Filed 4/4/18 Romo v. Los Angeles Dodgers, LLC CA2/8

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION EIGHT

LEONARD ROMO, Plaintiff and Respondent, v. LOS ANGELES DODGERS, LLC, Defendant and Appellant.	B280803 (Los Angeles County Super. Ct. No. BC469684)

APPEAL from the judgment of the Superior Court of Los Angeles County, Michael P. Linfield, Judge. Affirmed, as modified.

Jerome M. Jackson for Defendant and Appellant.

Law Offices of Martin N. Buchanan, Martin N. Buchanan; Girardi | Keese, Christopher T. Aumais and Ashkahn Mohamadi for Plaintiff and Respondent.

* * * * * * * * *

Plaintiff Leonard Romo was injured by security staff employed by defendant Los Angeles Dodgers, LLC, while attending a baseball game. Plaintiff filed a personal injury action against defendant, and the jury awarded him $175,000 in economic damages for past medical expenses, $150,000 for future medical expenses, $50,000 in past noneconomic damages, and $100,000 for future noneconomic damages. The damage award was reduced by 33.33 percent due to plaintiff's own negligence.

On appeal, defendant contends the award for past and future medical expenses is not supported by substantial evidence. Concerning past medical expenses, defendant contends there is no evidence that plaintiff incurred or paid any expenses. Defendant also contends that since the economic damages are not supported by substantial evidence, the noneconomic damages award also must be reversed, reasoning that "the cost of medical care is an important indicator of a plaintiff's non-economic damages." We find that the noneconomic damage award and the award of future medical expenses are supported by the record. However, because plaintiff did not demonstrate the reasonable value of a portion of the billed expenses for past medical care as required by law, we reduce the damages to the appropriate amount. (*Behr v. Redmond* (2011) 193 Cal.App.4th 517, 535.)

BACKGROUND

On September 16, 2009, plaintiff and his family attended a baseball game at Dodger stadium. Los Angeles Dodgers security personnel asked plaintiff's adult daughter to leave the stadium because of profanity printed on her shirt. A melee ensued. Plaintiff was tackled to the ground by security guards, suffering injuries to his neck, lower back, right shoulder, and right knee.

Plaintiff went to White Memorial Hospital for treatment that same day. He was discharged from the emergency room that evening and was told to return within 24 hours if his symptoms persisted. Plaintiff did not seek medical attention for several weeks, when he was referred by his attorney to Dr. Daniel Silver at the Silver Orthopedic Center. Dr. Silver treated plaintiff and referred him to other doctors for treatment.

In December 2009, plaintiff underwent surgery to repair a torn meniscus in his right knee. In November 2010, plaintiff underwent surgery to fix two herniated discs in his back. The surgery was performed by Dr. Fardad Mobin at the Sharp Surgery Center. Plaintiff was also diagnosed with arthritis and bursitis in his right shoulder that were exacerbated by the incident.

No bills or other exhibits documenting plaintiff's medical expenses were introduced into evidence at trial. Plaintiff testified that he never paid any doctors, received any bills, or received any demand for payment related to his treatment. No evidence was presented that plaintiff had medical insurance or that he was covered by a provider who negotiated a reduced rate for his treatment.

Dr. Jacob Tauber testified as one of plaintiff's medical experts. He reviewed "all the bills in this case" and determined that the amounts billed "w[ere] reasonable and necessary." According to Dr. Tauber, Sharp Surgery Center billed a total of $136,000 for plaintiff's back surgery, and this sum was "within the range of what [you] see charged" for that type of procedure. Dr. Tauber also testified that Dr. Silver billed $2,500 for services he provided. Dr. Tauber testified to the contents of various bills, including a "charge" for $396 from JJ&R Emergency Group;

charges by California Imaging for approximately $2,300; physical therapy bills totaling $12,871; bills from Bay Harbor Imaging and Landmark Imaging totaling $4,200; bills from Dr. Vance Eberly for knee surgery totaling $8,600; and anesthesia costs of $13,300. Dr. Tauber did not identify to whom any of these bills was sent, and there is no evidence in the record establishing to whom any of the bills was sent. Dr. Tauber also did not testify that plaintiff, or anyone else, ever paid any of these sums, or that liens secured their payment against any recovery in this case.

Dr. Mobin also testified to some of plaintiff's medical costs. He reviewed "all the billing" for plaintiff's spinal injuries, and opined that the bills were "reasonable" and consistent with what he has seen other patients billed for the same types of treatment plaintiff received. He testified that $5,200 billed for epidural steroid injections was reasonable and necessary. He also testified that his own bill of $25,000 was reasonable and necessary, as were additional charges of $6,600 for pain management services rendered by Dr. David Shoua. Dr. Mobin did not identify to whom any of these bills was sent, and there is no evidence in the record establishing to whom any of the bills was sent. Dr. Mobin also did not testify that plaintiff, or anyone else, ever paid any of these sums, or that services were rendered subject to a lien on the recovery in the case.

Plaintiff testified that the incident had a "big impact" on his life. His injuries prevented him from playing with his grandchildren. He also suffered from continuing pain in his right shoulder and knee.

