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NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION TWO

IV SOLUTIONS, INC., Plaintiff and Appellant, v. HEALTH NET OF CALIFORNIA et al., Defendants and Respondents.	B268816 c/w B275179 (Los Angeles County Super. Ct. No. BC571629)

APPEAL from a judgment and order of the Superior Court of Los Angeles County. William F. Fahey, Judge. Affirmed.

Wolf, Rifkin, Shapiro, Schulman & Rabkin, Marc E. Rohatiner and Eric Levinrad for Plaintiff and Appellant.

Cooley, William P. Donovan, Jr. and Matthew Caplan for Defendant and Respondent Health Net of California, Inc.

Musick, Peeler & Garrett, Dan Woods and Peter J. Diedrich for Defendants and Respondents Golden Empire Managed Care, A Medical Group, Inc. and Managed Care Systems, L.P.

IV Solutions, Inc. (appellant) appeals from a judgment entered after the trial court sustained a demurrer to appellant's First Amended Complaint (FAC) in this action. The FAC alleged causes of action for breach of written contract; breach of implied contract; intentional and negligent misrepresentation; and open book account against respondents Health Net of California, Inc. (Health Net); Golden Empire Managed Care, a Medical Group, Inc. (GEMCare); and Managed Care Systems, L.P. (Managed Care) (collectively respondents).[1]

The trial court sustained Health Net's demurrer, and GEMCare and Managed Care's motion for judgment on the pleadings, on the ground that the claims were barred by the applicable statutes of limitation. The trial court then heard and granted Health Net's motion for attorney fees, awarding Health Net fees in the amount of $78,763. Appellant separately appealed from the judgment and the attorney fee order, and we consolidated the appeals. Finding no error, we affirm both the judgment and the attorney fee order.

FACTUAL BACKGROUND[2]

During the relevant time period, appellant was a licensed clinical pharmacy. Respondents are licensed health care plans and insurers.

An individual known as A.C. was covered by health insurance policies issued by Health Net and GEMCare. A.C.

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[1] Appellant does not challenge on appeal the trial court's dismissal of appellant's second cause of action for breach of implied contract. Therefore, we do not discuss this cause of action further.

[2] The facts as stated here are allegations taken from the FAC. Properly pleaded facts are presumed true for the purposes of this opinion. (*Blank v. Kirwan* (1985) 39 Cal.3d 311, 318.)

suffered from an uncommon condition which can cause irreversible physical deformities and mental problems. Her physician prescribed Supprelin LA, which is designed to deliver medication continuously for 12 months after implantation. Insertion of the implant is a surgical procedure. On or about March 3, 2009, respondents authorized the Supprelin LA implant for A.C. They designated the implant and related services as "approved," and assigned them an authorization number. However, in early 2009, A.C.'s health care providers had difficulty obtaining Supprelin LA. Due to this problem, Health Net and GEMCare looked to obtain it from an out-of-network pharmacy. Appellant was able to promptly provide the implant.

Managed Care authorized the implant and the necessary surgery on or about March 9, 2009. On or about March 24, 2009, Children's Hospital of Central California or A.C.'s physician contacted appellant and requested that it provide the Supprelin LA. Appellant delivered the implant on or about March 25, 2009.

At the time that appellant provided the implant, appellant and Health Net were parties to an agreement containing the following provision:

> "'[IV Solutions] agrees that for any and all future services it provides to any insured or member under any insurance policy or evidence of coverage issued by Health Net (or any of its affiliates, parent companies, sister companies, subsidiaries, successors, or predecessors) it shall accept as payment in full the amount specified or otherwise defined under the particular insurance policy or evidence of coverage in effect at the time that the service was rendered . . . .'"

After providing the authorized Supprelin LA implant to A.C., appellant timely submitted its claims for payment to Health Net. Appellant submitted its standard "'billed charges,'" or retail rate to Health Net. However, Health Net failed to process or pay

the claims in a timely manner. Health Net set forth "completely and obviously" improper interpretations of its own health plan terms, and attempted to rely upon what respondents defined as "'usual and customary'" rates. Respondents used their health plan documents against appellant but refused to provide copies of those documents to appellant. When appellant finally obtained the plan documents, it discovered that respondents had misapplied the document terms in this matter to their benefit. Respondents misclassified the Supprelin LA implant as a stand-alone medication instead of an implant in order to invoke a lower payment rate.

