

**IN THE SUPREME COURT OF TEXAS**

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No. 09-0377

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AARON GLENN HAYGOOD, PETITIONER,

v.

MARGARITA GARZA DE ESCABEDO, RESPONDENT

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ON PETITION FOR REVIEW FROM THE  
COURT OF APPEALS FOR THE TWELFTH DISTRICT OF TEXAS

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**Argued September 16, 2010**

JUSTICE HECHT delivered the opinion of the Court, in which CHIEF JUSTICE JEFFERSON, JUSTICE WAINWRIGHT, JUSTICE GREEN, JUSTICE JOHNSON, JUSTICE WILLETT, and JUSTICE GUZMAN joined.

JUSTICE LEHRMANN filed a dissenting opinion, in which JUSTICE MEDINA joined.

Damages for wrongful personal injury include the reasonable expenses for necessary medical care, but it has become increasingly difficult to determine what expenses are reasonable. Health care providers set charges they maintain are reasonable while agreeing to reimbursement at much lower rates determined by insurers to be reasonable, resulting in great disparities between amounts billed and payments accepted. Section 41.0105 of the Texas Civil Practice and Remedies Code, enacted in 2003 as part of a wide-ranging package of tort-reform measures,<sup>1</sup> provides that “recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant.”<sup>2</sup> We agree with the court of appeals<sup>3</sup> that this statute limits recovery, and consequently the evidence at trial, to expenses that the provider has a legal right to be paid.

**I**

Aaron Glenn Haygood sued Margarita Garza De Escabedo for injuries he sustained when the car he was driving collided with Escabedo’s minivan as she was pulling out of a grocery store parking lot. Haygood’s injuries required surgeries on his neck and shoulder. Both were successful, but some

impairment remains.

Twelve health care providers billed Haygood a total of \$110,069.12, but he was covered by Medicare Part B, which generally “pays no more for . . . medical and other health services than the ‘reasonable charge’ for such service.”<sup>4</sup> Criteria for determining reasonable charges include customary charges for similar services and prevailing charges in the same locality for similar services.<sup>5</sup> Federal law prohibits health care providers who agree to treat Medicare patients from charging more than Medicare has determined to be reasonable.<sup>6</sup> Accordingly Haygood’s health care providers adjusted their bills with credits of \$82,329.69, leaving a total of \$27,739.43. At the time of trial, \$13,257.41 had been paid, and \$14,482.02 was due.<sup>7</sup>

Invoking section 41.0105, Escabedo moved to exclude evidence of medical expenses other than those paid or owed. Haygood, asserting the collateral source rule, moved to exclude evidence of any amounts other than those billed, and of any adjustments and payments. The trial court denied Escabedo’s motion and granted Haygood’s. At trial, Haygood offered evidence from each of his health care providers that the charges billed were reasonable and the services necessary. The jury found that Escabedo’s negligence caused the accident and that Haygood’s damages were \$110,069.12 for past medical expenses, \$7,000 for future medical expenses, \$24,500 for past pain and mental anguish, and \$3,000 for future pain and mental anguish. The trial court overruled Escabedo’s objection to an award of past medical expenses in excess of those paid or owed and rendered judgment on the verdict.

The court of appeals reversed, holding that section 41.0105 precluded evidence or recovery of expenses that “neither the claimant nor anyone acting on his behalf will ultimately be liable for paying”.<sup>8</sup> The court suggested a remittitur of the amount of the health care providers’ adjustments,<sup>9</sup> which Haygood did not accept, and the case was remanded for a new trial.<sup>10</sup> The court noted that two other courts had reached conflicting decisions.<sup>11</sup> We granted Haygood’s petition for review to resolve the conflict.<sup>12</sup>

## II

The Legislature enacted section 41.0105 against a backdrop of health care pricing practices and the collateral source rule. We discuss each before turning to the statutory text and its consequences.

