED BY CASE MANAGER. PLEASE CONTACT THE CASE MANAGER FOR FURTHER INFORMATION.

[17] *Histed* at 342.

[18] *See* 19 *Del. C.* §§ 2322F(h) and 2362(b).

Contrary to the defendants' contentions, these EOBs do not meet the requirements of section 2322F(e). This is because, though the EOBs purport on their face to deny coverage for the health care invoice in question, they fail to set forth any reason for the denial.

The harm caused by the defendants' use of the offending EOBs is concrete and substantial. Unless claimants and providers know the reason(s) why coverage for a particular health care invoice has been denied, the claimant and provider are deprived of a fair and meaningful chance to contest (or even evaluate) the denial. That is why, as a matter of hornbook law, insurers bear a duty to inform claimants and providers of their coverage determinations with reasonable promptness, and in a manner that allows the claimant and provider to protect their rights.[19]

In addition, the defendants use these form EOBs as a means of avoiding the General Assembly's mandate that insurers take meaningful action within 30 days of receipt of a health care invoice. By subverting the statutory 30-day deadline, the defendants prejudice the ability of claimants and their care providers to promptly assess and, if appropriate, contest coverage denials on a level playing field. The

[19] *See, e.g.*, *Viking Pump, Inc. v. Liberty Mut. Ins. Co*., 2007 WL 1207107 at *28 (Del. Ch. Apr. 13, 2018) ("It is hornbook law that an insurer bears a duty to inform its insureds of claims decisions, and to do so in a reasonably prompt and informative manner that allows insureds to protect their rights by pursuing other course[s] of action") (internal quotation omitted).

defendants thus subject workers'-compensation-related invoices to unreasonable delay, in contravention of the overarching public policy that underlies Delaware's workers' compensation scheme.

D. The Defendants' Repeated Defense of Their Conduct

i. The Defendants' Defense of Their Conduct in District Court

As noted above, the defendants improperly removed this case to the U.S. District Court for the District of Delaware, which ultimately remanded the case to Superior Court. While before the district court, the defendants argued that the offending practice was entirely lawful:

> THE COURT: So have you gone back and provided explanations for the denials that predate August 2018?
>
> MR. (*sic*) POWERS: I'm not sure I exactly understand that question, Your Honor, because it is our position in the case that the explanation we gave is a sufficient explanation for the denial under the statute.[20]

ii. The Defendants' Defense of Their Conduct on Their Motion to Dismiss

Having defended the offending practice in district court, the defendants proceeded to do the same in Superior Court. On their motion to dismiss, they

[20] *First State Orthopaedics, P.A. v. Emp'rs Ins. Co. of Wausau*, C.A. No. 1:19-cv-00509-LPS, hearing tr. at 41 (D. Del. Aug. 23, 2019) (B007). References to the alphanumeric sequence beginning with "B" are to the accompanying appendix.

devoted an entire argument to the proposition that "the challenged denial explanation satisfies the plain language of 19 *Del. C.* § 2322F(e)."[21]

iii. The Defendants' Defense of Their Conduct in the Course of Discovery

The Defendants' Rule 30(b)(6) designee likewise defended the use of Code x553, insisting that "the x553 we're looking at is meaningful."[22]

iv. The Defendants' Defense of Their Conduct on Summary Judgment

Predictably, the defendants repeatedly defended their use of Code x553 in connection with their summary judgment motion — just as they have defended the practice on this appeal.[23]

E. Other Revelations in the Course of Discovery

i. The Defendants' Disclosure on Numerosity

In the course of discovery, the defendants disclosed that since the start of the proposed class period (January 31, 2016), they "responded to one or more charges with Code x553" on over 800 occasions.[24]

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[21] A66, A66-69.

[22] A822.

[23] *See, e.g.*, A1109 (defendants dispute "plaintiff's theory of the case that it is not a meaningful explanation.")

[24] A483-85.

ii. Discovery Regarding the Defendants' Failure to Cure

On October 1, 2020, FSO served the defendants with an interrogatory aimed at determining whether the defendants had undertaken any global effort to correct the deficient EOBs:

> At any time since January 1, 2017, has any defendant instructed its employees, agents, or other representatives (in substance) that ***as a matter of general policy or practice***, instances in which Code x553 had previously been communicated to a Delaware care provider should be identified so that a new, revised, corrected, or supplemented explanation could be provided to the care provider?[25]

This question — whether the defendants had instructed their employees to correct the deficient denials as a matter of general policy or practice — was logically capable of three answers: *Yes*, *No*, or *We don't know*.

On November 13, 2020, the defendants served FSO with a nonresponsive answer. It consisted of an extended string of objections and evasions:

> Defendants incorporate their General Objections as if set forth fully herein. Defendants further object that Interrogatory No. 1 is vague and ambiguous because it is unclear what Plaintiff means by "(in substance)." Defendants further object that Interrogatory No. 1 is vague and ambiguous because Plaintiff does not explain what it means by "matter of general policy or practice." Defendants further object that Interrogatory No. 1 is unduly burdensome because determining whether Defendants issued "new, revised, corrected, or supplemented explanation[s]" in any instance in which Code x553 was used would require an individual, file-by-file review that is disproportionate to the needs of this case. Defendants further object that Interrogatory No. 1 is unduly burdensome because the information responsive to this Interrogatory is within Plaintiff's possession as Plaintiff received the

[25] B010 (emphasis added).

> explanations that Defendants provided in response to health care invoices submitted by Plaintiff and therefore would know whether Defendants submitted any "new, revised, corrected, or supplemented explanation[s]" for any invoice in which Defendants originally responded with Code x553. Defendants further object to the extent that Interrogatory No. 1 calls for information related to putative class members as no class has been certified in this case. ***
>
> *** Defendants state that FSO submitted 46 invoices during the relevant period to which one of the Defendants responded by denying coverage, in whole or in part, and listed Code x553 on the explanation of payments form ("EOP") as a basis for the denial. Of those 46 invoices, at least 21 have involved subsequent payment activity, including a supplemental or superseding EOP in which x553 was not used. The circumstances that led to the updated explanation of payment and supplemental payment vary based on the particular facts surrounding each invoice.[26]

Among other infirmities in this response, the defendants' insistence that determining the existence of a ***global instruction*** would require a claim-file-by-claim-file review is illogical on its face. By definition, a global directive to the defendants' employees would exist independently of individual claim files. Similarly, the assertion that "the information responsive to this Interrogatory is within Plaintiff's possession" made no sense; FSO obviously had no way of knowing whether the defendants had instructed their employees to correct EOBs on a global scale.

[26] B013-15.

On the same day the defendants served their response, FSO's counsel wrote to defense counsel, seeking a responsive answer.[27] Defense counsel responded on November 30, 2020, explaining that "if your question is whether defendants have issued a supplemental explanation for every instance [in which Code] x553 was used, the answer is no."[28] Roughly two hours later, FSO's counsel wrote again, asking the defendants to set forth their "no" in a verified interrogatory response.[29] On December 18, 2020, the defendants served the supplemental response. Though, like its predecessor, it included roughly three pages of objections and evasions, it did offer this helpful (and, finally, responsive) addendum: "[I]nsofar [as] this interrogatory asks whether Defendants have issued a supplemental explanation for *every* instance [in which] Code x553 was previously used, the answer is no."[30] There is thus no dispute that the defendants have undertaken no across-the-board effort to rectify the situation.