Respondents failed to pay appellant at the applicable pricing scheme, and involved their attorney to attempt to "strong-arm" appellant into believing that it was not entitled to see the plan documents that respondents insisted were applicable to this matter.

In addition, respondents regularly pointed their fingers at each other, claiming it was one of the others that was responsible for payment of appellant's charges.

From 2009 until at least April 2013, respondents issued partial payments, explanations of benefits, and other letters attempting to justify their underpayments to appellant. Throughout this time period, appellant made multiple demands and appeals for proper payments, and respondents reconsidered appellant's appeals and inquiries, issued partial checks and benefit explanations stating their adjudication positions. Respondents never issued a full and final refusal to pay the claims at issue and they continue to fail to pay the majority of appellant's claims.

PROCEDURAL HISTORY

Appellant filed its first complaint in this action on February 6, 2015. After Health Net demurred to the complaint,

appellant voluntarily amended. The FAC was filed on June 1, 2015.

Health Net demurred to all four causes of action in the FAC on the ground that each action was barred by the applicable statute of limitations. Health Net also demurred to the third cause of action for intentional and negligent misrepresentation on the ground that it failed to state facts sufficient to constitute a cause of action against Health Net, and was not pled with sufficient specificity. In addition, Health Net demurred to the fourth cause of action for open book account on the ground that appellant failed to allege that the cause of action was governed by an open book account instead of the agreement alleged in the FAC.

GEMCare and Managed Care filed a motion for judgment on the pleadings as to the second and fourth causes of action, which were the only causes of action alleged against these entities. GEMCare and Managed Care argued that the causes of action were barred by the applicable statutes of limitations.

On October 26, 2015, the court granted the motion for judgment on the pleadings and sustained the demurrer without leave to amend. The court held:

> "On its face, the FAC shows that [appellant's] claims accrued on March 25, 2009 but no later than in May, 2009 . . . . This action was not filed until February 6, 2015, long after all applicable statutes of limitations had expired."

The court noted that respondents' other arguments were well-taken. Appellant's request for leave to amend was denied on the ground that appellant had proffered no new facts. In addition, "in light of the judicial admissions in the FAC," the trial court could not "envision how [appellant] could now plead viable claims."

On February 5, 2016, the trial court entered judgment in favor of respondents.

Health Net then moved to recover its attorney fees, pursuant to the terms of the 2008 agreement between Health Net and appellant.[3] The court granted Health Net's motion, awarding Health Net $78,763 in attorneys' fees.

On December 7, 2015, appellant appealed from the judgment. On May 25, 2016, appellant appealed the attorney fee award. The two matters were consolidated.

DISCUSSION

I. Standards of review

When reviewing a trial court's order sustaining a demurrer without leave to amend, we apply well-established rules of review. "'A demurrer tests the legal sufficiency of the complaint. [Citation.] Therefore, we review the complaint de novo to determine whether it contains sufficient facts to state a cause of action. [Citation.] "We treat the demurrer as admitting all material facts properly pleaded, but not contentions, deductions or conclusions of fact or law." [Citation.] . . .' [Citations.]" (*Czajkowski v. Haskell & White, LLP* (2012) 208 Cal.App.4th 166, 173.)

"'"The standard of appellate review of a judgment on the pleadings is . . . identical to that on a judgment following the sustaining of a demurrer."'" (*Kempton v. City of Los Angeles* (2008) 165 Cal.App.4th 1344, 1347-1348.)

Where, as here, the trial court has sustained a demurrer without leave to amend, "we must decide whether there is a reasonable possibility the plaintiff could cure the defect with an

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[3] The 2008 agreement provided that, "[i]n any dispute arising out of this AGREEMENT, the prevailing PARTY shall be entitled to recover its reasonable costs, including, but not limited to . . . reasonable attorneys' fees."

amendment. [Citation.] If we find that an amendment could cure the defect, we conclude that the trial court abused its discretion and we reverse; if not, no abuse of discretion has occurred. [Citation.]" (*Schifando v. City of Los Angeles* (2003) 31 Cal.4th 1074, 1081.)

An award of attorney fees is generally reviewed for abuse of discretion. (*Soni v. Wellmike Enterprise Co. Ltd.* (2014) 224 Cal.App.4th 1477, 1481.)

