Case No. 85369

In the Supreme Court of Nevada

SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.,

Appellant,

vs.

SANDRA L. ESKEW, as special administrator of the Estate of William George Eskew,

Respondent.

Appeal from the Eighth Judicial District Court, Clark County
The Honorable Nadia Krall, District Judge
District Court No. A-19-788630-C

JOINT APPENDIX
Volume 5 of 18

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DISTRICT COURT

CLARK COUNTY, NEVADA

SANDRA ESKEW, ET AL., Plaintiff, vs. SIERRA HEALTH AND LIFE INSURANCE COMPNAY, INC., ET AL., Defendants.	CASE#: A-19-788630-C DEPT. IV

BEFORE THE HONORABLE NADIA KRALL
DISTRICT COURT JUDGE
WEDNESDAY, MARCH 16, 2022

RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 3

APPEARANCES

For the Plaintiffs: MATTHEW L. SHARP, ESQ.
DOUGLAS A. TERRY, ESQ.

For the Defendants: D LEE ROBERTS, JR., ESQ.
RYAN T. GORMLEY, ESQ.
PHILLIP NELSON SMITH, JR., ESQ.

RECORDED BY: MELISSA BURGENER, COURT RECORDER

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None		

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Las Vegas, Nevada, Wednesday, March 16, 2022

[Case called at 9:04 a.m.]

[Outside the presence of the jury]

THE COURT: Thank you. Good morning, Counsel. Do the parties have something they need to put on the record outside the presence of the jury?

MR. ROBERTS: Your Honor, it's the glass. I didn't hear that.

THE COURT: Do the parties have anything outside the presence of the jury they would like to put on the record?

MR. ROBERTS: Yes, Your Honor. We've met and conferred on the preliminary instructions, and we've reached agreement on the instructions that we would like to jointly request. What we did have a loose end that we needed the Court's assistance on, and that was, as you know, the jury commission a long time back now recommended that the jurors be able to ask questions. But the 9th Circuit still contains alternative instructions, and we were wondering what the Court's preference is. We don't have a preference as to whether we want to tell the jury they're allowed to ask questions or not do that.

THE COURT: The Court tells the jury they're allowed to ask questions. And so what the Court tells the jury is that they need to put it on a piece of paper with their name and their badge number, alert the marshal. The marshal will give it to the Court. The Court will read it with the lawyers at the bench and if there's any objections, the Court will decide whether or not the question is being asked.

MR. SHARP: And is that done -- do we ask the questions, like, for example, when we finish our direct, do we then ask questions?

THE COURT: No. During the process, they will start writing their questions down. And once you're both done --

MR. SHARP: Okay. Got it.

THE COURT: -- then we will review the questions and determine whether or not they can be asked.

MR. SHARP: Got it. Okay.

THE COURT: Yes.

MR. ROBERTS: Very good. So Mr. Gormley will make that one revision and then he will email a copy of our proposed instructions for the Court's review in chambers if that's --

THE COURT: How many is it?

MR. ROBERTS: There are about ten.

MR. GORMLEY: Yeah. It's nine. One of them is the elements. One of them is a little intro, and then seven of them are just the general 9th Circuit, this is the order of trial, this is what evidence is, and those type of things.

THE COURT: What intro?

MR. GORMLEY: The intro just says, "Members of the jury, you are now the jury in this case. It is my duty to instruct you on the law. It is your duty to find the facts from all the evidence. You will factually apply the laws I give to you. You must follow the law as I give it to you whether you agree with it or not. And you must not be influenced by any personal likes or dislikes, opinions, prejudice, or sympathy. That

means that you must decide the case solely on the evidence before you. You recall that you took an oath to do so. At the end of the trial, I will give you final instructions. It is the final that will outline your duty. Please do not read any of the instructions or anything I may say or do that I have an opinion regarding the evidence or what your verdict should be."

THE COURT: All right. Thank you, Counsel. Ms. Rodolfo was running a little late. She was admonished to be here before 9:30. So just so the parties are aware.

All right. Any other issues?

MR. ROBERTS: None for the Defendants, Your Honor.

MR. SHARP: None, Your Honor.

THE COURT: All right. Since we have some time, the Court wants to go over your anticipated schedule of witnesses. So today, we have openings. And who else do we have this afternoon, possibly?

MR. SHARP: We have Dr. Ahmad. If he is completed, we have Ms. Sweet. I think that will take us through today.

THE COURT: And on Monday, who do you plan on calling?

MR. SHARP: Monday, we have Dr. Chang. And depending on how -- but I need to confer with the Defense on how long they anticipate with Dr. Chang. But if there's filler, we have Dr. Liao's deposition that we can fill in, or Mr. Guerrero. He's another witness that we can fill in with. And then on Tuesday, we plan on bringing Mr. Prater in the morning, which would then follow with finish Dr. Liao. And then Holland-Williams, which we can fill Monday or Tuesday. Frankly, she's

only going to take ten minutes. And so that gets us through -- Mr. Flood would also likely be on Tuesday, and that's not going to be very long. So that's Tuesday.

And then Wednesday, we would anticipate Tyler Eskew, B.J. Eskew, Sandra Eskew. I mean, obviously, this is all consistent on predictions. And then, Christina Armington. So how that would get through, probably sometime Thursday is my guess. And that would be our case. Did I miss anybody?

THE COURT: So Dr. Liao is not testifying in person? It's just her depo?

MR. SHARP: It's just her depo. And I had not had -- well, I need to talk to the Defense about that. We had a screw up with the video, so we're going to have to read it. Whoever was doing the video hit stop right in the middle of Mr. Gormley's cross. And there's nothing I can do. I'm trying to figure out where it's being saved, but I mean, that's not fair, obviously, for the Defense for us to put her on video and then right in the middle of Mr. Gormley's cross, it just stops. So that's the best we can -- I mean, it is what it is, unfortunately.

THE COURT: Thank you. So Mr. Roberts, who do you have then?

MR. GORMLEY: Your Honor, the plan is we have our experts, Dr. Chandra, scheduled for Friday. And then, the treating physician, Dr. Cohen, has expressed availability for Friday also. So they should both be able to fit. Monday, we have Dr. Owens, our expert. And then on Tuesday, we have Dr. Kumar, our other, third and final expert.

And Dr. Bhatnagara will be testifying remotely. And the plan would be for her to testify either all on Monday or a combination of Monday and Tuesday depending on how long both those experts take. And I think it sounds like they're not planning to call Amogawin, so we would plan to call her remotely as well. She's no longer employed, lives in California. And she would -- could be filled in on Monday and Tuesday, as well, most likely. She wouldn't take very long.

MR. SHARP: And I would say also with Ms. Amogawin, I'll -- we can work because she kind of affects both sides. So we can take her out of order. And you know, I understand that with experts, if we go a little long, they may need to be taken out of order and that sort of stuff.

MR. GORMLEY: And then we have --

MR. ROBERTS: And we have reached agreement to accommodate each other on that issue, Your Honor.

THE COURT: Thank you, Counsel. Appreciate it.

MR. GORMLEY: I think I missed -- then we have a deposition from Mr. Palmer that I think would only last probably 10 or 15 minutes, and that would be short, as well.

THE COURT: So that would be the week of the 28th, so we're only going Monday through Wednesday that week. So the parties anticipate closings to happen on Monday, April 4th?

MR. SHARP: I think that would be --

MR. GORMLEY: That's how it's been looking like to me, probably Monday or Tuesday.

THE COURT: Okay. And Tuesday, just so the parties are

aware, the Court has an evidentiary hearing and calendar call in the morning. So it would just be -- April 5th, we only have the afternoon.

MR. SHARP: April 5th, we only -- and that's Tuesday?

THE COURT: Yeah. Tuesday, April 5th, we only have the afternoon.

MR. SHARP: And then, you -- do we have that whole week or?

THE COURT: Yes.

MR. SHARP: Okay.

THE COURT: Thank you. Any other issues the parties need to bring to the Court's attention?

MR. SHARP: No, Your Honor.

MR. GORMLEY: None come to mind, Your Honor.

THE COURT: All right. We'll take a break and as soon as we have all the jurors here, we'll start.

[Recess taken from 9:13 a.m. to 9:32 a.m.]

[Outside the presence of the jury]

THE COURT: Good morning, everyone. Please be seated. Are the parties ready to proceed?

MR. ROBERTS: Yes, Your Honor.

THE COURT: Mr. Sharp?

MR. SHARP: Yes, Your Honor.

THE COURT: Thank you. The parties have agreed on a series of preliminary instructions. The Court has read them. The Court doesn't use the word "I". The Court will say "the Court". So the Court's

going to change that language. The Court wants the jurors to know it's not a personal opinion of the Court, of myself. It's not my personal opinion. It's what the court and the law requires, not my own personal opinion. So I don't like using the word "I" because it's not what I personally want. I make rulings based on the law.

All right. Any objections to that?

MR. SHARP: None, Your Honor.

MR. ROBERTS: No objection, Your Honor.

THE COURT: All right. This will be marked as Court's Exhibit 1. The parties are ready?

[Court's Exhibit 1 admitted into evidence]

MR. SHARP: Yes, Your Honor.

THE COURT: Thank you.

MR. ROBERTS: Yes, Your Honor.

THE COURT: Thank you.

[Jury in at 9:35 a.m.]

THE COURT: Do the parties stipulate to the presence of the jury?

MR. SHARP: Yes, Your Honor, on behalf of Plaintiff.

MR. ROBERTS: Yes, Your Honor, on behalf of the Defense.

THE COURT: Thank you. Please be seated.

Ladies and gentlemen of the jury, thank you for coming back today. We're going to start the actual substance of the trial today. And what the Court is going to do is give you an overview of what you can expect over these next days and weeks. And the Court is also going to

give you some preliminary legal instructions at that time.

So in this case, you have been admonished multiple times that you're not supposed to talk with anyone outside the courtroom related to this case. You can't discuss this case with any of -- a physician friend or anyone who works in the medical field regarding any medical issues that come up in the case. The only thing that you can base your decision on is what you hear from the witnesses and arguments from Counsel.

If you hear another juror talking to someone about this case, you must report it to the marshal immediately. This has happened in the past and it must be done. Do you understand that? Thank you.

Counsel, do the parties waive reading of the pleadings?

MR. SHARP: Yes, Your Honor, for the Plaintiff.

MR. ROBERTS: Yes, Your Honor, for the Defendant.

THE COURT: Thank you.

During this time period, also please make sure that you wear your badges when you're in the courthouse. Although you were given a list of names of the witnesses, you don't know what they look like. And so if you see them in the hallway and you start chatting with someone, you may not know it's a witness in this case. So just speak to only people who have juror badges or the marshal in this case. This way, we know there's no contamination of your verdict.

Also, please remember that the attorneys are not even allowed to say hello to you. If an attorney or one of their staff members tries to speak to you or any witness tries to speak to you, please advise

the marshal immediately. Is that understood?

Also, please remember that there will be objections that take place during this case. Whether the Court allows a question or not, do not be concerned with that. If the Court doesn't allow the question, you can't consider the question itself. So only listen to what the witness has testified to. And if the Court tells you to disregard a statement from a witness, you're required by law to do so.

During this case, you will also have your juror notebooks with you. Those are yours. No one will be allowed to look at them. You'll leave those here at the end of each day and you'll take those back with you to the jury deliberation room. And only when you take them back to the jury deliberation room, it's your choice whether or not you want to disclose those notes to your fellow jurors.

During this case, if you cannot hear a witness, please raise your hand, let the marshal know so that we can make sure that you can hear. If anyone needs headphones, we can provide them. Also, I may be taking notes during this trial. Whether I take notes or not, I'm required to by law. So don't infer anything if I'm taking notes or not taking notes in this case.

As we've done in the past, we'll take a break about every hour and a half, but if you have to use the restroom prior to that, just raise your hand and let the marshal know and we'll take a sooner break. Please feel free to bring in something to drink. Or if the breaks we take, you need to have a snack if you have low blood sugar, feel free to bring that in. If you're cold, feel free to bring in a shawl or a blanket. I know

it's very cold in here. It's designed for people who are wearing multiple layers of clothing.

During this process, you'll also have the opportunity to ask questions of the witness. Please note that it's the lawyer's job to ask the questions, but if you do need a point of clarification during the jury question and answer period, some people were concerned that they may not have understood a medical term. So if you don't understand something when both the lawyers are done, what you'll do is you'll put the question on your notepad with your name and your badge number. And you'll alert the marshal and the Judge -- I will have the lawyers come up. We'll discuss the question. If your question is not asked, there are legal reasons why it can't be asked. So your questions will be asked only at the end when the lawyers are done.

For an overview, after I give you this information right now, I'm going to actually instruct you on some of the points of law that the parties have asked the Court to do ahead of time. You'll get further instructions at the very end. This is just a preliminary instruction, so you have a road map of what's happening.

So what's going to happen is after the Court reads you some law that you have to apply, the lawyers are going to get up and give their opening statements in the case. It's argument. It's just what they believe that the case will show. It's not evidence in this case. Then the Plaintiff will present their case. Then the Defense will present their case. Afterwards, the Court will give you the final jury instructions. Then the parties will make their closing arguments. The Plaintiff will go first, then

the Defense, and the Plaintiff actually has a chance to do a final rebuttal.