Regarding future medical expenses, Dr. Tauber testified that plaintiff's shoulder would require surgery in the future to relieve his symptoms and that the surgery would cost between

$25,000 and $30,000, and he would require $3,000 to $5,000 in postoperative care. He also opined that due to continuing pain in his knee, plaintiff would require another knee surgery, requiring additional MRI studies costing between $2,000 and $2,200. Plaintiff would also benefit from physical therapy and medications. He opined that medications could cost approximately $1,000 per year and that physical therapy would cost approximately $1,350 per year. He did not state how long plaintiff would require continuing treatment.

Plaintiff's pain management expert, Dr. Adam Weitzman, testified that plaintiff would require ongoing pain management, including medications, epidural injections, physical therapy, and psychological care. He opined that over the course of a year, it could cost approximately $3,000 for a pain management doctor. Physical therapy sessions would cost approximately $200 each, totaling over $10,000 per year in physical therapy costs. Psychological treatment could cost up to $300 per session and should occur first on a weekly basis, and then become more spaced out. Dr. Weitzman did not state how long plaintiff would require continuing treatment.

Dr. Mobin testified that plaintiff would need to see a spine specialist for approximately 10 years following the surgery to monitor his progress. An initial visit would cost $1,000, and annual followup visits would cost approximately $450 per session. He would also require further imaging studies such as X-rays, MRI's, and CT scans, totaling $5,800. Medications would cost approximately $1,000 per year. Except for the spine specialist, Dr. Mobin did not state how long plaintiff would require continuing treatment.

The jury was instructed that plaintiff was expected to live an additional 28.8 years and that his life expectancy should be considered if the jury determined plaintiff suffered damages that will continue for the duration of his life.

Defendant presented no evidence that plaintiff's damages were other than what had been testified to by Dr. Mobin, Dr. Tauber, and Dr. Weitzman.

The jury awarded plaintiff $175,000 in economic damages for past medical expenses, $150,000 for future medical expenses, $50,000 in past noneconomic damages, and $100,000 for future noneconomic damages. The damage award was reduced by 33.33 percent due to plaintiff's contributory negligence.

Defendant filed a new trial motion, arguing the jury's award for past and future medical expenses was not supported by substantial evidence that the expenses were both incurred and reasonable. Defendant presented no evidence that any of plaintiff's medical expenses were reduced by their provider pursuant a contractual or other obligation or by way of a voluntary "write down." The trial court denied the motion for new trial.

DISCUSSION

The issue in this appeal is whether the evidence presented at trial is sufficient to support the award of damages. For the reasons stated below, we find that evidence supports an award of $83,697 for past medical expenses and the full amount awarded for future medical expenses.

1. Standard of Review

The amount of damages is a question of fact first committed to the discretion of the jury and next to the discretion of the trial judge on a motion for new trial. (Code Civ. Proc., § 43; *Behr v.*

Redmond, *supra*, 193 Cal.App.4th at p. 533; *Iwekaogwu v. City of Los Angeles* (1999) 75 Cal.App.4th 803, 820.) A "contention that the evidence does not support the verdict is reviewed under the substantial evidence standard. In reviewing a claim of insufficiency of evidence, the appellate court must consider the whole record, view the evidence in the light most favorable to the judgment, presume every fact the trier of fact could reasonably deduce from the evidence, and defer to the trier of fact's determination of the weight and credibility of the evidence." (*Rufo v. Simpson* (2001) 86 Cal.App.4th 573, 614.)

After reviewing the record in light of this standard, an appellate court may reduce an award found to be excessive and unsupported by the record. (*Behr v. Redmond, supra*, 193 Cal.App.4th at p. 535.)

2. Past Medical Expenses

A plaintiff seeking compensation for medical expenses has the burden of establishing (1) the cost of the medical services he or she incurred and (2) the reasonableness of those amounts. (*Moore v. Mercer* (2016) 4 Cal.App.5th 424, 436-437 (*Moore*).)

This case raises two related issues regarding the judgment for past medical expenses. First, the record reflects only how much was *billed* for plaintiff's past medical treatment, which, according to defendant, raises the questions of whether the expenses were "reasonable" and whether plaintiff actually "incurred" the billed amount or some unknowable lesser amount, meaning that he failed to meet his burden of establishing his actual damages. Second, the evidence presented at trial did not establish that plaintiff was personally billed for his past medical expenses or that he expected to be billed for those expenses, which, again according to defendant, and also the dissent, also

raises the question of whether he "incurred" those expenses. We conclude that plaintiff did incur those past medical expenses, albeit in an amount less than he was awarded.

a. Amount of Damages

Applied to medical damages, the general rule of recovery as set forth in Civil Code section 3333[1] is that "a person injured by another's tortious conduct is entitled to recover the reasonable value of medical care and services reasonably required and attributable to the tort." (*Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635, 640 (*Hanif*); see *Moore, supra*, 4 Cal.App.5th at pp. 436-437.) "Before 1988 a plaintiff, relying on the collateral source rule, could recover the full amount of a health provider's charges despite the fact that an insurer or governmental agency had prenegotiated a discounted rate for the services and the plaintiff was not liable for the full amount. (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 6.) The collateral source rule states that 'if an injured party receives some compensation for his injuries from a source wholly independent of the tortfeasor, such payment should not be deducted from the damages which the plaintiff would otherwise collect from the tortfeasor.' " (*Moore*, *supra*, 4 Cal.App.5th at p. 437.)

