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NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS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 SEVEN

ALLSTATE INSURANCE COMPANY et al., Plaintiffs and Appellants, v. DAVID SHAWA et al., Defendants and Respondents.	B257459 (Los Angeles County Super. Ct. No. BC525911)

APPEAL from a judgment of the Superior Court of Los Angeles County, Maureen Duffy-Lewis, Judge. Reversed with directions.

Manning & Kass, Ellrod, Ramirez, Trester, James J. Perkins, Janette H. Glaser and Ladell Hulet Muhlestein for Plaintiffs and Appellants.

Buchalter Nemer, Carol K. Lucas and Efrat M. Cogan for Defendants and Respondents.

INTRODUCTION

Plaintiffs Allstate Insurance Company, Allstate Indemnity Company, and Allstate Fire and Casualty Insurance Company (collectively, Allstate) appeal from a judgment entered against them and in favor of defendants David Shawa, M.D. (Shawa), Andrew Morris, D.C. (Morris), Nicholas Loloee, D.C. (Loloee), the S.H.A.R.P. Treatment of South Bay, Inc. (Sharp Treatment) and SHARP Surgery, Inc. (Sharp Surgery) after the trial court sustained defendants' demurrer, without leave to amend, to plaintiffs' original complaint alleging violations of the Unfair Competition Law (UCL; Bus. & Prof. Code, §§ 17200 et seq.). We conclude that plaintiffs should have been granted leave to amend their complaint and thus reverse the judgment.

FACTUAL AND PROCEDURAL BACKGROUND

A. THE PARTIES

Allstate is an insurance company licensed to issue automobile insurance policies to policyholders in California. As part of its business, Allstate indemnifies its insureds against liability arising out of automobile accidents with third parties. That is, when one of its insureds is legally responsible for injuring a third party in an accident, Allstate has a contractual obligation to pay for the damage caused by that insured, including medical and chiropractic treatment.

Defendants Shawa, Morris, and Loloee are healthcare providers and owners, officers and shareholders of the two corporate defendants, Sharp Treatment and Sharp Surgery (collectively, defendants). Defendants provided healthcare services to third parties who were in car accidents caused by Allstate insureds. Allstate alleges that defendants engaged in an ongoing conspiracy to create fraudulent medical and chiropractic bills and records that were used to support the filing of false insurance claims to Allstate.

B. THE ALLEGED FRAUDULENT BILLING SCHEME

Allstate has identified 136 third parties who submitted claims to Allstate for payment for treatment by defendants (hereinafter, claimants). In submitting their claims, the claimants included reports, records, and bills for medical and/or chiropractic services that they purportedly received from defendants. Between 2007 and 2012, the claimants submitted bills from defendants for a total of more than $3.5 million. Allstate paid most of the amount claimed—more than $2.2 million in settlements of the personal injury claims.

Suspecting that defendants' billing practices were illegal, unfair, or fraudulent, Allstate initiated an investigation in January 2011. In preparing their bills, defendants use Current Procedural Technology (CPT) codes, which are published annually by the American Medical Association. The CPT code set is a comprehensive list of medical, surgical, and diagnostic services that is widely used in the healthcare industry. (*People ex rel. Allstate Insurance Co. v. Muhyeldin* (2003) 112 Cal.App.4th 604, 607.) By using the codes in their bills to the claimants, defendants represented that they rendered the type of services described by those codes. Those representations were false and made as part of a fraudulent billing scheme to pad defendants' bills.

The scheme involved submitting bills for services that were not performed and/or overbilling for services that were performed. The overbilling for services performed was accomplished by two fraudulent practices that involve intentional manipulation of the use of CPT codes—"upcoding" and "unbundling." "Upcoding" refers to the use of a higher level code than is warranted for the actual service rendered. For example, the CPT code set describes different types of office visits, recognizing that the level of service required for an initial consultation for a multiple trauma victim presenting a complex case is higher than that required for an office visit for someone complaining about chronic back pain. The CPT code set assigns a higher code for the initial treatment of a multiple trauma victim (99245) than for the treatment of chronic back pain (99243), as designated by the last digit (5 v. 3). The higher code translates into higher payment. "Unbundling" refers to the use of multiple codes to describe services performed when one global code

should be used. For example, "[d]efendants unbundled the CPT codes by billing multiple spinal injections done at the same visit as if they were done separately." The use of separate billing for a global service results in higher payment than is warranted.

