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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION TWO

ANNA VERTKIN,

Plaintiff and Appellant,

v.

CALIFORNIA PHYSICIANS' SERVICE

et al.,

Defendants and Appellants.

A122175

(Marin County

Super. Ct. No. CV035101)

**INTRODUCTION**

In 2003, defendant California Physicians' Service, doing business as Blue Shield of California (Blue Shield), terminated plaintiff Anna Vertkin, M.D., from her status as a Blue Shield member physician. Vertkin sued Blue Shield for damages. In 2008, the trial court denied Vertkin leave to file a fourth amended complaint alleging new causes of action. The court initially granted Blue Shield's motion for summary judgment. It later granted Vertkin's new trial motion, finding it had made an "error in law" (Code Civ. Proc., § 657, subd. (7))<sup>1</sup> in refusing to consider extrinsic evidence as to the meaning of the term "managed care" in the contract between the parties.

Blue Shield appeals from the order granting the new trial, contending that the trial court erred in considering Vertkin's subjective belief as to the meaning of the term "managed care" and her expert's opinion as to the reasonableness of that belief. Vertkin

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<sup>1</sup> All statutory references are to the Code of Civil Procedure, unless otherwise indicated.

contends an alternative ground for affirming the new trial order is that she raised a triable issue of fact regarding Blue Shield's asserted breach of its contractual obligation to provide her a fair administrative procedure. Vertkin cross-appeals from the order denying her leave to amend in order to assert a cause of action for violation of a common law right to fair procedure. We shall affirm both the order granting a new trial and the order denying leave to amend.

## **FACTS AND PROCEDURAL BACKGROUND**

### ***A Short Tutorial on Health Service Plans***

Instead of purchasing individual or group health insurance policies, most persons now receive health care services through “*managed care organizations*” . . . known in California as “*health care service plans*. . . .” (Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2011) ¶ 6:900 (Croskey et al., Insurance Litigation).)<sup>2</sup> Health care service plans “are defined as ‘(a)ny person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.’ (Health & Saf. C[ode,] § 1345[ , subd.] (f)(1); *Viola v. California Dept. of Managed Health Care* (2005) 133 [Cal.App.]4th 299, 307.)” (Croskey et al., Insurance Litigation, *supra*, ¶ 6:901.) “This term includes health maintenance organizations (‘HMOs’), preferred provider organizations (‘PPOs’), and an array of hybrid models (e.g., ‘point of service’ or ‘POSs’) that have elements of traditional fee for service and indemnity systems, while applying managed care’s utilization management, gatekeeper, and case management techniques. [Citation.]” (*Id.* at ¶ 6:900, citing Health & Saf. Code, § 444.20, subd. (a).)

“In the health care industry, ‘Health Maintenance Organization’ (HMO) has been defined as ‘(a) prepaid organized delivery system where the organization *and* the primary care physicians assume some financial risk for the care provided to its enrolled members.

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<sup>2</sup> “Under federal law, these organizations are called “Managed Care Organizations.” The term ‘refers to any number of systems combining health care delivery with financing.’ [Citation.]” (Croskey et al., Insurance Litigation at ¶ 6:901.)

. . . In a pure HMO, members must obtain care from within the system if it is to be reimbursed.’ [Citation.] [¶] HMOs are commonly organized in one of the following basic forms: [¶] (a) ‘Staff model’: The ‘staff model HMO’ *directly employs physicians and other medical providers*, and often owns its health care facilities. [¶] (b) ‘IPA [(Independent Practice Association)] model’: The ‘IPA model HMO’ is one that *contracts with an association* to provide health care services to the HMO members, and the association in turn contracts with private practice physicians who agree to provide such services to the HMO members. (The private practice physicians are usually independent contractors who also treat non-HMO patients.) [Citations.] [¶] (c) ‘Group model’: The group model HMO *contracts with individual health care provider groups* (or entities with health care provider employees) to provide prepaid health care for its members. [Citation.]” (Croskey et. al., Insurance Litigation, *supra*, at ¶¶ 6:904 to 6:908.)

“The PPO form of managed health care is created where physicians, hospitals and other medical providers contract with [health service organizations] to provide health care services to a defined group of patients on a prearranged, discounted, fee-for-service basis.” (Croskey et al., Insurance Litigation, *supra*, at ¶ 6:915.)

### ***Vertkin Becomes a Preferred Provider of Blue Shield Under a PPO Agreement***

On July 1, 1991, Vertkin entered into a one-page “Physician Membership Agreement” with Blue Shield to become a Blue Shield “preferred provider” (“1991 Agreement”). It is undisputed that the 1991 Agreement was a preferred provider agreement, relating to services provided to patients covered under a preferred provider network or PPO. Under the terms of the 1991 Agreement, Vertkin agreed to provide medical care to Blue Shield subscribers, to “accept Blue Shield’s payment for covered services as payment in full,” and to collect the copay and the deductible directly from the subscriber. She also agreed that she would make “no surcharge for covered services.” Under the terms of Blue Shield’s contracts with its network physicians, physicians are contractually prohibited from billing their patients for any remaining balance based upon

the physicians' "billed" charges. This practice, which by law must be contractually prohibited, is commonly referred to as "balance billing."