The 1988 change came when the Court of Appeal decided *Hanif*. *Hanif* limited awards for medical damages in cases where the plaintiff has a benefit (in that case Medi-Cal) that has a

---

[1] Civil Code section 3333 provides, "[f]or the breach of an obligation not arising from contract, the measure of damages, except where otherwise expressly provided by this code, is the amount which will compensate for all the detriment proximately caused thereby, whether it could have been anticipated or not."

prenegotiated arrangement with the medical services provider for reduced cost of the services on the theory that the reduced fee is the actual cost to the plaintiff. A similar rule was adopted for private medical insurance in *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541 (*Howell*). Since *Hanif* and *Howell*, "the measure of medical damages is the lesser of (1) the amount paid or incurred, and (2) the reasonable value of the medical services provided." (*Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311, 1330 (*Bermudez*).)

The former measure is generally applicable to cases where the plaintiff is insured or the beneficiary of some prenegotiated reduction or write down. (*Bermudez, supra*, 237 Cal.App.4th at p. 1330.) "Conversely, the measure of damages for *uninsured* plaintiffs who have not paid their medical bills will usually turn on a wide-ranging inquiry into the reasonable value of medical services provided, because uninsured plaintiffs will typically incur standard, nondiscounted charges that will be challenged as unreasonable by defendants." (*Id.* at pp. 1330-1331, italics added.)

The court in *Bermudez* held that in the case of an "apparently" uninsured plaintiff, the amounts billed for medical services are "relevant and admissible with regard to the reasonable value of [the plaintiff's] medical expenses." (*Bermudez, supra*, 237 Cal.App.4th at p. 1335.) In *Bermudez,* the plaintiff apparently had no medical insurance, had paid no medical bills and testified that he "believed" that his medical bills would be paid out of his recovery but acknowledged that he would be responsible regardless of the outcome of the litigation. (*Id.* at p. 1324.) This evidence was held to be sufficient to uphold an award of the entire billed amount of his past medical services.

In this case, the amounts billed for past medical expenses were proven by billing summaries that were testified to and explained by Drs. Tauber and Mobin. Defendant made no objection to the introduction of this evidence, concedes that it was properly admitted, and offered no contrary evidence.[2] There was no evidence that plaintiff had insurance or some other benefit that resulted in a reduction of his medical costs. Defendant has never suggested that plaintiff had such a benefit. This evidence met the plaintiff's legal burden of establishing the cost of the medical services he received.

These facts should be compared to cases where the plaintiff *had* insurance or was the beneficiary of some other program that resulted in a prenegotiated fee reduction. In *Howell*, for example, the plaintiff introduced evidence of the amount that was billed for the medical services that he received as the result of the defendant's actions. (*Howell, supra*, 52 Cal.4th at pp. 549-550.) The *defendant* made a posttrial motion to reduce the award by the amount that was "written off" by the provider pursuant to the plaintiff's prenegotiated PPO contract. Similarly, in *Hanif,* the plaintiff introduced evidence of the amount that was billed for his medical services and the amount that Medi-Cal actually paid for those services was received by stipulation. (*Hanif, supra*, 200 Cal.App.3d at p. 639, fn. 2.) In *Sanchez v. Strickland* (2011) 200 Cal.App.4th 758, one of the plaintiffs produced evidence showing the amount that he had been billed for past medical expenses. Again, the *defendant* made an unsuccessful motion to reduce that

---

[2] This is similar to the procedure employed in *Moore* and held to be sufficient. (See *Moore, supra*, 4 Cal.App.5th at p. 434.)

award by the amount gratuitously "written off" by the medical service provider. (*Id.* at pp. 761-762.)

The defendant here certainly made no effort to reduce the amount of damages based on any negotiated "write off" or reduction. It is clear from *Howell*, *Hanif*, and similar cases that defendants are entitled to introduce such evidence if it exists to reduce a damages award. In virtually every case where setoffs or reductions have been an issue, the defendant has either made a postverdict motion to reduce or has made a pretrial motion to limit evidence of past medical expenses to the lower amount under the *Howell* rule. In *Olson v. Reid* (2008) 164 Cal.App.4th 200, 203 (abrogated on other grounds in *Howell*), for example, the Court of Appeal reversed an order reducing damages pursuant to *Hanif* because the evidence presented by the *defendants* at a posttrial hearing was insufficient to establish a reduction.

The reality of modern civil litigation is that all parties know the plaintiff's coverage status prior to the commencement of trial through the pretrial discovery process. (See Code Civ. Proc., § 2017.210; *Norton v. Superior Court* (1994) 24 Cal.App.4th 1750 [holding that evidence of a plaintiff's insurance coverage may be discoverable if admissible, which it surely would be in cases involving the *Howell* rule].) That is certainly true in this case, where there was a pretrial discussion about evidence relating to plaintiff's workers' compensation recovery for a possibly related injury. If there had been a setoff or other factor that reduced plaintiff's medical costs, the defendant would surely have made a pretrial motion to limit the evidence to the setoff amount and/or it certainly would have made a motion to reduce per *Howell* and *Hanif*, and their progeny. It could even have asked the doctors

who explained the billings whether the plaintiff had received a setoff.

