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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SIXTH APPELLATE DISTRICT

MARIA LEON, et al.,

Plaintiffs and Appellants,

v.

EMERGENCY MEDICAL GROUP OF
WATSONVILLE, et al.,

Defendants and Respondents.

H040521

(Santa Cruz County

Super. Ct. No. CV163961)

Appellants Maria and Rafael Leon visited the emergency room of Watsonville Community Hospital on multiple occasions in 2006 and 2007. During those visits, they received treatment from physicians employed by respondent Emergency Medical Group of Watsonville (Medical Group). Watsonville Community Hospital was a participating provider in the Leons' health plan.¹ However, as the Leons later learned, Medical Group was not a participating provider in their health plan. The Leons were charged Medical Group's "chargemaster rate" for the treatments they received. (The Leons also refer to this as the "full, list or sticker" price.) Their health plan covered only a portion of their medical bills. Respondent Marina Medical Billing Service, Inc.² (Billing Service) billed

¹ We use the term "health plan" to refer broadly to any third-party payor or managed care program, including health care service plans governed by the Knox-Keene Health Care Service Plan Act of 1975, Health & Saf. Code, § 1340 et seq. (Knox-Keene Act), health insurance policies, self-funded plans, Medi-Cal, and Medicare.

² While this action was pending, Billing Service merged with RevCycle+; RevCycle+ is the surviving corporation that merger.

the Leons for the balance of those medical bills. The Leons argue that by doing so, Billing Service and Medical Group engaged a practice known as “balance billing,” which is both illegal and violative of Medical Group’s contract with Watsonville Community Hospital. The Leons further contend that Billing Service’s billing practices violated the Rosenthal Fair Debt Collection Practices Act ((Rosenthal Act), Civ. Code, § 1788 et seq.).

Medical Group and Billing Service (collectively, respondents) maintain that balance billing was legal until late 2008; balance billing remains legal in connection with health plans that are not governed by the Knox-Keene Act (Health & Saf. Code, § 1340 et seq.); and the Leons misconstrue Medical Group’s contract with Watsonville Community Hospital. Billing Service contends that its actions were not subject to the Rosenthal Act.

The Leons filed this putative class action against respondents on behalf of two classes of patients: those who received communications from Billing Service that did not comply with the Rosenthal Act and those who were balance billed or charged the chargemaster rate for medical treatment by Medical Group.

The trial court denied the Leons’ motion for class certification. After summarily adjudicating all of the Leons’ claims against Billing Service in Billing Service’s favor, the court granted summary judgment in favor of Billing Service. The Leons appeal both rulings. We affirm the order denying class certification and reverse the judgment in favor of Billing Service with directions.

I. FACTUAL AND PROCEDURAL BACKGROUND

A. *Medical Group and Billing Service*

Medical Group contracted with Watsonville Hospital Corporation, Inc. (Hospital) to provide physicians for the emergency department at the Watsonville Community Hospital. Paragraph 6.5 of the contract between Medical Group and Hospital provides: “[Medical Group] shall participate in all third-party payment or managed care programs

in which Hospital participates, render services to those patients covered by such programs, and accept payment amounts provided for under those programs as payment in full for services of the [Medical Group]. If requested by Hospital, [Medical Group] agrees to discount his/her charges proportionately to any discounts given by Hospital of its charges to a third-party payor or any patient participation plan, provided such discounts are within the normal ranges provided by similar contractors in central California.”

The Leons read the first sentence of paragraph 6.5 as requiring Medical Group to contract with any health plan with which Hospital contracts and as prohibiting Medical Group from balance billing patients with such health plans. Medical Group construes paragraph 6.5 as requiring it to attempt to contract with particular health plans only at Hospital’s request and, where Medical Group does so, allowing it to negotiate its own reimbursement rates with each health plan.

Billing Service provides medical billing services to hospital-based emergency medical groups. It provided such services to Medical Group between April 1, 1998 and December 31, 2008.

Medical Group patients invoiced by Billing Service submitted payment directly to Medical Group. Billing Service charged Medical Group a fee for its services. That fee was based on Medical Group’s net collections and on the average payment per patient.

The contract between Billing Service and Medical Group provided that Billing Service would review Medical Group’s medical fee schedule (i.e., list of chargemaster rates) and propose changes to that fee schedule as appropriate. However, the contract further provided that Medical Group “shall, in [its] sole and absolute discretion, determine [its] medical fee schedule and shall advise [Billing Service] of such fee schedule(s).”

B. *Billing Service's Billing Practices*

The phrase “balance billing” refers to the practice of billing patients directly for the balance of medical bills not covered by their health plan. (See *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 502 (*Prospect*)). Prior to October 1, 2008, Billing Service engaged in balance billing in some instances, as discussed below.

Billing Service’s practice was to bill Medical Group’s chargemaster rate, regardless of whether it was sending a bill to a patient, a health plan with which Medical Group had an agreement, or a health plan with which Medical Group did not have an agreement. If Billing Service had health plan information for a patient, its practice was to bill the health plan first.

Where the bill went to a health plan with which Medical Group had an agreement, the health plan would pay the rate it had negotiated with Medical Group for the service, rather than the full chargemaster rate. The patient would not be balance billed for the difference between the chargemaster rate and the negotiated rate. Medi-Cal and Medicare patients also were never balance billed.

When a health plan with which Medical Group did not have an agreement paid less than the full amount of the bill, Billing Service would balance bill the patient. Prior to October 2008, Billing Service simply billed the patient for the entire unpaid portion of the bill; the statement the patient received would not indicate what portion of that amount constituted the patient’s copay or deductible.

Billing Service would bill the patient in full where it had no insurance information for that patient or it received no payment from the patient’s health plan.

Billing Service’s billing software included a field titled “delinquency code.” A delinquency code of 1 prompted the system to send the patient a first statement. Thirty days later, the delinquency code would automatically change to 2, prompting the system to send the patient a second statement. If the bill remained unpaid 30 days later, the

delinquency code would change to 3, prompting the system to send the patient a final notice.

If patients did not pay their Medical Group bills, Billing Service would refer those bills to a debt collector, CMRE Financial Services, after sending a final notice.

C. *The Knox-Keene Act and Restrictions on Balance Billing*

“In 1975, the Legislature enacted the Knox-Keene Act, which provides the legal framework for the regulation of California’s individual and group health care plans, including health maintenance organizations (HMO) and other similarly structured managed care organizations (MCO). While HMO’s and MCO’s are regulated by the Department of Managed Health Care . . . , traditional health insurance companies are regulated by the Department of Insurance.”³ (*Rea v. Blue Shield of California* (2014) 226 Cal.App.4th 1209, 1215.)

On October 8, 2008, the Department of Managed Health Care issued a regulation categorizing balance billing, which it defined as “billing an enrollee of a health care service plan for amounts owed to the provider by the health care service plan or its capitated provider for the provision of emergency services,” as an “unfair billing pattern.” (Cal. Code Regs., tit. 28, § 1300.71.39.) Shortly thereafter, the Supreme Court considered the propriety of balance billing in *Prospect*. There the court considered whether emergency room doctors are permitted to balance bill a patient whose HMO

³ The Knox-Keene Act applies only to “health care service plans” and “specialized health care service plan contracts,” which are defined as “either of the following: [¶] (1) Any 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. [¶] (2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.” (Health & Saf. Code, §§ 1343, subd. (a), 1345, subd. (f).)

submits payment for less than the full amount billed for emergency medical services. (*Prospect, supra*, 45 Cal.4th at p. 502.) Because HMOs are health care service plans subject to the Knox-Keene Act, that statute governed the case. (*Prospect, supra*, at p. 504.) The HMO at issue in *Prospect* had no contract with the emergency room doctors. Noting that the Knox-Keene Act requires HMOs to pay for emergency care and permits emergency room doctors to sue HMOs directly over billing disputes, the court concluded that the Knox-Keene Act prohibits emergency room doctors from balance billing HMO patients. (*Prospect, supra*, at pp. 506-507.) The court expressly limited its holding “to the precise situation before [it]—billing the patient for emergency services when the doctors have recourse against the patient’s HMO.” (*Id.* at p. 507 fn. 5.)