### A

Charges for health care, once based on the provider’s costs and profit margin, have more recently

been driven by government regulation and negotiations with private insurers.<sup>13</sup> A two-tiered structure has evolved: “list” or “full” rates sometimes charged to uninsured patients,<sup>14</sup> but frequently uncollected,<sup>15</sup> and reimbursement rates for patients covered by government and private insurance.<sup>16</sup> We recently observed that “[f]ew patients today ever pay a hospital’s full charges, due to the prevalence of Medicare, Medicaid, HMOs, and private insurers who pay discounted rates.”<sup>17</sup> Hospitals, like health care providers in general,<sup>18</sup> “feel financial pressure to set their ‘full charges’ . . . as high as possible, because the higher the ‘full charge’ the greater the reimbursement amount the hospital receives since reimbursement rates are often set as a percentage of the hospital’s ‘full charge.’”<sup>19</sup>

Although reimbursement rates have been determined to be reasonable under Medicare or other programs, or have been reached by agreements between willing providers and willing insurers, providers nevertheless maintain that list rates are also reasonable. Providers commonly bill insured patients at list rates, with reductions to reimbursement rates shown separately as adjustments or credits.<sup>20</sup> Portions of bills showing only list charges are admitted in evidence, with proof of reasonableness coming from testimony by the provider, or more often, by affidavit of the provider or the provider’s records custodian as permitted by section 18.001 of the Texas Civil Practice and Remedies Code.<sup>21</sup>

In all these respects, the present case is entirely typical. The providers testified the charges billed to Haygood were reasonable, even though those charges were four times the amount they were entitled to collect.

## **B**

As a general principle, compensatory damages, like medical expenses, “are intended to make the plaintiff ‘whole’ for any losses resulting from the defendant’s interference with the plaintiff’s rights.”<sup>22</sup> The collateral source rule is an exception.<sup>23</sup> Long a part of the common law of Texas<sup>24</sup> and other jurisdictions,<sup>25</sup> the rule precludes any reduction in a tortfeasor’s liability because of benefits received by the plaintiff from someone else — a collateral source. Thus, for example, insurance payments to or for a plaintiff are not credited to damages awarded against the defendant.<sup>26</sup> “The theory behind the collateral source rule is that a wrongdoer should not have the benefit of insurance independently procured by the injured party, and to which the wrongdoer was not privy.”<sup>27</sup>

Haygood contends that an adjustment in billed medical charges required by an insurer is a

collateral benefit covered by the rule. We disagree. The benefit of insurance to the insured is the payment of charges owed to the health care provider. An adjustment in the amount of those charges to arrive at the amount owed is a benefit to the insurer, one it obtains from the provider for itself, not for the insured. Haygood argues that the adjustment reduces the insured's liability, but the insured's liability is for payment of taxes, if a government insurer, or premiums, if a private insurer, and for any deductible. Any effect of an adjustment on such liability is at most indirect and is not measured by the amount of the adjustment.

The collateral source rule reflects “the position of the law that a benefit that is directed to the injured party should not be shifted so as to become a windfall for the tortfeasor.”<sup>28</sup> To impose liability for medical expenses that a health care provider is not entitled to charge does not prevent a windfall to a tortfeasor; it creates one for a claimant, as we recently wrote in *Daughters of Charity Health Services of Waco v. Linnstaedter*.<sup>29</sup> Linnstaedter and Bolen sued Jones for injuries they sustained in a motor vehicle accident, claiming damages for the full amount of their hospital expenses.<sup>30</sup> The hospital was reimbursed part of those expenses by workers' compensation insurance and was precluded from seeking payment of the unpaid balance from its patients by the Workers' Compensation Act.<sup>31</sup> Nevertheless, the hospital asserted a lien on any damages the patients recovered against Jones.<sup>32</sup> Jones settled with the patients and paid the hospital the balance on its bill to discharge the lien.<sup>33</sup> The patients then sued the hospital for the amount of that payment.<sup>34</sup> We held that the hospital's claim to part of the patients' recovery against Jones was a claim against the patients themselves that was precluded by the Act.<sup>35</sup> Furthermore, we said, to allow the hospital to recover more than the reimbursement allowed by the Act would defeat its purpose of controlling medical costs.<sup>36</sup> But the patients had sued Jones for “the full medical charges billed by the hospital rather than the reduced amount paid by their compensation carrier”.<sup>37</sup> “[A] recovery of medical expenses in that amount”, we said, “would be a windfall; as the hospital had no claim for these amounts against the patients, they in turn had no claim for them against Jones.”<sup>38</sup> Moreover, we noted, “[t]his rule has since been codified [in TEX. CIV. PRAC. & REM. CODE § 41.0105]”.<sup>39</sup>