***1993 Physician Membership Agreement for Managed Care***

On July 1, 1993, Vertkin entered into a second agreement entitled "Physician Membership Agreement for Managed Care" (the "1993 Agreement"). Under the terms of the 1993 Agreement, Vertkin remained a "preferred provider," but also agreed to participate in Blue Shield's "Managed Care Network." Part One of the 1993 Agreement repeats the provisions of the 1991 Blue Shield physician membership agreement. Like the 1991 Agreement, Part One of the 1993 Agreement states that Vertkin agrees to "render professional services" to Blue Shield subscribers and dependents, and that she agrees to accept direct payment only from Blue Shield, but may collect deductibles and copayments from the patients. Thus, balance billing is prohibited by the 1993 Agreement.

Part Two of the 1993 Agreement established Vertkin's participation in the "Managed Care Network." Specifically, the paragraph immediately preceding Part Two states: "Part Two of this Agreement provides for participation in the Managed Care Network. Blue Shield must approve the application, applying Blue Shield's credentialing criteria. In addition to the provisions of Part One, there are special conditions and restrictions when providing care under managed care arrangements. Part Two establishes those conditions or restrictions." Part Two of the 1993 Agreement identifies the additional specific restrictions on physician practice, involving external coordination and oversight of a patient's overall care, including: (1) Under most circumstances, the physician admits members only to hospitals identified by Blue Shield as "Preferred Hospitals"; (2) under most circumstances, the physician may only refer patients to other Blue Shield Physician Members identified as participating in Blue Shield's Managed Care Network; (3) physicians who participate in the Managed Care Network agree to bill Blue Shield directly and to accept Blue Shield's determination of allowed charges as payment in full for covered services. The physician is no longer allowed to bill the patient directly for deductibles or copayments, without the express permission of Blue

Shield, which determines the amounts that may be directly billed to the patient; (4) The physician agrees to be subject to “managed care arrangements” that require “compliance with Blue Shield rules and regulations establishing medical policy, quality assurance, and utilization review requirements” and that “may be implemented by various means, such as requirements for pre-admittance or pre-service authorization”; (5) the physician shall maintain professional liability insurance in such reasonable limits as Blue Shield shall require; and (6) the physician ensures, “through an appropriate call schedule, that covered services” required by patients “are readily available during regular business hours” and that emergency services are available at all times.

An “Ancillary Agreement,” applicable only to Part Two of the 1993 Agreement, “extends the provisions of Part Two . . . to managed care arrangements established by Blue Shield subsidiaries,” including California Physicians’ Insurance Corporation (CPIC) and California Physicians’ Service Agency, Inc. (CPSA), and other affiliated entities under Blue Shield’s control. The terms of the Ancillary Agreement were to remain in effect so long as Part Two of the 1993 Agreement remained in effect.

The express terms of the 1993 Agreement state that Part One and Part Two are separate and independent, and either part may be terminated by either party without affecting the continued viability of the other part. Part One provides in relevant part: “Physician may terminate this Agreement and resign as a Physician Member by ninety days prior written notice to Blue Shield. Blue Shield may terminate this entire Agreement, including Part One, thereof, pursuant to Blue Shield’s Bylaws. In the event that Part Two of this Agreement alone is terminated by Physician or Blue Shield, Physician shall remain a Physician Member Pursuant to Part One of this Agreement, but Physician shall cease to be eligible to participate in arrangements requiring membership pursuant to Part Two of this Agreement. . . .” The bylaws provided that terminations for cause relating to the physician member’s professional competence or professional conduct shall not become final until the corporation has afforded the physician member a fair procedure, including notice of the reasons for such action, and a reasonable opportunity to respond thereto.

Blue Shield maintained that the managed care network was “a newly-developed PPO network that was developed specifically for the group health market” and that the 1993 Agreement was not an HMO agreement. Vertkin believed when she signed the 1993 Agreement that Part One set forth her obligations as a PPO provider and that the terms of Part Two set forth her obligations as a managed care provider under an HMO plan. At that time, the only Blue Shield patients she was seeing who were subject to external coordination and oversight of the sort specified in Part Two were patients she saw through an arrangement with the Camino Real Medical Group, an Independent Practice Association (IPA), that provided HMO services exclusively for Blue Shield in Marin County. Vertkin had entered her contractual relationship with Camino Real allowing her to receive payments for treating HMO subscribers in 1991.

### ***Later Developments***

In March 1994, Vertkin was fired from Camino Real. (Vertkin was not terminated for reasons relating to her medical competency.)

In an April 4, 1994 letter, responding to Vertkin’s inquiry as to her HMO provider status, Blue Shield stated: “You are correct you are a participating physician in our PPO plan since July 1, 1991. You are also a physician member in the Managed Care Network since July 1, 1993. However, since you are not currently a member of the Camino Real Medical Group as you have stated you are not a HMO physician member with Blue Shield. Camino Real is currently the only Blue Shield HMO Medical Group doing business with Blue Shield in Marin County.” Vertkin concluded from the April 4, 1994 letter that because Part One pertained to her involvement as a PPO provider and Part Two pertained to her involvement with a managed care network such as an HMO, Part Two was no longer in effect by virtue of her disassociation from Camino Real Medical Group. In 1998, Blue Shield sent Vertkin a letter terminating a letter of agreement between Blue Shield and Camino Real Medical Group physicians. When she called Blue Shield to inform them she was not associated with Camino Real Medical Group, Blue Shield told her to ignore the notice as it did not apply to her.