Defendants submitted their fraudulent bills and records to Allstate for payment as part of the claims submitted by the claimants. As a result of this fraudulent billing practice, Allstate "suffered direct monetary loss" by overpaying for the healthcare services. For instance, claimants submitted false claims for tens of thousands of dollars for a 30-minute procedure involving spinal injections and chiropractic manipulations, which either were not done or were unnecessary and overcharged when done. Sharp Treatment's average bill exceeded $9,000 per claimant; Sharp Surgery's average bill for "'facility fees'" for spinal injections and manipulations exceeded $40,000 per claimant.

C. THE ALLEGED ILLEGAL CORPORATE PRACTICE OF MEDICINE AND FAILURE TO DISCLOSE A BENEFICIAL INTEREST

Allstate claims that defendants engaged in other unlawful and unfair business practices. Allstate first alleges that defendants violated laws prohibiting the corporate practice of medicine. According to the complaint, Morris and Loloee owned 66 percent of Sharp Surgery in violation of Corporations Code section 13401.5, which prohibits chiropractors from owning more than 49 percent of a medical corporation.

Allstate next alleges that the individual defendants failed to disclose their ownership of Sharp Surgery in violation of Business and Professions Code section 654.2. Section 654.2 prohibits a licensed healthcare provider from billing a patient who receives services from, or referring a patient to, an organization in which that provider has a significant beneficial interest, unless the provider discloses that interest in writing and advises the patient that he or she may obtain the services elsewhere.

D. THE UCL CAUSE OF ACTION

Allstate asserts, as its sole cause of action, a violation of the UCL. In doing so, Allstate relies exclusively on its allegations of fraudulent billing. There is no mention, in

the description of its claim, of the alleged illegal corporate practice of medicine or the failure to disclose the individual defendants' interest in Sharp Surgery.

In setting out its claim, Allstate alleges that defendants knowingly "prepared and submitted the false, misleading and fraudulent bills and reports to Allstate as a demand for payment for services that [d]efendants did not actually render or which were unnecessary," and that they did so for financial gain. Allstate further alleges that these fraudulent bills "were intended to be presented to Allstate in connection with or in support of claims or payments pursuant to insurance policies . . . ." According to Allstate, the creation of the fraudulent bills and records were intended to defraud: "Defendants . . . caused to be made . . . fraudulent claims for payments . . . with an intent to defraud." Allstate alleges that it relied on and was harmed by the fraudulent billing practices.

Allstate claims that this fraudulent billing scheme constitutes an unlawful and unfair business practice in violation of Business and Professions Code section 17200, Civil Code section 1708,[1] and section 318, subdivision (b), of the Chiropractic Initiative Act of California (as applied to Morris and Loloee).[2] For these alleged violations, Allstate seeks restitution and injunctive relief under the UCL and attorneys' fees and costs under Code of Civil Procedure section 1021.5 for conferring "a significant benefit upon the general public by preventing" the alleged fraud.

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[1] Civil Code section 1708 provides: "Every person is bound, without contract, to abstain from injuring the person or property of another, or infringing upon any of his or her rights."

[2] The Chiropractic Initiative Act is an uncodified initiative measure, whose provisions are contained in the California Code of Regulations, title 16, section 200 et seq. (*Kifle-Thompson v. State Bd. of Chiropractic Examiners* (2012) 208 Cal.App.4th 518, 521, fn. 1) Under this measure, "[e]ach licensed chiropractor is required to ensure accurate billing of his or her chiropractic services . . . ." (Cal. Code Regs., tit. 16, § 318, subd. (b).)

E. THE DEMURRER, MOTION TO STRIKE, AND REQUEST FOR JUDICIAL NOTICE

Allstate filed this lawsuit on October 28, 2013. On December 13, 2013, defendants filed a demurrer to the complaint and a separate motion to strike allegations in the complaint.