The defendant did none of these things because, we may infer, it knew through discovery that there was no setoff. There is no rule of procedure that compels a *plaintiff* to take up the defendant's mantle and present evidence to the trier of fact that undermines its claim nor is there any rule of procedure that requires a *plaintiff* to prove that he or she does not have insurance or some other type of setoff. Moreover, it would be unjust to suggest that the defendant can essentially sit on evidence that is favorable to the amount of damages for which it is liable, say nothing in the trial court, and then ask an appellate court to set aside an entire damages award because the *plaintiff* did not introduce evidence that he did not get a setoff. That would be sandbagging at its worst.

The defendants have repeatedly cited *Howell* and *Hanif* as authority for the proposition that plaintiff's damages were subject to reduction and, therefore, unknown. This case, however, is not controlled by *Howell* and *Hanif* because there is no evidence that plaintiff's billed medical costs were reduced by any prenegotiated obligation or arrangement on the part of the providers to reduce their fees. As previously discussed, this distinction is well established; and, if such evidence existed, defendant could have produced it either at a pretrial motion, trial, or in a posttrial motion to reduce damages. It did not.

There is nothing in the record that establishes that the costs of past medical services were anything other than amounts to which Drs. Tauber and Mobin testified. The jury found those amounts to have been proven and the trial judge agreed.

Both defendant and the dissent maintain that the damage award in this case is defective because the plaintiff did not produce any evidence of the actual amount that *he* would pay.

There is no evidence that the medical providers in this case do not expect repayment. Indeed, defendant itself suggested in its closing argument that plaintiff's lawyers retained "strip mall" doctors as part of a "lawsuit abuse" scheme to secure a payout from which both the lawyers and the doctors would benefit.

Our Supreme Court has repeatedly suggested that the collateral source rule of not reducing damages for unpaid medical services applies when those services were "rendered 'with the expectation of repayment out of any tort recovery.' " (*Howell, supra*, 52 Cal.4th at p. 558, quoting *Helfend v. Southern California Rapid Transit District*, *supra*, 2 Cal.3d 1, 7, fn. 5 (*Helfend*).) While these statements are dicta, they are also accurate in the context of personal injury cases where unsophisticated persons who are injured by others but not able to immediately pay their medical bills must rely on attorneys and other professionals to both treat their injuries and secure just compensation for those injuries. (See *Moore, supra*, 4 Cal.App.5th 424, 427.)

Adoption of defendant's position would deny damages to any plaintiff who was clearly injured by a defendant's wrongful actions but who fails to produce evidence that he or she was *personally* liable for medical expenses. Such a rule would be contrary to well-established law. Plaintiffs who are insured are still entitled to recovery of their actual damages even though insurance relieves them of personal liability for their medical expenses. (*Helfend*, *supra*, 2 Cal.3d 1.) Moreover, plaintiffs are entitled to recover damages that were either gratuitously paid or

written off. (S*anchez v. Strickland, supra*, 200 Cal.App.4th 758, 769 [medical costs]; *Arambula v. Wells* (1999) 72 Cal.App.4th 1006, 1014-1015 [earnings loss]; see *Regalado v. Callaghan* (2016) 3 Cal.App.5th 582, 600-601 [same].) In *Bermudez*, there was no evidence from which a conclusion about the plaintiff's personal liability for medical services other than his "belief" that he would be if there was no tort recovery. We find that there is nothing in this case prevents defendant from being liable for the damage it caused.

Applying the standard that we "must consider the whole record, view the evidence in the light most favorable to the judgment, presume every fact the trier of fact could reasonably deduce from the evidence, and defer to the trier of fact's determination of the weight and credibility of the evidence," we conclude record supports the jury's determination of the amount of damages. (*Rufo v. Simpson, supra*, 86 Cal.App.4th at p. 614.) The amount of plaintiff's past medical costs was sufficiently clear to establish that he incurred them, even if they had not yet been paid.

b. Reasonableness of Damages

Drs. Tauber and Mobin also testified that, with one exception, the amounts billed were reasonable. That one exception, as defendant correctly observes, is that the doctors' testimony did *not* establish the reasonable value of many of the services that plaintiff received at the Sharp Surgery Center. The record is virtually silent on this point. While the billed amount may be sufficient to establish the *amount* of medical expenses, by itself it is insufficient to establish the *reasonableness* of those expenses. (*Bermudez*, *supra*, 237 Cal.App.4th at pp. 1335-1337.) Therefore, the evidence is not sufficient to sustain the award for

part of the past medical expenses related to Sharp Surgery Center.

The question regarding the amount of past medical expenses raised by the first issue is whether the evidence is sufficient to sustain the jury's verdict and the trial court's ultimate judgment regarding whether plaintiff incurred these expenses and the reasonable value of many of those past medical services. With the one exception of some of the services plaintiff received at Sharp Surgery Center, we conclude that it is.

Thus, we conclude that substantial evidence, which both the jury and the trial judge accepted, proved that plaintiff actually underwent the medical procedures reflected in the billings that was summarized at trial. We further conclude that substantial evidence established the reasonable value of the services for which they were generated with the exception of some of the services rendered by the Sharp Surgical Center. Therefore, plaintiff is entitled to recover the $83,697 that is supported by the evidence.