II. Appellant's claims are barred as a matter of law

A. Breach of written contract

The statute of limitations for an action for breach of written contract is four years. (Code Civ. Proc., § 337.)

"A cause of action for breach of contract accrues at the time of breach, which then starts the limitations period running. [Citation.]" (*Cochran v. Cochran* (1997) 56 Cal.App.4th 1115, 1120.)

Accepting appellant's claims as pled, the breach occurred in 2009. In March 2009, appellant was asked to provide the Supprelin LA, which it provided on or about March 25, 2009, then timely submitted its claim for payment to respondents. The written agreement between the parties, dated May 20, 2008, defined the pricing mechanism that Health Net should have paid. However, Health Net failed to process or pay the claim in a timely manner. Appellant admits that payment was due no later than May 2009, as appellant has alleged "[a]s a direct and proximate result of [Health Net's] breach, [appellant] has been damaged in an amount exceeding the jurisdictional limit of this Court, according to proof at trial, plus interest at the legal rate of 10%, which has been accruing since May, 2009."

Appellant did not file its claim for breach of contract against Health Net until February 2015. Thus, it is barred by the four-year statute of limitations.

B. Intentional and negligent misrepresentation

The statute of limitations for an action for intentional misrepresentation is three years. (Code Civ. Proc. § 338, subd. (d).) The statute of limitations for an action for negligent misrepresentation is two years. (§ 339, subd. (1); *Butcher v. Truck Ins. Exchange* (2000) 77 Cal.App.4th 1442, 1467-1468.) A claim for intentional or negligent misrepresentation accrues when a plaintiff is on notice that the defendant has made the misrepresentation. (*E-Fab, Inc. v. Accountants, Inc. Services* (2007) 153 Cal.App.4th 1308, 1323.)

Appellant alleges that "[o]n or about March 5, 2009," GEMCare and Managed Care made misrepresentations regarding the payments and the categorization of Supprelin LA. Appellant also alleges that Health Net made "various representations" to appellant, including "that [appellant] was authorized to provide services to A.C., that Health Net would make full payment to [appellant] and that it would follow the terms of its various health plans when calculating payments to [appellant]." Appellant should have been on notice of these misrepresentations when it received less than full payment in 2009. Further, appellant alleges that "[a]s a direct and proximate result of Health Net's fraudulent, intentional and/or negligent misrepresentations, [appellant] has been damaged in an amount in excess of the jurisdictional minimum of this Court, plus interest at the legal rate of 10%, which has been accruing since May, 2009." The cause of action accrued in May 2009 when proper payment was due.

Appellant did not file its claim for intentional or negligent misrepresentation against respondents until February 2015, more than three years beyond the accrual of its claim. Thus, the claim is barred.

C. Open book account

Claims for open book account are subject to a four-year statute of limitations, which begins to run "as of the last entry in the book account." (*R.N.C., Inc. v. Tsegeletos* (1991) 231 Cal.App.3d 967, 972 (*R.N.C.*); Code Civ. Proc., § 337, subd. (2).) "A book account does not remain open indefinitely so that any payment towards the debt necessarily becomes an 'entry' for purposes of the applicable limitations period. Instead, a book account . . . becomes closed once . . . there will be no further activity on the account other than the payments by a creditor towards the settled debt." (*R.N.C.*, at p. 972.) In *R.N.C.*, the statute of limitations began to run on a claim for open book account either when the creditor summed up the debt, or when the creditor demanded payment in full. (*Id.* at pp. 973-975.) Partial payments made later did not re-open the account. (*Ibid.*)

In its allegations regarding open book account, appellant incorporated by reference all previous allegations set forth in its FAC. Appellant alleged that respondents became indebted to appellant for the services appellant provided to A.C., and despite appellant's demands for payment, failed to pay the outstanding balance on the account. Under the law set forth above, the claim for open book account accrued when appellant "timely submitted" its claims for payment after providing the Supprelin LA in 2009. (*R.N.C., supra,* 231 Cal.App.3d at p. 972.)

Appellant did not file its claim for open book account until February 2015, more than four years after the last possible entry in an open book account. Thus, the claim is barred.