Consistent with our views in *Daughters of Charity*, we hold that the common-law collateral source rule does not allow recovery as damages of medical expenses a health care provider is not entitled to charge.<sup>40</sup>

## C

With this background, we turn to the text of section 41.0105, which states simply: “In addition to any other limitation under law, recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant.”<sup>41</sup> Haygood argues that a claimant incurs the full charges billed by a provider, even if the provider is required by law or contract to reduce those charges because the claimant is covered by insurance, and therefore the statute imposes no limit on recovery. In his view, “actually” modifies only “paid”, or if it also modifies the second “incurred”, then the first “incurred” and “actually incurred” mean the same thing. Either way, the sentence reads: “recovery of . . . expenses incurred is limited to the amount . . . incurred”. This is a meaningless tautology. “Statutory language should not be read as pointless if it is reasonably susceptible of another construction.”<sup>42</sup> An amount “actually paid” unquestionably means one for which payment has been made. And it is reasonable to read “actually” as also modifying “incurred”,<sup>43</sup> referring to expenses that are to be paid, not merely included in an invoice and then adjusted by required credits. Thus, “actually paid and incurred” means expenses that have been or will be paid, and excludes the difference between such amount and charges the service provider bills but has no right to be paid.

Haygood argues that this construction is inconsistent with our decision in *Black v. American Bankers Insurance Co.*,<sup>44</sup> but it is not. Black sued his health insurer, American Bankers, for medical bills, a portion of which had been paid by Medicare.<sup>45</sup> The policy covered expenses Black “actually incurred”, and American Bankers argued that Black had not actually incurred the expenses paid by Medicare because he was never liable for them.<sup>46</sup> We held that the issue had been “resolved by the stipulation of the parties, which recites that plaintiff ‘incurred the reasonable, necessary and customary charges by said Hospital . . . as shown by the bill’”.<sup>47</sup> We added: “Further, as a matter of law, we hold that when plaintiff entered the hospital and received its services, there was created an implied contract to pay for same, and he was liable therefor until he or someone else paid the bill.”<sup>48</sup> *Black* differs from the present case, not only because it involved the construction of a policy and primary insurance issues, but also because Black’s entire bill was actually paid while most of Haygood’s bill was adjusted with credits the service provider was required to apply.

Haygood concedes that in *Daughters of Charity*,<sup>49</sup> “[t]his court has previously implied that

§ 41.0105 affects the recovery of medical expenses”,<sup>50</sup> but our decision in that case was more than an implication. As already explained, we held that a tortfeasor is not liable to a health care provider or its patients for medical expenses the patients were not required to pay the provider. For the patients to recover such expenses from the tortfeasor “would be a windfall”.<sup>51</sup> Our holding, we said, had been “codified” in section 41.0105.<sup>52</sup> The effect of section 41.0105 is thus to prevent a “windfall” to a claimant. Our decision in *Daughters of Charity* does not merely imply that Haygood’s argument is without merit; it rejects the argument outright.