Respondents contend that balance billing was legal as to all health plans prior to the Department of Managed Health Care’s October 8, 2008 regulation. Moreover, they maintain that regulation and *Prospect* apply only to health care service plans governed by the Knox-Keene Act. The Leons take the position that *Prospect* applies to all health plans and applies retroactively, such that respondents can be held liable for balance billing prior to October 2008.

D. *Appellants Are Treated by Medical Group Doctors at the Emergency Room and Billed by Billing Service*

Rafael⁴ received treatment from a Medical Group physician at the Watsonville Community Hospital in May 2006. Billing Service issued a \$364 bill to Rafael for that treatment on August 4, 2006. Billing Service sent two subsequent statements to Rafael regarding the \$364 bill on August 11, 2006 and September 8, 2006. On October 6, 2006, Billing Services sent Rafael a “Final Notice” regarding the \$364 bill, stating, “If we do not receive payment within 10 business days we will be forced to conclude that payment [cannot] be obtained from you by us, therefore this obligation will then be turned over to

⁴ We will sometimes refer to the Leons by their first names for the sake of clarity.

our outside collection agency.” It is not clear from the record what, if anything, the Leons’ insurance paid toward that bill.

Rafael was treated by Medical Group physicians at the Watsonville Community Hospital on three occasions in December 2006. He was billed \$502, \$318, and \$318 for those visits. On each occasion, his insurance, Blue Cross Blue Shield Federal Employee Program, paid only a portion of the bill and issued an explanation of benefits to Rafael explaining that he was responsible for his coinsurance and the noncovered charges. Billing Service issued a bill to Rafael for each visit.

Maria was treated by a Medical Group physician at the Watsonville Community Hospital in September 2007. Blue Cross Blue Shield Federal Employee Program paid \$101.07 of the resulting \$318 bill and informed Maria that she was responsible for \$11.23 in coinsurance and \$205.70 in noncovered charges. Billing Service sent Maria a bill for \$318 on November 30, 2007 and a “Final Notice” on December 28, 2007. The final notice, like the one Rafael received, stated, “If we do not receive payment within 10 business days we will be forced to conclude that payment [cannot] be obtained from you by us, therefore this obligation will then be turned over to our outside collection agency.”

The Leons paid the bills in full.

E. *Operative Fourth Amended Complaint*

The Leons filed the operative fourth amended class action complaint against Medical Group and Billing Service on September 2, 2011. They asserted claims for declaratory relief, breach of contract, breach of the implied covenant of good faith and fair dealing, unjust enrichment, and violation of Business and Professions Code section 17200 et seq. (UCL) against both respondents. They also asserted conversion and fraud causes of action against Medical Group.

The declaratory judgment cause of action alleges that “there is a controversy as to whether [Medical Group] could and can charge patients having plans [with] which the hospital has agreements more than what their plans allow for [the] service provided.”

In the breach of contract cause of action, the Leons allege that they and other class members “entered into an implied-in-fact contractual relationship with” Medical Group for the receipt of Medical Group’s services. They further allege that the contract’s price term was left open, such that the “reasonable and usual rate” should have been implied. Instead, however, Medical Group “breached this promise by charging and directly billing plaintiffs at [Medical Group’s] full, list or sticker prices [(i.e., the chargemaster rate)], which are and were much more than the usual, customary and reasonable rate.” The Leons allege that “[t]his breach extends to [Billing Service]” because Billing Service was assigned to bill them. Alternatively, the Leons allege that they are third party beneficiaries of Medical Group’s contract with Hospital, such that they are entitled to enforce that agreement. They allege that Medical Group breached its contract with Hospital by not accepting “their plan’s payment amounts as payment in full.”

The fourth amended complaint alleges that Medical Group and Billing Service breached the implied covenant of good faith and fair dealing by charging “full, list and sticker prices which are much more than the usual, customary and reasonable rates.”

As to unjust enrichment, the Leons allege that Medical Group and Billing Service were unjustly enriched when they obtained the “full, list and sticker prices” from the Leons and other class members. They further allege that the “full, list and sticker prices” were “unreasonable, unlawful, unfair and wrongful.”

The Leons allege that Medical Group violated the UCL by charging unreasonable full, list, or sticker prices, conduct that allegedly was fraudulent, unlawful, and unfair. The Leons allege that Billing Service violated the UCL by violating the Rosenthal Act.

In their conversion claim, the Leons allege that Medical Group converted money paid by patients that “was not due and owing.”

Finally, the Leons allege that Medical Group committed fraud by representing to patients whose health plans had contracts with Hospital that they owed more for medical care than their health plans agreed to pay.

F. *Billing Service's First Motion for Summary Judgment or Summary Adjudication*

Billing Service moved for summary judgment or, in the alternative, summary adjudication, on July 3, 2013. It argued that it was entitled to summary adjudication on the declaratory relief claim because its relationship with Medical Group had ended, such that no actual controversy existed. As to the Leons' breach of contract and breach of the duty of good faith and fair dealing claims, Billing Service maintained that it had never entered into a contract with the Leons or any class members, such that the contract-based claims were not viable. Billing Service urged the court to grant summary adjudication as to the unjust enrichment claim on the ground that no such independent cause of action existed. Finally, Billing Service asserted that the Rosenthal Act did not apply because (1) it was a biller, not a debt collector; (2) plaintiffs' bills were not in default; and (3) the provision of emergency medical services does not constitute a consumer credit transaction under the Rosenthal Act.

In an order filed on October 16, 2013, the trial court granted summary adjudication in Billing Service's favor as to the declaratory relief, contract-based, and UCL claims, but denied it as to the unjust enrichment cause of action. The court reasoned that declaratory relief was not appropriate given that Billing Service's relationship with Medical Group ended in 2009. The court concluded that the contractual claims failed because the Leons had no written or implied-in-fact contract with Billing Service. As to the UCL cause of action, the court concluded that Billing Service did not act as a debt collector for purposes of the Rosenthal Act. It did not reach the question whether there was a consumer credit transaction for purposes of the Rosenthal Act.

G. *Class Certification Motion*

While Billing Service's first motion for summary judgment or adjudication was pending, the Leons moved to certify the matter as a class action. The Leons

“alternatively offer[ed]” the following five class definitions as to their “debt collection disclosure allegations” (debt collection classes):

a. “As to all California consumers who received a bill from [Billing Service] that lacked any of the required [Rosenthal Act] disclosures alleged when the bill was first sent.”

b. “As to out of network patients with health plans, all California consumers who received a bill from [Billing Service] that lacked any of the disclosures alleged as required by the [Rosenthal Act] after the bill was not paid in full by a plan.”

c. “All California patients who received a Final Notice from [Billing Service] that lacked any of the alleged disclosures required by the [Rosenthal Act].”

d. “All California patients who received a bill after their account was marked as having a delinquency code changed indicating a statement would be generated to the patient in the patient’s Selected Family/Patient Report by [Billing Service] that lacked any of the alleged disclosures required by the [Rosenthal Act].”

e. “All California patients who received a bill after their account was marked as being ‘added to collections’ in the patient’s Selected Family/Patient Report by [Billing Service] that lacked any of the alleged disclosures required by the [Rosenthal Act].”

The Leons sought to certify the debt collection classes as to Billing Service only. While the class certification motion was pending, the court granted summary adjudication in Billing Service’s favor on the Leons’ Rosenthal Act-based UCL claim. In view of that ruling, the Leons informed the court that “the debt collection classes are not a concern for the court now.”