In support of their demurrer and motion to strike, defendants filed a request for judicial notice of Sharp Treatment's and Sharp Surgery's articles of incorporation; photographs of Sharp Surgery; and pleadings, evidence, and rulings in other litigation. Defendants later filed a supplemental request for judicial notice of Allstate's amended responses to defendants' special interrogatories. In their interrogatories, defendants sought a breakdown of the $2.2 million Allstate allegedly paid them. Allstate objected, asserting that it did not know how the payments were disbursed because it made a lump sum payment, that the information sought was privileged, and that its investigation was ongoing.

In their demurrer, defendants argued that the complaint sought damages that were not available under the UCL, and that the complaint was vague and uncertain by failing to allege facts showing that Allstate has standing and by failing to offer separate allegations for each plaintiff against each defendant. Allstate filed oppositions to the demurrer and motion to strike and objections to the request for judicial notice.

On May 13, 2014, the court sustained the demurrer without leave to amend. The minute order briefly recounted the court's basis for its ruling, finding that: (1) "[n]on-restitutionary damages are not available in [Business and Professions Code section] 17200 claims"; (2) "[t]he complaint is vague"; and (3) "[t]here is no private right of action for unfair competition."[3] In light of its ruling, the court did not address the motion to strike.

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[3] In concluding there was no private right of action for unfair competition, the trial court cited *Moradi-Shalal v. Fireman's Fund Ins. Companies* (1988) 46 Cal.3d 287, 292 (*Moradi-Shalal*). That case, however, addressed the narrow question whether the California Legislature intended to create a private cause of action under the Unfair Insurance Practices Act (UIPA; Ins. Code, § 790 et seq.) for unfair settlement practices as

On June 5, 2014, the court issued an order dismissing the action and then entered judgment in defendants' favor. On June 23, 2014, notice of entry of judgment was filed. On June 27, Allstate timely filed a notice of appeal.

DISCUSSION

A. THE STANDARD OF REVIEW

A demurrer serves a limited role: it tests the legal sufficiency of the facts alleged in a complaint to determine whether they state a viable cause of action. (*Chapman v. Skype Inc.* (2013) 220 Cal.App.4th 217, 225.) In considering a demurrer, a court must read the complaint as a whole and accept as true all properly pleaded allegations that do not contradict the law or judicially noticed facts. (*Ibid.*) Our review of a trial court's order sustaining a demurrer is de novo, while our review of a denial of leave to amend is for abuse of discretion. (*Ibid.*) Such discretion is abused if there is "a reasonable probability" that a plaintiff can cure the defect by amendment. (*Id.* at p. 226.) The plaintiff bears the burden to show how the defect can be cured, which may be done for the first time on appeal. (*Ibid.*)

In reviewing the trial court's ruling, defendants invite us to take judicial notice of documents outside the complaint, including Allstate's discovery responses. We deny defendants' request, because none of the documents outside the allegations of the complaint is subject to judicial notice. Defendants rely on Allstate's discovery responses as evidence that Allstate will not be able to prove its allegations. They claim that these responses show that Allstate paid the claimants "lump sums in settlement for all personal injuries claimed," and that Allstate "did not and could not state that [it] paid for a particular service . . . or that the money paid to the claimants went to [defendants] at all."

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defined in Insurance Code section 790.03, subdivision (h). (*Ibid*; see *Zhang v. Superior Court* (2013) 57 Cal.4th 364, 369 [noting the narrow holding in *Moradi-Shalal*].) As this suit is not against an insurer under the UIPA for unfair settlement practices, *Moradi-Shalal* is inapplicable.

(Bold and italics omitted.) To consider these responses for such purposes, however, would transform a demurrer into a summary judgment proceeding. This we will not do. (*Bounds v. Superior Court* (2014) 229 Cal.App.4th 468, 478 [denying request to take judicial notice of discovery responses].)

B. THE THREE PRINCIPAL ISSUES ON APPEAL

The trial court sustained the demurrer on the original complaint without leave to amend. Defendants urge us to affirm that ruling for three principal reasons. First, they contend that Allstate lacks standing to assert a UCL claim for fraudulent billing practices. Second, they argue that Allstate improperly seeks nonrestitutionary damages related to those practices. Third, they claim that Allstate cannot maintain a Business and Professions Code section 17200 claim based on the allegations about the illegal corporate practice of medicine and failure to disclose a beneficial interest in Sharp Surgery. We discuss each issue below.