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[27] B016.

[28] B019.

[29] *Id*.

[30] B023-26 (emphasis in original).

iii. Defendants' Testimony Under Superior Court Civil Rule 30(b)(6)

Other useful information was gleaned from the testimony of the defendants' Rule 30(b)(6) designee. Though the defendants argue on this appeal that "if the General Assembly had intended to include a meaningfulness requirement in Section 2322F(e) it would have done so," the defendants' designee admitted that the statute does in fact require meaningful explanations:

> Q. *** [I]s it defendant's position that the explanation does not have to be meaningful?
>
> A. I do believe that it does have to be meaningful, and I do believe at least the x553 we're looking at is meaningful.[31]

At the same time, the designee refused to concede that its supposedly meaningful "explanations" need actually explain anything. In the remarkable exchange that follows, the designee rejected the proposition that when explaining why a medical bill will not be paid, the carrier must actually offer some basis in fact or law for its decision:

> Q. Okay. Um, the explanation — the written explanation has to provide basic factual or legal reasoning for the denial of the claim; right?
>
> ***
>
> THE WITNESS: I can just tell you what the statute says, and it says that it requires a written explanation of the denial.

[31] B042. The passage quoted from the defendants' opening brief appears at page 36 of their brief, and is shown here with internal quotations and citations omitted.

> Q. I'm not asking you what the statute says. I'm asking you what Defendant's interpretation is and what their procedures are. The defendants are providing EOPs (*sic*) to providers and providing them with an explanation of why they're denying the claim. That's to provide a factual or legal reasoning for their denial; correct?
>
> MR. HATCHETT: Object to form.
>
> THE WITNESS: It's to provide a written explanation of the denial. It's — it's to be understood by the health care provider, or anyone in the industry just looking at that description of the denial, a written description of the denial.[32]

F. The Defendants' Admissions at Oral Argument

The defendants' presentation at oral argument below was revealing. Addressing the defendants' summary judgment motion, the trial judge presented defense counsel with a straightforward hypothetical question — and elicited an equally straightforward answer:

> THE COURT: Okay. Let me make maybe a more simple hypothetical. If the explanation is we're not going to pay this because we don't want to pay it, does that meet the statutory requirement in your view?
>
> MR. HATCHETT: No.[33]

Whether intended by the defendants or no, this was an admission of liability — an admission, that is, that the declaratory relief sought by FSO was appropriate.

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[32] B042.

[33] A1129.

Moments later, the trial judge posed a question of obvious importance to the defendants' contention on this appeal that the offending conduct is unlikely to recur: *Would the defendants do it again?*

> THE COURT: And this bears on other issues in the case. But you've spent a substantial amount of time here this morning explaining to me why you believe this is an appropriate denial under the Workers' Compensation Law. Does that mean that you or your client may use this in the future?
>
> MR. HATCHETT: We don't —
>
> THE COURT: You don't what?
>
> Mr. HATCHETT: We do not use this denial.[34]

In other words, despite the clarity and simplicity of the Court's question, defense counsel attempted to evade it. And so the court tried again:

> THE COURT: You don't use it now. But if you believe it is appropriate, then why don't you think your client would be free to use it in the future?[35]

Here defense counsel might have offered that the fact that the denial engendered years of litigation was reason enough to avoid its use in the future. But that was not his answer:

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[34] A1142.

[35] *Id.*

> MR. HATCHETT: For Tim the chiropractor, who is not a certified healthcare provider in the State of Delaware, he doesn't get — neither him or his patient is getting some treatment that is abstract, novel therapy. He's not a certified provider. We are not required to cover that unless it is pre-authorized.
>
> And so he submits that to us. What are we supposed to say when we deny that invoice, but for you failed to secure prior authorization for this treatment? That is, in fact, the reason we are not required to cover it?[36]

Defense counsel's observations regarding "Tim the chiropractor" did not, of course, answer the trial judge's question. Moreover, the question posed by defense counsel — *What are we supposed to say when we deny for lack of prior authorization?* has an obvious answer, and it involves issuing a denial that actually uses the terms "pre-authorization," "prior authorization" or "authorization in advance," rather than a denial that (like Code x533) mentions none of these. But more to the point, defense counsel evaded the court's question a second time.

Undeterred, the trial judge made a third attempt:

> THE COURT: Okay. But I'm not sure that quite answers my question, Mr. Hatchett.
>
> My question is, given the argument you've made here to me this morning, do you believe that your client would be free to use this code in the future for Delaware medical providers?[37]

Remarkably, defense counsel evaded the question yet again:

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[36] A1142-43.
[37] A1143.

> MR. HATCHETT: That are certified?
>
> THE COURT: Either one. Let's do each.
>
> MR. HATCHETT: No, not for certified — certified healthcare providers, the answer is no.
>
> THE COURT: And how about for non-certified health providers?
>
> MR. HATCHETT: So the current explanation — so I will tell you this, and this is outside the record. We have completely discontinued the use of prior authorization in the State of Delaware, regardless. In between the time that this case was filed and that that decision was made, the word prior was injected into this to add clarity.
>
> THE COURT: It was put into the notice that the provider would not just get — there is no authorization, it would be there is no prior; that's what you instructed?
>
> MR. HATCHETT: For 20 years, nobody said anything about it until we have this lawsuit, and then it's like, okay, if one provider is telling us that the word prior would be helpful —[38]

At this point, defense counsel had ducked the court's question not once, not twice, but three times. The fourth time proved the charm:

> THE COURT: Okay. But, Mr. Hatchett, like I said, I'd appreciate an answer to my question.
>
> Given the argument you've made here today, and we can limit it if you want to non-certified, do you believe that the explanation given under Code x553 would be appropriate under Delaware law?
>
> MR. HATCHETT: I do.[39]

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[38] A1143-44.

[39] A1144.

In short, the answer to the question *Would the defendants do it again?* is undeniably *Yes, they would.*

ARGUMENT

I. HAVING CORRECTLY FOUND THAT ALL PREREQUISITES TO CLASS CERTIFICATION WERE MET, THE SUPERIOR COURT ERRED BY THEN DENYING CLASS CERTIFICATION

A. Question Presented

Did the Superior Court err in denying class certification where the court found that all prerequisites to class certification had been met? (Preserved at A407-520, A807-59, A1051-97.)

B. Scope of Review

Generally speaking, this Court reviews determinations on class certification for abuse of discretion. Where, however, any party contends that the trial court's Rule 23 analysis either formulated or applied legal precepts incorrectly, those contentions are reviewed *de novo.*[40]

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[40] *In re Celera Corp. Shareholder Litig.*, 59 A.3d 418, 428 (Del. 2012) (footnotes omitted). *Celera* set forth these standards in the context of objections raised by certain class members to the trial court's certification of a class:

> We review the [trial court's] determinations on Rule 23 class certification for abuse of discretion. To the extent that objectors to the class contend that the Court of Chancery formulated "incorrect legal precepts or applied those precepts incorrectly," we review those claims *de novo.*

Id. There is no principled reason why any different standard of review would apply to a named plaintiff's assignment of error.