On July 10, 2000, Blue Shield and CPSA entered into a “Network Access Agreement” with United Health Networks, Inc. (United), according to the terms of the Ancillary Agreement applicable to Part Two of the 1993 Agreement. The Network Access Agreement was effective between March 1, 2001 and June 22, 2006. Vertkin received written notice from Blue Shield and United regarding the Network Access Agreement.

Blue Shield maintained that, under the Network Access Agreement, United subscribers were given access to CPSA’s provider network, in which Vertkin participated by virtue of the 1993 Agreement’s “Ancillary Agreement” provision. Blue Shield also maintained that Blue Shield and United notified Vertkin before March 1, 2001, that covered services she provided to United subscribers would be reimbursed based upon her contractual arrangement with Blue Shield under the 1993 Agreement. Vertkin maintains she disregarded this notice, as Blue Shield had previously sent her notices that did not apply to her and then informed her to ignore them. She further maintained that her 1994 disassociation from HMO Camino Real terminated Part Two of the 1993 Agreement and its Ancillary Agreement as to her. Vertkin never unilaterally terminated any part of the 1993 Agreement.

After March 1, 2001, Vertkin rendered medical care to patients with United coverage. She directly billed her United patients for treatment she rendered on a “fee for service” basis according to her personal fee schedule. Sometimes she would “courtesy” bill United with the expectation that United would send money directly to the United patient, not her. Between the effective date of the Network Access Agreement and July 9, 2003, Blue Shield instructed Vertkin not to balance bill patients with United coverage. In May 2001, Vertkin notified United of her belief that Part Two did not apply to her on the basis of Blue Shield’s 1994 and 1998 letters to her.

On July 9, 2003, Blue Shield sent Vertkin a letter informing her that her “status as a Blue Shield Member Physician is being Administratively Terminated effective ninety days [October 7, 2003] from the date of this letter,” and without a right to be reinstated, because of the manner in which she billed her United health care patients. This was the

first and only written communication from Blue Shield regarding the balance billing dispute. Vertkin never balance billed Blue Shield subscribers, only United's.

### ***This Litigation***

On October 30, 2003, Vertkin filed a complaint for damages against Blue Shield and others alleging causes of action for breach of contract, and breach of the covenant of good faith and fair dealing, based on her termination from Blue Shield. The cause of action for breach of the covenant of good faith and fair dealing alleged breach by a course of conduct including, among other things: "Refusing to respond to plaintiff's communications and refusing to respond to plaintiff's attorney's communications" and "terminating plaintiff against public policy and without a fair hearing and in fact, no hearing whatsoever." After demurrers and amendments to the complaint, the operative pleading, the third amended complaint, was filed on March 29, 2005 against Blue Shield, United Health Group, and its wholly owned subsidiary United Health Care. It alleged a single cause of action against Blue Shield for breach of contract.

The third amended complaint alleged in its "operative facts" that "[d]espite repeated requests by both VERTKIN and her attorney, Johnson, to reconsider its position and/or for some type of Administrative Hearing, effective October 9, 2003, BLUE SHIELD unilaterally terminated its relationship with VERTKIN, advised her patients of that termination, and discontinued its payment of her fees. Thus this lawsuit." The breach of contract claim against Blue Shield alleged "[d]efendants' conduct as specified in this Complaint constituted an unjustified breach of both the 1991 Agreement and Part One of the 1993 Agreement with Plaintiff in that BLUE SHIELD has unjustifiably and without proper cause, terminated its long standing PPO agreement with VERTKIN to provide both patients and fees."

### ***Defendant Moves for Summary Judgment and Plaintiff Moves To Amend Her Complaint***

On December 14, 2007, Blue Shield filed a summary judgment motion. Six days later, Vertkin filed a motion for leave to file a fourth amended complaint, alleging several new causes of action against Blue Shield and United defendants, in addition to the

original breach of contract cause of action against Blue Shield. Also included in the proposed fourth amended complaint were tort causes of action against Blue Shield for defamation, intentional and negligent interference with prospective economic relations, violation of common law right to fair procedure, and breach of fiduciary duty. The complaint sought punitive damages. Among the new causes of action against Blue Shield was a cause of action for “violation of common law right to fair procedure” based in part on it’s alleged failure to provide Vertkin notice and a fair procedure before, during and after her termination. On February 4, 2008, the trial court denied the motion to amend.

The trial court granted Blue Shield’s summary judgment motion on March 3, 2008. In granting summary judgment, the trial court rejected Vertkin’s argument that a triable issue of fact existed because she reasonably believed Part Two of the 1993 Agreement related only to Blue Shield HMO patients and that she reasonably believed it was terminated when she was fired in March 1994, by Camino Real Medical Group. The court reasoned that Vertkin’s subjective belief as to the meaning of the contract was immaterial to whether Part Two was still in effect when she balance billed the United patients. Hence, the court sustained Blue Shield’s objections to portions of Vertkin’s declaration and to the declaration of her expert witness, R. Myles Riner, M.D., opining that Part Two was reasonably interpretable by a physician at the time to refer to an HMO plan and the 1994 letter was reasonably interpreted as notice that Part Two was no longer in effect because Vertkin was no longer a member of an IPA or medical group.