At that time, you will select one person to be your foreperson. Two of you are alternates in this case, in case something happens. So because this is a civil case, only six of the eight of you will render a verdict. So at the very end, two of you will go in one room and eight of you will go in another room, if that makes sense to you. But we need to have multiple jurors because if something happens to one of you, we can't start this process all over again. We need to make sure we have people here who know everything that's going on in the case.

So does any party wish to invoke the exclusionary rule?

MR. SHARP: Yes, Your Honor, on behalf of Plaintiff.

MR. SMITH: Yes, Your Honor, on behalf of the Defendant.

THE COURT: If anyone is in the courtroom that is a witness, they are required to leave who's not an expert witness. Also, just so you're aware, you're not going to get a transcript of what happened here today. So feel free to take notes, but be mindful to pay attention to the witness so you're not too busy taking notes that you don't really catch what the witness is saying. And we also ask that you keep an open mind and let both parties present their case before you reach any conclusions.

So the Court is going to instruct you on some points of the law now. Number one, members of the jury, you are now the jury in this case. It is my duty to instruct you on the law. It is your duty to find the facts from all of the evidence in this case. To those facts, you'll apply the law as the Court gives it to you. You must follow the law as the Court gives it to you whether you agree with it or not. You must not be

influenced by any personal likes or dislikes, opinions, prejudice, or sympathy. That means you must decide the case solely on the evidence before you. You will recall that you took an oath to do so.

At the end of the trial, the Court will give you final instructions. It is the final instructions that will govern your duties. Please do not read into these instructions or anything the Court may say or do or whether the Court has an opinion regarding the evidence or what your verdict should be.

Number 2. To help you follow the evidence, the Court will give you a brief summary of the positions of the parties. Plaintiff Sandra L. Eskew, as Special Administrator for the Estate of William G. Eskew, asserts that Defendant Sierra Health and Life violated the implied covenant of good faith and fair dealing, otherwise known as bad faith, by denying a prior authorization request for coverage for a treatment known as proton therapy submitted on February 3, 2016, on behalf of William G. Eskew. The Defendant denies this claim. The Plaintiff has the burden of proving this claim.

Number 3. In every insurance contract, there is an implied covenant of good faith and fair dealing that neither the insurance company nor the insured will do anything to injure the rights of the other party to receive the benefits of the agreement. The relationship of an insured to an insurer is one of special confidence, akin to that of a fiduciary. A fiduciary relationship exists when one has the right to expect trust and confidence in the integrity and fidelity of another.

This special relationship exists in part because as insurance

companies are well aware, consumers contract for insurance to gain protection, peace of mind, and security against calamity. To fulfill its implied covenant of good faith and fair dealing, an insurance company must give at least as much consideration to the interests of the insured as it gives to its own interests.

Number 4. In order to establish a breach of the implied covenant of good faith and fair dealing, Plaintiff Sandra Eskew, as the Special Administrator of the Estate of William George Eskew, must prove the following. One, the proton beam therapy was a covered service under the terms of the agreement of coverage. Two, Sierra Health and Life had no reasonable basis for its February 5, 2016, denial of the prior authorization claim. Three, Sierra Health and Life knew or recklessly disregarded the fact that there was no reasonable basis for the February 5, 2016, denial of the prior authorization claim. And four, Sierra Health and Life's denial was the legal cause of harm to William Eskew.

Number 5. A legal cause of injury, damage, loss, or harm is a cause which is a substantial factor in bringing about the injury, damage, loss, or harm.

6. The evidence which you are to consider in this case consists of the testimony of the witnesses, the exhibits, and any facts admitted or agreed upon by counsel. There are two types of evidence: direct and circumstantial. Direct evidence is direct proof of a fact, such as testimony by a witness about what the witness personally saw or heard or did. Circumstantial evidence is the proof of one or more facts from which you could find another fact. The law makes no distinction

between the weight to be given either direct or circumstantial evidence. Therefore, all evidence in this case, including the circumstantial evidence, should be considered by you in arriving at your verdict.

Statements, arguments, or opinions of counsel are not evidence in the case. However, if the attorneys stipulate, meaning to agree to the existence of a fact, you must accept the stipulation of evidence and regard that fact as proven. Questions are not evidence. Only the answer is evidence. You could consider a question only if it helps you to understand the witness' answer. Do not assume that something is true just because a question suggests that it is.

You must also disregard any evidence to which an objection was sustained by the Court and any evidence stricken by the Court. Anything you may have seen or heard outside the courtroom is not evidence and must also be disregarded.

7. I will not say a few words about your conduct as jurors. First, keep an open mind throughout the trial and do not decide what the verdict should be until you and your fellow jurors have completed your deliberations at the end of the case. Second, because you must decide this case based solely on the evidence received in the case and not on the Court's instructions as to the law that applies, you must not be exposed to any other information about the case or the issues it involves during the course of your jury duty.

Thus, until the end of the case or unless I tell you otherwise, do not communicate with anyone in any way and do not let anyone else communicate with you in any way about the merits of the case or

anything to do with it. This includes discussing the case in person, in writing, by phone, tablet, computer, or any other electronic means, via email, text messaging, or any internet chatroom, blog, website, or application, including but not limited to Facebook, YouTube, Twitter, Instagram, LinkedIn, Snapchat, TikTok, or any other form of social media.

This applies to communicating with your fellow jurors until the Court gives you the case for deliberation and it applies to communicating with everyone else, including your family members, your employer, the media or press, and the people involved in the trial, although you may notify your family or your employer that you have been seated as a juror in the case and how long you expect the trial to last. But if you are asked or approached in any way about your jury service or anything about this case, you must respond that you have been ordered not to discuss the matter and report the conduct to the Court.

Because you will receive all the evidence and legal instruction you may properly consider to return a verdict, do not read, watch, or listen to any news or media accounts or commentary about the case or anything to do with it. Although, the Court has no information there will be any media on this case. Do not do any research, such as consulting dictionaries, searching the internet, or using reference materials, and do not make any investigation or in any other way try to learn about the case on your own.

Do not visit or view any place discussed in this case, and do not use the internet or any other resource to search for or view any place

discussed during the trial. Also, do not do any research about the case, the law, or the people involved, including the parties, the witnesses, or the lawyers, until you've been excused as jurors. If you happen to read or hear anything touching on the case in the media, turn away and report it to the Court as soon as possible.

These rules protect each party's right to have the case decided only on the evidence that has been presented here in court. Witnesses here in court take an oath to tell the truth and the accuracy of their testimony is tested through the trial process. If you do any research or investigation outside the courtroom or gain any information through improper communications, then your verdict may be influenced by inaccurate, incomplete, or misleading information that has not been tested through the trial process.

Each of the parties is entitled to a fair trial by an impartial jury and if you decide the case based on information not presented in court, you will have denied the parties a fair trial. Remember, you've taken an oath to follow the rules and it will be very important to follow the rules. A juror who violates these restrictions jeopardizes the fairness of these proceedings and a mistrial could result that would require the entire process to start over. If any juror is exposed to outside information, please notify the Court immediately.

Number 8. If there are any news media accounts or commentary about the case or anything to do with it, you must ignore it. You must not read, watch, or listen to any news media account or commentary about the case or anything to do with it. The case must be

decided solely by you and exclusively on the evidence that will be received in the case and on the Court's instructions as to the law that applies.

If any juror is exposed to any outside information, please notify the Court immediately.

9. If you wish, you may take notes to help you remember the evidence. If you do take notes, please keep them to yourself until you go to the jury room to decide. Do not let note-taking distract you. When you leave, your notes must be left in the courtroom. No one will read your notes. Whether or not you take notes, you should rely on your own memory of the evidence. Notes are only to assist your memory. You should not be overly influenced by your notes or those of your jurors.

10. When the attorneys have finished their examination of witnesses, you may ask questions of the witness by raising your hand and passing your written notes to the marshal. If the Rules of Evidence do not permit a particular question, the Court will advise you. After your questions, if any, the attorneys may ask additional questions.

11. From time to time during the trial, it may become necessary for the Court to talk with the attorneys out of the hearing of the jury, either by having a conference at the bench when the jury is present in the courtroom or by calling a recess. Please understand that while you are waiting, we are working. The purpose of these conferences is not to keep relevant information from you, but to decide how certain evidence is to be treated under the Rules of Evidence and to avoid confusion and error.

Of course, we will do what we can to keep the number and length of these conferences to a minimum. The Court may not always grant an attorney's request for a conference. Do not consider the Court's granting or denying a request for a conference as any indication of the Court's opinion of the case or what your verdict should be.

And the final instruction, trials will proceed in the following way. First, each side may make an opening statement. An opening statement is not evidence. It's simply an outline to help you understand what a party expects the evidence will show. A party is not required to make an opening statement. The Plaintiff will then present evidence and Counsel for the Defendant may cross-examine.

The Defendant may then present evidence and Counsel for the Plaintiff may cross-examine. After the evidence has been presented, the Court will instruct you in the law that applies to this case and the attorneys will make closing arguments. After that, you will go to the jury room and deliberate on your verdict.

Thank you. Counsel, ready to proceed with openings?

PLAINTIFFS' OPENING STATEMENT

MR. SHARP: Yes, Your Honor. Thank you. Good morning, ladies and gentlemen. You are part of an American institution that is important to our society. And you're here to pass judgment on one of the largest health insurance companies in this community, Sierra Health and Life. And you're here to pass judgment on what we will prove is a rigged system that has injured, will injure, and did injure William Eskew.

And in order to pass judgment, as the Court instructed you,

what I say is not evidence. What Defense has in their opening statement is not evidence. I'm here to assist you, to give an overview of the evidence we intend to present. And it begins with a framework. And the framework was given by Her Honor as to what the breach -- what's called the breach of the duty of good faith and fair dealing.

And these are generally the four things we have to prove. The request for prior authorization -- and we'll get into all these details -- was covered under the insurance policy. You'll hear the term "agreement of coverage" and "insurance policy". They mean the same thing. You'll see that next element that we have to prove, that on February 5 of 2016, Sierra Health and Life had no reasonable basis to deny the request for prior authorization.

The third element, on February 5, 2016, Sierra Health and Life knew or recklessly disregarded that it had no reasonable basis to deny the requests for prior authorizations. Fourth element, the February 5, 2016, denial was a legal cause of damage or harm to William Eskew.

The other thing that we will ask you at the close of this case is for you to consider whether or not to award punitive damages. And we talked a little bit yesterday about the concept of punitive damages. But what's important for today is in order to make that claim, we have to prove to you on February 5, 2016, Sierra Health and Life acted with a conscious disregard for William Eskew's rights.

So when we talk about throughout this trial concepts of reasonable basis, knowledge of absence of the reasonable basis, conscious disregard, we're going to provide a framework to define those

terms. And you think about it in your own -- in daily lives, there are things like rules of the road. We all know what those rules are. We drive. Don't turn in front of somebody, drive carefully, don't turn on -- you know, don't cross over in a double yellow line, those concepts.

Well, the same idea exists in the industry, in the insurance industry. And they're called insurance industry standards. And the next thing we'll prove to you is that Sierra Health and Life chose to violate those standards. And then we'll prove to you as the third aspect that Sierra Health and Life's decision to violate the industry standards resulted in harm to William Eskew.

So we begin with the concept of insurance. And as I say, insurance is unlike many products that we buy. Nobody wants to use their insurance policy. So it's basically you're buying a promise. The premium is paid, and in exchange for the premium, you get an insurance contract. Like I said, in this case, that contract generally is referred to as an insurance policy. In this case, Sierra Health and Life calls it an agreement of coverage. It's all the same thing.

And that's what you get. That's the physical thing you receive. So if you think about it, what the insurance industry is in the business of providing is protection, peace of mind, and security. Now, if you take that to the document you receive, the insurance contract or insurance policy, that's a document that's written by the insurance company. They write it. You don't negotiate the terms.

And there's two things that you're going to hear about a lot through the course of this case. There's what's called provisions that

provide coverage. In this case, it's called a covered service. But the important thing is to know that there is one part of the policy that provides coverage, what's covered under the contract, and then there are provisions that exclude coverage. They say certain things are not covered.

And the insurance company writes this contract. And they get to decide what's covered, and they get to decide what's excluded. And that's fine. That's the way it works. But because of that, when the insurance company writes a contract, they're the experts on that insurance policy. And that's a principle of insurance.

Through this case, we're going to present to you an expert by the name of Steven Prater, and he's going to come in and talk to you about the insurance industry standards that I'm outlining today and the violation of those standards. Mr. Prater's been a professor for many years at the University of Santa Clara, has devoted his life to -- basically, his professional life, to insurance industry standards, both helping consumers and helping insurance companies. And why we say it's important that an insurance company is an expert on its insurance policy is because oftentimes, when people ask for benefits, they can be in a vulnerable state and they're dependent upon their insurance company.

And so what that all revolves around is the Judge instructed you this concept of a special relationship between the insurance company and their customer, is what the law says is fiduciary-like. Well, a trustee is a fiduciary. And a trustee has to consider the interests of the beneficiaries of the trust above their own. So fiduciary-like means you

have to as an insurance company, when you're processing a claim, consider your customer's interests equal to that of the insurance company. And that's really what the customer receives when they pay the premium, is the duty of good faith and fair dealing.