C. Merits of Argument

The Superior Court denied class certification for one reason and one reason only: because in the court's view, the fact that relief could be afforded on an individual basis obviated the need for representative treatment. Relying on the denial of class certification in *FSO v. Liberty*, and noting that it had already found Code x553 unlawful in its earlier decision on the defendants' motion to dismiss, the court stated:

> The Court explained that an earlier summary judgment decision had "already establishe[d] Defendants' duty to pay interest, which was the declaratory relief sought in the complaint. "[B]ecause the Court's previous Opinion serves the same purpose as declaratory judgment, under the facts here the Court finds that Rule 23(b)(2) relief is not appropriate." *** Instead, the Court held that "if Defendants continued the practice asserted by Plaintiff, perhaps at that time injunctive relief and class certification under Rule 23(b)(2) would be appropriate." In my view, the same analysis applies here.
>
> ***
>
> Ultimately my decision is my opinion. It is now the law of this case. It binds the parties. Precedent is precious, until it is not. In any event, adding a class element changes none of these principles.
>
> My rulings in favor of Plaintiff and my ruling on the Motion for Summary Judgment, below, resolve the case in a manner that will bind Defendants even if no class is certified. Furthermore, like the statutory interest case [that is, *FSO v. Liberty*], injunctive relief is not necessary or warranted, as I am unwilling to punish Defendants for

> past conduct, particularly given their abandonment of the use of Code x553.[41]

Respectfully, this approach was error.

i. Class Certification Entails a *Two-Step* Analysis

Under settled Delaware law, "certification of a class action [entails] a two-step analysis."[42] The first step requires that the action satisfy the four prerequisites of Rule 23(a).[43] The second step requires the Court to "properly fit the action within the framework provided in subsection (b)."[44] There is no "third step."

The Superior Court correctly found that all criteria under Rules 23(a) and (b)(2) were met.[45] And how could it have done otherwise? The case at bar — involving uniform misconduct, perpetrated through the use of standard form mailings — makes the classic case for class certification. But having completed its two-step analysis, and found that all prerequisites to class certification were met, the Superior Court should not have proceeded to any third step; and certainly it

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[41] *First State Orthopaedics, P.A. v. Emp'rs Ins. Co. of Wausau*, 2022 WL 18228287, at *3-4 (Del. Super. Ct. Dec. 29, 2022) (citing and quoting *FSO v. Liberty*, 2020 WL 6875218 at *12-14) (other citations omitted).

[42] *Prezant v. De Angelis*, 636 A.2d 915, 920 (Del. 1994) (citing *Nottingham Partners v. Dana*, 564 A.2d 1089, 1094 (Del. 1989)).

[43] *Prezant*, 636 A.2d at 920 (citing *Nottingham Partners* at 1094).

[44] *Prezant*, 636 A.2d at 920 (citing *Nottingham Partners* at 1095).

[45] FSO incorporates by reference its showing below that the requisite criteria under Rules 23(a) and (b)(2) were met. *See* A431-38.

should not have denied class certification based on the perceived "need" for class treatment.

The relative "need" for class treatment involves policy considerations that have already been made; for they are embedded within Rule 23 itself. In other words, Rule 23 itself tells us all we need to know on the subject of need. If the Rule 23 criteria are met, then representative treatment is needed on the one hand, and required on the other. If the criteria are not met, then class treatment is neither needed nor permitted. Indeed, it is hard to imagine a more fundamental legal error than for a trial court to consult the rule, apply the rule, conclude that the rule is satisfied, and then promptly discard the rule.

ii. The Superior Court's Own Analysis Identified the "Need" for Class Treatment

The Superior Court itself identified the need for class treatment. As shown above, the court relied on *FSO v. Liberty*, citing that decision for the proposition that "if Defendants continued the practice asserted by Plaintiff, perhaps at that time injunctive relief [or in Superior Court, corresponding declaratory relief] and class certification under Rule 23(b)(2) would be appropriate."[46] But the Superior Court

[46] *First State Orthopaedics, P.A. v. Emp'rs Ins. Co. of Wausau*, 2022 WL 18228287, at *3 (Del. Super. Ct. Dec. 29, 2022) (citing *FSO v. Liberty* at *13) (internal quotation omitted).

also found that the defendants' unlawful conduct ***is*** continuing, every hour of every day:

> ***The challenged conduct and the dispute over it are ongoing***. Defendants have not proffered a global effort to withdraw their explanations, or to correct them with new explanations. Even if Defendants have corrected the explanations for Plaintiff's patients, the challenged claim denials remain the operative explanations for other numerous patient claims in Delaware. Defendants' designee would not concede that claim denials must communicate an actual basis in fact or law for the insurer's position. Thus, there remains an ongoing dispute between the parties.[47]

In other words, the Superior Court found that the defendants (i) failed to supply proof that they had corrected the deficient denials that were sent to FSO; (ii) made no effort to correct the deficient denials sent to absent class members; and (iii) were continuing to insist that their claim denials need not identify any basis in fact or law for their refusal to pay any particular medical bill — and for these reasons, the offending conduct was continuing in nature. It then concluded that class certification would only be appropriate if the offending conduct proved to be continuing in nature; and it cited that proposition as a reason for denying class certification. This self-contradictory analysis was error.

[47] *First State Orthopaedics, P.A. v. Emp'rs Ins. Co. of Wausau*, 2022 WL 18228287, at *6-7 (Del. Super. Ct. Dec. 29, 2022) (emphasis added).

Nor can there be any doubt that the defendants' misconduct is ongoing. When payment for a covered insurance claim is delayed, that delay is inherently injurious; for such is the nature of insurance.[48] But this is particularly true of workers' compensation insurance, which serves as a vital safety net for workers: "The philosophy of the [Workers' Compensation] Act is to obviate the need for litigation and to give an injured employee, irrespective of fault, prompt compensation."[49] It is against this backdrop that this Court has found that a workers' compensation insurer "violates the duty of good faith and fair dealing when it ***delays*** or terminates payment of a claim in bad faith."[50]

The defendants failed to show that they had corrected the deficient claim denials that were sent to FSO; and they admittedly made no effort to correct the offending denials that were sent to absent class members. The entire proposed class is therefore saddled — and for as long as the offending denials are not corrected, will ***continue to be*** saddled — with meaningless denials that leave them not only without payment, but even without the basic information needed to inform

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[48] *See E.I. duPont de Nemours and Co. v. Pressman*, 679 A.2d 436, 447 (Del. 1996) (explaining the unique market forces that underlie insurance products).

[49] *Histed v. E.I. duPont de Nemours & Co.*, 621 A.2d 340, 342 (Del. 1993).