Finally, Haygood argues that if the Legislature had intended to limit recovery, it would also have had to amend section 18.001 of the Civil Practice and Remedies Code, which states in part:

Unless a controverting affidavit is filed as provided by this section, an affidavit that the amount a person charged for a service was reasonable at the time and place that the service was provided and that the service was necessary is sufficient evidence to support a finding of fact by judge or jury that the amount charged was reasonable or that the service was necessary.<sup>53</sup>

But this statute is purely procedural, providing for the use of affidavits to streamline proof of the reasonableness and necessity of medical expenses. The statute does not establish that billed charges are reasonable and necessary; on the contrary, it expressly contemplates that the issue can be controverted by affidavit, which could aver that only the amount actually paid was reasonable.

Accordingly, we hold that section 41.0105 limits a claimant’s recovery of medical expenses to those which have been or must be paid by or for the claimant. All the courts of appeals that have addressed the issue have reached the same conclusion,<sup>54</sup> although as we have said, there has been disagreement over the effect of section 41.0105 on the evidence at trial, the issue to which we now turn.

## D

Haygood argues that even if section 41.0105 precludes recovery of expenses a provider has no right to be paid, evidence of such expenses is nonetheless admissible at trial. “Evidence which is not relevant is inadmissible.”<sup>55</sup> This includes evidence of a claim of damages that are not compensable.<sup>56</sup> Since a claimant is not entitled to recover medical charges that a provider is not entitled to be paid, evidence of such charges is irrelevant to the issue of damages.

The question remains whether such evidence has any other probative value. A few courts in other jurisdictions have expressed concern that limiting the evidence to amounts that have been or must be paid

provides the jury an unfairly low benchmark with which to gauge the seriousness of the plaintiff's injuries and awarding non-economic damages, such as for physical pain and mental anguish.<sup>57</sup> But there is no unfairness if reimbursable amounts are reasonable for the services provided. In this case, Medicare, as required by federal law, determined that the charges it reimbursed were reasonable, given customary and prevailing rates where Haygood was treated. Even so, Haygood argues, if he were uninsured, his medical expenses would not be subject to adjustments or credits, and evidence of more expensive treatment would suggest to the jury that his injuries were more serious. It is unfair, he contends, to treat insured and uninsured claimants differently. Haygood's solution is to allow the jury to consider evidence of non-recoverable economic damages in setting non-economic damages. But we think that any relevance of such evidence is substantially outweighed by the confusion it is likely to generate, and therefore the evidence must be excluded.<sup>58</sup>

Haygood argues that if the Legislature had intended to allow evidence of amounts actually paid to be offered at trial, it would also have had to amend sections 41.012 and 18.001 of the Civil Practice and Remedies Code. Section 41.012 states that “[i]n a trial to a jury, the court shall instruct the jury with regard to Sections 41.001, 41.003, 41.010, and 41.011”<sup>59</sup> — that is, the jury must be instructed on the standards for recovery of exemplary damages and the factors to be considered in setting any award. But an instruction on the limit on recovery of medical expenses would be necessary only if evidence of amounts charged were admitted along with evidence of amounts paid or to be paid. The absence of a statutorily required jury instruction suggests that the Legislature intended either that juries not be given the only evidence relevant to recovery or that they be given only evidence relevant to recovery. Since the jury cannot determine what expenses were necessary absent evidence relevant to recovery, we think the Legislature must have intended the latter. As for section 18.001, as already explained, it merely provides for any dispute over reasonable and necessary expenses to be teed up by affidavit, and says nothing about whether unpaid expenses are reasonable and necessary.