III. Estoppel is not applicable

A defendant's actions may estop the defendant from asserting the statute of limitations if the defendant's acts or conduct wrongfully induces the plaintiff to believe an amicable adjustment of his claim will be made. (*Bertorelli v. City of Tulare*

(1986) 180 Cal.App.3d 432, 440.) "Whether an estoppel exists -- whether the acts, representations, or conduct lulled a party into a sense of security preventing him from instituting proceedings before the running of the statute, and whether the party relied thereon to his prejudice -- is a question of fact, not of law. [Citation.]" (*Industrial Indem. Co. v. Industrial Acci. Com.* (1953) 115 Cal.App.2d 684, 690.)

Appellant claims that the FAC alleges facts which, if true, would be sufficient to establish that respondents are estopped from asserting the running of the statute of limitations until April 2013. Appellant points out that the FAC states: "From 2009 to at least April, 2013, [respondents] issued partial payments, explanations of benefits, and other letters attempting to justify their underpayments to [appellant]." The FAC further alleges that, "Throughout this time period, [appellant] made multiple demands and appeals for proper payments, and [respondents] reconsidered [appellant's] appeals and inquiries, issued partial checks, and benefit explanations stating their adjudication positions." Appellant argues that, if proven, these allegations are sufficient to support a conclusion that respondents lulled appellant into a false sense of security until April 2013, thereby preventing appellant from bringing an action against respondents. Appellant argues that it was error for the trial court to dispose of this factual question on demurrer.

The law does not support appellant's position that repeated requests for reconsideration of the payment amount serve to toll the statute of limitations. In *Singh v. Allstate Ins. Co.* (1998) 63 Cal.App.4th 135 (*Singh*), the insureds argued that the statute of limitations should be tolled during an approximately one-month time period during which they asked the insurance company to reconsider its initial denial of their claim and received a second denial of their claim. The Court of Appeal held that a request for

reconsideration did not serve to toll the statute of limitations. The court reasoned, "Plaintiffs were aware of the right to sue, and of potential grounds, before any request for reconsideration. The justifications for equitable tolling are absent, once the carrier has initially denied the claim." (*Id.* at p. 142.)

More recently, in *Vishva Dev, M.D., Inc. v. Blue Shield of California Life & Health Ins. Co.* (2016) 2 Cal.App.5th 1218 (*Vishva Dev*), a provider of medical care appealed an insurer's decision to pay less than the full amount of emergency medical services through the insurer's internal appeal process. The provider had received a written Explanation of Benefits (EOB) as to each patient, setting forth the amount that the insurance company would pay for each patient. These EOBs put the provider on notice that its claims for payments were being denied in part. Because the provider filed suit more than two years after receiving the EOBs, its claim was barred. (*Id.* at p. 1224.) The insurer's "willingness to consider additional evidence, or provide a voluntary appeal process, after it had given unequivocal notice that a claim was rejected did not toll the limitations period. [Citations.]" (*Ibid.*)

These cases show that the statute of limitations begins with the insurer's notice to the claimant that its "claim for payments [is] being denied in part or in whole." (*Vishva Dev, supra*, 2 Cal.App.5th at p. 1224.) Upon receipt of the insurance company's initial denial, the provider has "knowledge of the facts essential to" the provider's claim -- therefore, the limitations period begins to run. (*Id.* at p. 1223.) The provider's subsequent requests for reconsideration or demands for further payment do not serve to extend the statute of limitations. This is true even where partial payment of money due under a contract is subsequently made. Such partial payment does not extend the

applicable statute of limitations. (Code Civ. Proc., § 360; *Boyle v. Lampe* (1963) 223 Cal.App.2d 715, 719).

Further, the factual allegations of the operative pleading do not suggest that appellant was lulled into believing that its claim would be paid. Instead, appellant alleges that during these subsequent communications, respondents attempted to justify their underpayments to appellant. Under these circumstances, respondents are not estopped from asserting the statute of limitations as a defense to appellant's claims.