1. *Standing to Assert UCL Claim for Fraudulent Billing Practices*

The UCL prohibits three types of unfair competition—namely, acts or practices that are "unlawful," "unfair," or "fraudulent." (Bus. & Prof. Code, § 17200; accord, *Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.* (1999) 20 Cal.4th 163, 180.) "[T]he UCL encompasses a broad range of activity, but provides only limited remedies: restitution and injunctive relief." (*Shersher v. Superior Court* (2007) 154 Cal.App.4th 1491, 1497). To prosecute a UCL claim, a private party must have standing to do so. (Bus. & Prof. Code, § 17204; accord, *Sarun v. Dignity Health* (2014) 232 Cal.App.4th 1159, 1166.) The standing requirement imposes a two-part burden, requiring the plaintiff to show: (1) it suffered "economic injury"; and (2) the injury was "caused by" the unlawful, unfair, or fraudulent business practice. (*Kwikset Corp. v. Superior Court* (2011) 51 Cal.4th 310, 322, italics omitted.)

Defendants assert that Allstate lacks standing because Allstate has not alleged that it detrimentally relied on the defendants' bills. According to defendants, Allstate has not

and cannot so allege because Allstate did not pay their bills, but rather paid for a settlement with the claimants in exchange for a release of further claims. Defendants state: "Nowhere in their [complaint] do the Allstate companies allege that [they] . . . relied on any one or all of the bills as a basis for settlement, or that the bills caused them to settle, dictated the settlement amount, or had the effect of making them pay more than the reasonable amount necessary to settle the underlying claim." While we agree that Allstate must allege reliance and injury, we conclude that Allstate has adequately done so here.

In its complaint, Allstate clearly alleges that it detrimentally relied on defendants' fraudulent billing practices. Paragraph 33 states: "Defendants operated their business and repeatedly prepared and submitted medical and chiropractic reports, records, and bills to Allstate, thereby demanding payment from Allstate, without regard for the accuracy of the representations in those bills and reports. Allstate issued payments *based upon, and* [*d*]*efendants accepted payment on, the false, fraudulent and misleading bills*." (Compl., ¶ 33, at p. 10, italics added; see also Compl., ¶ 8, at p. 4 ["Allstate suffered actual loss as a result of the submission of these claims by [d]efendants"]; ¶ 10, at p. 5 ["Defendants knowingly caused these [fraudulent] writings to be submitted to Allstate in support of bodily injury claims," and "Allstate paid more than $2.2 million in settlements of these bodily injury claims"]; ¶ 14, at p. 6 ["Allstate was the victim of [d]efendants' . . . fraudulent practices or acts, and suffered direct monetary loss as a result"].)

Less clear is whether Allstate is alleging that defendants billed Allstate directly or indirectly through the claimants. At one point, Allstate seems to allege that defendants submitted the bills directly to Allstate (Compl., ¶ 33, at p. 10). At other points, Allstate alleges that the bills were submitted indirectly to Allstate. (Compl., ¶ 10, at p. 5 ["[d]efendants knowingly caused these [fraudulent] writings to be submitted to Allstate in support of [third-party] bodily injury claims"]; ¶¶ 12-14, at pp. 5-6 [same]; ¶¶ 31-32, at pp. 9-10 [same].) Taken as a whole, the allegations appear to state that the defendants billed the claimants, who then submitted the bills to Allstate for payment, and that Allstate ultimately paid the bills as part of a settlement with the claimants. Allstate seems

to confirm this view on appeal, stating that it seeks the return of money that "merely passed through the hands of the claimants."

The ambiguity on this point is not fatal to the theory of standing here. To demonstrate standing, Allstate need only allege that it relied on the fraudulent bills to pay for services that defendants did not render or to overpay for services that were rendered. Economic injury occurs in "innumerable ways," including when a party "surrender[s] in a transaction more . . . than he or she otherwise would have" or when a party is "deprived of money or property to which he or she has a cognizable claim." (*Kwikset Corp. v. Superior Court*, *supra*, 51 Cal.4th at p. 323.) Allstate claims that it surrendered money to pay claims for fraudulently billed services. This is all that is required under Business and Professions Code section 17204. (*Id.* at p. 323; see *Chapman v. Skype Inc.*, *supra*, 220 Cal.App.4th at p. 228 [interpreting *Kwikset Corp.* as requiring economic harm and "'but for'" causation].)