3. Future Medical Expenses

Defendant also contends there was insufficient evidence of plaintiff's future medical expenses. " 'An injured plaintiff is entitled to recover the reasonable value of medical services that are reasonably certain to be necessary in the future.' " (*J.P. v. Carlsbad Unified School Dist.* (2014) 232 Cal.App.4th 323, 341.) " 'It is for the jury to determine the probabilities as to whether future detriment is reasonably certain to occur in any particular case. [Citation.] It is "not required" for a doctor to "testify that he [is] reasonably certain that the plaintiff would be disabled in the future. All that is required to establish future disability is that from all the evidence, including the expert testimony, . . . it

satisfactorily appears that such disability will occur with reasonable certainty. [Citations.]" [Citation.] The fact that the amount of future damages may be difficult to measure or subject to various possible contingencies does not bar recovery.' " (*Id.* at pp. 341-342.)

Here, the evidence supported the jury's finding that plaintiff would incur future medical expenses of approximately $150,000. There was testimony that plaintiff would require two surgeries and continuing medical management of his symptoms, including physical therapy, psychotherapy, pain management, medications, and imaging studies. The shoulder surgery could cost upwards of $35,000; the knee surgery could cost approximately $8,000; and physical therapy and pain medications could cost over $11,000 per year. Assuming, as the defendant posits, that these treatments were limited to 10 years, these costs exceed the jury's award.

4. Noneconomic Damages

Defendant contends the unsubstantiated economic damages award "infected" the noneconomic damages award. Defendant cites cases finding that the cost of plaintiff's medical care is an "indicator" of a plaintiff's general damages. (See *Helfend*, *supra*, 2 Cal.3d at p. 11; *Smock v. State of California* (2006) 138 Cal.App.4th 883, 887.) These cases do not hold that plaintiff must prove economic damages in order to recover noneconomic damages, or that the economic damages award must bear some proportionate relationship with the noneconomic damages.

The evidence at trial supports the award for noneconomic damages. Plaintiff underwent multiple surgeries, experienced pain, and is no longer able to play with his grandchildren. To

recover for pain and suffering, "compensatory damages reasonably proportioned to the intensity and duration of the harm can be awarded without proof of amount other than evidence of the nature of the harm. There is no direct correspondence between money and harm to the body, feelings or reputation." (*Duarte v. Zachariah* (1994) 22 Cal.App.4th 1652, 1664-1665.)

DISPOSITION

The award of past medical expenses is reduced to $83,697. In all other respects, the judgment is affirmed. The parties will bear their own costs on appeal.

HALL, J.*

I CONCUR:

RUBIN, Acting P. J.

---

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

Leonard Romo v. Los Angeles Dodgers LLC
B280803
GRIMES, J., Dissenting.

The majority departs from established law of the proof required to recover past medical expenses in a personal injury case. The majority ignores the unequivocal holding of the Supreme Court that a plaintiff may not recover past medical expenses that he did not pay or incur. (*Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541, 549 (*Howell*) ["The collateral source rule precludes certain deductions against otherwise recoverable damages, but does not expand the scope of economic damages to include expenses the plaintiff never incurred."].)

There is literally nothing in the record to suggest that plaintiff paid or incurred any past medical expenses for which he is entitled to receive compensation. Despite that, the majority finds defendant liable to plaintiff for $83,697 in past medical expenses, with no analysis whatsoever to explain how it arrived at that measure of damages; conflates proof of the reasonable value of medical services with the separate question whether plaintiff paid or incurred any expenses for medical services; conflates the *admissibility* of the evidence with the *sufficiency* of the evidence; and flips upside down the burdens of proof.

I respectfully dissent.

1. The Legal Principles

A plaintiff may recover no more than the "actual amount expended or incurred for past medical services so long as that amount is reasonable." (*Hanif v. Housing Authority* (1988) 200 Cal.App.3d 635, 643 (*Hanif*).)

"California decisions have focused on 'reasonable value' in the context of *limiting* recovery to reasonable expenditures, not expanding recovery beyond the plaintiff's actual loss or liability. To be recoverable, a medical expense must be both incurred *and* reasonable." (*Howell*, *supra*, 52 Cal.4th at p. 555.)

"[T]he measure of medical damages is the lesser of (1) the amount paid or incurred, and (2) the reasonable value of the medical services provided." (*Bermudez v. Ciolek* (2015) 237 Cal.App.4th 1311, 1330 (*Bermudez*).)

2. Plaintiff's Medical Experts

No bills or other exhibits documenting plaintiff's medical expenses were introduced into evidence at trial. The only evidence relating to past medical expenses was the brief testimony of two medical experts.

As the majority correctly notes, plaintiff's medical experts reviewed "all the bills in this case[,]" but did not testify that plaintiff, or anyone else, ever paid any of these sums, or that liens secured their payment against any recovery in this case, or that any amounts were gratuitously written off.

Other than the testimony of Doctors Tauber and Mobin, there is no evidence in the record concerning past medical expenses, except for plaintiff's testimony, quoted below.

3. Plaintiff's Testimony

Plaintiff testified that he never paid any doctors, received any bills, or received any demand for payment related to his treatment. He testified as follows:

"Q: Have you ever gotten a single bill for any of the medical care and treatment that you've had as a result of alleged -- as a result of this incident?

[Objection overruled.]

"[A]: No, I haven't.

"Q: By [defense counsel]: Have you ever gotten a single late notice from any doctor or health care provider for the money allegedly due and owing for the medical care and services rendered to you?

"A: Not that I'm aware of.

"Q: Have you ever had to pay a dime for the medical care and services rendered to you for anything? Co-pay? Supplemental? Anything?

"A: Up to this moment, no."