IV. Equitable tolling is not applicable

The doctrine of equitable tolling applies "'"[w]hen an injured person has several legal remedies and, reasonably and in good faith, pursues one."' [Citations.]" (*McDonald v. Antelope Valley Community College Dist.* (2008) 45 Cal.4th 88, 100 (*McDonald*).) In *McDonald,* a statute of limitations on an employment claim was subject to equitable tolling where the plaintiff took advantage of internal grievance procedures offered by the Antelope Valley Community College District before filing suit pursuant to the Fair Employment and Housing Act (FEHA). (*McDonald*, at pp. 96-97). The *McDonald* court explained that, "The filing of an administrative claim, whether mandated or not, affords a defendant notice of the claims against it so that it may gather and preserve evidence, and thereby satisfies the principal policy behind the statute of limitations. [Citation.]" (*Id.* at p. 102.)

The doctrine of equitable tolling also applies between the date of an insured's timely notice to an insurance company and the date that the insurance company formally denies coverage in writing. (*Prudential-LMI Com. Insurance v. Superior Court* (1990) 51 Cal.3d 674, 700 (*Prudential*). In *Prudential*, the insureds discovered a crack in the foundation of a building they owned. In December 1985, they filed a claim with their brokers,

who immediately notified the insurance companies who had issued insurance policies on the property during the plaintiffs' period of ownership. (*Id.* at p. 680.) Prudential conducted an investigation of the claim. In August 1987, shortly before receiving formal written notice that their claim had been denied, the plaintiffs filed suit against Prudential and three other insurers, alleging breach of contract, bad faith, breach of fiduciary duties and negligence. (*Id.* at p. 681.) Although plaintiffs filed their lawsuit beyond the one-year statute of limitations, the statute was tolled from December 1985 until September 1987, when plaintiffs were notified by Prudential that coverage was denied. (*Id.* at p. 693.) The court reasoned that such a policy "allows the claims process to function effectively, instead of requiring the insured to file suit *before* the claim has been investigated and determined by the insurer." (*Id.* at p. 692.)

Appellant argues that the doctrine of equitable tolling should apply in this case based on the following allegations:

> "From 2009 to at least April, 2013, [respondents] issued partial payments, explanations of benefits, and other letters attempting to justify their underpayments to [appellant]. Throughout this time period, [appellant] made multiple demands and appeals for proper payments, and [respondents] reconsidered [appellant's] appeals and inquiries, issued partial checks, and benefit explanations stating their adjudication positions. [Respondents] have never issued a full and final refusal to pay the claims at issue here . . . ."

Appellant insists that we must deem true its allegation that it was never given a formal written denial of its claims. As a result, appellant argues, the statute of limitations remains equitably tolled, or was equitably tolled until at least April 2013, the end of the time period during which respondents reconsidered

appellant's claims. Appellant argues that to hold otherwise would create the anomalous situation where appellant would be forced to file a lawsuit before it was finally and unequivocally informed that the claim would not be paid.

Appellant cannot avoid its own allegations that respondents issued EOBs and then attempted to "justify" its underpayments. Pursuant to *Vishva Dev*, EOBs put the provider on notice of its claims. (*Vishva Dev, supra,* 2 Cal.App.5th at p. 1223.) Appellant's "demands and appeals for proper payments" do not serve to toll the statute of limitations. (*Singh, supra*, 63 Cal.App.4th at p. 142.) Furthermore, appellant admits that it was on notice of its claims in 2009 through its allegation that its claims accrued in 2009. Appellant's contention that respondents "never issued a full and final refusal to pay the claims at issue here" is undermined by its own allegations that it received EOBs and disputed those EOBs.

Important policy supports the rule that an EOB starts the statute of limitations running without regard to a provider's protests. If such back and forth between the parties following the issuance of an EOB could toll the statute of limitations, "any party engaging in an insurance company's optional appeals process could continuously toll the statute of limitations, thereby rendering it a nullity. [Citation.]" (*Vishva Dev, supra*, 2 Cal.App.5th at p. 1225.)

Unlike the situation in *McDonald,* appellant did not pursue its remedy in any other forum. Appellant's allegations show that appellant received EOBs and partial payments beginning in 2009. This put appellant on notice of its claims and commenced the running of the statute of limitations. Because an EOB

issued, commencing the running of the statute of limitations, a further full and final refusal to pay was unnecessary.[4]