Now, how is this concept implemented? And I want to talk a little bit about just generally the idea of the business of insurance. If you imagine a circle, and we had a series of pie charts, now, insurance companies, they have -- and this is going to be simplistic. So don't, you know, obviously, a complex business. But in core, there's basically kind of four concepts. You have what's called the marketing department. And they might decide this is the type of insurance we want to sell. In our case, it's health insurance. It could be auto insurance.

And then the underwriters decide, well, these are the type of people we want to insure. We're going to insure automobiles. These are the type of customers we want. And then, you have what's called the actuaries, who say this is the amount of money we need to charge to make a reasonable profit. And then you have within all those areas the investment by the insurance company to make their profit.

But what the rule is, is that there's another part. And that's the part of the company that delivers on the promise. And in the auto industry, it's called claims department. Here, it's going to be called utilization management department. But it's that part of the company that fulfills the promise. And when that time comes, that promise has to be made and performed without regard to what it means to the profit of the company. That doesn't mean, you know, you have to pay every

claim. But you have to consider your interests -- or your insured's interests equal to that of your own.

And so when we proceed forward to fulfill this promise, there are certain insurance industry standards. And I've just illustrated a few of these. There are going to be more that we talk about. But the three basic standards that we're going to talk about this morning, and that's -- the first one is when a claim comes in, an insurance company should conduct a prompt, fair, and thorough investigation of the claim. And that doesn't mean they just look for things to deny the claim.

So the second rule I have in front of you is the insurance company must diligently search for and consider evidence that supports coverage, in this case of the requested treatment. And the third standard, which interrelates, and I'll show you how, is the insurance company should interpret the insurance policy fairly and objectively. They wrote it and they need to interpret fairly and objectively.

So what that means in practice is you have a client that comes in. That's the insured's responsibility. You heard about there being each side has a duty of good faith and fair dealing. So the customer, which sometimes we call the insured. Just so you get those terms. It can be confusing. And the insured reports the claim. That's their job. The insurance company's job is to investigate and evaluate the claim, see if it's covered under the policy.

And then, they reach a decision and communicate and decide. Because they can reach a decision that says we need more information. They can go back and say, Mr. Insured, I need more

information. And then -- or they can make a decision. But the point in this whole three points is this is non-adversarial. The insurance company is performing its promise.

So one of the insurance industry standards we'll talk about in the coming weeks is that an insurance company should pay a claim unless it has a proper reason in the insurance policy not to do so. And the corollary to that is not every claim is covered. But if they're going to deny a claim, an insurance company should promptly provide a reasonable explanation of the basis in the insurance policy it relied upon to deny the claim.

So the point here is what you'll hear is that it's an open book communication so that the insured customer's interests are considered equal. So if you're going to take the position the claim is denied, put your cards on the table. That's the concept. And if you can't -- and if you look at this consistently and objectively, looking for coverage and it's covered and you don't have a reason not to pay it, you accept the claim. That's the concept.

And so one of the other things is that these things are documented. The insurance industry documents how it's making this decision so there's a form of accountability and responsibility. So here's the standard. The claim file, which in this case is going to be called the proton beam therapy file, should contain all the information regarding the investigation into and the reasons for denying or approving a request for prior authorization. It's just supporting and a medical record. You're supporting your documentation for the decision you made so you can be

accountable to why you made that decision.

So in this case, we're dealing with what's called utilization management. And Sierra Health and Life chose to write into their insurance policy a form of utilization management that we're going to be dealing with this week called prior authorization. Doctor recommends a particular type of treatment; it's submitted to the insurance company for prior authorization. Sierra Health and Life chose to accept that responsibility. And when they chose to accept that responsibility, they agreed to implement this in a reasonable manner consistent with its obligation of equal consideration.

So the essence of the deal is when you're submitting prior authorization, is it medically necessary? That's the question. And the process of making that decision is non-adversarial. What do I mean by that? Well, you have the insurance contract. And I don't know if you can see it this far away, but basically, the policy, the agreement of coverage, defines what's medically necessary. And Sierra Health and Life chose to provide itself with the discretion to determine what's medically necessary. So when they accepted that responsibility, they accepted an obligation to do so fairly.

Now, there's a number of items that they say they can consider in determining medical necessity. But at the bottom of this thing, it says, "Services and accommodations will not automatically be considered medically necessary simply because they were prescribed by a physician." That makes sense. Wouldn't be much point to do utilization management if all you have to do is accept the physician.

But what it doesn't say in there is you don't consider the physician. And so what I mean by that is that one of the principles or rules is that if a request for a prior authorization is denied, the insured may not obtain the treatment recommended by the treating doctor. That's how important this process of utilization management is. Because as a practical matter, a denial can result in people not getting the treatment recommended by their doctor.

So what does that mean? As a standard, consistent with its obligation to investigate, the insurance company should give the treating doctor's opinion respect and weight. They should consider it. It's part of their equal consideration.

So what we have here is you've got three parties. You have the insured, the person who's paying the premium or the person who's insured under the policy, the doctor, and the insurance company. And those three things are important because the doctor's role is to make medical decisions, the insurance company's role is to make insurance decisions, and they need to work together. And they need to consider what the doctor has to say as part of their evaluation.

And so what happens, and the risk that utilization management creates, is that the insurance company stops fulfilling their industry standard obligations and they stop considering the doctor, the customer or the insured is out on an island. And that's the risk that utilization management creates.

So I've gone through the industry standards. And now I want to talk to you a little bit about what we believe the evidence will

show as to how those standards have been violated. So you'll hear a lot in this trial about how Sierra Health and Life, through United Healthcare. Sierra Health and Life is a subsidiary of United Healthcare. So you can see Sierra Health and Life documents. You'll also see United Healthcare documents.

And you'll see that United Healthcare, a document which they call medical policies or guidelines. And the first standard with respect to those is that the insurance company cannot use a medical guideline as the basis for denying a claim. So what Mr. Prater will talk to you about is what that means. But basically, it's that you just can't use that guideline that's been created as the reason for denying a claim.

So Sierra Health and Life, as I told you, they're part of the United Healthcare company. And around 2011, corporate medical policies or guidelines began replacing fair claims data. And what you'll see through this process is that these corporate medical policies that have been created by people that won't come into this court, that created these on behalf of United Healthcare, created and adopted these medical policies to effectively supersede the insurance policies.

That's why I have a cross there. It's like you have two documents: medical policy, insurance policy. The insurance policy is the thing that was provided to the customer that's governing, and you have these medical policies that have been used, the evidence will show, for Sierra Health and Life to basically cross it out. We're not going to follow the insurance policy.

And you'll see through the documents -- you'll be given

information about the insurance policies. But what you'll see is that the corporate medical policies are being adopted by United Healthcare for Sierra Health and Life are not part of the insurance contract. And that's the provision I have in front of the entire agreement. And we'll get onto that in more detail. But the basic point is this so-called -- this corporate medical policy is not part of the insurance policy.

And so what has happened is once these medical guidelines have been used to supersede the insurance policy, you have a number of events that are occurring. And what I think it's analogous to is a form of roulette, except when your number comes up, you're not winning. And what I mean by that is you start with the first step, prior authorization. Doctor's office submits the prior authorization. The insured does their job by reporting the claim.

And then, there's assigned what's called a CPT code. And that's a code that is used within the insurance industry for procedures. Like, an MRI has a CPT code. So that CPT code goes into Sierra Health and Life. And if the CPT code says yes, it's approved, it's approved. Nobody cares why the doctor is doing it. He could be doing it for fraudulent reasons. It's automatically approved without review.

If the CPT code that comes up on the computer -- so what happens is that a person, a desk clerk, looks at the CPT code and says, is this something that we automatically approve no matter what the reason is or is it something that needs further review? And that, if it says no, then the preauthorization goes to a nurse who looks at the medical policy.

The medical policy, what does the medical policy say? If the medical policy says yes, the claim is approved. Again, without regard to why the doctor is doing it. He could be doing it for fraudulent reasons, but it's automatically approved. Now, some of the medical policies will say no, you need further review by what's called a medical director. And a medical director is just somebody with a doctor name in front of him who's been hired either as an independent contractor or as an employee by United Healthcare to review the prior authorization.

So the medical doctor -- director, he looks at the medical policy. Again, the medical policy, not the insurance policy. And if the medical policy says yes, it's covered, it's approved, again, without regard to why the doctor actually needs it. Could be doing it for fraudulent reasons. But if the medical policy says no, the claim is denied without regard to why the doctor wanted this particular procedure and without regard to direct input by the doctor.

And so once the claim is denied, and you'll see these in emails. The medical director sends an email, claim denied. It goes to what's called the adverse benefit determination team. And that team is filled with essentially -- I don't mean to be rude -- I mean, essentially desk clerks. And the desk clerk -- one desk clerk informs the doctor verbally, your preauthorization has been denied based on the medical policy.

And then that desk clerk writes the denial letter and mails the denial letter to the insured. And then, you can file an appeal, but the appeal goes back to the medical policy. And literally, the medical policy

is just a piece of paper. And so the evidence we'll ask you to consider is how do you argue with a piece of paper?

And so what you're seeing is missing from my chart. What does this process remove? The investigation of the facts. Actual investigation and analysis of the facts as to why this particular doctor wants the treatment. An analysis of the insurance policy defining medical necessity. The evaluation of the facts. So the second part of my little three-part diagram is gone. And the third point is due weight and consideration of the treating doctor's medical judgment.

And so when I had that little diagram up of the problems that can happen when an insurance company adopts the process that removes itself from its own accountability to fulfill its industry standards to deliver on the promise of good faith and fair dealing. The doctor is out of the equation and the insurance company has also removed itself from accountability. In the meantime, the insured customer is on an island.

And so what happens is that for certain procedures, as I showed in my diagram, this medical policy is adopted by United Healthcare to be used by Sierra Health and Life, it becomes a hidden exclusion to your insurance contract.

So let me talk now and kind of transition to what the specific medical issue we are here about in this case. And we're here about, generally, radiation oncology. And I just have in front of you radiation oncology and therapeutic ratio. These are terms you're going to hear. The radiation oncologist is the doctor who treats people with radiation.

An oncologist treats cancer with drugs. The radiation oncologist treats cancer with radiation.

And the principle that exists within the radiation oncology world is you want to increase radiation to the cancerous tumor while decreasing radiation to health organ and tissues. So let's look here through the evidence. And we have two doctors who are going to testify about radiation oncology. One is the treating doctor. Dr. Liao is her name, and I'll get to her later. But there's another doctor by the name of Dr. Kenneth Chang, and he'll be here on Monday.

But basically, the idea is no amount of radiation is helpful in the sense of it's good for you. Now, what I mean by that is if you can imagine going to a dental office, when you get your X-rays done and they put the lead apron on you. And so the introduction of radiation into the body is considered harmful. Now obviously, for medical reasons, you have to do that. Like, if somebody has got cancer, they want to kill that tumor, you have a therapeutic reason to induce radiation.

But the problem is that radiation also can impact other organs and tissues. So that's the therapeutic ratio. You're maximizing radiation to the cancerous tumor while minimizing radiation to healthy organ and tissue. And so -- this is a crude drawing. Sorry, this is mine. Don't hold me to -- I mean, I'm just giving you this as an example, that if we imagine somebody had a tumor where I marked a black X and another tumor where I marked a black X. The idea is you want to induce radiation onto those X's while mitigating radiation to other parts of the body because those parts are still healthy and the radiation to the other

parts can cause damage.

So in the course of this case, you'll be hearing principally about two forms of radiation. One is called proton beam therapy. And the important thing to know about that one and keep in mind is it uses protons. IMRT is another form of radiation, and it uses photons. And those two things can become confusing. So if you remember, it's easier when you've heard of proton beam therapy as proton, IMRT is photons.

And the concept of proton beam therapy is it delivers a fine particle to the cancerous tumor. And so this is actually out of the corporate medical policy for United Healthcare. This says, "After they enter the body, the protons release most of their energy within the tumor, and unlike photon, deliver a minimal dose beyond the tumor boundaries." So they limit that red circle that I had on my crude drawing. That's the concept. And that's the science behind it.

And here's a different drawing of how it works. So you have on the left, the proton. You see how it comes in and doesn't disperse. And you see how the IMRT disperses throughout the body. So the yellow part here, all of this, this is all radiation. This would be the area of the tumor. And this is the same concept here with the protons. So it's delivering a finer particle to the tumor, and it doesn't pass through the tumor to disperse to healthy parts of the body.

And proton beam therapy is a proven and medically necessary therapy. It's been approved by the FDA since approximately 1984. I mean, the science behind proton beam therapy I think dates back to the '50s. It's a procedure that's recognized by Medicare and it's

recognized by elite medical institutions such as MD Anderson Cancer Center and the Mayo Clinic, and others.

And another interesting thing -- well, let's just say what happened. And what happened is literally money gets in the way. And what I mean by that is proton beam therapy, which uses a higher form of technology, is more expensive than IMRT. And so what the insurance company decided is that we are going to make a judgment on the piece of paper that certain people are not going to get proton beam therapy regardless of what their treating physician says because the other form is cheaper.