The majority repeatedly states there is evidence plaintiff incurred expenses, without identifying what evidence it finds in the record. The majority seems to reason that amounts were billed, and therefore plaintiff incurred them, a leap that is unwarranted by any evidence or any reasonable inferences to be drawn from the evidence.

4. In All the Cases Discussing Recovery of Special Damages for Past Medical Expenses, There Was Testimony to Prove Who Paid the Expenses and in What Amount.

The cases discussing recovery of special damages for past medical expenses address the evidentiary burden required of plaintiffs who have private insurance, those whose expenses are paid by Medicare or Medi-Cal, those whose unpaid medical debts were purchased by factors, and those for whom medical expenses were gratuitously written off. In all of these cases -- unlike this case -- there was clear evidence of the amounts of medical bills that were sent to, and paid by whom, and of the nature of the plaintiffs' personal obligation to reimburse the payors or gratuitous providers of medical services.

In *Howell*, the plaintiff had private insurance. Defendant moved to reduce past medical expenses that were written off by plaintiff's medical providers, Scripps Memorial Hospital

Encinitas (Scripps) and CORE Orthopaedic Medical Center (CORE). Defendant submitted billing and payment records from the providers and two declarations, the first by Scripps's collections supervisor, the second by an employee of CORE's billing contractor. The Scripps declaration stated that of the $122,841 billed for plaintiff's surgeries, plaintiff's private insurer paid $24,380, plaintiff paid $3,566, and the remaining $94,894 was " ' "written off" or waived' " by Scripps pursuant to the agreement between Scripps and the private insurer. The CORE declaration stated that of the surgeon's bill for $52,915, the private insurer paid $9,665, and $35,392 was waived or written off pursuant to CORE's agreement with the private insurer. Both declarants stated the providers had not filed liens for, and would not pursue collection of, the written-off amounts. (*Howell*, *supra*, 52 Cal.4th at p. 550.)

In *Sanchez v. Strickland* (2011) 200 Cal.App.4th 758 (*Sanchez*), the medical expenses of plaintiffs' decedent were paid by Medicare and Medi-Cal. The court held "[w]here a medical provider has (1) rendered medical services to a plaintiff, (2) issued a bill for those services, and (3) subsequently written off a portion of the bill gratuitously, the amount written off constitutes a benefit that may be recovered by the plaintiff under the collateral source rule." (*Id.* at p. 769.)

The evidence in *Sanchez* included a declaration of the operations manager of the medical services provider indicating that it (1) charged $113,988.58 for the treatment provided to plaintiffs' decedent, (2) billed Medicare as the primary payor, and (3) received $66,704 from Medicare as payment with a $40,264.58 contract allowance. The declaration also stated the provider " 'billed the remaining $7,020.00 to Medi-Cal, but wrote off that amount, as we were not contracted with Medi-Cal.' " (*Sanchez*, *supra*, 200 Cal.App.4th at p. 767.)

In *Hanif*, *supra*, 200 Cal.App.3d 635, Medi-Cal paid plaintiff's medical expenses. The trial court found the reasonable value of the physician services was $4,618, and the reasonable value of the hospital services was $27,000. However, Medi-Cal had paid only $2,823 for physician services, and only $16,494 for hospital services. There was no evidence that plaintiff was or would become liable for the difference between the amounts billed and the amounts paid. The difference between the amount billed to Medi-Cal and the amount paid was written off by the hospital. The trial court awarded $31,618, the full amount billed, although Medi-Cal paid only $19,317. The court in *Hanif* found that "[p]laintiff was therefore overcompensated in the amount of $12,301, by which amount the judgment will be reduced." (*Id.* at p. 644.)

In *Bermudez*, *supra*, plaintiff was uninsured. Plaintiff "testified that the amount of his outstanding medical bills was approximately $450,000. He had not paid any of the bills. [Plaintiff] believed his medical providers will be paid out of any recovery he receives in this case, but he will be responsible for the bills no matter what happens in the litigation. [¶] The parties stipulated to the *admissibility* (not the reasonableness) of [plaintiff's] exhibit No. 239, a summary of past medical bills. The total of the past bills was $445,430.64. The parties also stipulated to the *reasonableness* (not just the admissibility) of $15,000 in recent medical charges not reflected in exhibit No. 239." (*Bermudez*, *supra*, 237 Cal.App.4th at p. 1324.) The *Bermudez* court found that substantial evidence supported all but $46,175.41 of the amount awarded for past medical expenses and reduced the judgment by that amount. (*Id.* at p. 1338.)

The bulk of the discussion of past medical expenses in *Bermudez* dealt with how to determine the reasonable value of services in the absence of evidence that an insurer, or Medicare,

or Medi-Cal paid any amount. While recognizing that *Howell* was controlling authority, the court observed, "[T]he holding in *Howell* ultimately depended upon the 'paid or incurred' prong of the test, not the 'reasonable value' prong. [Citation.] Insured plaintiffs incur only the fee amount negotiated by their insurer, not the initial billed amount. Insured plaintiffs may not recover more than their actual loss, i.e., the amount incurred and paid to settle their medical bills. [Citation.] It was not necessary in *Howell* to examine the mechanics of properly measuring damages in the case of an uninsured plaintiff." (*Bermudez*, *supra*, 237 Cal.App.4th at p. 1329.)