The court also rejected Vertkin’s claim to have raised “a triable issue with respect to ‘fair procedure’ theories of liability raised in opposition” to summary judgment. It reasoned she had failed to allege such claims in her third amended complaint and had been denied leave to plead them, and the court recognized that a summary judgment motion “must be directed to issues raised in the pleadings.” It further reasoned that “any claim that Blue Shield breached the ‘fair procedure’ provision of its bylaws is barred by plaintiff’s failure to exhaust her administrative remedies. [Citation.]”

Vertkin moved for a new trial. The trial court granted the new trial motion on May 19, 2008, based on its having made an “ ‘error in law’ . . . in excluding plaintiff’s

expert evidence as to the meaning of the term ‘managed care’ and in granting Blue Shield’s motion for summary judgment based on erroneous application of substantive principles of contract law. (Code Civ. Proc. § 657[, subd.] (7); *Wolf v. Superior Court* (2004) 114 Cal.App.4th 1343, 1350-1351 [(*Wolf I*)].” The court then denied Blue Shield’s summary judgment motion.

Blue Shield timely appealed the trial court’s order granting a new trial. (§ 904.1, subd. (a)(4); *Aguilar v. Atlantic Richfield Co.* (2001) 25 Cal.4th 826, 858 (*Aguilar*) [order granting new trial after grant of summary judgment is appealable]; Eisenberg et al., Civil Appeals and Writs (The Rutter Group, 2011) ¶ 2:138, p. 2-72.5.) Vertkin filed a timely cross-appeal of the trial court’s refusal to grant her motion to file a fourth amended complaint.<sup>3</sup>

## DISCUSSION

### I. Appeal of the New Trial Order

#### *Standard of Review*

“[A]s a general matter, orders granting a new trial are examined for abuse of discretion. [Citations.]” (*Aguilar, supra*, 25 Cal.4th at p. 859.) However, where, as here, the new trial order reversed the summary judgment due to the court’s “asserted error of law,” in granting summary judgment, our review is *de novo*. (*Id.* at pp. 859-860.) “An order granting a new trial following a grant of *summary judgment* is subject to *de novo* review on appeal. This is because any determination *underlying* the order must be scrutinized according to the test applicable to that determination. [Citations.]” (Eisenberg, et al., Civil Appeals and Writs, *supra*, ¶ 8:158.3, at p. 8-119, citing *Aguilar*,

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<sup>3</sup> “[W]hen there is an appeal from a new trial order, the party aggrieved by the underlying judgment *must* take a ‘protective’ cross-appeal from that judgment to preserve the right to appellate review of the judgment in the event the new trial order is reversed on appeal [citation].” (Eisenberg et al., Civil Appeals and Writs, *supra*, ¶ 2:139, at p. 2-72.5.)

at p. 859; *Doe v. United Airlines, Inc.* (2008) 160 Cal.App.4th 1500, 1505; *Wall Street Network, Ltd. v. New York Times Co.* (2008) 164 Cal.App.4th 1171, 1176-1177.)<sup>4</sup>

With two exceptions, not applicable here, a new trial order will be affirmed if it should have been granted on *any ground stated in the motion*, regardless of whether the trial judge specified that ground. (§ 657; *Oakland Raiders v. National Football League* (2007) 41 Cal.4th 624, 634; Eisenberg et al, Civil Appeals and Writs, *supra*, ¶ 8:220, at p. 8-151.) However, we cannot affirm on a ground not stated in the underlying new trial motion. (*Mercer v. Perez* (1968) 68 Cal.2d 104, 119; Eisenberg et al., Civil Appeals and Writs, *supra*, ¶ 8:221 at p. 8-151.)

### ***Evidence of Ambiguity in the 1993 Agreement***

Vertkin admits she balance billed United patients. The parties agree that if Part Two of the 1993 Agreement was in effect, Vertkin was contractually obligated not to balance bill patients with United coverage after March 1, 2001 (the effective date of the Network Access Agreement). The dispute centered on the question whether Part Two of the 1993 Agreement was in effect at the time she balance billed the United patients.