[50] *Pierce v. Int'l Ins. Co. of Ill.*, 671 A.2d 1361, 1366 (Del. 1996) (emphasis added; internal quotation omitted).

their decision to contest the denials. It must also be stated that the Superior Court's stated unwillingness to "punish Defendants for past conduct" makes no sense in light of its express finding that "[t]he challenged conduct and the dispute over it are ongoing."[51]

In short, the decision below can ultimately be reduced to a head-scratching syllogism:

- *There is no need for class certification unless the defendants continue their unlawful conduct.*
- *The defendants have continued their unlawful conduct.*
- *Therefore, class certification is denied.*

This was manifest error.

iii. The Superior Court's "Needs" Analysis Effectively Repeals Rule 23

The decision below is unmistakably clear as to its rationale: class certification was denied because relief was available on an individual basis — that is, it "could be afforded in an individual action."[52]

[51] *First State Orthopaedics, P.A. v. Emp'rs Ins. Co. of Wausau*, 2022 WL 18228287, at *4, *7 (Del. Super. Ct. Dec. 29, 2022).

[52] *First State Orthopaedics, P.A. v. Emp'rs Ins. Co. of Wausau*, 2022 WL 18228287, at *3 (Del. Super. Ct. Dec. 29, 2022).

But individual relief can be afforded in ***every*** proposed class action. If the availability of individual relief determines the propriety of class certification, no class should ever be certified, either under Superior Court Rule 23 or its Chancery Court counterpart. The decision below thus effectively repeals Rule 23; and to the extent it is followed in the future, it promises profound mischief in the Delaware trial courts.

As a 2018 Congressional Research Service report noted, the class action device is rooted in the earliest English common law:

> Class actions have an ancient pedigree; analogues to class actions "have been recognized in various forms since the earliest days of English law," and class actions have "been a fixture" of federal litigation in the United States "for over seventy-five years."[53]

To be sure, the device has its champions and its detractors. But there is no question that, when managed properly, class actions are a positive good. As the federal courts' Special Committee on Class Action Improvements has stated, "[T]he class action is a valuable procedural tool affording significant opportunities to implement important public policies."[54]

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[53] Congressional Research Serv., *Class Action Lawsuits: A Legal Overview for the 115th Congress* (Apr. 11, 2018) (internal citations omitted).

[54] Richard O. Cunningham, George B. Mickum, III, W. Robert Brown, N. Lee Cooper, et. al., *Report and Recommendations of the Special Committee on Class Action Improvements*, 110 F.R.D. 195, 198 (1986).

Class actions thus play an important role in the administration of justice, particularly for the many Davids among us who daily contend with the world's Goliaths. If class actions are to be banished from the Delaware courts, that blow should properly be struck, not by judges, but by elected officials. A rule that effectively renders class treatment unavailable in every case involves public policy considerations that are too far-reaching and too controversial to be resolved on a single motion in a single lawsuit, decided by a single (unelected) judge.

Judicial discretion may properly be exercised on a broad range of legal issues. But where class treatment is sought, "[t]here are dangers associated with robust judicial discretion."[55] They include the threat of "a lack of uniformity in the treatment of requests for certification and an appearance of inconsistency in the rule of law."[56] These threats are nowhere more profound than in a case where, by the trial court's own admission, all prerequisites for class certification were met and yet class certification itself was denied.

[55] Tobias Barrington Wolff, *Discretion in Class Certification*, 162 U. Pa. L. Rev. 1897, 1942 (2014).

[56] *Id.*

iv. The Decision Below Removes the Incentives that Class Actions Are Intended to Create, Thereby Placing Justice Out of Reach for Small Businesses and Consumers

a. The Decision Below Disincentivizes Litigants

A plaintiff's ability to aggregate claims on a classwide basis often determines the very viability of a lawsuit: "Sometimes a class-action lawsuit is the only way in which consumers would know of their rights at all, let alone have a forum for their vindication."[57] Courts thus recognize that a class representative's personal stake in the dispute is often quite modest, so that in the absence of class treatment, the economics of litigation make no sense: "The device is especially important when each claim is too small to justify the expense of a separate suit, so that without a class action there would be no relief, however meritorious the claims."[58] In such cases, a denial of class certification sounds the death knell of a proposed class representative's efforts: no class certification means, as a practical matter, no lawsuit.

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[57] 4 Herbert B. Newberg and Alba Conte, *Newberg on Class Actions* § 18.01 (3d ed. 1992) (quoting *Coleman v. Cannon Oil Co.*, 141 F.R.D. 516, 520 (M.D. Ala. 1992)).

[58] *Eubank v. Pella Corp.*, 753 F.3d 718, 719 (7th Cir. 2014). *See also Mitchell-Tracey v. United Gen. Title Ins. Co.*, 237 F.R.D. 551, 560 (D. Md. 2006) (quoting *Van Jackson v. Check 'N Go of Ill., Inc.*, 193 F.R.D. 544, 547 (N.D. Ill. 2000).

This "death knell" doctrine was first recognized in *Eisen v. Carlisle & Jacquelin*, 370 F.2d 119 (2d Cir. 1966), *cert. denied*, 386 U.S. 1035 (1967). There the Second Circuit, addressing the propriety of a permissive appeal from the district court's denial of class certification, concluded (with abundant common sense) that "[one] can safely assume that no lawyer of competence is going to undertake this complex and costly case to recover $70 for Mr. Eisen."[59] That dynamic has not changed since *Eisen* was decided.[60] Class actions thus remain a widely recognized means of empowering individuals and small businesses to seek justice in cases they could not otherwise afford to pursue.

The Superior Court's decision to deny class certification in a case where all the criteria for class certification were met will lead lawyers to insist on hourly fee arrangements in cases that (like this one) involve nonmonetary relief only, or that involve only modest economic harm — cases that, to borrow from *Mitchell-Tracey v. United Gen. Title Ins. Co.*, 237 F.R.D. 551 (D. Md. 2006), involve "piecemeal highway robbery."[61] That would have the effect of disempowering individuals and small businesses, and permitting powerful commercial actors to act with impunity.

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[59] *Eisen*, 370 F.2d at 120.

[60] *See Newton v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 259 F.3d 154, 165 (3d Cir. 2001) ("[S]ome of the securities claims pressed by the putative class members may be too small to survive as individual claims.")

[61] *Mitchell-Tracey*, 237 F.R.D. at 560 (internal citation omitted).

b. The Decision Below Disincentivizes Lawyers

In a case of this kind — one seeking nonmonetary relief only — a successful outcome for the class would ordinarily have resulted in an award of attorneys' fees under the common benefit doctrine:

> It is well established that in a class action the plaintiff's counsel will be entitled to an award of counsel fees and expenses where counsels' litigative efforts achieve a benefit that inures to all members of the class. Often the benefit consists of a monetary fund created by a judgment or settlement of the litigation. However, it is not a prerequisite that the benefit be monetary. If the benefit is nonmonetary, counsel would still be entitled to a counsel fee award, so long as the benefit is specific, substantial, and inures to the class as a whole.[62]

It is axiomatic, meanwhile, that the class action device is designed to incentivize lawyers to act as private attorneys general. The Chancery Court has thus observed that when class counsel are successful, they merit "sizable" fee awards "because of the benefit received and because of the risk that was taken by counsel that if there is not success, then there would be no compensation."[63] In the context of shareholder derivative litigation, the Chancery Court has viewed the

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[62] *Friedman v. Baxter Travenol Labs., Inc*., 1986 WL 2254 (Del. Ch. Feb. 18, 1986). *See also See Chrysler Corp. v. Dann*, 223 A.2d 384, 386-89 (Del. 1966) (rejecting Chrysler's contention that attorneys' fees should not be awarded where the benefit to shareholders was purely nonmonetary).