In *Katiuzhinsky v. Perry* (2007) 152 Cal.App.4th 1288 (*Katiuzhinksy*), plaintiffs received services from medical providers who secured a lien against any recovery in plaintiffs' personal injury actions. Some of the providers later sold plaintiffs' accounts, at a discount, to a factor. The medical providers wrote off the balance but plaintiffs remained fully liable for the amount of the medical providers' charges for care and treatment. (*Id.* at pp. 1291, 1296.)

"In the case of plaintiff Katiuzhinsky, Mercy General Hospital sold its $144,000 medical lien for approximately $72,000. Dr. Kali Eswaran sold [the factor] his $2,955 bill for $1,477.50. Dr. Pasquale Montesano sold one bill for $13,860 to [the factor] for $7,623, but retained others for himself. Several of plaintiff Kiryukhina's bills were also purchased by [the factor] at a discounted rate." (*Katiuzhinsky*, *supra*, 152 Cal.App.4th at pp. 1292-1293.)

The *Katiuzhinsky* court reversed and remanded for a new trial on damages because the trial court had limited proof of plaintiffs' damages to the amounts paid by the factor. The court reasoned, "The intervention of a third party in purchasing a medical lien does not prevent a plaintiff from recovering the

amounts billed by the medical provider for care and treatment, as long as the plaintiff legitimately incurs those expenses and remains liable for their payment." (*Katiuzhinsky*, *supra*, 152 Cal.App.4th at p. 1291.)

In all these cases, there was evidence of the amount of payments made by insurers, factors or others for past medical expenses, or the amount of charges that medical providers gratuitously wrote off, and the amounts for which the plaintiffs remained liable to pay. There is no such evidence here.

There is no evidence that this is a case where the plaintiff was not immediately able to pay the medical bills and relied on attorneys and other professionals to treat his injuries and secure just compensation for those injuries, as the majority posits. (Maj. opn. *ante*, at p. 13.) There is no evidence of any gratuitous write off. Plaintiff's counsel never mentioned insurance, a factor, or a gratuitous write off in his brief or in oral argument. The majority's finding that plaintiff incurred $83,697 in past medical expenses rests on no evidence whatsoever.

The majority reasons: Doctors Tauber and Mobin testified to amounts billed; defendant did not (1) object to their testimony, (2) offer contrary evidence of amounts billed, or (3) offer evidence that plaintiff had insurance; ergo, plaintiff proved the cost of the medical services he received. (Maj. opn. *ante*, at p. 10.) I do not follow the logic of this reasoning. The majority simply refuses to follow the law requiring that plaintiff must prove he paid or incurred medical expenses in order to recover past economic damages.

5. *Howell* Is Controlling in All Personal Injury Cases.

The majority concludes that *Howell* and *Hanif* do not control this case because defendant made no posttrial motion to reduce the past medical expenses by amounts paid by insurance or amounts written off by medical providers. The majority

reasons that it is "sandbagging at its worst" for defendant to ask this court to reduce the damages award without having made a posttrial motion to reduce the past medical expenses by amounts that insurance paid or medical providers wrote off. (Maj. opn. *ante*, at p. 12.)

Let's revisit the holding of *Howell:*

"When a tortiously injured person receives medical care for his or her injuries, the provider of that care often accepts as full payment, pursuant to a preexisting contract with the injured person's health insurer, an amount less than that stated in the provider's bill. In that circumstance, may the injured person recover from the tortfeasor, as economic damages for past medical expenses, the undiscounted sum stated in the provider's bill but never paid by or on behalf of the injured person? We hold no such recovery is allowed, for the simple reason that the injured plaintiff did not suffer any economic loss in that amount. (See Civ. Code, §§ 3281 [damages are awarded to compensate for detriment suffered], 3282 [detriment is a loss or harm to person or property].)

"The collateral source rule, which precludes deduction of compensation the plaintiff has received from sources independent of the tortfeasor from damages the plaintiff 'would otherwise collect from the tortfeasor' (*Helfend v. Southern Cal. Rapid Transit Dist.* (1970) 2 Cal.3d 1, 6 (*Helfend*)), ensures that plaintiff here may recover in damages the amounts her insurer paid for her medical care. The rule, however, has no bearing on amounts that were included in a provider's bill but for which the plaintiff never incurred liability because the provider, by prior agreement, accepted a lesser amount as full payment. Such sums are not damages the plaintiff would otherwise have collected from the defendant. They are neither paid to the providers on the plaintiff's behalf nor paid to the plaintiff in indemnity of his or

her expenses. Because they do not represent an economic loss for the plaintiff, they are not recoverable in the first instance. The collateral source rule precludes certain deductions against otherwise recoverable damages, but does not expand the scope of economic damages to include expenses the plaintiff never incurred." (*Howell*, *supra*, 52 Cal.4th at pp. 548-549.)

I simply do not understand the majority's conclusion that "[t]his case . . . is not controlled by *Howell*." (Maj. opn. *ante*, at p. 12.) As seen above, *Howell* was applied in *Sanchez* where medical expenses were paid, not by a private insurer, but by Medicare and Medi-Cal. (*Sanchez*, *supra*, 200 Cal.App.4th at p. 760 ["[W]e conclude this case is governed by the California Supreme Court's recent decision, *Howell* . . . ."].) *Howell* was applied in *Bermudez*, where the plaintiff was uninsured. (*Bermudez*, *supra*, 237 Cal.App.4th at p. 1330 ["*Howell* offered no bright-line rule on how to determine 'reasonable value' when uninsured plaintiffs have incurred (but not paid) medical bills."].)