The Leons also moved to certify one or more of the following five class definitions as to their “balance billing/Chargemaster allegations” (balance billing classes):

a. “All out of network patients with health plans that [hospital] had price agreements with, but [Medical Group] did not and who were charged more than the plans’ rate.”

b. “All [Medical Group] patients who were billed more than their health plans allowed.”

c. “All [Medical Group] patients who were billed more than their Knox-Keene regulated health plans regarded as the allowable rate.”

d. “All [Medical Group] patients responsible to pay at [Medical Group]’s full, chargemaster rate.”

e. “All uninsured patients who are billed and held responsible to pay at the [Medical Group]’s full, chargemaster rate.”

The Leons sought to certify the balance billing classes as to both Medical Group and Billing Service.

On December 10, 2013, following briefing and a hearing, the court denied the motion. As to Medical Group, the court concluded that the Leons had failed to establish the existence of a community of interest, that the class was ascertainable, or that certification would result in substantial benefits making a class action superior to the alternative. The court expressly adopted the reasoning set forth in Medical Group’s opposition to the motion for class certification in its order denying class certification as to Medical Group.

As to Billing Service, the court concluded that the Leons had failed to establish the existence of a community of interest, that the class was ascertainable, that the class was sufficiently numerous, or that certification would result in substantial benefits making a class action superior to the alternative. The court expressly adopted the reasoning set forth in Billing Service’s opposition to the motion for class certification in its order denying class certification as to Billing Service. The portions of Billing Service’s opposition that the court referenced in its order addressed only the balance billing classes.

H. *Billing Service’s Second Motion for Summary Judgment*

Billing Service filed a motion for summary judgment on November 12, 2013, while the motion for class certification was pending, as to the remaining unjust enrichment cause of action. The trial court granted that motion on February 21, 2014,

concluding the Leons had “provided no evidence of any impropriety by [Billing Service] in issuing bills to plaintiffs . . . and in being paid for its services by co-defendant [Medical Group] that would raise a triable issue of fact as to [Billing Service’s] alleged liability for Unjust Enrichment.” In the same order, entitled “Order Granting . . . Motion for Summary Judgment and Judgment,” the court concluded that Billing Service was entitled to judgment in its favor and ordered the fourth amended complaint dismissed, with prejudice, as to Billing Service.

I. *Appeal*

The Leons timely appealed from the order denying their motion for class certification on January 3, 2014.

They timely appealed from the order granting summary judgment on February 24, 2014. However, “an order granting summary judgment is not an appealable order. [Citations.] The appeal must be taken, instead, from a judgment entered on the basis of the summary judgment order.” (*Levy v. Skywalker Sound* (2003) 108 Cal.App.4th 753, 761, fn. 7.) Here, the court apparently granted summary judgment and entered judgment on the basis of that summary judgment in a single filing. Because Billing Service has not moved to dismiss the appeal, and in the interests of justice and to avoid delay, we construe the notice of appeal to apply to the judgment rather than the nonappealable order. (*Bame v. City of Del Mar* (2001) 86 Cal.App.4th 1346, 1353, fn. 5. [construing notice of appeal liberally in favor of its sufficiency]; *Slater v. Lawyers’ Mutual Ins. Co.* (1991) 227 Cal.App.3d 1415, 1418, fn. 1 [construing order granting motion for summary judgment to incorporate a judgment in the interests of justice and to avoid delay].) As such, we also may review the prior order granting Billing Service’s motion for summary adjudication, as the Leons request on appeal. (Code Civ. Proc., § 906.)

II. DISCUSSION

A. *Summary Judgment in Billing Service's Favor*

1. *Standard of Review*

In reviewing an order granting summary judgment, we review the entire record de novo in the light most favorable to the nonmoving party to determine whether the moving and opposing papers show a triable issue of material fact. (*Addy v. Bliss & Glennon* (1996) 44 Cal.App.4th 205, 214 (*Addy*)). “A defendant moving for summary judgment has the burden of showing that a cause of action lacks merit because one or more elements of the cause of action cannot be established or there is a complete defense to that cause of action.” (*Jones v. Wachovia Bank* (2014) 230 Cal.App.4th 935, 945 (*Jones*)). A defendant cannot “simply point out that the plaintiff does not possess, and cannot reasonably obtain, needed evidence” (*Aguilar v. Atlantic Richfield Co.* (2001) 25 Cal.4th 826, 854 (*Aguilar*), fn. omitted), but “*must* ‘support[]’ the ‘motion’ with evidence.” (*Id.* at p. 855.) “The defendant may, but need not, present evidence that conclusively negates an element of the plaintiff’s cause of action. The defendant may also present evidence that the plaintiff does not possess, and cannot reasonably obtain, needed evidence—as through admissions by the plaintiff following extensive discovery to the effect that he has discovered nothing.” (*Ibid.*) “If a defendant’s moving papers make a prima facie showing that justifies a judgment in its favor, the burden of production shifts to the plaintiff to make a prima facie showing of the existence of a triable issue of material fact.” (*Jones, supra*, at p. 945.)

In reviewing an order granting summary adjudication of issues, we are governed by the rules generally applicable to review of summary judgments. (See *Tauber-Arons Auctioneers Co. v. Superior Court* (1980) 101 Cal.App.3d 268, 273.) Accordingly, we review the entire record de novo to determine whether the moving and opposing papers show a triable issue of material fact. (*Addy, supra*, 44 Cal.App.4th at p. 214.) We may

affirm on any legally correct ground, “regardless of the grounds relied upon by the trial court.” (*Becerra v. County of Santa Cruz* (1998) 68 Cal.App.4th 1450, 1457.)

2. *Declaratory Relief Cause of Action*

“Code of Civil Procedure section 1060 authorizes ‘[a]ny person . . . who desires a declaration of his or her rights or duties with respect to another . . . in cases of *actual controversy relating to the legal rights and duties of the respective parties*, [to] bring an original action . . . for a declaration of his or her rights and duties’ ” (*Jenkins v. JPMorgan Chase Bank, N.A.* (2013) 216 Cal.App.4th 497, 513 (*Jenkins*), disapproved on another point in *Yvanova v. New Century Mortgage Corp.*, 62 Cal. 4th 919, 939.) “The purpose of a judicial declaration of rights in advance of an actual tortious incident is to enable the parties to shape their conduct so as to avoid a breach.” (*Babb v. Superior Court* (1971) 3 Cal.3d 841, 848.) Declaratory relief is therefore a remedy that “ ‘operates *prospectively*, and not merely for the redress of past wrongs. It serves to set controversies at rest before they lead to repudiation of obligations, invasion of rights or commission of wrongs; in short, the remedy is to be used in the interests of preventive justice, to declare rights rather than execute them.’ ” (*Ibid.*, italics added.)

Here, the Leons seek a remedy for a past wrong: balance billing that occurred prior to 2009. They offer no evidence that an actual, present controversy exists between themselves and Billing Service, which no longer provides medical billing services to Medical Group. Accordingly, we conclude the trial court did not err in granting summary adjudication to Billing Service on the Leons’ claim for declaratory relief.

3. *Contract-Based Causes of Action*

The Leons assert two contract-based claims for breach of contract and breach of the implied covenant of good faith and fair dealing. A valid contract is an essential element of either claim. (*Careau & Co. v. Security Pacific Business Credit, Inc.* (1990) 222 Cal.App.3d 1371, 1388 (*Careau & Co.*); *Rosenfeld v. JPMorgan Chase Bank, N.A.*

(N.D.Cal. 2010) 732 F.Supp.2d 952, 968; CACI No. 325.) It is undisputed that no contract exists between the Leons and Billing Service. On appeal, the Leons offer two theories for why Billing Service nevertheless is contractually liable to them.

First, the Leons argue they are third party beneficiaries of the contract between Medical Group and Billing Service, which they maintain Billing Service breached by balance billing. As counsel for the Leons conceded at a hearing on Billing Service's first motion for summary judgment or adjudication, the operative complaint does not allege that the Leons are third party beneficiaries of the contract between Medical Group and Billing Service. The contract-based actions are premised on an implied-in-fact contractual relationship between the Leons and Medical Group and on Medical Group's contract with Hospital.