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[4] Appellant cites two district court cases from the Central District of California in support of its argument that the allegation that "[respondents] have never issued a full and final refusal to pay the claims at issue here" mandates reversal of the judgment sustaining the demurrer. (*IV Solutions, Inc. v. Pacificare Life & Health Ins. Co.* (C.D.Cal Dec. 19, 2016, CV 16-07153 SJO) 2016 U.S. Dist. LEXIS 182727 (*Pacificare*); *IV Solutions, Inc. v. Conn. Life Ins. Co.* (C.D.Cal. Dec. 5, 2016, CV 13-9026-GW) 2016 U.S. Dist. LEXIS 182755 (*Connecticut*).) These cases are not controlling authority in this court. Further, they are factually inapposite. In *Connecticut*, the district court was considering a motion for reconsideration of a denial of summary judgment on the grounds that the statute of limitations barred IV Solution's claim. In contrast to the matter before us, there were allegations in the complaint that the defendant had repeatedly requested more documentation and had encouraged IV Solutions to pursue internal appeals. Here, the allegations suggest that following the issuance of the EOB, respondents' communications were restricted to justifications of their position. Similarly, in *Pacificare*, the district court was considering a motion to dismiss IV Solution's complaint on the ground that the statute of limitations barred the claims. IV Solutions had alleged that after it brought the shortfall in payment to Pacificare's attention, Pacificare specifically stated that it was reviewing the claims and would have a final answer at some later date. No such allegations exist here. Nor can appellant amend its complaint to include allegations that contradict its prior allegations that respondents' communications were attempts to "justify their underpayments" and state their "adjudication positions." (See *People ex rel. Gallegos v. Pacific Lumber Co.* (2008) 158 Cal.App.4th 950, 957 [""'A plaintiff may not discard factual allegations of a prior complaint, or avoid them by contradictory averments, in a superseding, amended pleading.' [Citation.]' [Citation.]."")

V. The discovery rule is not applicable

Pursuant to the discovery rule, a plaintiff's cause of action begins to run from the time the plaintiff discovers, or through the exercise of diligence should have discovered, the injury. (*April Enterprises, Inc. v. KTTV* (1983) 147 Cal.App.3d 805, 826.) The rule applies when a breach or violation is difficult to detect, but not where the breach is immediate and obvious. (*William L. Lyon & Associates, Inc. v. Superior Court* (2012) 204 Cal.App.4th 1294, 1309 (*Lyon*) [discovery rule applicable where real estate broker failed to disclose its knowledge of construction defects and sellers concealed defect with dark paint].)

Appellant argues that this rule should apply here, concerning both appellant's breach of contract and misrepresentation claims.

A. Breach of Contract

As to the contract cause of action, appellant points to its allegation that the agreement between appellant and respondent provided that appellant would accept as payment "the amount specified or otherwise defined under the particular insurance policy or evidence of coverage in effect at the time that the service was rendered." Appellant argues that it could not have determined that respondent breached its agreement until it obtained A.C.'s policy and other documents related to the coverage in place at the time that appellant provided such services to A.C. However, as alleged in the FAC, respondents refused to provide those documents to appellant. Appellant asserts that it finally was able to obtain the applicable documents in April 2013.[5] When respondents finally provided the applicable documents, appellant discovered that respondents had

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[5] The FAC does not allege that the plan documents were produced in April 2013.

misapplied the document terms, and that the partial payments to appellant on A.C.'s claims were in breach of the 2008 agreement. Thus, appellant argues, it did not discover, and could not reasonably have discovered, Health Net's breach of the 2008 agreement until April 2013 when Health Net finally produced the applicable insurance plan documents.

The allegations of the FAC show that appellant was aware of the alleged underpayment long before April 2013. Appellant alleges that after it submitted its claims for payment to Health Net, Health Net "failed to process or pay the claims in a timely or proper manner. Health Net set forth completely and obviously improper interpretations of its own health plan terms, and attempted to rely upon what [respondents] unilaterally defined as 'usual and customary' rates. In fact, [respondents] intentionally and fraudulently asserted their health plan documents against [appellant], in a knowing attempt to misrepresent the plan terms to [appellant], while at the same time refusing to provide a copy of those documents to [appellant]." These allegations reveal that appellant was aware of respondents' "obviously" improper interpretations of the health plan terms even before it received the documents in question.