And what has happened is Sierra Health and Life uses the medical policy as an undisclosed exclusion for proton beam therapy. And you'll see this policy in more detail, and it's hard to see. And we'll pull it up. But basically, what it says is that for many cancers, including lung, that proton beam therapy is not medically necessary. Period. So you got the bad CPT code in my example, and it's going through this automatic denial.

And what you'll find in this case is that Sierra Health and Life recognizes that proton beam therapy works. It recognizes it for certain cancers. And if you -- the idea a technology works for one cancer, the same technology logically works for others. But what you'll see through the course of this idea is that rather than really using science and background to establish these policies, their decision is made for business reasons.

And you'll hear from a witness that the Defense will bring by

the name of Dr. Bhatnagara. And she's in charge of the medical policy now. She wasn't in charge in 2016 and really doesn't have any personal knowledge to get us to how we're here in 2016. But interestingly, she will talk about how these policies, certain aspects have been adopted for business reasons.

The ironic part of this whole thing about proton beam therapy is United Healthcare recognizes it's a good technology and it works. Because in 2015, United Healthcare, on its provider arm -- you heard about that -- I think those of you that were here on Monday, you might have heard the questioning of the highway patrolman whose wife worked for Optum. Optum is the medical arm of United Healthcare. So through Optum, in 2015, United Healthcare is investing money to operate the New York Proton Center to treat lung cancer, as one example. So the technology, the process, the therapy works.

And so what happens once we have United Healthcare directing through -- Sierra Health and Life through United Healthcare disregarding the insurance industry standard, what happens to people like William Eskew? And that's the third part of the case we're going to talk about. The harm. And here's William Eskew. Let me tell you a little bit about Mr. Eskew, just so you have some background. He was married to Sandy Eskew for 35 years. Two children. You'll meet both of them, Tyler and B.J. He's William Eskew, Jr., but he goes by B.J.

He was a salesman. And as salesmen are, they're personable, outgoing people that like to be around people and they like to have fun. And William Eskew and Sandy Eskew, they built a life

together. Sandy Eskew is a dental hygienist. Raised a family. And in 2015, they were kind of enjoying what we refer to as the golden years of their lives. Tyler had had a granddaughter, Sophia, that was kind of the light of Bill's life.

And then, as life happens, Mr. Eskew was on the -- and I apologize. This is a formal process, so if I say Bill and Sandy as Mr. and Mrs. Eskew, I'm just trying to keep the process more formal. It's not like I'm disassociating myself in any way. It's just I think that this is an important process. So I'm going to try and use Mr. and Mrs. Mr. Eskew was on the golf course with his son and swinging his golf club, and he broke his arm. Went to the hospital, they found out that he had had cancer. And the cancer originated most likely from his lung and spread to a metastasis on his bone.

He was 64 years old when that happened. And he had a lot to look forward to in life and a lot to extend his life for. His granddaughter, Tyler was pregnant with their soon to be grandson. And so remarkably, at stage 4, Bill felt good. He had stage 4 because he had a metastasis. It spread from his original site. He went through a chemotherapy, radiation to the bone, to his arm. But he was feeling good. Relatively. I mean, obviously, stage 4, you're maintaining weight and increasing weight, you're still active, you're having family get-togethers and such.

And at the same time, Mr. Eskew needed new insurance. His other insurance company was leaving the state. So Sandy Eskew looks into things. And Sierra Health and Life had gone into the business of the

Affordable Healthcare Act. And by making that decision to go into the business, they agreed to insure people with preexisting conditions, under the same standards that we had talked about earlier.

And so Sandy Eskew contacts a lady by the name of Janet Holland-Williams, who's what's called a producer. She's an insurance agent. She sells policies for Sierra Health and Life. Sandy calls and says Bill Eskew has lung cancer. He's going to MD Anderson, because Sandy had done her research and felt that that was the best cancer center for lung cancer. She says he's going to the MD Anderson to be evaluated for proton beam therapy. And she asks the question, is proton beam therapy covered?

And Janet Holland-Williams goes Sierra Health and Life. And Ms. Holland-Williams responds to the question by providing two things. The agreement of coverage and the benefit schedule. Well, nobody here is saying that Ms. Holland-Williams did anything wrong. She provided the information like she should have done.

Now, the information within the contracts has what's covered and what isn't covered. And this thing I have in front of you is called a benefits schedule. And it basically says one of the things that Sierra Health and Life covers is therapeutic radiology, and that's -- proton beam therapy is a type of therapeutic radiology, as is IMRT. You see, therapeutic radiology is radiology therapy for cancer.

No limitations on that coverage. And then you go to the insurance agreement, the agreement of coverage. And the insurance policy has what's called covered services. And it says, "This section tells

you what services are covered under this plan." This says, "Only medically necessary services are considered to be covered services." And then you go to section 5.18, and it says one of the things that is a covered service is therapeutic radiology. And nothing within this contract says explicitly that proton beam therapy is not covered.

Now, I went back, and I told you as part of the rules for an insurance company, they get to write the contract. They could have written a contract that said we don't cover proton beam therapy. They could have written that contract. They didn't. And when they made that choice, they made the choice to evaluate proton beam therapy claims equally to all other claims.

So after the insurance policy is issued in January 2016, Bill -- Mr. Eskew goes to see MD Anderson. And he sees a doctor by the name of Dr. Zhongxing Liao with MD Anderson. And you'll hear testimony from Dr. Liao. And she's a radiation oncologist who treats thoracic cancer. So thoracic cancer, lung cancer is a type of thoracic cancer. So her specialty is things like lung cancer.

She's a professor of medicine at MD Anderson. She's the director of clinical research. She has over 300 peer-reviewed publications. She literally creates the standards within the medical industry. You'll hear about her educational history. I think it's like -- don't hold me to this number. I want to say, like, she spent ten -- over ten years just studying to become a radiation oncologist. It may have been even more than that. A very educated doctor.

She takes a look at Bill Eskew. She meets with him; she does

an exam. You'll see that Bill's weight was pretty good, and that will be explained to you, that's kind of an aspect that the radiation oncologist considered to even determine whether you need radiation. And she did a comparison between proton beam therapy and IMRT. And this is how radiation oncologists make clinical decisions. They make comparison analyses.

So she did an evaluation as to what would happen if Bill had proton beam therapy versus IMRT. And you'll see these lines around from -- the colored lines represent the radiation going in. And you'll see -- and it'll be more visible through other documents. So if you can't see it clearly from where you're at, we'll make sure you can through the course of trial. But there's this little lip out here, which is a border that reflects where Mr. Eskew's esophagus is.

So what he had is he had two tumors, both of which were very close to his esophagus. And Dr. Liao ran two studies. And the IMRT one is over here. I've blown it up. And based on those two studies, she made a medical judgment. And she made the medical judgment that Mr. Eskew would benefit to the use of proton beam therapy primarily because she could introduce more radiation to the tumors but mitigate radiation to the esophagus and to the lung, the healthy lung part, and the heart.

And the esophagus is basically where you swallow and how it gets to your intestine. So it's a very important organ. And she made that medical call. And she made it, I think the evidence will show, objectively. This is a professor of medicine who has, frankly, has studied

IMRT. She studies both aspects of the clinical research. She looks at all aspects. But she brings the breadth of knowledge of both treating people with proton beam radiation and IMRT to make medical judgments. And the medical judgment she made was Mr. Eskew would benefit from proton beam therapy.

And so by February 4, 2016, Mr. Eskew had met his obligation under the insurance policy. MD Anderson had reported the claim for prior authorization. And you'll see at the bottom there it says, "All relevant clinical information has been reviewed and this patient is meeting eligibility criteria for treatment with proton beam therapy." And that information was submitted to Sierra Health and Life.

And under the terms of the agreement of coverage, Sierra Health and Life promised that the medical director or a committee will review the proposed service to determine if the services are medically necessary. And when I -- when these things are capitalized in the insurance policy, that means they're defined somewhere else. And I had shown you the definition earlier.

And the evidence will show that the proton -- the evidence that was provided by MD Anderson was that proton beam therapy for Mr. Eskew was medically necessary. First thing that you have to determine for medical necessity, it's really not a very onerous proof. First thing is, is the proposed treatment consistent with the diagnosis and treatment of lung cancer. Proton beam therapy is consistent with the diagnosis and treatment of lung cancer.

Second thing you have to show, is the level of service

appropriate. And what the industry means by level of service is the concept of if you imagine in a hospital, you can be in ICU or general ward. That's a level of service. Hospital versus outpatient. Those are different levels of service. So the outpatient care is the most appropriate level of service. Radiation therapy is done on an outpatient basis. The proton beam therapy was not being done solely for Mr. Eskew's convenience or Dr. Liao's convenience.

So those are the three things that one has to look at to determine if something is medically necessary. Consistent with level of service and convenience. As to the -- is it solely for the convenience of someone other than, you know. And so they're pretty simple things. And that's the task that has to be done.

And so what you'll see is that once the preservice claim comes in -- and we call it a -- I have it preservice because that's actually what the insurance policy calls prior authorization. It's a claim. And so it comes in and it goes through the first stage. CPT code doesn't match. It goes to the second stage of the nurse. She sees in medical that proton beam therapy is never considered medically necessary, so then the claim now goes to the third step. And it goes to Dr. Ahmad. And he's an oncologist. He's not trained in radiation oncology.

In 2011, he was hired by United Healthcare, Sierra Health and Life at $200 per hour to review oncology claims against the corporate medical policy. And just to give you a frame of reference, the oncologist -- well, I believe both sides are bringing in are being paid roughly $700 to $800 per hour.

So Dr. Ahmad gets the claim from a nurse called Lou Ann Amogawin. And Dr. Ahmad shortly thereafter sends the denial in an email. And he says, "Decision: metastatic cancer to unknown primary, the requested procedure does not meet current HPN policy." HPN is part of -- they're like sister companies with Sierra Health and Life. So when you hear HPN, it means Sierra Health and Life. And when you hear policy, that's the medical policy.

So once Dr. Ahmad sends the email, now -- he admits in his deposition, and he'll admit in trial that he never looked at the insurance policy before he denied the claim. And he'll -- and he admits that he's never -- that he was taught you should never use the medical policy as the sole basis to deny a claim, that when he communicated the denial, you'll hear from the evidence that the sole basis was the Sierra Health and Life, United Healthcare Health Plan of Nevada medical policy.

So then, the claim goes to the adverse benefit determination team. And the first thing that happens is the adverse benefit determination says to MD Anderson, claim denied based on medical policy. Then, the denial letter is typed out by a gentleman by the name of Mr. Guerrero. And he takes literally verbatim the wording from the medical policy, and he inserts it into a denial letter dated February 5, 2016. And the denial letter, you'll see, "The reason for our determination is based upon United Healthcare, Inc., medical policy for proton beam radiation therapy. Coverage is denied." That's the medical policy that should not be used as the sole basis for the denial of a claim.

In the meantime, Nurse Amogawin noted that Dr. Ahmad

had not cited to the correct medical policy. So she sends an email back saying, "I need a new denial email, and I'm attaching the corporate medical policy." And then Dr. Ahmad responds back and says, "The requested procedure does not meet current HPN/UHC policy." And this time he cites the correct policy number.

The email is sent over to Mr. Guerrero, a denial letter is sent by mail with Dr. Ahmad, Shamoon Ahmad's signature as medical director, when in fact, he never reviewed this letter. He never wrote the letter. It's just a stamp signature.

And so what happens next? Now, we talked about the insurance policy. It says, "All decisions of SHL's managed care program may be appealed by the insured or his authorized representative." May is discretionary. And so claim comes into -- the note of the denial comes into Dr. Liao, who's not an expert in insurance. And Dr. Liao says, you know, my experience with United Healthcare is they never change their mind. They always deny these claims.

So she's placed in a conundrum. She has a patient with stage 4 lung cancer who needs care. And if she delays the process of providing that care, that poses a risk to Mr. Eskew. And if she's only delaying that care for a futile purpose, then it's not serving any medical purpose. So she makes a medical judgment to say, "Mr. Eskew, you know, we're going to have to go with IMRT," because she knows at least the IMRT will kill the cancer.

Now, the interesting thing, then, is that Sierra Health and Life approves the IMRT. So Sierra Health and Life recognizes that he needs

radiation. Mr. Eskew needs radiation, and he needs a type of radiation that will avoid damage to healthy tissue. They know this. And they approve the IMRT. They don't give a reason why the IMRT is better than the proton beam therapy. They approve it pursuant to the corporate medical policy.

February, late February to March 2016, Mr. Eskew has IMRT. And the IMRT injures his esophagus. I just have this crude drawing so it's clear the importance of the esophagus. The food comes down, goes right into your stomach. It's your form of getting nutrients. You can't swallow, you can't get nutrients. And what Dr. Liao will say in her testimony is that he had a grade -- what's called a grade 3 esophagitis. That in her medical judgment, based on the vast training and experience that she has, had she been able to use proton beam therapy, he would not have had grade 3. He could have had some injury, but not the type of injury he got.