"[T]he pleadings set the boundaries of the issues to be resolved at summary judgment." (*Oakland Raiders v. National Football League* (2005) 131 Cal.App.4th 621, 648.) A " 'plaintiff cannot bring up new, unpleaded issues' " in opposition to a motion for summary judgment or adjudication. (*Ibid.*) Because the first legal theory advanced by the Leons on appeal regarding their contract-based claims was not alleged in the complaint, we decline to consider whether it creates a triable issue of material fact to defeat Billing Service's summary adjudication motion.

Second, the Leons contend that Billing Service aided and abetted Medical Group's breach of its contract with Hospital, of which the Leons maintain they were third party beneficiaries. The theory appears to be that paragraph 6.5 of the contract between Medical Group and Hospital prohibited Medical Group from balance billing patients whose health plans had contracts with Hospital. Medical Group breached paragraph 6.5 by balance billing the Leons, whose health plan had a contract with Hospital. The Leons' opening brief cites cases holding that those who aid and abet a fraud may be held liable along with the fraudster. (*People v. Bestline Products, Inc.* (1976) 61 Cal.App.3d 879, 918 ["All parties to a conspiracy to defraud are directly liable for all misrepresentations

implied covenant of good faith and fair dealing for as to him no such implied covenant exists.” (*Ibid.*)

For the foregoing reasons, we conclude the trial court did not err in granting summary adjudication to Billing Service on the Leons’ contract-based claims.

4. *Unjust Enrichment*

The Leons’ fourth cause of action against Billing Service is labeled as one for “unjust enrichment.” On appeal, Billing Service reiterates an argument advanced in its first motion for summary adjudication – there is no cause of action for unjust enrichment in California. We agree. “Unjust enrichment is not a cause of action . . . or even a remedy, but rather ‘ ‘a general principle, underlying various legal doctrines and remedies’ ’. . . . [Citation.] It is synonymous with restitution.’ ” (*McBride v. Boughton* (2004) 123 Cal.App.4th 379, 387 (*McBride*)). Restitution must be made by an individual who is unjustly enriched at the expense of another. (*Durell v. Sharp Healthcare* (2010) 183 Cal.App.4th 1350, 1370 (*Durell*)). Put differently, where one person benefits another, the person receiving the benefit is required to make restitution where it is unjust for him or her to retain the benefit. (*Ibid.*)

Despite our agreement with Billing Service, we decline to affirm on the ground that there is no cause of action for unjust enrichment. “ ‘[W]hen a motion for summary judgment is used to test whether the complaint states a cause of action,’ ” as did Billing Service’s first motion in connection with the unjust enrichment claim, “ ‘the court will apply the rule applicable to demurrers’ ” (*Navarrete v. Meyer* (2015) 237 Cal.App.4th 1276, 1283.) Under those circumstances, “[w]e ignore erroneous or confusing labels in the pleading and look to its gravamen to determine what cause of action is stated.” (*Ibid.*) Doing so here, we construe the Leons’ fourth cause of action as a quasi-contract claim seeking restitution. (See *Rutherford Holdings, LLC v. Plaza Del Rey* (2014) 223 Cal.App.4th 221, 231 (*Rutherford Holdings*)).

As a threshold matter, the Leons maintain that the trial court violated the law of the case doctrine or the rules regarding reconsideration by permitting a second motion for summary adjudication as to their unjust enrichment cause of action. We disagree. Code of Civil Procedure section 437c, subdivision (f)(2) prohibits a party from moving “for summary judgment based on issues asserted in a prior motion for summary adjudication and denied by the court unless that party establishes, to the satisfaction of the court, newly discovered facts or circumstances or a change of law supporting the issues reasserted in the summary judgment motion.” But that section has no application, as Billing Service’s motions raised different issues. The first motion raised the question whether there exists a cause of action for unjust enrichment. The second raised the question whether the evidence was sufficient to create a triable issue of fact. For the same reason, the court was not compelled to reconsider its ruling on the first motion in adjudicating the second. Finally, the law of the case doctrine does not apply to prior rulings of the trial court. (*Kowis v. Howard* (1992) 3 Cal.4th 888, 892-893; see *Providence v. Valley Clerks Trust Fund* (1984) 163 Cal.App.3d 249, 256 (*Providence*) [law of the case applies to appellate court decisions, not trial court rulings].)

Turning to the merits, to establish entitlement to restitution, the Leons must show (1) they conferred a benefit on Billing Service and (2) it would be unjust for Billing Service to retain that benefit. (*Durell, supra*, 183 Cal.App.4th at p. 1370.) With respect to the first element, Billing Service submitted evidence establishing that patients it billed on Medical Group’s behalf paid Medical Group directly and that its fee was paid by Medical Group, not patients. Billing Service maintains that this evidence establishes that it received no benefit from the Leons or any purported class members. The Leons respond that Billing Service did benefit from their payments to Medical Group because Billing Service’s fee was based on a percentage of Medical Group’s net collections from patients.

“To confer a benefit, it is not essential that money be paid directly to the recipient by the party seeking restitution.” (*Hirsch v. Bank of America* (2003) 107 Cal.App.4th 708, 722 (*Hirsch*)). In *Hirsch*, the plaintiffs deposited money with escrow and title companies as part of a real estate transaction. The escrow and title companies deposited the plaintiffs’ funds in demand deposit accounts with the defendant banks. The banks charged the escrow and title companies a variety of fees to service the demand deposit accounts, which were “passed on to consumers as higher fees for separate services or higher fees for escrow services generally.” (*Id.* at p. 721.) The Court of Appeal held that the plaintiffs had “stated a valid cause of action for unjust enrichment based on [the] Banks’ unjustified charging and retention of excessive fees which the title companies passed through to them. [The] Banks received a financial advantage—excessive fees charged to the title companies—which they unjustly retained at the expense of [the plaintiffs], who absorbed the overage.” (*Id.* at p. 722.)

Here, there is evidence showing that the Leons paid Medical Group, which in turn paid Billing Service a percentage of its net collections from patients, presumably including the Leons. That evidence is sufficient to raise a triable issue of material fact as to whether the Leons conferred a benefit on Billing Service.

As to the second element, the Leons argue it would be inequitable for Billing Service to retain the portion of its fee based on collections of balance bills because (1) “imposing a fee in an unusual, uncustomary and unreasonable amount is not equitable”; (2) balance billing is prohibited under *Prospect*, which applies to all health plans and has retroactive application; and (3) Medical Group’s contract barred balance billing as to them because their insurance had a contract with Hospital. Triable issues of material fact exist as to the first and third theories. Specifically, there is a triable issue of material fact as to whether the amounts the Leons paid above what their insurance agreed to pay were “unusual, uncustomary and unreasonable.” (The Leons seem to assume this is the case, but it cannot be that whatever amount a health plan agrees to is the usual,

customary, and reasonable amount, as different health plans agree to different rates.) To the extent Medical Group’s contract barred balance billing as to the Leons (something that remains in dispute), there is no evidence that Billing Service had any knowledge of that contract.⁵ Billing Service’s knowledge is relevant because “[d]etermining whether it is unjust for a person to retain a benefit may involve policy considerations. For example, if a person receives a benefit because of another’s mistake, policy may dictate that the person making the mistake assume the risk of the error.” (*First Nationwide Savings v. Perry* (1992) 11 Cal.App.4th 1657, 1663.) By contrast, “restitution may be required when the person benefitting from another’s mistake knew about the mistake and the circumstances surrounding the unjust enrichment. In other words, innocent recipients may be treated differently than those persons who acquire a benefit with knowledge.” (*Id.* at p. 1664.)

A number of legal disputes exist as to the Leons’ second theory. Respondents say *Prospect* applies prospectively and bars balance billing only of patients covered by Knox-Keene Act plans. Record evidence indicates that the Leons’ health plan was a federal employee plan.⁶ Respondents contend that, accordingly, the Leons’ plan was governed by the Federal Employee Health Benefits Act (FEHBA, 5 U.S.C. § 8901 et

⁵ Billing Service points to this lack of evidence in support of the trial court’s grant of summary adjudication. As noted, a defendant must support a motion for summary adjudication with evidence, including “evidence that the plaintiff does not possess, and cannot reasonably obtain, needed evidence—as through admissions by the plaintiff following extensive discovery to the effect that he has discovered nothing.” (*Aguilar, supra*, 25 Cal.4th at p. 855.) But Billing Service points to no evidence showing that the Leons cannot obtain evidence that it had knowledge of the Medical Group-Hospital contract.