The court initially determined that Vertkin’s belief (reasonable or not) that Part Two of the 1993 Agreement had been terminated, was *irrelevant* to its summary judgment determination, reasoning that a “party’s subjective belief as to the meaning of a contract is immaterial. (*Brant v. California Dairies, Inc.* (1935) 4 Cal.2d 128, 133 [(*Brandt*)].)” *Brandt* states a “settled principle of the law of contract that the undisclosed intentions of the parties are, in the absence of mistake, fraud, etc., immaterial; and that

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<sup>4</sup> “The new trial motion may seek reversal of the summary judgment on the ground that there are triable issues of fact. [Citation.] In addition, the motion may assert that the summary judgment should be reversed because there is ‘[n]ewly discovered evidence’ (Code Civ. Proc., § 657, subd. 4). [Citation.] [¶] The determinations underlying the new trial order dictate our standard of review. [Citation.] To the extent the order relies on the resolution of a question of law, including the existence of triable issues of fact, we examine the matter de novo. [Citations.] To the extent the order relies on the assertion of newly discovered evidence, we examine the order for an abuse of discretion. [Citation.]” (*Doe v. United Airlines, Inc.*, *supra*, 160 Cal.App.4th at pp. 1504-1505.) There was no assertion of newly discovered evidence in this case.

the outward manifestation or expression of assent is controlling. This is the ‘objective’ standard, established by the modern decisions and approved by authoritative writers. [Citations.]” (*Id.* at p. 133.) This is consistent with the well-established rules governing the role of the court in interpreting a written instrument. “The interpretation of a contract is a judicial function. [Citation.] In engaging in this function, the trial court ‘give[s] effect to the mutual intention of the parties as it existed’ at the time the contract was executed. (Civ. Code, §1636.) Ordinarily, the objective intent of the contracting parties is a legal question determined solely by reference to the contract’s terms. (Civ. Code, § 1639 [‘[w]hen a contract is reduced to writing, the intention of the parties is to be ascertained from the writing alone, if possible . . .’]; Civ. Code, § 1638 [the ‘language of a contract is to govern its interpretation . . .’].)” (*Wolf v. Walt Disney Pictures & Television* (2008) 162 Cal.App.4th 1107, 1125-1126 (*Wolf II*).

“The court generally may not consider extrinsic evidence of any prior agreement or contemporaneous oral agreement to vary or contradict the clear and unambiguous terms of a written, integrated contract. (Code Civ. Proc., § 1856, subd. (a); [citations].) Extrinsic evidence is admissible, however, to interpret an agreement when a material term is ambiguous. (Code Civ. Proc., § 1856, subd. (g); [citation].)” (*Wolf II, supra*, 162 Cal.App.4th at p. 1126.)

Upon Vertkin’s motion for new trial, the trial court concluded it had made an error of law in refusing to consider the declaration of Vertkin’s expert, Riner, as to whether ambiguities in the 1993 Agreement relating to the term “managed care” rendered the agreement susceptible to Vertkin’s interpretation that Part Two related to her participation in a Blue Shield HMO and that Part Two had been terminated in 1994 when she was fired by Camino Real. The court cited *Wolf I, supra*, 114 Cal.App.4th 1343, in support. In *Wolf I*, the dispute centered on the meaning of the term “gross receipts” for purposes of triggering Disney’s obligation to pay Wolf royalties on character merchandising. (*Id.* at p. 1350.) The trial court granted summary adjudication for Disney, concluding the term was not ambiguous and further finding the term was not reasonably susceptible to the meaning Wolf urged. (*Ibid.*) The Court of Appeal issued a

writ of mandate compelling the trial court to reverse its grant of summary adjudication. (*Id.* at p. 1360.)

The *Wolf I* court reasoned: “ ‘Where the meaning of the words used in a contract is disputed, the trial court must provisionally receive any proffered extrinsic evidence which is relevant to show whether the contract is reasonably susceptible of a particular meaning. (*Pacific Gas & E. Co. v. G. W. Thomas Drayage etc. Co.* (1968) 69 Cal.2d 33, 39-40; *Pacific Gas & Electric Co. v. Zuckerman* (1987) 189 Cal.App.3d 1113, 1140-1141.) Indeed, it is reversible error for a trial court to refuse to consider such extrinsic evidence on the basis of the trial court’s own conclusion that the language of the contract appears to be clear and unambiguous on its face. *Even if a contract appears unambiguous on its face, a latent ambiguity may be exposed by extrinsic evidence which reveals more than one possible meaning to which the language of the contract is yet reasonably susceptible.* [Citations.]” (*Wolf I, supra*, 114 Cal.App.4th at pp. 1350-1351, fn. omitted, italics added.)

Where the meaning of words in a contract is disputed, the court engages in a process, variously described as a two or three step process. (See *Wolf I, supra*, 114 Cal.App.4th at p. 1351 [two-step process]; *Winet v. Price* (1992) 4 Cal.App.4th 1159, 1165 [same]; *Wolf II, supra*, 162 Cal.App.4th at p. 1126 [three-step process].) No matter the calculation, the court deals with the extrinsic evidence as described in *Wolf I*: “First the court provisionally receives (without actually admitting) all credible evidence concerning the parties’ intentions to determine ‘ambiguity,’ i.e., whether the language is ‘reasonably susceptible’ to the interpretation urged by a party. If in light of the extrinsic evidence the court decides the language is ‘reasonably susceptible’ to the interpretation urged, the extrinsic evidence is then admitted to aid in the second step—interpreting the contract. [Citation.]” (*Winet v. Price*, at p. 1165.) The trial court’s determination of whether an ambiguity exists is a question of law, subject to independent review on appeal. (*Ibid.*) The trial court’s resolution of an ambiguity is also a question of law if no parol evidence is admitted or if the parol evidence is not in conflict. However, where the parol evidence is in conflict, the trial court’s resolution of that conflict is a question of

fact and must be upheld if supported by substantial evidence. (*Id.* at p. 1166.)  
*Furthermore, “[w]hen two equally plausible interpretations of the language of a contract may be made . . . parol evidence is admissible to aid in interpreting the agreement, thereby presenting a question of fact which precludes summary judgment if the evidence is contradictory.” (Walter E. Heller Western, Inc. v. Tecrim Corp. (1987) 196 Cal.App.3d 149, 158.)’ ” (Wolf I, supra, 114 Cal.App.4th at p. 1351, fn. omitted, italics added; accord, Wolf II, at pp. 1126-1127.)*