And what happened to Mr. Eskew is he lost a bunch of weight. And when he lost that weight -- he lost a bunch of weight from not being able to eat. And he ended up at one point in the emergency room. And his quality of life changed. Now, the -- you'll see it as we've gone through this insurance policy. Nothing in this policy excludes coverage for people that have stage 4 cancer and need assistance to live a better life. Not in the insurance contract. You won't see it.

And so the promise that was made is if you can -- if you have a proposed medical plan that's consistent with a condition you have and it's at the appropriate level of service and it's not done solely for your

insured's convenience, it should be approved. And what happened to Mr. Eskew is his life changed.

So what the family will say, particularly Sandra Eskew, is that Bill just became a different person in a lot of ways. He obviously had the pain of being able to swallow and eat. The family will say that was a constant struggle to get him to eat. Constant, he complained about feeling like something was always stuck in his throat.

But that's part of it, and that's the physical aspect. And you'll hear about Bill. He -- Mr. Eskew. He was to his generation. He was a fighter. And so he kept -- he would eat. He gained some weight back. But whenever he got sick, he'd go right back down because it just never really got back to where he was physically. But that's just this small aspect, really, of what happened.

And you'll hear about before the IMRT and before the claim denial, Bill was still trying to be pretty active. He and his son operated a Meineke muffler shop. They had two shops. Bill would go in and talk to the customers like a salesman would. He was enjoying things. He had a family dinner every week. He was enjoying his grandson and his granddaughter.

And once the events after the denial took place, he became a different person. He kind of lost hope. He had anger because of how he had been treated in the sense that why would this insurance company overrule a doctor like Dr. Liao. And that anger changed his quality of life. And so when we're talking about damages, what we're saying is that end period of your life means something.

You know, if you had an example in mind, if you took somebody, you took a healthy person and an almost blind person and you put them side by side. And the healthy person would lost the sight of their eye. You would say, well, they had a perfect eye, so they lost that perfect eye. You take that same man who can barely see out of his eye, and his other eye is blind, and he loses vision from that eye. Well, he's now blind. But you would say, but he didn't have a healthy eye. But the quality of his life has changed much more markedly than the healthy person.

It's the same kind of thing here. And the evidence we'll produce to you is the moments of Bill's life were lost because of the denial. And at the end of the day, we'll ask you to place a value on that. And I suggested the, you know, millions of dollars that we'll talk about at the end of closing. But when you analyze that damage, that's what we will be presenting in evidence, the loss of that quality.

So harms and losses, I've gone through them. There are mental pain and suffering, mental suffering, emotional distress, and loss of enjoyment of life. And then, as I get ready to sit down, you're going to hear about the defenses. And what you'll hear, we believe that the evidence will show, is that the defense of this case is built by the rigged system that was created by the corporate people at United Healthcare.

And what I mean by that, to go back to the simple deal, when the insurance company stops fulfilling its industry standards, they stop considering the doctor, but the doctor becomes the blame, the fall guy. And the insured becomes nothing more than a statistic. And the first

thing they're going to say to you is, well, you know, yeah, it doesn't look very good, but we have this medical policy that says many types of cancer, including lung cancer, are never medically necessary. So our medical policy is discretionary.

Well, when you evaluate this defense, we suggest you look at the terms of the medical policy itself, number one. And number two, look at the discretion. How did they exercise the discretion? Is it in the medical policy? Third, what's the consequence of exercising discretion? What you'll hear is that nobody asks Dr. Ahmad to justify his decision unless he doesn't follow the policy.

We blame MD Anderson, Dr. Liao, and William Eskew. And what I mean by that is you'll hear that investors thought -- they believed in proton beam therapy. The people that know what they need to invest in and how to make money for their shareholders or their -- they believe in proton beam therapy, so they invested in it. These machines are expensive. And they invested in it with MD Anderson. So a for-profit company, Sierra Health and Life, will suggest to you there's something untoward because another for-profit company decided proton beam therapy served a purpose, a useful purpose for patients and was a good technology to help.

Dr. Liao, it's her fault. She didn't file the appeal. She should have done the appeal. She should have done this. Remember, the first -- one of the first rules I talked to you about, the first principle, the doctor is not an expert in the insurance policy. Nor should they be. Then, they're going to take one more step with Dr. Liao and say, well,

you didn't really believe in the treatment you had.

You'll hear this morning about when Dr. Liao received notice of the denial, she made a decision quickly and strongly, as good doctors do, and within about 25 minutes, she had said we got to go with IMRT. So now, they're going to come in and say, well, she didn't really believe in the treatment. But what I'm suggesting to you and the evidence of this case, don't let them get away with blaming Dr. Liao.

Because what they're really saying is that Dr. Liao decided one day, on February 3, 2016, that she was going to commit insurance fraud. Because that's what it is. If you submit a claim that you don't believe in, that's fraud. So let them prove that. She made a medical judgment that she felt was in her patient's best interests and she's going to stand behind that judgment. And an insurance company used medical policy to overrule.

Third, William Eskew. Oh, he could have paid for it. He should, you know, he could have done all sorts of things. But where the root cause of this problem is, is the decision by the corporate people to disregard the industry standard.

And the final defense is William Eskew would have died anyway, so what's the big deal? That's the core defense. We created a rigged system that can hurt people. And when it hurts somebody, we say, well, wash your hands. He would have died anyway. And we're not saying in this case -- stage 4 lung cancer. I mean, we can't say that he would have died, you know, events took over.

But what we are saying is he bought a promise. The promise

was good faith. Unbeknownst to him, despite Sandra Eskew's efforts in educating herself, there was a hidden exclusion to the contract that said any time proton beam therapy is recommended for lung cancer, it's automatically denied without regard to the insurance contract, with no investigation and evaluation, and that process harmed William Eskew and deprived him of the peace in the last moments of his life so that he can enjoy what he worked many years to establish. And he died at 65.

So with that, I'll just recap and tell you what we're going to prove. We're going to prove to you that Sierra Health and Life breached the duty of good faith and fair dealing and did so with conscious disregard for Mr. Eskew's rights, that Sierra Health and Life harmed Mr. Eskew. And at the conclusion of this case, we're going to ask you to find liability, to find monetary damages, and to find that punitive damages are appropriate.

I look forward to presenting the evidence in front of you. My co-counsel, Doug Terry, looks forward to doing that. As part of this, you should understand we're trying to split this thing up a little bit. Doesn't always work that way. But when Mr. Terry stands up, it's usually going to be a medical issue or a damage issue. When I stand up, it's going to be primarily insurance. It won't always be that, but that's to kind of give you a heads up on that.

So again, I look forward to presenting the evidence and on behalf of Mrs. Eskew.

THE COURT: Thank you. We're going to take a 15-minute recess. Ladies and gentlemen, you are instructed not to talk to each

other or anyone else about any subjects or issues connected with this trial. You're not to read, watch, or listen to any report of or commentary on the trial by any person connected with the case or by any medium of information, including without limitation newspapers, television, internet, or radio.

You are not to conduct any research on your own relating to this case, such as consulting dictionaries, using the internet, or using reference materials. You are not to conduct any investigation, test any theory of the case, recreate any aspect of the case, or in any other way investigate or learn about the case on your own.

You're not to talk with others, text others, tweet others, Google issues, or conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney involved in this case. You're not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

So what this means is do not research proton therapy or other therapies that Counsel has suggested in his opening. That will be for the witnesses. Do you understand?

All right. So we'll come back at 11:25.

[Jury out at 11:09 a.m.]

THE COURT: We'll restart at 11:25, Counsel.

[Recess taken from 11:10 a.m. to 11:27 a.m.]

THE MARSHAL: On the record.

THE COURT: Thank you, please be seated, Counsel.

Are the Parties ready for the jury?

MR. ROBERTS: Yes, Your Honor.

MR. SHARP: Yes, Your Honor.

THE COURT: Thank you.

THE MARSHAL: All rise for the Jury.

[Jury in at 11:28 a.m.]

THE MARSHAL: And all jurors present.

THE COURT: Thank you.

Do the Parties stipulate to the presence of the Jury?

MR. ROBERTS: Yes, Your Honor.

MR. SHARP: Yes, Your Honor.

THE COURT: Thank you, please be seated.

Mr. Smith?

MR. SMITH: Thank you, Your Honor.

DEFENDANTS' OPENING STATEMENT

MR. SMITH: Good morning, everyone.

THE JURY: Good morning.

MR. SMITH: This case is fundamentally about the substantive reasonableness of a decision that was made by a trained physician, and not some knowledgeless bureaucrat, in regards to a specific type of radiation treatment for a specific type of cancer.

There is not going to be any evidence throughout this trial that the treatment that Mr. Eskew's Texas doctor requested for him would have saved his life, or that it would have changed the ultimate outcome.

Mr. Eskew was in fact approved by Sierra Health and Life,

which I will refer to as Sierra from this point forward, for a different type of radiation the next day after the initial request was denied.

Mr. Eskew received IMRT, which Mr. Sharp did a good job of explaining what it is. But it's one type of radiation therapy used to treat cancer. It was requested by the same Texas doctor, who initially requested proton beam therapy, also known as PBT.

The evidence is going to show you that the IMRT treatment that Mr. Eskew actually received, and that Sierra paid for works just as well as any alternative treatment for lung cancer.

This case is not about any side ventures that we anticipate the Plaintiff is going to want you to go on, such as any typos in Sierra's internal records documenting the decision, how the letter was prepared, how it was provided to Mr. Eskew's doctor, or the verbiage contained in that letter.

So, the first thing we're going to do -- excuse me, the first thing we're going to ask you to do throughout this case is to focus on what's important. And to keep an open mind until you hear all of the evidence. The ultimate decision that you're going to have to make is whether Sierra had any reasonable basis to deny the request for proton beam therapy.

So, let me tell you a little bit about my client, to the extent that you haven't heard of it, and to the extent that Mr. Sharp tried to tell you some negative things about my client. Sierra offers health benefit programs for a variety of groups, including individuals. Sierra partners with physicians, hospitals, healthcare professionals, other care facilities

nationwide, in order to provide managed healthcare to those who need it. Sierra began operations in 1906 as a life, accident, and health insurer. It's certified as a life, accident, and health insurer here in Nevada. And in fact, its headquarters are located here in Las Vegas, and it employs approximately 1,000 people.

Now, folks, there are some undisputed facts here. In July of 2015, as Mr. Sharp indicated, Mr. Eskew, while in his early sixties, suffered an arm fracture while playing golf. He sought medical treatment for that fracture, which was related to him having cancer which had not been diagnosed at that time. Between August and December of 2015, he received a combination of chemotherapy and radiation therapy to his arm region. Doctors ultimately determined that he had a tumor in his lung, and that he had stage four lung cancer that had metastasized to other parts of his body, specifically, his bones.

Now, generally speaking, stage four lung cancer that has metastasized has a very high mortality rate. In late 2015, Mr. Eskew obtained a health insurance policy from Sierra that became effective on January 1st, 2016. This was an individual plan and one not obtained through an employer. Based on some research that Mr. Eskew's wife did, he decided to try and pursue protein -- excuse me, proton beam therapy for his lung cancer, as opposed to IMRT. Again, they are both a form of radiation therapy.

He consulted with the MD Anderson Cancer Center, which is located out of state, and the provider there named Dr. Liao recommended concurrent chemotherapy and radiation therapy. Dr. Liao

decided that proton beam therapy, as opposed to IMRT, was the -- preferred course of action, and submitted a prior authorization request for proton beam therapy to Sierra. That request contained a cover letter and about a dozen pages of medical records. It did not, however, contain the comparative results of proton beam therapy versus IMRT therapy that Mr. Sharp showed you on the screen. In fact, those studies were not provided to Sierra Health and Life at any point during the process. Dr. Ahmad didn't have the opportunity to see those documents, to see those graphs, to see those images.

Now, Dr. Ahmad, who is an oncologist himself and who was the Sierra Medical Director responsible for handling that particular request, received the request and determined that the requested proton beam therapy was not covered by Mr. Eskew's plan and was not medically necessary based upon the specific type of cancer that Mr. Eskew had, and in previously established medical policy pertaining to proton beam therapy and, specifically, lung cancer.

Importantly, folks, he did not rely solely on that proton beam therapy policy as Mr. Sharp would have you believe. Again, as Mr. Sharp said in his opening, once that request denied, there was an option to appeal that determination. But Dr. Liao ultimately elected to go with IMRT. Again, an equally effective radiation treatment for killing lung cancer. That request for IMRT was promptly approved by Sierra. Mr. Eskew underwent IMRT and chemotherapy from February to March, 2016. He developed esophagitis, which is an inflammation of the esophagus. He lived for about another year after his treatment ended,

but his cancer unfortunately progressed to other parts of his body until he ultimately passed away in March, 2017.

Incidentally, the recommendation for Mr. Eskew to even go to MD Anderson in the first place for treatment or for the use of proton beam therapy did not come from his local Las Vegas-based radiation oncologist, who had been managing his care here in the Las Vegas from the point that Mr. Eskew was first diagnosed with lung cancer. His local treating -- doctor didn't recommend proton beam therapy, as you're going to learn, and he didn't think it was necessary. Also, incidentally, proton beam therapy is not even available anywhere here in the State of Nevada.