⁶ The Leons declared that their health plan was Blue Cross Blue Shield FEP. A Blue Cross Blue Shield Service Benefit Plan document attached to Rafael’s declaration indicates the plan was available to federal employees and annuitants. Billing Service’s Client Services Manager declared that Rafael had insurance through a Federal Employee Program.

seq.), not Knox-Keene. They further contend that the FEHBA preempts the Knox-Keene Act. (5 U.S.C. §§ 8901, 8902, subd. (m)(1), 8914.) The Leons maintain that *Prospect* applies retroactively to all health plans (not only health care service plans as defined by the Knox-Keene Act) and disagree that federal law preempts Knox-Keene. Given the existence of triable issues of material fact as to the Leons' other theories, we decline to determine the scope of *Prospect* and its specific application here at this time.

Because there are triable issues of material fact as to the Leons' fourth cause of action, we conclude that the trial court erred in granting summary adjudication to Billing Service on that claim.

5. *UCL Claim*

a. *The UCL and the Scope of the Leons' Claim*

“The UCL prohibits, and provides civil remedies for, unfair competition, which it defines as ‘any unlawful, unfair or fraudulent business act or practice.’ ” (*Kwikset Corp. v. Superior Court* (2011) 51 Cal.4th 310, 320.) “The California Supreme Court has held the UCL’s ‘coverage is “sweeping, embracing ‘ “anything that can properly be called a business practice and that at the same time is forbidden by law.” ’ ” [Citation.] ’ ” (*Jenkins, supra*, 216 Cal.App.4th at p. 520.)

The Leons contend that their UCL claim against Billing Service alleged violations of all three prongs of the statute: (1) unlawful acts in violation of the Rosenthal Act, (2) unspecified unfair acts, and (3) deceptive acts “in that the balance bills and billings at the chargemaster rate, billings in excess of that allowed by para. 6.5 of the contract between [Hospital] and [Medical Group] represent that a certain amount is due when in fact such amounts are not properly owed.” Therefore, they suggest the trial court erred by focusing exclusively on whether Billing Service had violated the Rosenthal Act.

The only acts alleged in the UCL claim are five Rosenthal Act violations. While the fourth amended complaint does broadly allege that the acts were “unlawful, unfair and/or deceptive,” the claim plainly is premised on alleged Rosenthal Act violations. The

Leons' argument to the contrary is specious. Accordingly, we agree with Billing Service that the UCL claim against it fails if the Leons cannot prove a Rosenthal Act violation.

b. *Law of the Case*

The Leons argue the trial court violated the law of the case doctrine by granting summary adjudication to Billing Service on the UCL claim on the ground that Billing Service did not act as a debt collector for purposes of the Rosenthal Act. According to the Leons, that ruling was “in contravention of [the court’s] own earlier rulings on demurrers and motions to strike” That argument fails for three reasons.

First, the Leons' opening brief fails to direct us to the trial court's supposedly inconsistent prior rulings in the record. On appeal, “ [a]ll intendments and presumptions are indulged to support [the judgment] on matters as to which the record is silent, and error must be affirmatively shown.” (*Denham v. Superior Court* (1970) 2 Cal.3d 557, 564 (*Denham*)). To affirmatively show error, a party challenging a judgment or an appealable order has the burden of producing and citing to an adequate record. (*Ballard v. Uribe* (1986) 41 Cal.3d 564, 574; Cal. Rules of Court, rule 8.204(a)(1)(C) [matters referenced from the record in appellate briefs must be supported “by a citation to the volume and page number of the record where the matter appears”].) Where the appellant fails to provide an adequate record as to any issue the appellant has raised on appeal, the issue must be resolved against the appellant. (*Maria P. v. Riles* (1987) 43 Cal.3d 1281, 1295-1296.) Likewise, failure to include citations to the appellate record may result in forfeiture of a claim. (*Dietz v. Meisenheimer & Herron* (2009) 177 Cal.App.4th 771, 800-801.) Here, the Leons forfeited the issue by failing to cite the record.

Second, the argument fails on the merits because, as noted above, the law of the case doctrine does not apply to prior rulings of the trial court, but to prior appellate court decisions. “The law of the case doctrine states that when, in deciding an appeal, an appellate court ‘states in its opinion a principle or rule of law necessary to the decision, that principle or rule becomes the law of the case and must be adhered to throughout its

subsequent progress, both in the lower court and upon subsequent appeal’ ” (*Kowis, supra*, 3 Cal.4th at pp. 892-893.) “The doctrine is generally applied upon retrial of a case following reversal of the judgment on appeal, and ‘deals with the effect of the *first appellate decision* on the subsequent *retrial or appeal*: The decision of an appellate court, stating a rule of law necessary to the decision of the case, conclusively establishes that rule and makes it determinative of the rights of the same parties in any subsequent retrial or appeal in the same case.’ ” (*Wilder v. Whittaker Corp.* (1985) 169 Cal.App.3d 969, 972.) Thus, the trial court’s prior rulings do not constitute the law of the case. (*Providence, supra*, 163 Cal.App.3d at p. 256.)

Finally, demurrers and motions to strike concern the pleadings, whereas a motion for summary adjudication concerns the evidence. Given that, and other, procedural differences, it is hardly inconsistent for a court’s rulings on demurrer (or a motion to strike) and on a motion for summary adjudication to differ. (See *Doe v. California Lutheran High School Assn.* (2009) 170 Cal.App.4th 828, 835 [“because the demurrer concerned the pleadings, whereas the motion for summary judgment concerned the evidence, the two rulings were not inconsistent”].) For these reasons, we conclude the trial court did not violate the law of the case doctrine in granting summary adjudication to Billing Service of the Leons’ UCL claim.

c. *The Rosenthal Fair Debt Collection Practices Act*

The purpose of the Rosenthal Act is “to prohibit debt collectors from engaging in unfair or deceptive acts or practices in the collection of consumer debts and to require debtors to act fairly in entering into and honoring such debts, as specified in this title.” (Civ. Code, § 1788.1, subd. (b).) It imposes various prohibitions and requirements on debt collectors, including that they comply with certain provisions of the federal Fair Debt Collection Practices Act (15 U.S.C. §§ 1692 et seq.). (Civ. Code, § 1788.17.)

The Rosenthal Act defines “debt collection” as “any act or practice in connection with the collection of consumer debts.” (Civ. Code, § 1788.2, subd. (b).) “Debt” is defined as “money, property or their equivalent which is due or owing or alleged to be due or owing from a natural person to another person.” (*Id.*, subd. (d).) “Consumer debt” is defined as “money, property or their equivalent, due or owing or alleged to be due or owing from a natural person by reason of a consumer credit transaction.” (*Id.*, subd. (f).) The term “consumer credit transaction” is defined as “a transaction between a natural person and another person in which property, services or money is acquired on credit by that natural person from such other person primarily for personal, family, or household purposes.” (*Id.*, subd. (e).) Finally, a “debt collector” is “any person who, in the ordinary course of business, regularly, on behalf of himself or herself or others, engages in debt collection. The term includes any person who composes and sells, or offers to compose and sell, forms, letters, and other collection media used or intended to be used for debt collection, but does not include an attorney or counselor at law.” (*Id.*, subd. (c).)

d. *There Exists a Triable Issue of Material Fact as to Whether Billing Service Acted as a Debt Collector Under the Rosenthal Act*

Billing Service maintains that it was not a “debt collector” engaged in “debt collection” for purposes of the Rosenthal Act for two reasons. First, the Leons’ medical bills were not “due or owing” when Billing Service billed them. Second, the medical bills were not the result of a “consumer credit transaction.”

i. *“Due or Owing”*

The Rosenthal Act governs acts related to the collection of money that is *due or owing*. (Civ. Code, § 1788.2, subds. (b) & (f).) The phrase “due or owing” is not defined in the statute.