So long as Allstate detrimentally relied on the fraudulent billings, it has standing even if it paid the bills indirectly by paying the claimants for reimbursement or remittance to defendants. Numerous courts have permitted recovery under the UCL despite the absence of direct dealings between the parties. For example, in *Troyk v. Farmers Group, Inc.* (2009) 171 Cal.App.4th 1305, the plaintiff filed a class action against Farmers Insurance Exchange and two related entities (Farmers), seeking to recover service charges that the plaintiff wrongfully paid to Prematic Service Corp. (Prematic), a Farmers subsidiary that handled Farmers's monthly billings. (*Id*. at pp. 1314-1315.) Farmers argued the trial court erred in awarding restitution of the service charges, "because the service charges were paid *directly* to Prematic and not to" Farmers. (*Id*. at p. 1338.) The court rejected that argument, concluding that the "case law does not support Farmers' argument that they cannot be liable for restitution under the UCL because Prematic, rather than [Farmers], was the direct recipient of the service charges. [Citations.]" (*Id*. at p. 1340; see also *Shersher v. Superior Court, supra,* 154 Cal.App.4th at p. 1500 [holding that the UCL permits a consumer of a Microsoft product to sue Microsoft for restitution even though the consumer bought the product from a

third-party retailer]; *Hirsch v. Bank of America* (2003) 107 Cal.App.4th 708 [holding that UCL permits recovery of restitution even though the plaintiff did not deal directly with the defendant].)

The cases upon which defendants rely are distinguishable, as they did not involve any economic injury, direct or indirect. In *Hall v. Time Inc*. (2008) 158 Cal.App.4th 847, the plaintiff alleged that Time Inc. engaged in deceptive practices when offering to send books to consumers for a free trial period. Despite this offer, Time Inc. then sent them invoices and demanded payment before the expiration of the trial period. (*Id*. at p. 850.) The plaintiff kept the book beyond the trial period and later paid for it when he received demands from a collection agency. On appeal, the court concluded that the plaintiff had not alleged economic injury, reasoning: "[The plaintiff] expended money by paying Time $29.51—but he received a book in exchange. He did not allege he did not want the book, the book was unsatisfactory, or the book was worth less than what he paid for it." (*Id*. at p. 855.)

Similarly, the plaintiffs in *Peterson v. Cellco Partnership* (2008) 164 Cal.App.4th 1583, 1586 did not sustain economic harm. In that case, the plaintiffs sued Cellco Partnership, doing business as Verizon Wireless, claiming that Verizon Wireless violated the UCL by unlawfully selling phone insurance without a license. The plaintiffs asserted that they could pursue their UCL claim because Verizon Wireless unlawfully retained a portion of the premium they paid, which constituted an illegal commission for selling insurance. The court held that the plaintiffs lacked standing, stating: "[P]laintiffs here do not allege they paid more for the insurance due to defendant's collecting a commission. They do not allege they could have bought the same insurance for a lower price either directly from the insurer or from a licensed agent. Absent such an allegation, plaintiffs have not shown they suffered actual economic injury. Rather, they received the benefit of their bargain, having obtained the bargained for insurance at the bargained for price." (*Id*. at p. 1591.)

Defendants try to liken this case to *Hall* and *Peterson* by asserting that "Allstate . . . received a bargained for settlement [with the claimants] in exchange for a release of

any further claims." This assertion, however, ignores a critical part of Allstate's case. Allstate alleges that, in settling those claims, it was fraudulently induced to pay for services that defendants did not perform or for which they were overcharged. If Allstate can prove that allegation, Allstate has suffered economic injury caused by defendants.[4]

2. *The Availability of the Restitution Remedy*[5]

Defendants next assert that even if Allstate has standing to sue, its prayer for restitution is improper because Allstate's theory of recovery is one of damages, which are not recoverable under the UCL. (Bus. & Prof. Code, § 17203 [authorizing injunctive and restitutionary relief]; *Shersher v. Superior Court*, *supra*, 154 Cal.App.4th at p. 1497 [damages not permitted].) Defendants contend that Allstate made lump sum payments to the claimants to settle their personal injury claims, and that if Allstate overpaid those claims because of inflated medical bills, "the remedy lies against those injured parties." This contention misconstrues Allstate's UCL claim and the law of restitution.