Now, folks, I want to pause now for a second to acknowledge for you all that it's not lost on my client, it's not lost on me, it's not lost on our colleagues, Mr. Gormley and Mr. Roberts, that Mr. Eskew's death was sad and unfortunate. He lived approximately 18 months after he was diagnosed with stage four lung cancer that had metastasized to other parts of his body. But I also need to point out to you that, again, that there was no claim that my client's conduct in any way caused or contributed to Mr. Eskew's death from cancer.

Now, that's not the same as blaming him, Ladies and Gentlemen, as Mr. Sharp suggested, and that's not the same as saying he would have died anyway. But the fact that my client is not responsible for Mr. Eskew's death is something that we're going to ask you to consider as a relevant circumstance throughout the course of this case.

Nor is there any claim that the use of IMRT versus -- proton beam therapy had any effect on the progression of the cancer, and that's because the science supports the conclusion that proton beam therapy and IMRT are equally effective at killing cancer cells. Because I'm sure you're aware of, and I'm sure your common sense can tell you, unfortunately, the progress for someone with stage four lung cancer is pretty bleak. Mr. Eskew's prospects were pretty bleak given the stage of the cancer when he was first diagnosed with it. And while you may naturally have some sympathy for Mr. Eskew and for his wife, sympathy does not equate or justify you finding my client liable on that basis alone.

So, here's where our position differs somewhat from the Plaintiff's. Number one, it's our position the system is not rigged. We believe the evidence is going to show that while it may be an appropriate choice for certain conditions, proton beam therapy had not been proven superior in randomized clinical trials when it comes to specifically to lung cancer. The science had not and has not established that.

Now, while Plaintiff's doctors and experts may disagree with our doctors and our experts, that does not govern your decision. The test here is not whether Sierra's decision to deny proton beam therapy was correct, or rather, it's whether a reasonable basis existed for the decision to deny the request for proton beam therapy under these facts and circumstances, and in this situation.

And the evidence is going to show you that there were in fact several reasonable bases for Sierra's decision because Sierra had

reviewed all of the information provided by MD Anderson and saw no reason in those records to deviate from its policies. It's also going to show that Sierra acted consistent with Mr. Eskew's health insurance contract and prevailing industry standards. It's also going to show you that Sierra's process to evaluate the medical necessity of a requested medical procedure is not arbitrary, it's not part of a rigged system, but rather, it's important.

And as I mentioned earlier, Dr. Ahmad is an oncologist. At the time of his review of the proton beam therapy request, he had been practicing medicine for decades. He's well-versed in treating cancer. He's qualified to evaluate oncology-related matters, such as a request, or the medical necessity for radiation treatment. And when this particular proton beam therapy request came to him, he reviewed all the clinical records provided by MD Anderson.

There was nothing he couldn't understand. There was nothing outside of his realm of experience and training. He there relied on that experience, his training, his knowledge, and his review of the information that he had received, along with the proton beam therapy policy, which incidentally is an established set -- of criteria that applied equally to everyone, as you will see.

And he relied on all of that to conclude that the policy should govern and that the specifically requested treatment was not covered based on the provisions of Mr. Eskew's health insurance contract. That contract, as Mr. Sharp correctly point out, also known as an agreement of coverage, laid out the terms and conditions of Mr. Eskew's coverage.

And that contract specifically stated that for a treatment to qualify as a covered service, it must be medically necessary, as defined by the contract.

Under that contract, once a request for prior authorization for proton beam therapy was made, Dr. Ahmad indeed had the discretion to make the determination as to whether or not it was medically necessary for Mr. Eskew's specific case based on certain objective criteria. And Dr. Ahmad, ladies and gentlemen, acted consistent with the terms of that contract, regardless of how much he was getting paid.

Now, the evidence is also going to show you, Ladies and Gentlemen, that Dr. Ahmad acted consistent with the standards for the insurance industry, which as you've heard is called utilization management. Now, utilization -- management is not an evil, but rather, it's an approach where the managed care program helps to provide health care in a medically appropriate and cost-effective manner. And it's why all treatments must be determined to be medically necessary.

Again, Plaintiff's Counsel wants you to think that utilization management is unfair, and that it exists solely to put profits above people, profits ahead of patient care. But that's simply not the case. It translates to efficient health care. And efficient health care is important for everyone. It's important because the cost of health care per person, per patient in the United States is the highest in the world. And it's on the rise. And while it may be counterintuitive to all of you as you sit here now, we anticipate that you will learn that insurance companies and insurers are actually in the best position to try and combat that issue, to

keep healthcare costs manageable for all of us.

Also, ladies and gentlemen, the evidence is going to show you that Mr. Eskew's subsequently developed esophagitis had apparently resolved well before the time of his death. The medical records and science do not support the conclusion that Mr. Eskew developed esophagitis solely due to the use of IMRT as opposed to proton beam therapy. Nor do they support the conclusion that he had to go to the hospital several times before he died, based on him being unable to swallow due to esophagitis.

In fact, we believe the evidence is going to show you that Mr. Eskew would have developed esophagitis regardless of what particular type of radiation treatment he used, and that's because he was receiving chemotherapy at the same time.

The evidence is not going to support the conclusion that esophagitis rendered Mr. Eskew unable to swallow food throughout the remainder of his life, and that it caused him unnecessary pain and suffering. We anticipate that you will indeed hear evidence about how much weight Mr. Eskew lost after he received IMRT. But as you will see, that weight loss was not solely tied to Mr. Eskew's bout with esophagitis.

Rather, the evidence is going to show you that between August 2016 and his death in March 2017, Mr. Eskew would lose weight on several occasions, but up until the end of his life, he put that weight back on. And, the evidence is going to show you that the weight loss during that period was almost always connected to another issue that had nothing to do with esophagitis. He wasn't even receiving any

treatment for esophagitis after those initial -- few months following his IMRT therapy.

Now, at the end of his life, yes, he lost a significant amount of weight, and he probably was in pain. But, unfortunately, that's the reality of late stage terminal cancer. You lose weight, you waste away, and it's typically not a peaceful and a serene death. And if any of you have seen someone dying of cancer, you know that.

Now, one point during Mr. Sharp's presentation, he put up a slide about how Medicare approves proton beam therapy, and the federal government approves proton beam therapy. That's a little bit misleading for a couple of reasons. Because, number one, again, it's not our position that proton beam therapy is never appropriate, or that it's never medically necessary. The question here is was it appropriate and was it medically -- necessary with regards to this particular case which involved stage four lung cancer.

Additionally, while Medicare may sanction proton beam therapy, it stands to be pointed out that the government at this point is actually trying to reduce healthcare costs. But they're currently required to cover any treatment that does not cause harm. And that's why Medicare has approved or covered proton beam therapy indiscriminately in the past. But the standard that applied to Sierra, the standard that's relevant for the purposes of your decision, is not the same as the standard that applies for Medicare's approval of proton beam therapy in any particular situation.

So, that brings me to my next point. You're going to hear

from some experts on behalf of the Defense. And throughout the course of their expert testimony, we anticipate that you're going to learn that Mr. Eskew's diagnosis was dire.

You're going to learn that the use of IMRT instead of PBT did not cause Mr. Eskew's side effects. You're going to learn that the procedures Sierra used in evaluating the proton beam therapy request comported with insurance industry standards, and therefore, it was not capricious or arbitrary. And you're going to learn that it's entirely common for insurance companies to use medical policies like the one at issue here to guide coverage determinations because they improve consistency, and they promote efficiency.

You're also going to learn that it's entirely common for insurers to use medical directors to review treatments for medical necessity, and that the particular medical director does not have to be an exact specialty match, but can be someone qualified to evaluate the patient's condition and medical records, much like what Dr. Ahmad did here. You're also going to learn that Dr. Ahmad was appropriately qualified to evaluate this particular request, regardless of whether he was an oncologist or a radiation oncologist. You're also going to learn that it's entirely common for insurers to use an administrative team, as Mr. Sharp pointed out, a team of desk clerks. They're more qualified than that, folks.

But it's entirely appropriate for an insurer to use an administrative team to improve efficiency and consistency like what was done here with the intake nurse and the person who wrote the denial

letter. And you're going to learn importantly all the reasons why efficient healthcare and utilization management is a good thing.

Now, folks, at the end of this trial, after you hear the testimony of experts from both sides and the law that's applicable to this case as told to you by the Judge, we believe the evidence will have clearly shown you that proton beam therapy had not been proven superior to IMRT at the time when Sierra made its decision.

But even if you only determine that there is a legitimate good-faith debate as to the propriety of using proton beam therapy versus IMRT for treating Mr. Eskew's lung cancer, then Dr. Ahmad's decision is not unreasonable even if you decide in hindsight that Mr. Eskew should have received proton beam therapy.

And that's because, as you will learn after the Judge's instruction, it's perfectly okay in this case for the experts or even all of you to disagree about the appropriateness of proton beam therapy in Mr. Eskew's specific case, so long as that disagreement is not patently unreasonable.

Now, folks, the Plaintiff has sued my client alleging that they breached the implied covenant of good faith and fair dealing. So, in other words, Plaintiff is alleging that Sierra acted in bad faith with regards to Mr. Eskew. And Plaintiff is going to want you to give her a lot of money based on that alleged breach and the alleged pain and suffering and the stress that Mr. Eskew experienced as a result of that alleged breach. Despite the fact, again, that there is no allegation here that that alleged breach caused Mr. Eskew's death. So, let me briefly

discuss with you, remind you of what the Plaintiff must prove to prevail in this case.

Let me say that again. What the Plaintiff must prove, because my client doesn't have to prove anything. We could sit there at the table, present absolutely no witnesses or testimony, and the burden of proof is entirely on the Plaintiff to prove that my client did something wrong under the law, and that that wrong was the cause of Mr. Eskew's damages.

Plaintiffs are going to have to show that Dr. Ahmad wrongfully concluded, wrongfully, meaning, against the law, or against the covenant of bad faith. Not wrongly, right. It doesn't matter whether it's correct or incorrect. They have to show that it was a wrongful decision, that the requested proton beam therapy was an improvement and not medically necessary.

They're going to have to show that Dr. Ahmad had no reasonable basis for denying the request for proton beam therapy. And, furthermore, that he knew or recklessly disregarded the fact that there was no basis for denying the proton beam therapy request. And that his conduct was a legal cause of harm to Mr. Eskew. And, additionally, in terms of damages, that that harm should be compensated in a manner and to the amount of money that Plaintiff's Counsel is going to ask for.

So, importantly, folks, it's not enough for Plaintiff to show simply that in hindsight, Dr. Ahmad acted unreasonably. Plaintiff must also show that Dr. Ahmad knew or recklessly disregarded the fact that he was acting unreasonably. And simply put, folks, Plaintiff is not going to

be able to meet her burden to show that.

Even assuming, however, that the Plaintiff can show in hindsight that proton beam therapy was somehow superior to IMRT in Mr. Eskew's specific case, there is going to be zero evidence that Dr. Ahmad knew that his denial was unreasonable, and that he disregarded that knowledge and denied the proton beam therapy request anyway.

And it's our position that even if you somehow get to damages in this case, any such damages must necessarily and appropriately be tempered by the fact that any amount of pain and suffering and emotional distress attributable to Sierra should also be evaluated in the context of the natural circumstances and Mr. Eskew having stage four metastatic lung cancer.

Now, as I've said at the beginning, folks, and throughout, this case is about the reasonableness of Dr. Ahmad's decision to deny the requested proton beam therapy. And reasonableness here means whether the decision was both subjectively and objectively reasonable, meaning, it was reasonable based on the information that Dr. Ahmad had at the time, and reviewed, and that it was reasonable based on the totality of the circumstances, as you determine them to be after hearing all of the evidence.

As I alluded to earlier, we anticipate that Plaintiff's Counsel is going to attempt to illustrate to you some mistakes that may have been made, or errors made in regard -- regarding the procedure used to memorialize and/or communicate the denial of the proton beam therapy

request. But hearing that doesn't matter, because as you will learn, an insurer's honest mistake, bad judgment, or even negligence, is not enough for a finding of bad faith, so long as the insurer had a reasonable basis to take the position that it did.

Simply put, folks, bad faith requires a level of culpability that simply is not present here. And that's why the evidence is not going to support you finding in favor of Plaintiff.

Now, we trust that after you hear all the evidence, and as you hear the evidence, you are going to focus on what's important, the reasonableness of Dr. Ahmad's decision under the totality of the circumstances to decide against approving the requested proton beam therapy for Mr. Eskew. And it was indeed a reasonable decision, regardless of how it was arrived at, how it was communicated, or how it was documented. And that's why at the end of this trial, my partner, Mr. Roberts, is going to ask you to find that the Plaintiff did not meet their burden and to return a verdict in favor of my client.

Thank you.

THE COURT: Thank you.

Counsel, will you approach?

[Sidebar at 11:53 a.m., ending at 11:53 a.m., not recorded]

THE COURT: Ladies and gentlemen, due to witness availability, we're going to take our lunch break right now, and return at one o'clock.

You are instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You are not to

read, watch, or listen to any report of or commentary on the trial by any person connected with the case, or by any media of information including without limitation, newspapers, television, internet or radio. You are not to conduct any research on your own relating to this case such as consulting dictionaries, using the internet, or using reference materials.