[63] *Chappaqua Family Trust v. MGM/UA Communications Co.*, 1997 WL 33173285, at *1 (Del. Ch. July 10, 1997).

incentivization of class counsel as "a cornerstone of sound corporate governance."[64] Writing in the same vein, the Sixth Circuit has stated that "[i]f we are to encourage [class actions'] positive societal effects, class counsel must be adequately compensated."[65]

Indeed, when faithfully pursued, the role of private attorney general implies at least some dedication to the public good. One commentator thus argues that a class action lawyer's clients "are not just the class members, but the public and the class members," because "their goal is not just compensation, but deterrence and compensation."[66] It is for these reasons — not the selfish personal interests of the class action lawyer, but the promotion of the public good — that the class action device incentivizes lawyers.

The decision below destroys those incentives. One must ask, if only rhetorically (because the answer is so obvious): Why would any private practitioner prosecute a proposed class action in a jurisdiction where, even if the named plaintiff satisfies all the prerequisites for class certification under Rules

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[64] *In re Fuqua Industries, Inc. Shareholder Litig.*, 752 A.2d 126, 133 (Del. Ch. 1999).

[65] *Gascho v. Glob. Fitness Holdings, LLC*, 822 F.3d 269, 287 (6th Cir. 2016).

[66] William B. Rubenstein, *On What A "Private Attorney General" Is — and Why It Matters*, 57 Vand. L. Rev. 2129, 2168 (2004).

23(a) and (b), class certification will ***still*** be denied — and denied for a reason (the availability of individual relief) that applies in ***every*** case?

Unless the Superior Court's class certification analysis is reversed, it cannot be expected that lawyers will accept such assignments in the future, at least in Superior Court (and perhaps also in Chancery Court).[67] To avoid this result, and to safeguard the public good, the proposed class should be certified.

[67] After all, individual relief is always available in shareholder derivative cases; so why certify a class?

II. BECAUSE THE DEFENDANTS' MISCONDUCT CONTINUES EVEN TODAY, THE SUPERIOR COURT CORRECTLY REJECTED THEIR "STANDING" ARGUMENT

A. Question Presented

Did the Superior Court err in rejecting the defendants' "standing" argument where (i) FSO is even now suffering actual injury from the defendants' continued failure to explain their claim denials, (ii) that injury is directly traceable to the defendants' conduct, and (iii) the injury would be redressed by an outcome favorable to FSO on the merits? (Preserved at A882-88.)

B. Scope of Review

This Court reviews the Superior Court's grant or denial of summary judgment motion *de novo*.[68] Questions relating to standing are likewise reviewed *de novo*.[69]

C. Merits of Argument

The controlling test for standing is set forth in *Dover Hist. Soc. v. City of Dover Plan. Comm'n*, 838 A.2d 1103 (Del. 2003):

[68] *ConAgra Foods, Inc. v. Lexington Ins. Co.*, 21 A.3d 62, 68 (Del. 2011) (citing *Stonewall Ins. Co. v. E.I. duPont de Nemours & Co.*, 996 A.2d 1254, 1256 (Del. 2010).

[69] *Brookfield Asset Mgt., Inc. v. Rosson*, 261 A.3d 1251, 1262 (Del. 2021).

> To establish standing, a plaintiff or petitioner must demonstrate first, that he or she sustained an "injury-in-fact"; and second, that the interests he or she seeks to be protected are within the zone of interests to be protected. The requirements for Article III constitutional standing have been identified by the United States Supreme Court and were recently summarized by the United States Court of Appeals for the Third Circuit, as follows:
> (1) the plaintiff must have suffered an injury in fact — an invasion of a legally protected interest which is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; (2) there must be a causal connection between the injury and the conduct complained of — the injury has to be fairly traceable to the challenged action of the defendant and not the result of the independent action of some third party not before the court; and (3) it must be likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision.[70]

The defendants say that the Superior Court "conflated" standing and mootness. But this criticism comes with little grace when one considers the defendants' own approach to "standing": in their opening brief on summary judgment below — the vehicle by which they purported to win the day on "standing" — the defendants never even cited *Dover Historical Society*.[71]

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[70] *Dover Hist. Soc.*, 838 A.2d at 1110 (quoting *Society Hill Towers Owners' Ass'n v. Rendell*, 210 F.3d 168, 175-76 (3d Cir. 2000)).

[71] *See* A528-58. The specific section of defendants' opening brief on summary judgment that addresses standing appears at pages A547-49. Like the rest of the brief, it makes no mention of *Dover Historical Society*.

In any event, the Superior Court conflated nothing. To the contrary, the court expressly noted that standing and mootness are "distinct[] jurisdictional doctrines."[72] It then proceeded to an analysis that tracks the *Dover Historical Society* factors exactly:

> In my view, [the *Dover Historical Society*] test is met in this case. Plaintiff has alleged actual and concrete injury from Defendants' conduct, in the form of delayed processing of its claims for payment of health care invoices. Defendants' conduct is alleged to be the sole cause of the injury. Finally, a declaratory judgment that claim denials under 19 *Del. C.* § 2322F(e) must set forth meaningful explanations would redress the injury.[73]

This analysis was plainly correct. Though the defendants hammer away at their supposed pre-suit abandonment of Code x553, they do not dispute that "discontinuing" the code does nothing to "discontinue" its effect. This means that, once a provider is saddled with the code's tautological explanation, that provider remains without an explanation for as long as the denial remains uncorrected.

i. The Defendants Made No Showing that They Ever Corrected the Deficient Explanations that Were Sent to FSO, and They Admitted that They Never Sent Corrected Explanations to Absent Class Members

Did the defendants ever supplement and correct their deficient explanations? If they did, they made no showing of it below: "Defendants have not proffered a

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[72] *First State Orthopaedics, P.A. v. Emp'rs Ins. Co. of Wausau*, 2022 WL 18228287, at *5 (Del. Super. Ct. Dec. 29, 2022) (citations omitted).

[73] *Id.* at *6.

global effort to withdraw their explanations, or to correct them with new explanations."[74] The defendants ***did*** claim, in conclusory fashion within an interrogatory response, that they had corrected their deficient explanations ***as to FSO only***. Specifically, in amended responses to FSO's third set of interrogatories, the defendants stated as follows:

> *Interrogatory No. 1: At any time since January 1, 2017, has any defendant instructed its employees, agents, or other representatives (in substance) that as a matter of general policy or practice, instances in which Code x553 had previously been communicated to a Delaware care provider should be identified so that a new, revised, corrected, or supplemented explanation could be provided to the care provider?*
>
> **Response to Interrogatory No. 1:**
>
> *** Since January 1, 2017, each defendant has issued "a new, revised, corrected, or supplemented explanation" for every invoice submitted by FSO during the relevant period that was initially denied with Code x553.[75]

No doubt the defendants saw this as a clever stratagem; for it was obviously intended to undermine the "representativeness" of FSO's claims under Rule 23, and undercut FSO's standing as a proposed class representative. Yet it was too clever by half. Since the supposed "corrections" were withheld from hundreds of

[74] *Id.* at *6. As shown above, the defendants admitted, in response to an interrogatory on the subject, that they never made any global effort to correct their deficient explanations. *See* B023-26.