In seeking restitution, Allstate focuses on the money that it indirectly paid to defendants because of their allegedly fraudulent billing practices. Allstate alleges that those practices caused Allstate to overpay for defendants' services, and that defendants

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[4] In support of its standing argument, Allstate relies on two non-UCL cases finding criminal and civil liability for fraudulent billings to an insurance company. (*People v. Singh* (1995) 37 Cal.App.4th 1343 [criminal]; *People ex rel. Allstate Insurance Co. v. Muhyeldin*, *supra*, 112 Cal.App.4th 604 [civil]. Allstate's limited point seems to be that if a physician can be criminally or civilly liable for submitting—or causing to be submitted—fraudulent bills for payment by an insurer, then the insurer necessarily has suffered economic injury, whether the insurer paid the physician directly or indirectly "through a conduit." These cases do appear to support that rather straightforward conclusion.

[5] "The appropriate procedural device for challenging a portion of a cause of action seeking an improper remedy is a motion to strike." (*Caliber Bodyworks, Inc. v. Superior Court* (2005) 134 Cal.App.4th 365, 385.) Yet the parties and the trial court addressed the restitution issue in the context of the demurrer. We too will address this issue, as it has been fully litigated and because of its importance to the litigation. (*Ibid*. [noting court's discretion to consider striking a remedy in demurrer context].)

were therefore unjustly enriched at Allstate's expense. Construed this way, Allstate's claim, if proved, may allow for an order of restitution. (*People ex rel. Harris v. Sarpas* (2014) 225 Cal.App.4th 1539, 1558 [allowing restitution for payments made for fraudulent loan modification services]. The case cited by defendants does not suggest otherwise. (See *Pineda v. Bank of America, N.A.* (2010) 50 Cal.4th 1389, 1393 [holding that statutory penalties against employers for failing to timely pay final wages are "not recoverable . . . under the UCL because employees have no ownership interest in the funds"].)

Restitution under the UCL is defined as an order "compelling a UCL defendant to return money obtained through an unfair business practice to those persons in interest from whom the property was taken, that is, to persons who had an ownership interest in the property . . . ." (*Kraus v. Trinity Management Services, Inc.* (2000) 23 Cal.4th 116, 126-127.) Here, Allstate alleges that it had an interest in the money that it overpaid for defendants' services and is claiming that defendants benefited from those overpayments. If Allstate can prove that it made those overpayments to defendants as a result of fraudulent bills, it would have a claim in restitution to the extent of the overpayments to defendants. This is in the nature of restitution as it restores to Allstate monies that defendants wrongfully received at Allstate's expense. (*Kwikset Corp. v. Superior Court*, *supra*, 51 Cal.4th at p. 336 [stating that restitution under the UCL "is confined to restoration of any interest in 'money or property'" that defendant acquired through an unfair, unlawful, or fraudulent act].)[6]

While Allstate may be able to pursue a restitution remedy, the allegations in the complaint contain an ambiguity that Allstate must address before being permitted to do so. (Code Civ. Proc., § 430.10, subd. (f) [uncertain pleading subject to demurrer].) The complaint suggests that Allstate overpaid the claimants by detrimentally relying on

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[6] As demonstrated by the cases previously discussed in the standing context, the right to recover restitution, like the threshold question of standing, does not depend on whether Allstate paid fraudulent bills directly to defendants.

defendants' fraudulent bills, and that the overpayments were passed along to defendants. But the extent of Allstate's reliance on the allegedly fraudulent bills is not evident from the complaint, as Allstate pleads generally when specificity is needed to determine whether it is pursuing a restitutionary or damages remedy. As stated, if Allstate is seeking the return of overpayments ultimately *made to defendants*, then the UCL would allow restitution. However, if Allstate is seeking overpayments ultimately *made to the claimants* because of the fraudulent bills, then the recovery of such overpayments from defendants is in the nature of damages.[7]