The dissent argues that the jury should consider only evidence of charges billed, without adjustments or credits required by insurers. Evidence of expenses paid or to be paid, the dissent urges, should be presented to the trial court post-verdict by the defendant. A fundamental rule is that “[t]o recover damages, the burden is on the plaintiff to produce evidence from which the jury may reasonably

infer that the damages claimed resulted from the defendant's conduct."<sup>60</sup> The only justification the dissent has for shifting the burden of proof to the defendant is that section 41.0105's limitation on damages is like the monetary caps imposed by other statutes. But imposing a monetary cap never requires the court to resolve a disputed fact; limiting the recovery of expenses to those actually paid often does. For one thing, parties may dispute whether expenses are necessarily related to a plaintiff's injuries. In *Texarkana Memorial Hospital v. Murdock*, for example, we held that there was evidence that only some but not all of the plaintiff's medical expenses found by the jury were related to her injuries.<sup>61</sup> The issue could not simply be redetermined by the trial court; the case had to be retried to the jury.<sup>62</sup> Also, the parties may disagree whether any part of some providers' charges is reasonable. If the jury awards less than the total of all charges, the trial court may have no way of knowing which charges the jury found reasonable and which it did not. In all these situations, a requirement that the trial court resolve disputed facts in determining the damages to be awarded violates the constitutional right to trial by jury. "In enacting a statute, it is presumed that . . . compliance with the constitutions of this state and the United States is intended; . . . a just and reasonable result is intended; [and] a result feasible of execution is intended . . . ."<sup>63</sup> The dissent's construction of section 41.0105 is contrary to all three presumptions.

Accordingly, we hold that only evidence of recoverable medical expenses is admissible at trial. We disapprove the cases that have reached conflicting decisions.<sup>64</sup> Of course, the collateral source rule continues to apply to such expenses, and the jury should not be told that they will be covered in whole or in part by insurance. Nor should the jury be told that a health care provider adjusted its charges because of insurance.

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We agree with the opinion of the court of appeals, and therefore its judgment is

*Affirmed.*

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Nathan L. Hecht

Justice

Opinion Delivered: July 1, 2011

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<sup>1</sup> Act of June 2, 2003, 78th Leg., R.S., ch. 204, § 13.08, 2003 Tex. Gen. Laws 847, 889.

<sup>2</sup> TEX. CIV. PRAC. & REM. CODE § 41.0105.

<sup>3</sup> 283 S.W.3d 3 (Tex. App.–Tyler 2009).

<sup>4</sup> 42 C.F.R. § 405.501(a).

<sup>5</sup> 42 C.F.R. § 405.502(a).

<sup>6</sup> 42 U.S.C. § 1395cc(a)(1)-(2).

<sup>7</sup> The record indicates that almost all of what has been paid was by insurance.

<sup>8</sup> 283 S.W.3d at 7.

<sup>9</sup> The court of appeals miscalculated the adjustments by \$35. *Id.* at 5, 8.

<sup>10</sup> *Id.* at 8.

<sup>11</sup> *Id.* at 7 (citing *Irving Holdings, Inc. v. Brown*, 274 S.W.3d 926, 931-933 (Tex. App.–Dallas 2009, pet. denied), and *Gore v. Faye*, 253 S.W.3d 785, 789-790 (Tex. App.–Amarillo 2008, no pet.)). Since then, two other courts have followed *Brown*. *Arango v. Davila*, Nos. 13-09-00470-CV, 13-09-00627-CV, 2011 WL 1900189, at \*9 (Tex. App.–Corpus Christi May 19, 2011, no pet. h.); *Frontera Sanitation, L.L.C. v. Cervantes*, No. 08-08-00330-CV, 2011 WL 1157559, at \*5 (Tex. App.–El Paso Mar. 30, 2011, no pet. h.).

<sup>12</sup> 53 Tex. Sup. Ct. J. 562 (Apr. 9, 2010).

<sup>13</sup> See Keith T. Peters, *What Have We Here? The Need for Transparent Pricing and Quality Information in Health Care: Creation of an SEC for Health Care*, 10 J. HEALTH CARE L. & POL'Y 363, 366 (2007) (“The price of a particular provider’s services depends on many factors including geography, experience, location, government payment methods, and the desire to make a profit. Hospital prices are supposed to be determined by the cost of providing care. However, the reimbursement rates for federal programs such as Medicare and Medicaid drive the list price of health care.”) (footnotes omitted).