[75] A853, A855-56.

absent class members, it showed that the defendants cared a good deal more about defeating class certification than they did about complying with the workers' compensation statute — a fatal showing on the issue of whether defendants' misconduct is likely to recur. And it failed on the "representativeness" front, too: the defendants' refusal to issue corrected explanations on a global basis confirmed that all proposed class members (including FSO) share a common interest in overcoming the defendants' insistence that section 2322F(e) does not actually require an explanation in law or fact as to why a claim has been denied.

But when the defendants said that they gave FSO "corrected" explanations, what did they mean? They contended, after all, that Code x553 is entirely lawful, and that there was nothing to correct. It is something like hearing Volodymyr Zelensky declare that *Ukraine is a sovereign nation*, and then seeing Vladimir Putin nod in agreement. The one means that Ukraine is "sovereign" in the sense that the U.S., U.K., and France are sovereign. The other means that Ukraine is part of the ***Russian*** sovereign.

In the same way, when the Superior Court and FSO say that section 2322F(e) requires a written explanation, they mean when one thing. When the defendants say *We gave them an explanation*, they mean something else entirely — because, as they expressly argue on this appeal, they do not accept that such explanations must be meaningful.

The solution was for the defendants to make the supposed "corrections" a part of the record below, and demonstrate that they had finally complied with the statute (at least as to FSO). This they chose not to do; and that choice was revealing in itself.

ii. Had the Defendants Shown that They Genuinely Corrected the Deficient Explanations Sent to FSO, FSO Would Still Have Standing

Had the defendants demonstrated below that they supplied FSO with honest to goodness "corrections" (though they did not), FSO would still have standing to seek declaratory judgment. This is a function of defendants' legal position on the one hand, and the nature of declaratory judgment on the other.

a. The Defendants' Strident Defense of Code x553, and Their Insistence That They Need Not Identify Any Legal or Factual Basis for Claim Denials, Confers Standing

As shown above, the defendants' Rule 30(b)(6) designee refused to concede that claim denials under section 2322F(e) must identify some basis in law or fact for the denial. At oral argument, defense counsel repeatedly evaded the trial judge's question regarding whether his clients would engage in the offending conduct in the future, before finally admitting that they would. And on this very appeal, the defendants argue that their "explanations" need not be meaningful. On this record, it is clear that the defendants' misconduct is likely to recur.

It is significant, too, that the defendants cite *Friends of the Earth, Inc. v. Laidlaw Envtl. Serv.*, 528 U.S. 167 (2000) for the proposition that FSO must show that their "wrongful behavior will likely occur or continue . . . ."[76] For how do the federal courts determine whether wrongful conduct is likely to recur? They do so by determining whether a defendant has continued to defend its misconduct before the court. Thus, in *Knox v. Serv. Employees Intern. Union, Loc. 1000*, 567 U.S. 298 (2012), the U.S. Supreme Court viewed a labor union's misconduct as likely to recur precisely because it continued to defend that conduct in the lawsuit: "[S]ince the union continues to defend the legality of [its misconduct], it is not clear why the union would necessarily refrain from [that misconduct] in the future."[77] Similarly, in *Cooper v. Charter Commc'n Entm'ts, I, LLC*, 760 F.3d 103 (1st Cir. 2014) the First Circuit found that a cable provider could reasonably be expected to repeat its misconduct because, even though it had actually paid the credits sought by the plaintiffs, it "gave credits to the plaintiffs under a policy it adopted 'voluntarily,' which . . . according to [the cable provider], 'exceed[ed] requirements under the law.'"[78]

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[76] Opening brief at 21 (quoting *Friends of the Earth*, 528 U.S. at 190) (emphasis omitted).

[77] *Knox*, 567 U.S. at 307.

[78] *Cooper*, 760 F.3d at 107.

Meanwhile, the very purpose of Delaware's Declaratory Judgment Act is "to afford relief from uncertainty with respect to rights."[79] The uncertainty here is palpable, and it is by no means a thing of the past; it exists, and will continue to exist, unless and until the defendants' perverse reading of section 2322F(e) is rejected on appeal. And if the defendants' conduct does not create enough "uncertainty" to confer standing — if their endless defense of their misconduct, and their embrace of outlandish legal positions like *We don't have to identify a legal or factual basis for our claim denials* does not give care providers the right to sue — then the Declaratory Judgment Act is a dead letter.

The record is devoid of evidence that the defendants corrected the deficient denials that they dumped on FSO. But even were this not the case, FSO would still have standing.

b. The Defendants' Abandonment of Their "Mootness" Defense Confirms That Standing Exists

Though the defendants argued below that the parties' dispute was moot, they have abandoned the mootness argument on appeal. This leaves them in the odd position of conceding the existence of a live and actual controversy touching on important rights — rights important enough to be guaranteed by the General

[79] *Wal-Mart Stores, Inc. v. AIG Life Ins. Co.*, 872 A.2d 611, 631 (Del. Ch. 2005), *aff'd in part, rev'd in part*, 901 A.2d 106 (Del. 2006).

Assembly — while simultaneously arguing that the holder of those rights has no standing to have the controversy resolved. This, we submit, makes no sense.

III. THE SUPERIOR COURT CORRECTLY REJECTED THE DEFENDANTS' BIZARRE "LIMITATIONS" ARGUMENT

A. Question Presented

Did the Superior Court err in rejecting the defendants' contention that claims that first accrued during or after 2016 were somehow time-barred years earlier? (Preserved at A891-93.)

B. Scope of Review

This Court reviews the Superior Court's grant or denial of summary judgment motion *de novo*.[80] In addition, whether a complaint is barred by a statute of limitations is a question of law subject to *de novo* review.[81]

C. Merits of Argument

The defendants' "limitations" argument flows from a faulty premise. It is as though they view the lawsuit as unmoored from actual insurance transactions, and somehow tied to cosmic legal principles, free-floating in the ether. The defendants thus argue that, because they subjected FSO to the offending practice as early as

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[80] *ConAgra Foods, Inc. v. Lexington Ins. Co.*, 21 A.3d 62, 68 (Del. 2011) (citing *Stonewall Ins. Co. v. E.I. duPont de Nemours & Co.*, 996 A.2d 1254, 1256 (Del. 2010)).

[81] *LeVan v. Indep. Mall, Inc.*, 940 A.2d 929, 932 (Del. 2007).

2009, the applicable three-year limitations period commenced at that time. But that is not how statutes of limitations work.

As the amended complaint makes clear, FSO proceeds in this case in two capacities: in its own right under section 2322F(e), and as assignee of its patient-assignors.[82] The claims that it asserts in its own right are subject to the three-year limitations periods for actions based on a statute, while the claims assigned by its patients are subject to the three-year limitations period for actions based on a promise — the promise having its source in the workers' compensation insurance contract.[83] But these claims are ***specific*** claims, arising from specific transactions. For example: the EOB at page B001 of FSO's appendix relates to care rendered by FSO to an employee of a local laundromat. It is dated April 14, 2017. Accordingly, to the extent FSO takes issue with the EOB (and it does), FSO had until April 14, 2020 to sue on that EOB. The EOB attached at pages B002-03 relates to care that FSO rendered to a UPS employee. It is dated April 26, 2018. As to that EOB, FSO needed to sue by April 26, 2021.