Billing Service contends the phrase serves to differentiate between routine billing, which is not subject to the Rosenthal Act’s requirements, and debt collection, which is.

According to Billing Service, money is “due or owing” where a debt is in default. For that view, it relies on a 2002 opinion of the Office of the Attorney General, which construed the Rosenthal Act as applying “to debts that have become delinquent, making them subject to collection.” (85 Ops.Cal.Atty.Gen. 215, 217 (2002).) Billing Service’s position appears to be that a patient’s medical debt becomes delinquent when Billing Service assigns the patient’s bills to an outside collection agency. (The Leons paid their bills before that occurred.)

The Leons maintain that the Rosenthal Act does apply to routine billing, arguing that money is “due or owing” whenever a bill is sent. Alternatively, they contend that even if “due or owing” means delinquent, their debt became delinquent while Billing Service attempted to collect from them. For that position, the Leons rely on the fact that Billing Service sent documents labeled “Final Notice” and the fact that Billing Service’s software used the terms “delinquency code” and “collections” to classify their bills. The Leons also contend that the bills Billing Service sent them “characterize[d] the account as delinquent and in ‘collection.’” In fact, the words “delinquent” and “collection” appear nowhere on the Leons’ bills. Only the Final Notices used the word “collection” in explaining that the bills would be turned over to an outside collection agency in 10 days.

The Office of the Attorney General’s 2002 opinion is the only authority construing the phrase “due or owing” for purposes of the Rosenthal Act. We find that opinion persuasive, and therefore construe the phrase “due or owing” to mean delinquent. (85 Ops.Cal.Atty.Gen. 215, 216-217 (2002).)

The question remains, however, when is a debt “delinquent”? At issue in the Attorney General’s opinion was credit card debt. The Attorney General concluded that the Rosenthal Act does not apply to credit card obligations “before the date at which payment is required” because, at that point, the debt is not delinquent. (85 Ops.Cal.Atty.Gen. 215, 218 (2002).) Thus, the Attorney General equated “delinquent” with “past due.” That construction is consistent with dictionary definitions

of the term “delinquent.” For example, Black’s Law Dictionary defines “delinquent” as “past due or unperformed.” (Black’s Law Dict. (10th ed. 2014) p. 520.) The American Heritage Dictionary defines “delinquent” as “overdue in payment.” (American Heritage Dict. of the English Language (2016) <<http://www.ahdictionary.com>> [as of July 11, 2016].)

Here, then, the question is when were the Leons’ bills due? The bills themselves stated no due date. Rather, they included a statement date and characterized the bill as “current,” “30-60 days,” “60-90 days,” or “90-120 days.” Billing Service’s software’s use of the terms “delinquency code” and “collections” is not dispositive. Accordingly, there exists a triable issue of material fact as to whether the Leons’ bills were overdue (and thus delinquent and “due or owing”) while Billing Service sought to obtain payment from them.

ii. “*Consumer Credit Transaction*”⁷

Even if the Leons’ bills were due and owing during the time Billing Service sought to collect, Billing Service nevertheless was not a debt collector under the Rosenthal Act if the bills were not “consumer debt.” (Civ. Code, § 1788.2, subd. (b) [defining “debt collection” as “any act or practice in connection with the collection of consumer debts”].) The Rosenthal Act defines “consumer debt” as money due or owing “by reason of a consumer credit transaction.” (Civ. Code, § 1788.2, subd. (f).) “Consumer credit transaction,” in turn, is defined as “a transaction between a natural person and another person in which property, services or money is acquired on credit by

⁷ While the trial court did not reach the issue of whether the Leons and Medical Group engaged in a consumer credit transaction, the issue was fully briefed below. The Leons’ suggestion that this court cannot reach that issue is meritless. “We will affirm an order granting summary judgment or summary adjudication if it is correct on any ground that the parties had an adequate opportunity to address in the trial court, regardless of the trial court’s stated reasons.” (*Securitas Security Services USA, Inc. v. Superior Court* (2011) 197 Cal.App.4th 115, 120.)

that natural person from such other person primarily for personal, family, or household purposes.” (*Id.*, subd. (e).)

Here, there is no dispute that the Leons, natural persons, acquired personal services (i.e., medical treatment) in a transaction with Medical Group. At issue is whether the Leons acquired those services *on credit*. The Rosenthal Act does not define “on credit” or “credit.”

“The basic rules of statutory construction are well established. ‘When construing a statute, a court seeks to determine and give effect to the intent of the enacting legislative body.’ [Citation.] ‘We first examine the words themselves because the statutory language is generally the most reliable indicator of legislative intent. [Citation.] The words of the statute should be given their ordinary and usual meaning and should be construed in their statutory context.’ [Citation.] If the plain, commonsense meaning of the statute’s words is unambiguous, the plain meaning controls.’ ” (*People v. King* (2006) 38 Cal.4th 617, 622.)

Courts routinely consult dictionaries to determine the usual and ordinary meaning of a word. (*Coburn v. Sievert* (2005) 133 Cal.App.4th 1483, 1499.) The Oxford English Dictionary defines the phrase “on credit” as “without receiving or making immediate payment; in an agreement involving delayed payment; using borrowed money.” (Oxford English Dict. (2016) <<http://www.oed.com>> [as of July 11, 2016].) The same dictionary defines “credit” as “[t]rust or confidence in a customer’s ability and intention to pay at some future time, shown by allowing money or goods to be taken or services to be used without immediate payment.” (*Ibid.*) Black’s Law Dictionary defines “credit” as “[t]he time that a seller gives the buyer to make the payment that is due.” (Black’s Law Dict., *supra*, at p. 448.) American Heritage Dictionary defines “credit” as “[a]n arrangement for deferred payment of a loan or purchase”; “[t]he time allowed for deferred payment.” (American Heritage Dict. of the English Language, *supra*, <<http://www.ahdictionary.com>> [as of July 11, 2016].)

The foregoing definitions indicate that the “ordinary and usual meaning” of “on credit” is “without immediate payment.” We therefore construe section 1788.2, subdivision (e) of the Civil Code as follows: “The term ‘consumer credit transaction’ means a transaction between a natural person and another person in which property, services or money is acquired [*without immediate payment*] by that natural person from such other person primarily for personal, family, or household purposes.” Here, the Leons acquired medical treatment without immediate payment. Accordingly, we conclude there was a consumer credit transaction.

Another provision of the Rosenthal Act confirms our reading of section 1788.2, subdivision (e) and our conclusion that medical debt arises from consumer credit transactions. (*Walker v. Superior Court* (1988) 47 Cal.3d 112, 125 fn. 5 [“in construing a statute to discern its purpose, its provisions should be read together ‘so that all may be harmonized and have effect’ ”].) Civil Code section 1788.12, subdivision (a) expressly permits debt collectors to communicate with a debtor’s employer “in the case of a medical debt for the purpose of discovering the existence of medical insurance.” That provision establishes that the Rosenthal Act applies to medical debt, and thus supports our conclusion that medical services can be provided on credit in the course of consumer credit transactions. Civil Code section 1788.12, subdivision (a) further refers to “communication[s] in the case of a medical debt by a health care provider or its agent for the purpose of discovering the existence of medical insurance . . .” indicating that a health care provider or its agent can be a debt collector for purposes of the Rosenthal Act.

For the foregoing reasons, we conclude that the Leons’ medical bills arose out of a consumer credit transaction for purposes of the Rosenthal Act. Because there is a triable issue of material fact as to whether the Leons’ bills were due and owing such that Billing Service could have been acting as a debt collector under the Rosenthal Act, the trial court erred in granting summary adjudication to Billing Service on the Leons’ UCL claim.