I believe the principles of *Howell* govern the recovery of past medical expenses in every personal injury case, as the underlying premise of its holding is that compensatory damages are intended to *compensate for a loss*. "A person who undergoes necessary medical treatment for tortiously caused injuries suffers an economic loss by taking on liability for the costs of treatment. Hence, any reasonable charges for treatment the injured person has paid or, having incurred, still owes the medical provider are recoverable as economic damages." (*Howell*, *supra*, 52 Cal.4th at p. 551.) Where, as here, there was no evidence of any economic loss by plaintiff, he did not meet his burden of proof at trial.

6. The Majority Conflates Proof of the Reasonable Value of Medical Services With the Separate Question Whether Plaintiff Paid Or Incurred Any Medical Expenses. The Majority Also Conflates the *Admissibility* of the Evidence With the *Sufficiency* of the Evidence.

In the absence of any evidence that plaintiff paid or incurred any past medical expenses, the majority reasons that the medical experts testified to the amounts billed, ergo, plaintiff incurred them, without any explanation as to how it reaches that conclusion. The majority states "[t]here is nothing in the record that establishes that the costs of past medical services were anything other than amounts to which Doctors Tauber and Mobin testified. The jury found those amounts to have been proven and the trial judge agreed." (Maj. opn. *ante*, at p. 12.) It appears the majority conflates the "reasonable value" prong of the *Howell* test with the separate "incurred or paid" prong.

The majority also conflates the *admissibility* of the evidence with the *sufficiency* of the evidence. (See *Bermudez*, *supra*, 237 Cal.App.4th at pp. 1331-1337 [thorough discussion of the difference between the admissibility and the sufficiency of the proof of past medical expenses].) The majority says defendant did not object to the doctors' testimony from billing summaries about amounts billed, which has nothing to do with the sufficiency of the evidence of amounts plaintiff *incurred*. (See *People v. Butler* (2003) 31 Cal.4th 1119, 1126 [no objection below is necessary to challenge the sufficiency of the evidence].)

The majority then finds (with no analysis whatsoever) that $83,697 in past medical expenses were reasonable. Putting aside that the majority does not explain how it arrived at the conclusion that $83,697 in past medical expenses were

reasonable, the point here is that there is no evidence that plaintiff incurred any part of it.

7. The Majority Reverses the Burdens of Proof.

The majority says *defendant* presented no evidence that plaintiff's damages were other than what had been testified to by Dr. Mobin, Dr. Tauber, and Dr. Weitzman. (Maj. opn. *ante*, at p. 6.) The majority says *defendant* did not prove there was no insurance reduction or write off. (*Id.* at p. 11.) The majority says *defendant* did not prove the medical providers did not expect repayment out of plaintiff's recovery in this action. (*Ibid.*)

The majority turns the burden of proof on its head. Defendant had no burden to prove a negative, or to prove what medical expenses may have been reasonably incurred. To the contrary, plaintiff had the burden to prove his damages with reasonable certainty. (*Fields v. Riley* (1969) 1 Cal.App.3d 308, 313.) To prove damages for past medical expenses, plaintiff was required to establish that the amounts were both reasonable and actually paid or incurred. (*Howell*, *supra*, 52 Cal.4th at p. 566.) Plaintiff failed to do so in this case.

It was not the burden of the defense to inquire at trial about insurance, or insurance write offs, or any arrangements between plaintiff or his attorneys and the medical providers. Indeed, such questions by the defense on cross-examination, without testimony proffered by plaintiff on direct examination of his witnesses, would have sought inadmissible evidence under the collateral source rule. (*Howell*, *supra*, 52 Cal.4th at p. 567 ["Evidence that such payments were made in whole or in part by an insurer remains, however, generally inadmissible under the evidentiary aspect of the collateral source rule."].)

The absence of any evidence of insurance reductions or write offs, or that medical providers expected repayment from the recovery in this case, left a gap in plaintiff's case. There is no

evidence either that plaintiff had insurance, or that he was uninsured; there is no evidence that, if he had insurance, any amounts were reduced or written off; there is no evidence that, if he did not have insurance, medical services were provided gratuitously. There is no evidence that any medical provider was paid in full, in part, or not at all. There is no evidence that anyone did, or did not make any payments, except for plaintiff's testimony that *he* did not pay or incur any medical expenses.

It was not defendant's task to close these gaping holes in the evidence. The majority believes it is unfair for defendant to attack the damages award on appeal because the defense made no posttrial motion to reduce the damages by amounts paid by insurance or written off by medical providers. The majority infers the defense made no such posttrial motion because defendant "knew through discovery that there was no setoff." (Maj. opn. *ante,* at p. 12.) This reasoning utterly misses the point in this appeal. This appeal is not about how much the past medical expenses should be reduced by insurance set offs or write offs. This appeal is about the total absence of evidence that plaintiff incurred any amount of medical expenses for which he was entitled to any past economic damages whatsoever.

I would reverse the portion of the judgment awarding damages for past medical expenses and remand with instructions to reduce the judgment by $175,000 to eliminate recovery for past medical expenses, or remand for a new trial on damages.

GRIMES, J.