FSO could not sue on the two EOBs in question in 2009, or 2010, or 2011, etc., for the simple reason that those transactions did not occur until 2017 and 2018, respectively. So when defendants say that this lawsuit could have been filed

[82] Amended Compl. at ¶3 (A367).

[83] *See* 10 *Del. C.* § 8106(a).

in 2009, they do not mean ***this specific lawsuit*** — for this lawsuit arises from specific EOBs issued since January 31, 2016 — but rather a lawsuit ***like this one***, based on the same practice, but as to other EOBs and other patients.

The question thus arises: if a care provider's bill for Patient A is denied payment in 2009, does that preclude (on statute of limitations grounds) a later lawsuit by the care provider on a bill for Patient B in 2019? The answer is clearly no. Care providers routinely see payment denied because, for example, the insurer contests causation for this or that injured worker, or rejects the medical necessity of this or that treatment. But the provider is free to weigh the pros and cons of suing on a patient-by-patient, bill-by-bill basis; and it cannot sue on a particular bill until that bill comes into existence.

To some extent, disputes with insurance companies are an occupational hazard for care providers, a cost of doing business. But on occasion, the problem grows large enough to become intolerable. FSO did not sue here until the offending practice had become widespread enough to threaten its bottom line; but that approach does not constitute a waiver of the right to sue, and the defendants do not suggest otherwise. Meanwhile, the notion that FSO can simply challenge insurance company "practices," unmoored from actual patient care and actual ***medical bills***, makes no sense.

What is more, if the defendants' odd take on the statute of limitations is upheld, then every Delaware care provider will be forced to sue on every disputed medical bill under the theory that if the same insurer issues a similar claim denial on some other patient ten years down the road, the later-occurring claim will be time-barred.

The defendants' citation of *Kerns v. Dukes* does not change the result.[84] *Kerns* was a case in which the challenged transaction occurred in 1990, but the plaintiffs failed to sue until 1999. Here, by contrast, every denial sued upon was issued within three years of FSO's complaint; FSO has not sued with regard to any earlier denials.

The defendants' citation of *Ocimum Biosolutions* is likewise unavailing.[85] This is because *Ocimum* dealt with the "continuing breach" doctrine. As the Superior Court explained,

> The continuing breach doctrine creates an exception to the rule that a breach of contract claim accrues at the time a contract is breached. The doctrine acknowledges that there may be limited circumstances in which a breach of contract claim cannot be alleged at the time of breach because damages cannot be ascertained at that time. Under this exception, if there is a continuing injury for which the damages

[84] *Kerns v. Dukes*, 2004 WL 766529 (Del. Ch. April 2, 2004).

[85] *Ocimum Biosolutions (India) Ltd. v. AstraZeneca UK Ltd.*, 2019 WL 6726836 (Del. Super. Ct. Dec. 4, 2019), *aff'd*, 247 A.3d 674 (Del. 2021).

> cannot be determined until the alleged wrong ceases, the statute of limitations begins to run on the last date of the alleged wrong.[86]

Here, by contrast, the dates on which the claims accrued is known: as to each EOB, the claim accrued when the EOB was received by FSO.[87] Nor is this a case in which the breach could not be alleged at the time it occurred because of the uncertainty of damages. In short, the continuing breach doctrine has nothing to do with this case.

Stated simply, every EOB sued upon in this lawsuit falls squarely within the applicable three-year statute of limitations.[88]

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[86] *Ocicum* at *14 (footnotes omitted).

[87] *See Allstate Ins. Co. v. Spinelli,* 443 A.2d 1286, 1292 (Del. 1982) (claim for breach of coverage obligation accrues when insurer informs insured of denial of coverage).

[88] The defendants assert that FSO's claims are not "related to individual invoices," and that the Superior Court "observed that this case does not concern individual patient-level claims" (whatever that means). Opening brief at 31. But both the complaint and the amended complaint set forth the "patient assignment" language cited above. Both pleadings target "form EOBs" — communications that relate, in every instance, to a specific medical bill for a specific injured worker. Meanwhile, the excerpt from the decision below on which the defendants rely (stating that this case "is about claims handling . . . and not individual benefits") does not remotely support their attempt to divorce this lawsuit from specific transactions. When the Superior Court says that the case is not about "individual benefits," this simply means that FSO does not seek to recover insurance benefits — which is undeniably true, since FSO seeks declaratory judgment only, in the hope of forcing the defendants to explain their claim denials. At the same time, to say that the case is "about claims handling" is to say that it relates to actual claims; and actual claims arise from the treatment of actual patients.

IV. THE SUPERIOR COURT CORRECTLY FOUND THAT THE DEFENDANTS' TAUTOLOGICAL CLAIM DENIALS ARE UNLAWFUL

A. Question Presented

Did the Superior Court err in finding the defendants' tautological claim denials unlawful, and requiring that such denials set forth meaningful explanations? (Preserved at A35-49, A140-87, A241-46, A301-38, A366-83.)

B. Scope of Review

This Court reviews the Superior Court's grant or denial of summary judgment motion *de novo*.[89] In addition, "When interpreting a statute, Delaware courts must ascertain and give effect to the intent of the legislature."[90]

C. Merits of Argument

When construing a statute,

> this Court has established as its standard the search for legislative intent. Where the intent of the legislature is clearly reflected by unambiguous language in the statute, the language itself controls. If uncertainty exists, however, rules of statutory construction are applied. To that end, the statute must be viewed as a whole, and literal or perceived interpretations which yield mischievous or absurd results are to be avoided.[91]

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[89] *ConAgra Foods, Inc. v. Lexington Ins. Co.*, 21 A.3d 62, 68 (Del. 2011) (citing *Stonewall Ins. Co. v. E.I. duPont de Nemours & Co.*, 996 A.2d 1254, 1256 (Del. 2010).

[90] *State Farm Mut. Auto. Ins. Co. v. Davis*, 80 A.3d 628, 632 (Del. 2013).

[91] *Spielberg v. State*, 558 A.2d 291, 293 (Del. 1989) (citations omitted).

This case falls into the first category: it is one in which the statutory language is clear and the General Assembly's intent is obvious. When section 2322F(e) states that claim denials "shall be accompanied with written explanation of reason for denial," that injunction unambiguously contemplates a meaningful explanation; for anything less — and here "less" necessarily means a meaning***less*** explanation — is an absurdity. Indeed, the statute merely codifies the longstanding common law rule under which an insurer, when denying payment of a claim, must offer an informative explanation of its decision:

> Although an insurer may disclaim coverage for a valid reason . . . the notice of disclaimer must promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated. Absent such specific notice, a claimant might have difficulty assessing whether the insurer will be able to disclaim successfully. This uncertainty could prejudice the claimant's ability to ultimately obtain recovery.[92]

It bears noting, too, that the defendants' concern for the binding effect of Rule 30(b)(6) testimony does not extend to the testimony of its own designee, who conceded that denials under section 2322F(e) must indeed be meaningful:

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[92] *General Acc. Ins. Group v. Cirucci*, 387 N.E.2d 223, 225 (N.Y. 1979) (emphasis added). *Accord*, *Viking Pump, Inc. v. Liberty Mut. Ins. Co.*, C.A. No. 1465-VCS, 2007 WL 1207107, at *28 (Del. Ch. Apr. 13, 2018) (same).