This distinction may well present Allstate with proof problems. (*In re Tobacco Cases II* (2015) 240 Cal.App.4th 779, 792 [stating that "plaintiffs had the burden of proving entitlement to . . . restitution"].) Notwithstanding its assertions, Allstate must do more than simply calculate "the difference between what defendants were paid for the medical services they provided and the legitimate value of the medical services actually provided." This would be true only if Allstate settled a personal injury claim that solely involved reimbursement for defendants' medical bills that Allstate fully paid in reliance on the alleged fraud. But the settlement of a personal injury case is usually not that simple, as it often involves a resolution of both economic and noneconomic injuries. In addition, a settlement may involve reduced payments for the claimed injuries because of disputes over liability, the extent of the claimed injuries, and the reasonableness of the costs of treatment. In those instances, Allstate will have to demonstrate that the money it seeks from defendants stems from overpayments it paid to defendants based on their allegedly fraudulent bills (and not based on other factors). Such complexities of proof,

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[7] For example, if Allstate used a formula to value noneconomic harm that was tied to the amount of economic harm (e.g., paying $1 in noneconomic harm for each dollar of economic harm), and if Allstate relied on fraudulent bills in calculating the economic and noneconomic components of the overall settlement, then the fraud may have injured Allstate by overpaying for both components. If defendants received overpayments for the economic component, they are liable for restitution. But if the claimants received overpayments for the noneconomic component (which they otherwise would not have received), defendants are not liable for those damages under the UCL.

however, are not terminal at the pleading stage. (*Schmidt v. Foundation Health* (1995) 35 Cal.App.4th 1702, 1706 ["In reviewing the legal sufficiency of a demurrer, we are not concerned with plaintiff's ability to prove the allegations of the complaint, or the possible difficulties in making such proof"].)

In short, we agree with the trial court that Allstate's complaint is vague with respect to the allegations supporting its restitution claim. However, it appears "there is a reasonable probability that the defect can be cured by amendment." (*Chapman v. Skype Inc.*, *supra*, 220 Cal.App.4th at p. 226.) Allstate must therefore be permitted to amend its complaint to allege facts, if it can, that it relied on defendants' fraudulent bills resulting in overpayments to defendants.[8] If Allstate so alleges, then it has the right to seek restitution as described above. If Allstate is unable to allege facts sufficient to pursue restitution, it still may be able to seek injunctive relief (an issue we do not decide). The trial court therefore abused its discretion in denying Allstate leave to amend its original complaint. (*City of Stockton v. Superior Court* (2007) 42 Cal.4th 730, 747.)

3. *The Alleged Illegal Corporate Practice of Medicine and Failure to Disclose Beneficial Interest*

In its complaint, Allstate alleges two other unlawful practices: (1) the illegal corporate practice of medicine through Sharp Surgery, in violation of Corporations Code section 13401.5; and (2) the individual defendants' failure to disclose their ownership interest in Sharp Treatment, in violation of Business and Professions Code section 654.2. In addressing these two allegations on appeal, Allstate focuses on the illegal corporate practice of medicine and contends that it is entitled to recover payments for all services provided in violation of Corporations Code section 13401.5. Allstate recognizes that this law is designed to protect patients, not payors, and that Allstate would be enriched by its theory of recovery. Allstate nonetheless argues that such enrichment is not unjust when

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[8] As Allstate will be granted leave to amend, it also should clarify the ambiguity created by treating multiple plaintiffs as one entity and multiple defendants as one entity.

weighed against the need to enforce the prohibition against the corporate practice of medicine.

Whether Allstate can state a UCL claim based on these allegations is not clear. We need not and do not resolve this question, however, as it is not properly before us. Allstate did not specifically predicate its UCL cause of action on the illegal corporate practice of medicine and the failure to disclose; and defendants did not challenge these allegations in their demurrer. Instead, defendants filed a motion to strike the allegations, which the trial court did not decide because of its ruling on the demurrer.[9]

DISPOSITION

The judgment is reversed. The trial court is directed to vacate its order of dismissal and order sustaining defendants' demurrer without leave to amend and to enter a new order, granting Allstate leave to amend its complaint. Allstate is to recover its costs on appeal.

BLUMENFELD, J.[*]

We concur:

ZELON, Acting P. J. SEGAL, J.

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[9] For similar reasons, we do not address whether Allstate is entitled to attorneys' fees under Code of Civil Procedure section 1021.5, the private attorney general statute. This issue was raised in the motion to strike, which the trial court did not consider.

[*] Judge of the Los Angeles Superior Court, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.