Here, the meaning of Part Two of the 1993 Agreement was disputed. Vertkin’s subjective understanding of the terms is, as the court determined in its initial grant of summary judgment, irrelevant to the objective meaning of the contract, *unless* the agreement is susceptible to the interpretation she places on it.

The court was required to provisionally accept the extrinsic evidence submitted in declarations by Vertkin and her expert, Riner, in considering whether the 1993 Agreement was reasonably susceptible to the interpretation urged by Vertkin—that Part Two set forth her obligations as a managed care provider under an HMO plan and that termination of her HMO provider relationship terminated Part Two of the agreement so that Part Two did not govern services she later provided to United patients.

Riner’s declaration stated that he had practiced emergency medicine for 32 years, the last 10 in Marin County. Since 2004, he had served as the Managed Care Reimbursement Manager and then Director of Provider Relations for a national physician-owned partnership of emergency medicine physicians. He negotiates provider contracts with insurance companies offering health care service plans, including PPO contracts and managed care contracts. He was “intimately familiar with the language and terms used in those health care provider contracts.” Having reviewed the 1993 Agreement, the Blue Shield Provider Manual that had been provided Vertkin, Blue Shield’s bylaws, and the April 4, 1994 letter concerning Vertkin’s status as an HMO provider, Riner concluded that Part One of the 1993 Agreement “was consistent with a preferred provider agreement related to services provided under a PPO plan,” and

“commonly understood by physicians to be a discounted fee-for-service program where physicians are paid per service at a pre-determined discounted rate.”

He also concluded that “Part Two of the 1993 Agreement pertain[s] to ‘managed care,’ a term used to describe a physician’s obligation to integrate his/her services through a managed care organization such as an independent practice association (IPA) or medical group.”<sup>5</sup> In the balance of his declaration, Riner explained that the

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<sup>5</sup> As to Part Two, Riner’s declaration stated:

“8. In my review, it is clear that Part Two of the 1993 Agreement pertain[s] to ‘managed care,’ a term used to describe a physician’s obligation to integrate his/her services through a managed care organization such as an independent practice association (IPA) or medical group.

“9. Part Two requires a participating physician to refer patients only to Blue Shield providers, to comply with utilization requirements and pre-service authorization, to maintain an appropriate call schedule for patients and be readily available during regular business hours and that emergency services are available 24 hours a day, seven days a week. These services are typically consistent with what is provided under what is commonly known as a health maintenance organization (HMO) plan, as distinguished from services provided by a solo practitioner such as Dr. Vertkin.

“10. Moreover, in 1993 as the managed care industry in California was developing, the term ‘managed care’ typically referred to an HMO plan.

“11. From a physician’s perspective, at the time, the term ‘managed care’ normally implied services by a physician who was integrated into a group practice or association which facilitates coordination and oversight of a patient’s overall care, rather than services of a solo practitioner under a fee for service plan.

“12. The Department of Managed Health Care (‘DMHC’) regulates HMO products, and also Blue Shield’s and Blue Cross’ PPO products. This has created confusion as to whether ‘managed care’ also involves certain PPO plans that happens [*sic*] to be regulated by the DMHC.

“13. It is therefore incumbent upon health care service insurers to carefully explain to a participating physician the nature of the provider contract, and not assume that a physician understands the obligations set forth in the contract.

“14. It is entirely reasonable for Dr. Vertkin, or any physician, to have interpreted Part Two of the 1993 Agreement as an agreement to provide services as an HMO physician, or at least as a physician whose practice was integrated with other physicians in order to provide managed care services.

“15. It is entirely reasonable for Dr. Vertkin, or any physician, to interpret the April 4, 1994 letter as notice that because she was no longer a member of an IPA or medical group, that the provisions of Part Two were no longer in effect.

requirements Part Two placed on participating physicians “*are typically consistent with what is provided under what is commonly known as a health care maintenance organization (HMO) plan, as distinguished from services provided by a solo practitioner such as Dr. Vertkin.*” (Italics added.) He further declared that in 1993, “as the managed care industry in California was developing, *the term ‘managed care’ typically referred to an HMO plan*” (italics added) and *to physicians at that time, the term “managed care” normally implied services by a physician integrated into a group practice or association, rather than a solo practitioner under a fee for service plan.* He explained that because the Department of Managed Health Care regulates both HMO products and Blue Shield and Blue Cross PPO products, there is confusion whether “managed care” also involves certain PPO plans that happen to be regulated by the department. Finally, Riner opined that it was “entirely reasonable for Dr. Vertkin, or any physician, to have interpreted Part Two of the 1993 Agreement as an agreement to provide services as an HMO physician, or at least as a physician whose practice was integrated with other physicians in order to provide managed care services”; that it was “entirely reasonable . . . to interpret the April 4, 1994 letter as notice that because she was no longer a member of an IPA or medical group, that the provisions of Part Two were no longer in effect”; and that the “use of confusing language by Blue Shield in its contract and in its communication to Dr. Vertkin, made it impossible for her or any participating solo practitioner in her position to fully understand and substantially perform their obligations under Part Two.”