Do not conduct any investigation, test any theory of the case, recreate any aspect of the case, or in any other way investigate on or about the case on your own. You're not to talk with others, text others, tweet others, Google issues, or conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney involved in this case. You're not to form or express any opinion on any subject connected with this trial until it is finally submitted to you.

So, be back at one o'clock. With that, you're dismissed.

Thank you.

THE MARSHAL: All rise of the jury. Leave all your note pads.

[Jury out at 11:54 a.m.]

THE COURT: So, we'll come back at 1:00?

MR. SHARP: Yes. Thank you, Your Honor.

THE COURT: Thank you.

[Recess taken from 11:55 a.m. to 1:00 p.m.]

THE MARSHAL: Come to order. Back on the record.

THE COURT: Good afternoon, counsel. Please be seated. Do we have our first witness?

MR. TERRY: Yes.

THE COURT: Are the parties ready for the jury?

MR. TERRY: Yes. Would --

MR. ROBERTS: Yes, Your Honor.

MR. TERRY: Would you like us to retrieve the witness now, Your Honor, or wait until the jury is seated?

THE COURT: Retrieve the witness now.

THE MARSHAL: Judge, are we all set?

THE COURT: Yes, Marshall. Thank you.

THE MARSHAL: Okay.

All rise for the jury.

[Jury in at 1:02 p.m.]

THE MARSHAL: All jurors present.

THE COURT: Thank you. Do the parties stipulate to the presence of the jury?

MR. TERRY: Yes, Judge.

MR. ROBERTS: Yes, Your Honor.

THE COURT: Thank you. Please be seated.

Plaintiff, will you call you first witness.

MR. TERRY: Plaintiff calls Dr. Shamoon Ahmad.

THE COURT: Dr. Ahmad, will you stand to be sworn by the Clerk.

THE CLERK: Would you please raise your right hand?

SHAMOON AHMAD, PLAINTIFFS' WITNESS, SWORN

THE CLERK: Please state and spell your first and last name

for the record.

THE WITNESS: Shamoon Ahmad, S-H-A-M-O-O-N A-H-M-A-D.

THE CLERK: Thank you. You may be seated.

MR. TERRY: May I proceed, Judge?

THE COURT: Yes.

MR. TERRY: Thank you.

DIRECT EXAMINATION

BY MR. TERRY:

Q Good morning, Doctor -- or good afternoon I guess, Dr Ahmad.

A Good afternoon.

Q My name is Doug Terry. I represent Sandra Eskew. You and I have met one time before. Do you recall that?

A Yes.

Q And we met in sort of odd circumstances like these because we were on a Zoom conference deposition, right?

A That's correct, yes.

Q Do you recall that? So this is a little bit like that because we've got a plexiglass barrier and you're wearing a mask and so you have an accent, I have an accent. Mine happens to be an Oklahoma accent, so I'll try my best to speak in a way that you can hear me and understand me, and I'll hope I can hear and understand you. If I miss you a little bit, please bear with me. It's a little bit acoustically challenging. Okay.

A I'll do that.
Q All right. Thank you. Dr. Ahmad, you have a long history of working with and for United Healthcare and Sierra Health and Life, correct?
A Yes.
Q In fact, you've been working with them for ten years or more?
A Approximately.
Q And you're aware that Sierra Health and Life is a subsidiary company of United Healthcare?
A Yes.
Q And there was a period of time during you experience with the company that you worked for one of its other subsidiaries called Optum?
A Yes, that's correct.
Q Okay. But as I understand, and correct me if I'm wrong, today you are working for United Healthcare?
A Yes, that's correct.
Q Okay. And as I understand it, since the summer of last year or so, you have been working as an appeal's medical director. Is that right?
A Yes, that's correct.
Q And you hold that position today as we sit here?
A Yes, I do.
Q Okay. Thank you. Let's talk about this term medical director

if we can, please. The fact is, Dr. Ahmad, that a medical director doesn't direct any other employees. Is that true?

A Yes, that's correct.

Q Okay. So I just -- I always thought that term was a little bit odd because you're not exactly directing others, you're a medical director which is what the health insurance industry refers to doctors who work for the industry, right?

A Yes.

Q Okay. Thank you. And you are a medical oncologist, right?

A Yes, that's correct.

Q And you do what has been referred to here already in the courthouse in this case as you do utilization management, right?

A Yes.

Q And you do that today for United Healthcare?

A Yes, that's correct.

Q So the appeals position that you're in now is part of the utilization management system, right?

A Right.

Q Okay. You're doing it now as a full-time employee of United Healthcare, right?

A Yes.

Q Back in -- there was a time where you did it -- you did this utilization management work for Sierra and United Healthcare as an independent contractor, right?

A Yes.

Q Okay. And you had a company set up for yourself to do that, right?

A Yes.

Q And it was called I think Physician and Legal Consultants or something like that?

A Yes.

Q And your entity, Physician and Legal Consultants, was really an entity that you were the only person in, right?

A Correct.

Q And your entity, Physicians and Legal Consultants, contracted with UHC?

A Yes.

Q But there was an intermediary in that contractual relationship called MBO, MBO, right?

A Yes.

Q So your company contracted with MBO, and MBO contracted with Sierra Health and Life or United Healthcare?

A Right.

Q Right. Okay. We'll come back to that in a minute. But let's talk for a second about utilization management, utilization management. I don't like saying that word over and over. Can we -- can we call it UM?

A Okay. Sure.

Q Do you sometimes refer to it as UM?

A Yes.

Q Okay. Utilization management, UM. Isn't it true, Dr. Ahmad,

that UM or utilization management is a system for insuring efficient healthcare?

A Efficient and appropriate healthcare, yes.

Q Efficient healthcare for policy holders of the insurance company is the goal, right?

A Yes.

Q All right. And efficient is another way of saying cost effective, right?

A I mean, it would include that as one of the options in there I suppose.

Q And cost effective is another way of saying less expensive?

A No.

Q No? Less expensive is another way of saying cheaper, right?

A I suppose you can use that term.

Q Okay. So isn't it true, Dr. Ahmad, that the utilization management or UM system at SHL and -- Sierra and UHC is designed to pay as little for the healthcare services that are provided to the policy holders as possible?

A No, that's not correct.

Q Okay. Is it designed to make sure that you pay the most you can?

A No.

Q So cost is a factor?

A Generally, quality and medical recommendations is what we do using UM.

Q That cost is a factor; isn't it?

A Maybe a factor.

Q Okay. So Dr. Ahmad, for a number of years, about ten or so years, you've been working in the utilization management operation of United Healthcare. And I just want to sort of ask a couple of questions of you to kind of put you in the context of the whole system.

Okay. So as a medical director back in -- let's take it back to 2016 when you were contracting with United Healthcare through your company, Physician and Legal Consultants. Back then you were doing reviews of individual claims that were made by policy holders for pre-authorization, right?

A Yes.

Q All right. And you were doing that -- that job in the system that others at United Healthcare had created?

A Yes.

Q You were not the architect or the creator of the -- of the utilization management system at United Healthcare; were you?

A I was not.

Q Somebody else did that?

A Probably.

Q Somebody way above your pay grade did that?

A Yes.

Q Somebody at the home office in Minnesota did that?

A I'm not sure who set up the system.

Q The -- whoever set up the system, whoever that might be,

even you don't know who they are, right?

A Correct.

Q Okay. So if a person working in the utilization management system, like yourself, doesn't know who those people are who created the system, then certainly no one could ever expect that somebody like Sandy Eskew could know who those people were either, right?

A I would assume so.

Q Okay. Do you know, Dr. Ahmad, as you sit here now, did the designers and the architects of the utilization management system at United Healthcare put that system in place taking into account lowering costs?

A I don't know.

Q So let's talk about your role in the utilization management system, okay. So let's kind of talk about you for a second, then we'll talk about that. So as I understand it, Dr. Ahmad, back in 2016 and the years prior, you were a medical oncologist here in Las Vegas?

A Yes.

Q And you had a medical oncology practice here in Las Vegas for a period of years?

A Right. That's correct.

Q And when did you start working full time for Optum or UHC?

A 2018.

Q Okay. And so up until 2018, you had a medical oncology practice here in Las Vegas?

A Part time in the last few years, yes.

Q Part time in the last few years you say?
A Yes.
Q Okay. Now, in addition -- well, let me back up. The patients that you see in a medical oncology practice are cancer patients, right?
A Yes, that's correct.
Q Your patients have cancer, and they come to you for treatment for cancer, right?
A Yes.
Q Now, you're a medical oncologist and not a radiation oncologist, right?
A Yes --
Q So --
A -- correct.
A So your practice where you would actually see patients and treat them was a medical oncology practice not a radiation oncology practice, right?
A Correct. That's correct.
Q And so -- we'll come back to that in a minute too. So in addition to your work seeing patients, it's my understanding that you were on the side -- and I don't say that being -- to be dismissive, but in addition to, let's put it that way, in addition to your medical oncology practice, you were also doing utilization management reviews for United Healthcare or Sierra, right?
A Yes.
Q Okay. So that was in addition to your medical practice?

A Right.
Q Okay. So I just want to ask you, why? Why were you doing that?
A Well, I like to participate in the healthcare system since I am a utilizer of it.
Q I'm sorry, you're a utilizer?
A Meaning, yes, I use the healthcare system. So in my mind it's a good idea to be part of the systems here and to understand it better.
Q Okay. So you enjoy your work as a utilization management reviewer?
A Yes, I do.
Q All right. When you're a utilization management reviewer as a doctor, do you ever see utilization management patients?
A Can you ask that question again?
Q Let me try -- let me do a better job. As a utilization management doctor, you never see the patients who are asking for treatment from the insurance company, right?
A Correct, yes.
Q You review their cases from -- removed from the actual clinic where those people have been seen by a doctor for their cancer problem?
A Correct, yes.
Q And the way that you do your reviews, if I understand it, is that you look at the documentation, whatever that might be, and we'll

talk about some in a moment as well, whatever documentation you look at, you look at it on the computer?

A Yes, correct.

Q So you're able to sit at a computer, pull up somebody's request for coverage, review whatever it is that you need to review, make your decision, transmit your decision electronically, and then move onto the next one, right?

A Yes.

Q Okay. So as a utilization management reviewer, do you think as a doctor that you are helping people?

A Yes. One of the goals of the UM is to ensure quality --

Q Okay.

A -- in proper use of services.

Q So people like Mr. Eskew, who we're here to talk about today, who have trained physicians who make requests for coverage to Sierra or UHC who have those requests reviewed by you as a utilization management doctor whose claims you denied, like Mr. Eskew's, do you think you help those people?

MR. ROBERTS: Objection. Compound.

THE COURT: Sustained.

MR. TERRY: I'm sorry, Your Honor, I didn't hear.

THE COURT: Sustained.

MR. TERRY: Thank you.

BY MR. TERRY:

Q Let me ask you it this way. Do you think, Dr. Ahmad, that

you helped Sandy Eskew's husband, Bill, by denying his claim for proton therapy?

A The way I look at it is that as a UM reviewer, I'm trying to ensure that proper and quality services are provided and approved.

Q Do you think that you helped Bill Eskew by denying his proton therapy claim?

MR. ROBERTS: Objection. Argumentative and irrelevant.

THE COURT: Sustained.

BY MR. TERRY:

Q As a utilization management reviewer, do you ever meet with the patient and their family for any reason?

A For cases that I would review?

Q As a part of the utilization management review?

A No, I do not.

Q As a utilization management reviewer, Dr. Ahmad, do you ever have to look a patient and a family in the eye and say I'm denying that treatment?

A No.

Q You do it from behind a computer, right?

A Yes.

Q Now, let's go back to we talked earlier about your work when you with United Healthcare back in 2016 when you were contracted through MBO. Remember the MBO? And so it's my understanding, tell me if I'm wrong, that you billed your time by the hour, right?

A Yes.

Q So whatever amount of time you spent, you would right down something to indicated how many hours that was, right?

A On a daily basis, yes.

Q And then you would -- you would submit that time in some fashion to MBO, right?

A Correct.

Q And then MBO would take your time and send it to United Healthcare in some bill form, right?

A I would assume, yes.

Q So then that way United Healthcare would know what amount to pay you for the work that you had done in a given period of time, right?

A Correct.

Q Okay. And the amount of time -- or I'm sorry, the amount of money that you were charging per hour was $205, right?

A That's my recollection, yes.

Q And there are printed bills that are from MBO to United Health Group that are for your time, right?

A I would assume, yes.

Q So how did you get -- how did you come to the $200 an hour amount?

A I supposed it was just a number that we agreed upon when I signed up.

Q So that was a negotiated amount?

A Perhaps.

Q So I'd like to show you an example of a bill that you would have -- MBO would have sent to United Health Group on your behalf.

MR. TERRY: And so, Counsel, it's Exhibit 7. I don't think there's an objection to Exhibit 7.

MR. ROBERTS: No objection.

MR. TERRY: Your Honor, may I display Exhibit 7 to the witness?

THE COURT: Yes.

MR. TERRY: Thank you. Jason, would you pull up Exhibit 7, please.