Further, appellant has alleged that from 2009 to 2013, respondents "issued partial payments, explanations of benefits, and other letters attempting to justify their underpayments" to appellant. The FAC reveals that during this time period, appellant "made multiple demands and appeals for proper payments." These allegations reveal that appellant was aware that it had been underpaid well before April 2013. Unlike the situation in *Lyon*, respondents' alleged breach of contract was not difficult to detect. Thus, the discovery rule is inapplicable. Appellant's cause of action for breach of contract accrued as soon

as it had reason to believe it had been underpaid -- which, according to the FAC, was in 2009.

B. Misrepresentation

A cause of action for fraud or negligent misrepresentation does not accrue until "the discovery, by the aggrieved party, of the facts constituting the fraud or mistake." (Code Civ. Proc., § 338, subd. (d).) Appellant's third cause of action for intentional and negligent misrepresentations alleges that various representations made by Health Net were false. Those misrepresentations included representations that "Health Net would make full payment to [appellant] and that it would follow the terms of its various health plans when calculating payments to [appellant]."

Appellant argues that it could not have discovered the representations made by Health Net were false until it received the provider agreement which Health Net insisted was applicable to appellant's claim. Until it received this document in April 2013, appellant contends, it presumed the reimbursement checks sent to it were made properly pursuant to the applicable insurance policy or evidence of coverage.

Appellant's allegations undermine its present position that it did not discover the alleged misrepresentations until April 2013. For the same reasons set forth above as to the breach of contract, appellant cannot claim that it was ignorant of the misrepresentations at the same time as it made demands for "proper" payments. The discovery rule applies to postpone accrual of the cause of action until "the plaintiff suspects or should suspect that [the] injury was caused by wrongdoing." (*Jolly v. Eli Lilly & Co.* (1988) 44 Cal.3d 1103, 1110-1111). The allegations show that appellant, at the very least, suspected wrongdoing when it began making demands for "proper"

payment. Appellant was not required to have all of the specific facts in order for the statute of limitations to commence running:

> "A plaintiff need not be aware of the specific 'facts' necessary to establish the claim; that is a process contemplated by pretrial discovery. Once the plaintiff has a suspicion of wrongdoing, and therefore an incentive to sue, she must decide whether to file suit or sit on her rights. So long as a suspicion exists, it is clear that the plaintiff must go find the facts; she cannot wait for the facts to find her."

(*Jolly v. Eli Lilly & Co., supra,* 44 Cal.3d at p. 1111.)

The allegations show that appellant had suspicion of wrongdoing in 2009 when it began making demands for proper payment. Under the circumstances, the discovery rule does not apply.[6]

VI. The trial court did not abuse its discretion in denying leave to amend

Appellant argues that the trial court abused its discretion in denying leave to amend to cure the claimed deficiencies in the FAC. Appellant asserts that it could plead further facts to establish that respondents were estopped from asserting the statute of limitations until April 2013; that any applicable limitations periods were equitably tolled; and that appellant's claims did not accrue until April 2013 when it obtained the plan documents and determined that it would be improperly paid.

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[6] Because we have determined that the applicable statute of limitation bars each of appellant's claims, we need not discuss the alternative grounds on which the demurrer was sustained: that appellant's cause of action for intentional and negligent misrepresentation was not pled with sufficient specificity, and that a claim for open book account cannot stand where an express contract governs the relationship between the parties.

Appellant has the burden to show "'a reasonable possibility that the defect can be cured by amendment.'" (*Berryman v. Merit Property Management, Inc.* (2007) 152 Cal.App.4th 1544, 1550; see also *Goodman v. Kennedy* (1976) 18 Cal.3d 335, 349 ["Plaintiff must show in what manner he can amend his complaint and how that amendment will change the legal effect of his pleading"].)

Appellant has not met its burden of showing a reasonable possibility that a second amended complaint would change the result. In fact, appellant fails to set forth any specific allegations showing how appellant could cure the defects in the FAC. An allegation that appellant did not receive the relevant plan documents until April 2013 does not change the fact that payment was due in 2009, an EOB and partial payment were provided to appellant in 2009, and the parties began disputing the amount paid in 2009. Appellant's suspicion of wrongdoing -- which, according to the allegations of the FAC, began in 2009 -- was sufficient to commence the running of the statute of limitations. (*Jolly v. Eli Lilly & Co., supra*, 44 Cal.3d at p. 1111.)