The thrust of the Riner declaration is that Vertkin’s interpretation of Part Two of the 1993 Agreement to relate to an HMO, and not to a PPO, was reasonable, as was her understanding of the 1994 letter as notice that Part Two was no longer in effect as to her. Vertkin’s subjective understanding of the 1993 agreement is not the question at issue here and does not itself raise a triable issue of material fact sufficient to overcome summary

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“16. The use of confusing language by Blue Shield in its contract and in its communication to Dr. Vertkin, made it impossible for her or any participating solo practitioner in her position to fully understand and substantially perform their obligations under Part Two.”

judgment. Rather, the question is whether the court, considering this extrinsic evidence, could conclude that Part Two of the 1993 Agreement was *ambiguous* and, if so, whether it was “reasonably susceptible” to the meaning ascribed to it by Vertkin. (See *Wolf I, supra*, 114 Cal.App.4th at p. 1350.) We are persuaded, as was the trial court, that the Riner declaration provides extrinsic evidence that Part Two contained at least a latent ambiguity as to whether the physician was agreeing to render services under an HMO-type arrangement. As explained by Riner, the requirements Part Two imposed on physicians were more typically found in HMO contracts and the use of the term “managed care” at the time the agreement was entered was commonly associated with HMO arrangements.

Nor does the 1994 letter from Blue Shield to Vertkin conclusively establish Vertkin’s ongoing participation under Part Two of the 1993 Agreement, as Blue Shield contends. Although the letter may be interpreted as confirming Vertkin’s ongoing participation in the managed care network, it also advised her that she was no longer an HMO physician. Because Part Two the 1993 Agreement may be read as establishing her participation in a Blue Shield HMO network, the letter is at least ambiguous and is an insufficient basis for summary judgment.

The court did not err in granting the motion for new trial due to its legal error in refusing to consider Vertkin’s extrinsic evidence as to the meaning of Part Two of the 1993 Agreement. In this case there are two plausible interpretations of the language of Part Two of the 1993 Agreement. Consequently, a question of fact is presented that precludes summary judgment. (*Wolf I, supra*, 114 Cal.App.4th at p. 1351.)

Because we have determined the trial court properly granted the new trial motion on the ground that the 1993 Agreement was susceptible to the interpretation urged by Vertkin, we need not consider Vertkin’s additional argument that the new trial ruling was warranted and summary judgment was precluded because she raised triable issues of fact regarding Blue Shield’s breach of its contractual obligation to provide her a fair administrative procedure in terminating her.

## II. Cross-Appeal of the Denial of Leave to File a Fourth Amended Complaint

Vertkin contends on her cross-appeal that the court abused its discretion in refusing to allow her to file a fourth amended complaint. She focuses on the proposed cause of action alleging Blue Shield was required to, but did not, afford her the common law right to fair procedure. (*Potvin v. Metropolitan Life Ins. Co.* (2000) 22 Cal.4th 1060 (*Potvin*).

In *Potvin*, the Supreme Court explained that the common law has long recognized that decisionmaking by private organizations that affect the public interest must, in certain situations, be both substantively rational and procedurally fair. (*Potvin, supra*, 22 Cal.4th at pp. 1066, 1070; see *Yari v. Producers Guild of America, Inc.* (2008) 161 Cal.App.4th 172, 176 [right to fair procedure has its origin in cases “concern[ing] exclusion or expulsion from membership in a gatekeeper organization” and which hold that the right to practice a lawful trade or profession is fundamental and requires protection against arbitrary interference by either government or private entities]; *Palm Medical Group, Inc. v. State Comp. Ins. Fund* (2008) 161 Cal.App.4th 206, 215-218 [same].) *Potvin* held that the relationship between an insurer and its preferred provider physicians significantly affects the public interest (*Potvin, supra*, 22 Cal.4th at p.1071), and that an insurer who removes a doctor from one of its preferred provider lists must comply with the common law right to fair procedure, but “only when the insurer possesses power so substantial that the removal significantly impairs the ability of an ordinary, competent physician to practice medicine or a medical specialty in a particular geographic area, thereby affecting an important, substantial economic interest.” (*Ibid.*)

“ “An application to amend a pleading is addressed to the trial judge’s sound discretion. [Citation.] On appeal the trial court’s ruling will be upheld unless a manifest or gross abuse of discretion is shown. [Citations.] The burden is on the [appellant] to demonstrate that the trial court abused its discretion.” [Citation.] [¶] Code of Civil Procedure section 473, which gives the courts power to permit amendments in furtherance of justice, has received a very liberal interpretation by the courts of this state. (*Klopstock v. Superior Court* (1941) 17 Cal.2d 13, 19; *Atkinson v. Elk Corp.* (2003)

109 Cal.App.4th 739, 760.) In spite of this policy of liberality, a court may deny a good amendment in proper form where there is unwarranted delay in presenting it. (*Record v. Reason* (1999) 73 Cal.App.4th 472, 486; accord, *Yee v. Mobilehome Park Rental Review Bd.* (1998) 62 Cal.App.4th 1409, 1428-1429; *Magpali v. Farmers Group, Inc.* (1996) 48 Cal.App.4th 471, 475, 486-487.) On the other hand, where there is no prejudice to the adverse party, it may be an abuse of discretion to deny leave to amend. [Citation.]’ [Citations.]” (*Fair v. Bakhtiari* (2011) 195 Cal.App.4th 1135, 1147.)