> Q. *** [I]s it defendant's position that the explanation does not have to be meaningful?
>
> A. I do believe that it does have to be meaningful, and I do believe at least the x553 we're looking at is meaningful.[93]

But in truth, neither party's Rule 30(b)(6) designee can determine or alter the meaning of either the statute ***or*** Code x553. Statutory construction is a question of law, and solely the province of the Court.[94] The construction of written instruments — for example, an insurer's claim denial — is likewise the province of the Court, not of any litigant or witness: "[The interpretation of written instruments] is one of those things that judges often do and are likely to do better than jurors unburdened by training in exegesis."[95] The interpretation of writings is thus a question of law.[96] A designee's testimony simply cannot transform mere tautology into something better than or different from mere tautology.

The ultimate point is this: When ordinary English speakers demand that an actor explain his or her conduct, it is logically implied that they seek a meaningful explanation. This is because anything less is no explanation at all. But if, for some perverse reason, the General Assembly intended that workers' compensation

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[93] B042.

[94] *Dambro v. Meyer*, 974 A.2d 121, 129 (Del. 2009).

[95] *Markman v. Westview Instruments, Inc.*, 517 U.S. 370, 388 (1996).

[96] *In re Frank and Lotus Huxtable Living Trust*, 757 P.2d 1262, 1265 (Kan. 1988).

insurers offer ***meaningless*** explanations — perhaps as some cruel joke at the expense of injured workers — they could only have accomplished this by using the adjective "meaningless."[97]

i. An Insurer's Claim Denial Under Section 2322F(e) Cannot Mean What It Does Not Say

The defendants' Rule 30(b)(6) designee insisted that even though Code x553 says absolutely nothing about preauthorization, the Code is intended to convey that preauthorization is needed:

> Q. Um, what information does the language of Code 553 provide to the payee in a workers' compensation claim?
>
> A. Uh, the information that, um, I believe that it provides the health care provider is that this service requires preauthorization.
>
> Q. The language of the code does not state anything about preauthorization, does it?
>
> A. It does not. ***[98]

This is problematic for three reasons. ***First***, it is outrageous for the defendants to contend that that their "explanation" conveys something that is nowhere to be found within the explanation itself. That is not how insurer-

[97] *And see Sheehan v. Oblates of St. Francis de Sales*, 15 A.3d 1247, 1256 (Del. 2011) ("Under Delaware law, remedial statutes should be liberally construed to effectuate their purpose.")

[98] A899-900.

consumer communications work. ***Second***, the defendants' use of "authorization" to mean "preauthorization" is confusing at best: the two words are not synonymous, any more than the words "determination" and "predetermination" are synonymous.[99]

Third, preauthorization is only rarely relevant in the context of workers' compensation, because once a provider is properly certified pursuant to the statute — as the overwhelming majority of providers in the workers' compensation arena naturally are — the carrier cannot require preauthorization for that provider's services:

> Certification shall be required for a health-care provider to provide treatment to an employee, pursuant to this chapter, without the requirement that the health-care provider first preauthorize each health-care procedure, office visit or health-care service to be provided to the employee with the employer or insurance carrier.[100]

[99] No one blanches when an impartial decision-maker, like a judge, juror, or arbitrator, reaches a determination, because that is what such actors are meant to do. But it is universally understood that when a judge, juror, or arbitrator reaches a *predetermined* outcome, they act improperly. In other words, the prefix "pre-" can impart a very different meaning.

[100] 19 *Del. C.* § 2322D(a)(1).

ii. The Testimony of FSO's Designee Does Not Rescue Code x553

The defendants say that the testimony of FSO's Rule 30(b)(6) designee shows that Code x553, which says ***nothing*** about preauthorization, is ***entirely*** about preauthorization. That testimony merits quotation at length:

> Q. So what do you understand [Section 2322F(e)] to mean?
>
> A. Telling me that within the scope of the statute, I'm going to get something back from an insurance carrier that tells me why they are denying our claim.
>
> ***
>
> Q. And then we looked at the one that — that the service was not authorized by the case manager is the one we looked at earlier, right?
>
> A. Yes.
>
> Q. And you understand that to be saying the service is something that requires prior authorization, and the prior authorization was not supplied, correct?
>
> A. Right. Liberty's position was that it needed prior authorization.
>
> Q. And you don't dispute that that statement is a written explanation of the reason for denial, correct?
>
> A. It is a written explanation of the reason for denial.
>
> Q. ***Do you believe that that statement does not comply with this provision of the Delaware Code?***
>
> A. ***Right, yes.***
>
> Q. ***Yes, you believe it does not comply, or it does comply?***
>
> A. ***The denial that no authorization by case manager does not comply with Delaware Workers' Compensation Act.***

> Q. But does it satisfy this specific provision that the carrier provide a written explanation?
>
> A. Denial of payment pursuant to this chapter. I can definitely define that you provided a written explanation of reason for denial. But ***since no preauthorization is needed in Delaware, then it does not fall under an appropriate denial for a Delaware-based workers' comp claim***.[101]

FSO's designee thus made clear that FSO feels that the defendants' explanations — while explanations in the literal sense — do not comply with the statute. Moreover, the layman's translation of section 2322F(e) offered by the designee — that "I'm going to get something back from an insurance carrier that tells me why they are denying our claim" — is not just obviously correct, but a perfect counterpoint to the refusal of the defendants' designee to concede that the company's explanations must provide "factual or legal reasoning" in support of claim denials:

> Q. *** The defendants are providing EOPs (*sic*) to providers and providing them with an explanation of why they're denying the claim. That's to provide a factual or legal reasoning for their denial; correct?
>
> MR. HATCHETT: Object to form.
>
> THE WITNESS: It's to provide a written explanation of the denial. It's — it's to be understood by the health care provider, or anyone in the industry just looking at that description of the denial, a written description of the denial.[102]

[101] A928-29 (emphasis added).

[102] B042.

To be sure, FSO's designee struggled to understand what Code x553's "explanation" means. But the code's literal meaning, which cannot be denied with anything like intellectual honesty, is *We're not paying because we say so*. And as the defendants' designee admitted, that wording says absolutely nothing about preauthorization. Yet FSO, left to somehow divine the carrier's position, nonetheless interpreted it to mean that "preauthorization is denied."

In other words, the defendants have managed to thoroughly confuse Delaware's health care professionals, leaving them to guess at whatever Code x553's tautological nonsense is supposed to mean. And the defendants claim this as a triumph.

We submit that it is not a triumph, not for the defendants, and certainly not for care providers and injured workers. Better to describe it as a continuing disaster. But by no means is the defendants' success in sowing confusion — the exact opposite of what claim denials are supposed to accomplish — a reason to declare them victors in this lawsuit.

CONCLUSION

For the reasons set forth above, appellee/cross-appellant First State Orthopaedics, P.A. respectfully requests that this Court reverse that part of the decision below that denied class certification, and affirm that part of the decision that granted summary judgment to FSO.

Respectfully submitted,

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