The trial court found that "the FAC shows that [appellant's] claims accrued on March 25, 2009 but no later than in May, 2009." In light of "the judicial admissions in the FAC," the trial court could not envision how appellant could then plead viable claims. Under the circumstances, the trial court did not abuse its discretion in so holding.

VII. The trial court did not abuse its discretion in granting Health Net's motion for attorney fees

The 2008 settlement agreement, which was the subject of the first cause of action for breach of written contract against Health Net, contained a provision allowing a prevailing party to recover attorney fees. The contract provides:

> "In any dispute arising out of this AGREEMENT, the prevailing PARTY shall be entitled to recover its reasonable costs, including, but not limited to, all claims for costs, including reasonably attorneys' fees, expert witness or consultant fees, and other fees normally incident to litigation or arbitration, expended or incurred in connection with violation of any provision of this AGREEMENT."

Appellant argues that only the first cause of action for breach of written contract arose out of the 2008 settlement agreement, and only the fees attributable to the defense of that claim are recoverable by Health Net.

"In any action on a contract, where the contract specifically provides that attorney's fees and costs, which are incurred to enforce that contract, shall be awarded either to one of the parties or the prevailing party, then the party who is determined to be the party prevailing on the contract . . . shall be entitled to reasonable attorney's fees in addition to other costs." (Civ. Code, § 1717, subd. (a).) The phrase "on a contract" is construed liberally. (*Eden Township Healthcare Dist. v. Eden Medical Center* (2013) 220 Cal.App.4th 418, 426.) "Where a cause of action based on the contract providing for attorney's fees is joined with other causes of action beyond the contract, the prevailing party may recover attorney's fees under [Civil Code] section 1717 only as they relate to the contract action. [Citations.]" (*Reynolds Metals Co. v. Alperson* (1979) 25 Cal.3d 124, 129 (*Reynolds*).) "'In determining whether an action is "on the contract" under [Civil Code] section 1717, the proper focus is not on the nature of the remedy, but on the basis of the cause of action.' [Citation.]" (*Eden Township, supra*, at p. 426.)

"Attorney's fees need not be apportioned when incurred for representation on an issue common to both a cause of action in

which fees are proper and one in which they are not allowed." (*Reynolds, supra*, 25 Cal.3d at pp. 129-130.) Where the theories are "factually intertwined" and it is "impracticable, if not impossible, to separate the multitude of conjoined activities into compensable or noncompensable time units," attorney fees need not be apportioned. (*Fed-Mart Corp. v. Pell Enterprises, Inc.* (1980) 111 Cal.App.3d 215, 227 (*Fed-Mart*).) For example, where a bank's collection efforts on a note were interrelated with its defense against fraud allegations, and defense of the charge of fraud was necessary in the bank's efforts to collect on the notes, attorney fees incurred by the bank in defending against the fraud action were compensable under the attorney fee provision of the note. (*Wagner v. Benson* (1980) 101 Cal.App.3d 27, 37.)

A trial court has discretion to allocate the proportionate share of attorney fees attributable to one aspect of a case where appropriate, but a trial court is not required to make such an allocation where issues are "'inextricably interrelated.'" (*Fed-Mart, supra*, 111 Cal.App.3d at p. 228.) "The determination of what constitutes actual and reasonable attorney fees is committed to the sounds discretion of the trial court," and will be disturbed only where there has been a manifest abuse of discretion. (*Ibid.*)

Health Net's motion for attorney fees sought fees for briefing on the first demurrer and motion to strike; propounding written discovery; engaging in mediation; preparing for deposition and deposing one key witness; and attending court appearances and drafting the second demurrer. The trial court found that "the requested attorney fees were incurred in connection with Health Net's defense of this action on the contract, including the fees incurred in obtaining and defending the fee award, and were necessary, justified and reasonable given

the complexity of the case and the time spent on dispositive motion practice."

Appellant's theories were factually intertwined, and all activities for which Health Net sought fees were related to the contract action. Thus, apportionment was not required. (*Fed-Mart, supra*, 111 Cal.App.3d at p. 227.) Under the circumstances, the trial court did not abuse its discretion in failing to apportion attorney fees.

DISPOSITION

The judgment and attorney fee order are affirmed. Respondents are awarded their costs of appeal.

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS.

_____, J.
CHAVEZ

We concur:

_____, Acting P. J.
ASHMANN-GERST

_____, J.
HOFFSTADT