The trial court denied Vertkin’s motion to file a fourth amended complaint, explaining: “This case has been pending for over four years, and it has been well over two and one half years since plaintiff filed her third amended complaint. Plaintiff waited almost a year after announcing she was going to seek leave to file an amended complaint to actually do so, and she waited until after defendants filed their motions for summary judgment. Plaintiff has offered no explanation for the delay. This is not a situation where discovery revealed the new causes of action. Plaintiff has known of the facts all along. Allowing the amendment would require further discovery and postponement of trial.” We shall conclude the trial court did not abuse its discretion in denying the motion to amend in these circumstances.

Vertkin maintains that the amendment to allow her to plead a cause of action for denial of her common law right to a fair procedure is based on the facts already pleaded. However, such circumstance cuts in favor of the trial court’s determination and its finding that the lengthy delay in seeking leave to amend was unexplained. In *Record v. Reason, supra*, 73 Cal.App.4th 472, appellant sought to amend his complaint to allege a claim of intentional or reckless conduct. The appellate court upheld the denial of leave to amend, observing, “ ‘even if a good amendment is proposed in proper form, unwarranted delay in presenting it may—of itself—be a valid reason for denial.’ ” (*Roemer v. Retail Credit Co.* (1975) 44 Cal.App.3d 926, 939-940.) Appellant had knowledge of the circumstances on which he based the amended complaint on the day he was injured, almost three years before he sought leave to amend. Appellant’s reliance on *Honig v. Financial Corp. of America* (1992) 6 Cal.App.4th 960, 966, is misplaced. In that case the

court held the trial court abused its discretion by denying the appellant leave to amend his complaint after respondents moved for summary judgment. *Honig* is distinguishable from the instant situation because the events giving rise to new causes of action transpired subsequently to the filing date of the initial complaint. Here, appellant's amendment arises from the same conduct as that in the original complaint." (*Record v. Reason*, at pp. 486-487.)

Similarly, Vertkin here had knowledge of the facts underlying her common law fair procedure claim from the time she filed her original complaint. As the court found, her motion to amend was filed more than four years into the case, and nearly one year after her counsel first raised the prospect of a fourth amendment with Blue Shield. At a case management conference in February 2007, Vertkin's counsel requested the court to set a trial date because of the length of time the case had been pending, but also told the court he intended to seek to amend the complaint. The court held off setting a trial date, recognizing that additional discovery would likely be required. After finally moving to amend six days after the summary judgment motion was filed, Vertkin took no steps to expedite the January 30, 2008 hearing on her motion to amend. The court could consider that because the trial was set for April 1, 2008, and given a March 3, 2008 discovery cut-off date (§ 2024.020), the time left in which to conduct discovery on the newly asserted tort causes of action was insufficient and that Blue Shield would be foreclosed from seeking summary judgment or summary adjudication on those new claims. (§ 437c, subd. (a).) The trial court could well believe Blue Shield's accusation that Vertkin was seeking an unfair tactical advantage by waiting to file the motion until days after Blue Shield had moved for summary judgment, with the hearing on the motion to take place just 30 days before the discovery cut-off date. Moreover, the court could also conclude that amendment would prejudice Blue Shield in the circumstances, as it appears that both new discovery and possibly further delay of trial would be required. The new cause of action for common law denial of fair procedure—like the other new causes of action Vertkin sought to include in the proposed fourth amended complaint—is a tort cause of action, exposing defendant to punitive damages. Previous discovery had been conducted

in the context of the single contract cause of action. Discovery focused on rebutting a tort cause of action and punitive damages would likely be required, as would discovery into Blue Shield's market power in the region, as that is one of the elements of the cause of action for denial of fair procedure. (See § 2024.050 [motion to reopen discovery].)

Given the circumstances before it at the time, the court acted well within its discretion in denying Vertkin's motion for leave to file a fourth amended complaint.<sup>6</sup>

### DISPOSITION

On the appeal, we affirm the order granting Vertkin a new trial. On the cross-appeal, we affirm the order denying Vertkin's motion for leave to file a fourth amended complaint. Each party shall bear its own appeal costs.

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Kline, P.J.

We concur:

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Haerle, J.

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Lambden, J.

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<sup>6</sup> The pending motion by Blue Shield to strike the declaration of Dennis E. Lee in support of Vertkin's application for an extension of time to file her respondent's brief is **denied**. The extension was granted and no purpose would be served by exploring Blue Shield's allegations relating to Lee's statements regarding service of the Appellant's Appendix on respondent.