B. Class Certification

1. Governing Legal Principles and Standard of Review

“Section 382 of the Code of Civil Procedure authorizes class suits in California when ‘the question is one of a common or general interest, of many persons, or when the parties are numerous, and it is impracticable to bring them all before the court.’ ” (*Linder v. Thrifty Oil Co.* (2000) 23 Cal.4th 429, 435 (*Linder*)). “Class certification requires proof (1) of a sufficiently numerous, ascertainable class, (2) of a well-defined community of interest, and (3) that certification will provide substantial benefits to litigants and the courts, i.e., that proceeding as a class is superior to other methods.” (*Fireside Bank v. Superior Court* (2007) 40 Cal.4th 1069, 1089.) “In California it is settled that the class action proponent bears the burden of establishing the propriety of class certification.” (*Washington Mutual Bank v. Superior Court* (2001) 24 Cal.4th 906, 922.)

“The certification question is ‘essentially a procedural one that does not ask whether an action is legally or factually meritorious.’ ” (*Sav-On Drug Stores, Inc. v. Superior Court* (2004) 34 Cal.4th 319, 326 (*Sav-On*)). That said, “issues affecting the merits of a case may be enmeshed with class action requirements, such as whether substantially similar questions are common to the class and predominate over individual questions or whether the claims or defenses of the representative plaintiffs are typical of class claims or defenses.” (*Linder, supra*, 23 Cal.4th at p. 443.)

“We review the trial court’s ruling for abuse of discretion.” (*Sav-On, supra*, 34 Cal.4th at p. 326.) “Because trial courts are ideally situated to evaluate the efficiencies and practicalities of permitting group action, they are afforded great discretion in granting or denying certification. The denial of certification to an entire class is an appealable order [citations], but in the absence of other error, a trial court ruling supported by substantial evidence generally will not be disturbed ‘unless (1) improper criteria were used [citation]; or (2) erroneous legal assumptions were made [citation]’ [Citation.] Under this standard, an order based upon improper criteria or incorrect assumptions calls

for reversal “even though there may be substantial evidence to support the court’s order.” [Citations.] Accordingly, we must examine the trial court’s reasons for denying class certification.” (*Linder, supra*, 23 Cal.4th at pp. 435-436.) As such, “appellate review of orders denying class certification differs from ordinary appellate review . . . [under which] we do not address the trial court’s reasoning and consider only whether the result was correct.” (*Knapp v. AT&T Wireless Services, Inc.* (2011) 195 Cal.App.4th 932, 939.) “Any valid pertinent reason stated will be sufficient to uphold the order.” (*Linder, supra*, at p. 436.)

2. *The Trial Court Adequately Stated the Reasons for Its Ruling*

The trial court must state its reasons for denying class certification. (*Dailey v. Sears, Roebuck & Co.* (2013) 214 Cal.App.4th 974, 986.) However, “great detail” is not required. (*Ibid.*) “Indeed, California courts have held that even if the trial court’s order on class certification does not state reasons, or does so without providing detail, it will be deemed sufficient for review purposes so long as the basis for the court’s ruling may be discerned from the record.” (*Ibid.*)

Here, the trial court stated its reasons for denying class certification by referencing specific portions of Medical Group and Billing Service’s briefs opposing class certification. For example, it stated that the motion for class certification was denied as to Medical Group “because the class is not ascertainable, for the reasons set forth in section B of [Medical Group’s] Opposition.” Because the basis for the court’s ruling may be discerned by examining Medical Group and Billing Service’s briefs, the order is sufficient for purposes of review.

3. *The Debt Collection Classes*

In their opening brief, the Leons do not address their proposed debt collection class definitions. Billing Service contends that the Leons consequently have abandoned that set of proposed class definitions. We disagree. The trial court granted summary adjudication in Billing Service’s favor on the Leons’ Rosenthal Act-based UCL claim

while the class certification motion was pending. Because the debt collection classes pertain only to that cause of action, the Leons informed the court that it need not address the debt collection classes. The court apparently agreed, as it addressed only the balance billing classes in its orders. Therefore, there is no appealable order as to the debt collection classes and there can be no abandonment or forfeiture in this appeal.

4. *The Leons Fail to Show the Trial Court's Decision Was Based Upon Improper Criteria or Erroneous Legal Assumptions*

The Leons contend that the trial court used improper criteria and made incorrect assumptions in denying their motion for class certification, such that reversal is required. However, none of the Leons' accusations is accompanied by citations to the record, making review impossible and leading us to conclude that they have failed to affirmatively show error, as they must. (*Denham, supra*, 2 Cal.3d at p. 564.) Furthermore, in some instances where the Leons contend the court used improper criteria and made incorrect assumptions, they are merely complaining that the trial court did not adequately consider and address their arguments in favor of class certification. We reject that argument. The court's orders indicate that it considered all of the briefs filed in connection with the class certification motion and oral argument. And there is no requirement that a class certification denial address every argument in favor of certification.

5. *The Trial Court Did Not Abuse Its Discretion in Concluding that the Balance Billing Classes are not Ascertainable*

“ ‘Whether a class is ascertainable is determined by examining (1) the class definition, (2) the size of the class, and (3) the means available for identifying class members.’ ” (*Hale v. Sharp Healthcare* (2014) 232 Cal.App.4th 50, 58 (*Hale*)). The class definition “must be ‘precise’ and ‘objective.’ ” (*Marler v. E.M. Johansing, LLC* (2011) 199 Cal.App.4th 1450, 1459.) “The goal in defining the class is to use terminology that will convey sufficient meaning to enable persons hearing it to determine

whether they are members of the class plaintiff wishes to represent.” (*Cho v. Seagate Technology Holdings, Inc.* (2009) 177 Cal.App.4th 734, 746.) An ambiguous class “presents a problem of class ascertainability” (*Ibid.*) An overbroad class definition, meaning one that includes individuals without actionable claims, likewise poses an ascertainability problem. (*Hale, supra*, at p. 59.) “ ‘Class certification is properly denied for lack of ascertainability when the proposed definition is overbroad and the plaintiff offers no means by which only those class members who have claims can be identified from those who should not be included in the class.’ ” (*Id.* at pp. 58-59.) With respect to the means available for identifying class members, “ ‘ ‘ ‘ ‘[c]lass members are “ascertainable” where they may be readily identified without unreasonable expense or time by reference to official records.’ ’ ’ ’ ’ ” (*Id.* at p. 58.)

Substantial evidence supports the trial court’s ruling that the first proposed balance billing class—“[a]ll out of network patients with health plans that [hospital] had price agreements with, but [Medical Group] did not and who were charged more than the plans’ rate”—is not ascertainable. The phrase “the plans’ rate,” while not entirely clear (an ascertainability problem on which the court did not rely), presumably means the amount a patient’s health plan paid for the medical treatment he or she received. In that case, the class is overbroad. Any patient who paid a co-pay or deductible was charged more than his or her health plan’s rate. But those patients who paid only a co-pay and/or deductible were not balance billed and thus have no valid claim. Moreover, respondents submitted evidence showing there are no means available to identify members of the first proposed balance billing class other than an individualized analysis of each patient’s payment record. Specifically, respondents submitted the declaration of Maggie Camilleri, Billing Service’s Director of Operations between 2004 and 2011. She declared that Billing Service would “have to look at each visit under the patient’s account” to determine whether a patient’s visit was through a health plan with which Medical Group did not have a contract. Camilleri further declared that the “only way to determine what

was paid [by a health plan]” (i.e., “the plan’s rate”) “is to examine each patient’s [explanation of benefits].” According to Camilleri, “some [health plans] never sen[t] [Billing Service] an [explanation of benefits]” Evidence was submitted showing that Medical Group had a total of 98,432 patient visits during the class period. Thus, examining each patient’s payment record would involve unreasonable expense and time, making the members of the first proposed balance billing class unascertainable. (See *Hale, supra*, 232 Cal.App.4th at pp. 59-60 [class members not ascertainable where individual inquiry into more than 122,000 patient records would be required to identify putative class members].)