<sup>14</sup>

See Uwe E. Reinhardt, *The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy*, 25 HEALTH AFF. 57, 62 (2006) (“Partly under pressure from consumers and lawmakers and partly on their own volition, many hospitals now have means-tested discounts off their chagemasters for uninsured patients, which bring the prices charged the uninsured closer to those paid by commercial insurers or even below. Some very poor patients, of course, have received hospital care free of charge all along, on a purely charitable basis.”) (footnote omitted).

<sup>15</sup> See George A. Nation III, *Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured*, 94 KY. L.J. 101, 120 (2005-06) (“While all uninsured patients are expected to pay the hospital’s ‘full charges,’ it appears that in fact less than five percent actually pay the full charge.”).

<sup>16</sup> See Peters, *supra* note 13, at 366 (“The ‘price’ of health care . . . can be divided into two prices. First, there is the list price [,] . . . similar to the sticker price one might find when purchasing a new car — it serves only as a beginning point for the negotiations, for those who have the market share to negotiate. . . . From these list prices, private insurers, Medicaid and Medicare, and other groups negotiate discounts to arrive at . . . the ‘actual price.’ Although the list price of health care varies widely across different regions of the country, the actual price paid is relatively static.”) (footnotes omitted).

<sup>17</sup> *Daughters of Charity Health Servs. of Waco v. Linnstaedter*, 226 S.W.3d 409, 410 (Tex. 2007) (citing Nation, *supra* note 15, at 104 (“[A] hospital’s ‘regular rates,’ ‘full charges,’ or ‘list prices’ . . . are generally at least double and may be up to eight

times what the hospital would accept as payment in full for the same services from Medicare, Medicaid, HMOs, or private insurers. The labels for these charges, ‘regular,’ ‘full,’ or ‘list,’ are misleading, because in fact they are actually paid by less than five percent of patients nationally.”) (footnotes omitted)).

<sup>18</sup> See, e.g., *Vencor, Inc. v. Nat’l States Ins. Co.*, 303 F.3d 1024, 1029 n.9 (9th Cir. 2002) (“It is worth noting that in a world in which patients are covered by Medicare and various other kinds of medical insurance schemes that negotiate rates with providers, providers’ supposed ordinary or standard rates may be paid by a small minority of patients.”).

<sup>19</sup> See Nation, *supra* note 15, at 119.

<sup>20</sup> See James McGrath, *Overcharging the Uninsured in Hospitals: Shifting a Greater Share of Uncompensated Medical Care Costs to the Federal Government*, 26 QUINNIPIAC L. REV. 173, 183 (2007) (“Hospitals usually bill all patients at the list price for the same service, and then significantly discount these rates for third-party payers who contract with the hospital.”); Reinhardt, *supra* note 14, at 59 (“Typically, a hospital will submit, for all of its patients, detailed bills based on its chagemaster, even to patients covered by Medicare. An advantage of these bills is that at least in principle, patients can check whether all of the supplies and services listed on the bill were actually delivered. A disadvantage, for hospitals, is that these bills are very lengthy and add up to large totals that do not bear any systematic relationship to the amounts third-party payers actually pay them for the listed services.”).

<sup>21</sup> TEX. CIV. PRAC. & REM. CODE § 18.001(b) (“Unless a controverting affidavit is filed as provided by this section, an affidavit that the amount a person charged for a service was reasonable at the time and place that the service was provided and that the service was necessary is sufficient evidence to support a finding of fact by judge or jury that the amount charged was reasonable or that the service was necessary.”); *id.* § 18.001(c) (“The affidavit must: (1) be taken before an officer with authority to administer oaths; (2) be made by: (A) the person who provided the service; or (B) the person in charge of records showing the service provided and charge made; and (3) include an itemized statement of the service and charge.”).

<sup>22</sup> *Transp. Ins. Co. v. Moriel*, 879 S.W.2d 10, 16 (Tex. 1994).