The second and third proposed balance billing classes—“[a]ll [Medical Group] patients who were billed more than their health plans allowed” and “[a]ll [Medical Group] patients who were billed more than their Knox-Keene regulated health plans regarded as the allowable rate”—suffer from similar ascertainability problems as the first proposed balance billing class. The classes are overbroad because they appear to include patients who were charged only co-insurance or deductible amounts. In addition, as noted above, respondents submitted evidence showing that an analysis of each patient’s payment record would be required to determine their health plan’s allowable rate. Respondents submitted additional evidence that the third proposed class is not ascertainable: Camilleri’s declaration that analysis of a patient’s explanation of benefits, if one is available, is necessary to determine whether his or her health plan is subject to the Knox-Keene Act.

The fourth and fifth proposed balance billing classes are “[a]ll [Medical Group] patients responsible to pay at [Medical Group]’s full, chargemaster rate” and “[a]ll uninsured patients who are billed and held responsible to pay at the [Medical Group]’s full, chargemaster rate.” The phrase “responsible to pay” is ambiguous (an ascertainability problem on which the court did not rely). It might reasonably be understood to mean “paid.” On appeal, however, the Leons suggest their class definitions

include patients who were charged at the chargemaster rate, regardless of whether they paid that rate. In that case, the fourth and fifth proposed classes embrace all patients who received a bill for the chargemaster rate. Those classes are overbroad because Medical Group submitted evidence showing it always charged the chargemaster rate, including to individual patients where it did not receive payment from their health plans or for whom it lacked insurance information. But some of those patients have no claim, including those who provided insurance information showing their health plan had a contract with Medical Group and those who were in fact covered by Medi-Cal or Medicare.

The Leons contend that ascertainability is no obstacle because class members can self-identify. Courts have held that a “class is ascertainable if it identifies a group of unnamed plaintiffs by describing a set of common characteristics sufficient to allow a member of that group to identify himself as having a right to recover based on the description.” (*Estrada v. FedEx Ground Package System, Inc.* (2007) 154 Cal.App.4th 1, 14.) We disagree that self-identification resolves the ascertainability problems in this case. As discussed above, the proposed class definitions contain ambiguities that could prevent class members from self-identifying. Furthermore, we are unconvinced that patients would be able to obtain the information necessary to identify themselves as class members, including whether their health plan had a contract with Hospital when they received treatment; whether their health plan had a contract with Medical Group when they received treatment; their health plan’s “rate,” “allowable rate,” or what their health plan “allowed” when they received treatment; and whether they were charged Medical Group’s “full, chargemaster rate.” Finally, even assuming self-identification could alleviate the administrative burden of identifying class members using Billing Service’s records, it would not resolve the overbreadth issues discussed above.

For the foregoing reasons, the trial court did not abuse its discretion when it concluded that the Leons’ proposed balance billing classes were unascertainable.

6. *The Trial Court Did Not Abuse Its Discretion in Concluding that the Leons Failed to Demonstrate a Well-Defined Community of Interest*

“The community of interest requirement involves three factors: ‘(1) predominant common questions of law or fact; (2) class representatives with claims or defenses typical of the class; and (3) class representatives who can adequately represent the class.’ ” (Linder, *supra*, 23 Cal.4th at p. 435.) “The ‘ “ultimate question” for predominance is whether “the issues which may be jointly tried, when compared with those requiring separate adjudication, are so numerous or substantial that the maintenance of a class action would be advantageous to the judicial process and to the litigants.” [Citations.] “The answer hinges on ‘whether the theory of recovery advanced by the proponents of certification is, as an analytical matter, likely to prove amenable to class treatment.’ ” ’ ” (Hale, *supra*, 232 Cal.App.4th at p. 61.) Class certification is improper when class members have to prove individually their right to recover. (*Id.* at pp. 63-64; *Caro v. Procter & Gamble Co.* (1993) 18 Cal.App.4th 644, 669 [“Since class members would have to prove individually *the existence of liability and damages*, the community of interest requirement was not satisfied and class treatment would be proper only in an extraordinary situation”], italics added.)

All of the Leons’ theories of recovery require proof that class members were improperly balance billed. Determining that would involve certain common issues, including the meaning of the Medical Group-Hospital contract and the scope of the ban on balance billing. But, as alluded to above in the context of ascertainability, a putative class member also would be required to litigate numerous individual issues to prove he or she was balance billed. For the Leons’ contract-based definition of balance billing,⁸ those issues include (1) what health plan the putative class member had at the time he or she received medical treatment from Medical Group; (2) whether that health plan had a

⁸ By “contract-based definition of balance billing” we are referring to the Leons’ theory that the contract between Medical Group and Hospital prohibited respondents from balance billing.

contract with Hospital at the relevant time; (3) whether that health plan had a contract with Medical Group at the relevant time; and (4) whether the putative class member was billed directly for an amount more than his or her health plan paid (above and beyond the member's copay and deductible). For the Leons' *Prospect*-based definition of balance billing,⁹ the individual issues may include (1) whether the putative class member had a health care service plan governed by the Knox-Keene Act at the time he or she received medical treatment from Medical Group; (2) when the putative class member received medical treatment from Medical Group; and (3) whether the putative class member was billed directly for an amount more than his or her health plan paid (above and beyond the member's copay and deductible).

The Leons' various theories of recovery would entail other individual inquiries as well. For example, in connection with the conversion and unjust enrichment (or quasi-contract) claims, putative class members would be required to show they paid at least some portion of a balance bill. (See *Durell, supra*, 183 Cal.App.4th at p. 1370 [to establish entitlement to restitution, plaintiffs must show (1) they conferred a benefit on defendant and (2) it would be unjust for defendant to retain that benefit]; *Burlesci v. Petersen* (1998) 68 Cal.App.4th 1062, 1066 [defendant's wrongful conversion or disposition of property is one element of a conversion claim].) What each class member paid cannot be determined by “ ‘facts common to all members of the class,’ ” but would have to be litigated individually by each class member. (*Duran v. U.S. Bank National Assn.* (2014) 59 Cal.4th 1, 28.) To establish respondents' liability for breach of contract or fraud, class members would be required to prove that they incurred damages. (*Careau & Co., supra*, 222 Cal.App.3d at p. 1388 [damages in an element of a breach of contract claim]; *Rutherford Holdings, supra*, 223 Cal.App.4th at p. 234 [damages in an

⁹ By “*Prospect*-based definition of balance billing” we are referring to the Leons' theory that our Supreme Court's decision in *Prospect* prohibited respondents from balance billing.

element of fraud].) One way to do so would be by showing that they paid at least some portion of the balance bill. As discussed above, that issue cannot be litigated on a classwide basis. The Leons appear to contend that the mere existence of an outstanding debt constitutes damages. Even assuming that is the case, not every patient who received a balance bill necessarily paid the bill or has outstanding debt. Patients may have had their bill paid by a third party, for example. (*Hale, supra*, 232 Cal.App.4th at p. 63.) Thus, the issue remains one requiring litigation on an individual basis.

In sum, for each of the Leons' theories of liability, a putative class member's right to recover will turn on various issues specific to that class member. Therefore, the trial court did not abuse its discretion in denying class certification based on a lack of predominance. Because both lack of ascertainability and lack of predominance are dispositive, we need not consider whether the Leons established the other class certification requirements.

III. DISPOSITION

The order denying class certification is affirmed. The summary judgment in Billing Service's favor is reversed. On remand, the court is directed to deny summary adjudication as to the Leons' fourth and sixth causes of action against Billing Service (quasi-contract and UCL claims) and to grant summary adjudication as to their first, second, and third causes of action against Billing Service (declaratory relief, breach of contract, and breach of the implied covenant of good faith and fair dealing claims).

Medical Group shall recover its costs on appeal from the Leons. Billing Service and the Leons shall bear their own costs on appeal.

ELIA, ACTING P.J.

WE CONCUR:

BAMATTRE-MANOUKIAN, J.

MIHARA, J.