<sup>23</sup> See RESTATEMENT (SECOND) OF TORTS § 920A cmt. b (1977) (“Payments made or benefits conferred by other sources are known as collateral-source benefits. They do not have the effect of reducing the recovery against the defendant. The injured party’s net loss may have been reduced correspondingly, and to the extent that the defendant is required to pay the total amount there may be a double compensation for a part of the plaintiff’s injury.”).

<sup>24</sup> *Mid-Century Ins. Co. of Tex. v. Kidd*, 997 S.W.2d 265, 274 (Tex. 1999); *Brown v. Am. Transfer & Storage Co.*, 601 S.W.2d 931, 934 (Tex. 1980); *Tex. & Pac. Ry. Co. v. Levi & Bro.*, 59 Tex. 674, 676 (1883).

<sup>25</sup> See RESTATEMENT (SECOND) OF TORTS § 920A(2) (“Payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor’s liability, although they cover all or a part of the harm for which the tortfeasor is liable.”).

<sup>26</sup> *Mid-Century*, 997 S.W.2d at 274 (“The collateral source rule bars a wrongdoer from offsetting his liability by insurance benefits independently procured by the injured party.”); *Levi*, 59 Tex. at 676 (“The insurer and the defendant are not joint tortfeasors or joint debtors so as to make the payment or satisfaction by the former operate to the benefit of the latter; nor is there any legal privity between the defendant and the insurer so as to give the former the right to avail itself of a payment by the latter. The policy of insurance is collateral to the remedy against the defendant, and was procured solely by the plaintiff at his expense, and to the procurement of which the defendant was in no way contributory . . . . It cannot be said that the plaintiff took out the policy in the interest or behalf of the defendant, nor is there any legal principle which seems to require that it be ultimately appropriated to the defendant’s use and benefit.”) (internal quotation marks omitted).

<sup>27</sup> *Brown*, 601 S.W.2d at 934.

<sup>28</sup> RESTATEMENT (SECOND) OF TORTS § 920A cmt. b.

<sup>29</sup> 226 S.W.3d 409, 412 (Tex. 2007).

<sup>30</sup> *Id.* at 410, 412.

[31](#) *Id.* at 410-411.

[32](#) *Id.* at 410.

[33](#) *Id.*

[34](#) *Id.*

[35](#) *Daughters of Charity*, 226 S.W.3d at 411 (“[A] lien against a patient’s tort recovery is just as much a claim against the patient as if it were filed against the patient’s house, car, or bank account.”).

[36](#) *Id.* at 412 (“Further, granting hospitals a lien in excess of the established guidelines for fair and reasonable rates would frustrate the Legislature’s effort to achieve effective medical cost control through the Labor Code.”).

[37](#) *Id.*

[38](#) *Id.*

[39](#) *Id.* at 412 n.22.

[40](#) Courts in other jurisdictions have split on this issue. Some agree. *Slack v. Kelleher*, 104 P.3d 958, 967 (Idaho 2004); *Stanley v. Walker*, 906 N.E.2d 852, 857-858 (Ind. 2009); *Martinez v. Milburn Enters.*, 233 P.3d 205, 222-223 (Kan. 2010); *Robinson v. Bates*, 857 N.E.2d 1195, 1200-1201 (Ohio 2006). Others do not. *Helfend v. S. Cal. Rapid Transit Dist.*, 465 P.2d 61, 69 (Cal. 1970); *Wills v. Foster*, 892 N.E.2d 1018, 1030 (Ill. 2008); *Bozeman v. State*, 879 So. 2d 692, 701-702 (La. 2004); *Covington v. George*, 597 S.E.2d 142, 144-145 (S.C. 2004); *Acuar v. Letourneau*, 531 S.E.2d 316, 322-323 (Va. 2000); *Leitinger v. DBart, Inc.*, 736 N.W.2d 1, 14 (Wis. 2007).

[41](#) TEX. CIV. PRAC. & REM. CODE § 41.0105.

[42](#) *Franka v. Velasquez*, 332 S.W.3d 367, 393 (Tex. 2011).

[43](#) See, e.g., *McIntyre v. Ramirez*, 109 S.W.3d 741, 746 (Tex. 2003) (holding that the adverb “ordinarily” in the phrase “a person who would ordinarily receive or be entitled to receive a salary, fee, or other remuneration for administering care” modifies both “receive” and “be entitled to receive”).

[44](#) 478 S.W.2d 434 (Tex. 1972).

[45](#) *Id.* at 435.

[46](#) *Id.* at 435-436.

[47](#) *Id.* at 437.

[48](#) *Id.*

[49](#) 226 S.W.3d 409, 412 n.22 (Tex. 2007).

[50](#) Petitioner’s Brief on the Merits at 8 n.2 (emphasis omitted).

[51](#) *Daughters of Charity*, 226 S.W.3d at 412.

[52](#) *Id.* at 412 n.22.

[53](#) TEX. CIV. PRAC. & REM. CODE § 18.001(b).

[54](#) *Arango v. Davila*, Nos. 13-09-00470-CV, 13-09-00627-CV, 2011 WL 1900189, at \*9 (Tex. App.–Corpus Christi May 19, 2011, no pet. h.); *Frontera Sanitation, L.L.C. v. Cervantes*, No. 08-08-00330-CV, 2011 WL 1157559, at \*5 (Tex. App.–El Paso Mar. 30, 2011, no pet. h.); *Progressive Cnty. Mut. Ins. Co. v. Delgado*, 335 S.W.3d 689, 392 (Tex. App.–Amarillo 2011, no pet. h.); *Pierre v. Swearingen*, 331 S.W.3d 150, 155-156 (Tex. App.–Dallas 2011, no pet. h.); *Tate v. Hernandez*, 280 S.W.3d 534, 540-541 (Tex. App.–Amarillo 2009, no pet.); *Matbon, Inc. v. Gries*, 288 S.W.3d 471, 481-482 (Tex. App.–Eastland 2009, no pet.).

[55](#) TEX. R. EVID. 402.

[56](#) E.g., *State v. Wood Oil Distrib., Inc.*, 751 S.W.2d 863, 865 (Tex. 1988) (“[T]he introduction of evidence on [non-compensable] damages . . . is improper as a matter of law . . .”); *Interstate Northborough P’ship v. State*, 66 S.W.3d 213, 220 (Tex. 2001) (same).

[57](#) *Wills v. Foster*, 892 N.E.2d 1018, 1031-1032 (Ill. 2008); *Covington v. George*, 597 S.E.2d 142, 144-145 (S.C. 2004); *Leitinger v. DBart, Inc.*, 736 N.W.2d 1, 14 (Wis. 2007).

[58](#) TEX. R. EVID. 403 (“Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, or needless presentation of cumulative evidence.”).

[59](#) TEX. CIV. PRAC. & REM. CODE § 41.012.

[60](#) *Texarkana Mem’l Hosp., Inc. v. Murdock*, 946 S.W.2d 836, 838 (Tex. 1997).

[61](#) *Id.* at 840-841.

[62](#) *Id.* at 841.

[63](#) TEX. GOV’T CODE § 311.021.

[64](#) *Arango v. Davila*, Nos. 13-09-00470-CV, 13-09-00627-CV, 2011 WL 1900189 (Tex. App.–Corpus Christi May 19, 2011, no pet. h.); *Frontera Sanitation, L.L.C. v. Cervantes*, No. 08-08-00330-CV, 2011 WL 1157559 (Tex. App.–El Paso Mar. 30, 2011, no pet. h.); *Irving Holdings, Inc. v. Brown*, 274 S.W.3d 926 (Tex. App.–Dallas 2009, pet. denied); *Gore v. Faye*, 253 S.W.3d 785 (Tex. App.–Amarillo 2008, no pet.).