BY MR. TERRY:

Q I think you can see that there, Dr. Ahmad.

MR. TERRY: If you prefer to have a paper copy in your hand, Your Honor, there's some books behind the -- I pulled out the books that might contain the ones that he would -- he would need.

BY MR. TERRY:

Q So Dr. Ahmad, if you'd rather have a paper copy in your hands, I can help you find them behind you in that book. Is this sufficient for you to see it on the screen, Doctor?

THE COURT: Marshall --

THE WITNESS: I'll see if I can magnify this some.

THE COURT: One of -- one of the jurors has their hand raised.

THE WITNESS: I think I can make it bigger like this.

THE MARSHAL: Yeah.

UNIDENTIFIED JUROR: I don't know if this important for us to see or not, but I can't see that up on the screen.

THE COURT: Yeah.

MR. TERRY: We're going -- we're going to zoom in on it.

UNIDENTIFIED SPEAKER: Yeah.

THE COURT: Counsel, you have to make that larger for the jury and for the witness.

MR. TERRY: Yes. Yes, Your Honor.

BY MR. TERRY:

Q Dr. Ahmad, what we're showing you is Exhibit 7 in the case. And you can see at the top of it, it says MBO Partners, Inc. Do you see that?

A Yes.

Q And then there's a date on the invoice in the top right corner of 3/29/16. Do you see that?

A Yes.

Q Okay. And if you look --

MR. TERRY: Jason, could you scroll up a little bit? Just a little.

BY MR. TERRY:

Q Okay. So the body of the bill there, Dr. Ahmad, do you see where it says, "professional fee"?

A Yes.

Q And then under that professional fee language, is a table there that shows entries for different dates?

A Yes.

Q And the dates on this particular bill, Exhibit 7, are February 1, February 2, February 3, February 4, and February 5, that week of the year 2016. Do you see that?

A Yes.

Q Okay. So if you look --

MR. TERRY: Jason, can we go up a little bit and toward the -- up here? Blow that up, please.

BY MR. TERRY:

Q Okay. So you see here, Dr. Ahmad, up in the top left corner of the bill it says, "Bill to United Health Group in Minnetonka, Minnesota"?

A Yes.

Q You see that?

A I do.

Q And then it says, "Description" --

MR. TERRY: Highlight this for me, Jason.

BY MR. TERRY:

Q "Description employer and individual oncology services review program." Do you see that?

A Yes.

Q That's the program you were working in?

A I suppose that's the name that they had for it.

Q So all of the reviews that you did were oncology reviews?

A Correct.

Q Therefore, all of the reviews that you did for United Healthcare were for cancer patients?

A Well, in addition to that, these were -- I mean, I'm a hematologist as like a blood specialist, so the two things go together. So there's a lot of non-cancer blood diseases that I was reviewing for also.

Q Can you look at this bill --

MR. TERRY: And Jason, pull back to the body of the bill, please.

BY MR. TERRY:

Q Can you look at the bill portion of this bill, Dr. Ahmad, right under the professional fee language and tell us by looking at this bill if there were cancer cases or hematology cases or anything else by looking at the bill?

A No, I cannot tell.

Q Okay. So let's take a look at just sort of how this bill is set up.

MR. TERRY: So pull that back up again, Jason, please.

BY MR. TERRY:

Q So if we look here, let's look at February 1st of 2016. Do you see that?

A Yes.

Q Okay. On February 1st of 2016, it says right there --

MR. TERRY: Can you highlight this, Jason?

BY MR. TERRY:

Q -- 11 cases. Do you see that?

A Yes, I do.
Q So on February 1st of 2016, you reviewed 11 cases?
A Correct, yes.
Q Okay. And we don't know from looking at the bill, do we, how many hours you spent on February 1st of 2016 reviewing those 11 cases; do we?
A Correct, yes.
Q Okay. And the same is true -- you can ask -- I could ask you the same series of questions about the second, the third, the fourth, and the fifth and we can't look and see how many hours you spent on any one of those days, right?
A Correct.
Q And there's no record here to indicate what claims you looked at?
A Correct.
Q But we could go, if we wanted to, at tally up the number of cases from each of those days and come up with a total for the whole week?
A Yes.
Q Okay. And then right over here under the next column, it says "quantity"?
A Yes.
Q And that shows the total number of hours you spent on all the cases listed over here for that week?
A Correct.

Q So for that week, you spent 16.5 hours.

MR. TERRY: Highlight that, please, Jason.

BY MR. TERRY:

Q 16.5 hours, right?

A Yes.

Q And you charge at $205 an hour, right?

A Correct.

Q MBO got $5 of that as a service charge, right?

A Right. Yes.

Q And then -- so you take 16 1/2 times 205 and you get $3,382.50 for that week, right?

A Yes.

Q And so the total of invoice amount due is that amount 3382.50 and UHC is to pay that -- or United Health Group is to pay that to MBO, and then the money makes it way to you, right?

A Yes.

Q Okay. We'll come back to this in a little. Just want to kind of understand the way you did. So the utilization management system that you worked in, Dr. Ahmad, you had a -- you had a supervisor, right?

A I'm not sure what that --

Q Okay. Did anyone at UHC or Sierra review your work or supervise you in any way?

A There were other medical directors and physicians locally, yes.

Q Did you report to anyone about -- who was your report to?

A There was a chief medical officer. I suppose I would have reported to him; but as such, I do not report to anyone in particular.

Q So you weren't reporting to anyone in particular?

A I mean, not one person but several. I mean, if that's what you're asking.

Q Well, I think I heard you say that you would report to the chief medical officer of the whole company ultimately, right?

A I would assume as a consultant, yes.

Q But like on a regular basis did you ever have to tell your supervisor how things were going or did your supervisor ever come ask you how you were doing or anything like that?

A Yeah. We used to interact regularly with various people.

Q So who's your supervisor back then?

A Did not have one person that I could call that.

Q Have you ever heard of a lady named Shelean Sweet?

A She was as far as I can recollect one of the managers, I think.

Q She was one of the managers at the company?

A I believe so.

Q Of some kind?

A Yes.

Q Do you know what she managed?

A She was part of the UM program at least as far as I know.

Q The UM program you said?

A Yes.

Q Okay. Did you have any supervisory interaction with Ms.

Sweet where she would supervise or review any of your work?

A I cannot say if she did or did not.

Q Did anybody at United Healthcare or Sierra ever review the work you were doing?

A I would imagine, yes.

Q You don't know that for sure?

A I mean, the work that I did went to one or several of them. So somebody was looking at those cases and the decisions if that's what you're asking.

Q Somebody was looking at the cases and decisions that you were making?

A I mean, I -- yes, I would think so.

Q You would think so, but you don't know for sure?

A Correct.

Q Okay. So as you know, Dr. Ahmad, this case involves a prior authorization claim that was denied by you. You understand that, right?

A Yes.

Q And it's true to say, isn't it, that you, Shamoon Ahmad, are the person that made the decision on behalf of the insurance company to deny Mr. Eskew's prior authorization claim?

A Yes.

Q And you did that as part of the utilization management system, true?

A Yes.

Q And you did it the way in which you were taught to do it?

A To the extent that I knew what the general -- the way the system worked, yes.

Q Okay. So you knew the way the system worked and the way that you handled Bill Eskew's claim was just exactly the way the system dictated that you do your work, right?

A I wouldn't call it dictate, but it was kind of in the general rules.

Q So the way you did the review of Mr. Eskew's claim is consistent with the way you reviewed utilization management claims for United Healthcare, right?

A Yes.

Q Nothing different or stand out about it as compared to the others that you looked at?

A I would say correct.

Q Okay. Now, Dr. Ahmad, do you understand what an insurance contract is?

A The -- a policy that the order or the member has.

Q Okay. So --

MR. TERRY: Jason, would you pull up Exhibit 4, please? Oh, that -- that -- this is the one that's been -- no objection, right?

MR. ROBERTS: No, no objection.

BY MR. TERRY:

Q So Dr. Ahmad, I don't know if you can --

MR. TERRY: Can you blow that up some, Jason, so we can see some of the word? Yeah, like right there if you could.

BY MR. TERRY:

Q So can you see that, Dr. Ahmad? It says, "plan benefit information."

A Yes.

MR. TERRY: Now, reduce that, Jason, if you would and go to the next page. I'll tell you what, let me find the page that I want you to go to. It's the cover page of the actual document. A lot of pages. Here it is. Pull up page SHL-2619, Jason, please.

MR. ROBERTS: What's at the bottom? What's the bottom number?

MR. TERRY: I'm sorry?

MR. ROBERTS: What's the bottom number?

MR. TERRY: SHL-2619.

MR. ROBERTS: Okay.

MR. TERRY: There we go.

BY MR. TERRY:

Q Dr. Ahmad, do you see that?

MR. TERRY: Jason, blow this part up here, please.

THE WITNESS: Yes, I can see that.

BY MR. TERRY:

Q So this is -- this says "agreement of coverage" there?

A Yes.

Q Okay. So this packet of documents here is the insurance policy. Do you understand that?

A Yes.

Q Okay. So you'd agree, wouldn't you, that whether a claim is covered or not covered is governed by this document?

A I would imagine, yes.

Q Because whatever agreement there is between the insurance company and the policy holder about what the insurance company is going to pay for is in here, right?

A Yes.

Q Okay. And you understand, don't you, Dr. Ahmad, after having worked in the insurance industry as long as you have, that implied in this contract is a duty of good faith and fair dealing?

A Yes.

MR. ROBERTS: Objection. Calls for a legal conclusion.

THE COURT: Overruled.

BY MR. TERRY:

Q Now, you'd agree with me, wouldn't you, Dr. Ahmad, that in order to be in good faith, you have to be fair in your decision and not be influenced by other things?

A Correct.

MR. ROBERTS: Objection. Compound.

THE COURT: Overruled.

BY MR. TERRY:

Q Would you agree with that, Dr. Ahmad?

A Yes.

Q And the other things that you don't want to be influenced by are things like bias?

A I'm not sure I understand where bias is in this.

Q Okay. Well, when you made the decision on Bill Eskew's claim, you had been working at United Healthcare making money off of that part, right?

A I got paid for the work I did, yes.

Q Right. And so at the time you made that decision, you had a financial interest in keeping your relationship with United Healthcare happy?

A I would not characterize my work as such.

Q Okay. But what we do know is that there was money flowing from UHC and Sierra to Shamoon Ahmad, right?

A Like I said before, I was getting paid for the work I was doing for them.

Q In fact, the relationship that you've had with United Healthcare has been financially good for you; hasn't it?

A To the extent of what I got paid through them for that service, yes.

Q Okay. In fact, Dr. Ahmad, isn't it true that between 2015 and 2019 you earned almost $800,000 doing work for United Healthcare?

A I do not know that.

Q Let me --

MR. TERRY: Your Honor, may I confer with Mr. Roberts real quick?

THE COURT: Of course.

[Counsel confer]

BY MR. TERRY:

Q Dr. Ahmad, let me show you --

MR. TERRY: Don't put this up yet.

BY MR. TERRY:

Q Let me show you Exhibit 54.

MR. TERRY: Can you show it just right here, Jason? No.

May I approach, Your Honor?

THE COURT: Yes.

BY MR. TERRY:

Q Dr. Ahmad, I'm going to get in your space here. You should be able to find Exhibit 54 behind that tab. And I'm looking at the first page. Do you have it?

A Yes.

Q So Dr. Ahmad, this is a document that was produced to us in the discovery of this lawsuit by the lawyers for United Healthcare and SHL. And you see that there it indicates how much money you made between 2015 and 2019, correct?

A Yes.

Q And how much is that?

A The total?

Q Yes, the total, please.

A 791,494 and some change.

MR. TERRY: Your Honor, we move the admission of Exhibit 54?

THE COURT: Any objection?

MR. ROBERTS: No objection, Your Honor.

THE COURT: Exhibit 54 will be admitted into evidence.

[Plaintiffs' Exhibit 54 admitted into evidence]

MR. TERRY: Your Honor, before I forget, I would like to move admission of Exhibit 4 which I don't think there's any objection to.

MR. ROBERTS: No objection, Your Honor.

THE COURT: Exhibit 4 will be admitted into evidence.

[Plaintiffs' Exhibit 4 admitted into evidence]

MR. TERRY: And Exhibit 7, Your Honor.

THE COURT: Any objection, Mr. Roberts?

MR. ROBERTS: No objection, Your Honor.

THE COURT: Exhibit 7 will be admitted into evidence.

[Plaintiffs' Exhibit 7 admitted into evidence]

MR. TERRY: Sorry to get things out of order, Judge.

THE COURT: That's okay.

BY MR. TERRY:

Q Okay. So I guess what I'm getting to, Dr. Ahmad, is you're making decisions on utilization management claims for United Healthcare including the one for Bill Eskew for proton therapy for lung cancer at a time when you have a financial relationship with the company, right?

A Yes.

Q Do you think that United Healthcare would have been okay with it if Bill Eskew had come to the table with his claim with a doctor who was his brother-in-law saying that he needed proton therapy?

A Repeat that again. I'm sorry.

Q Do you think that UHC would have had a problem with it if Dr. -- or if Mr. Eskew brought his brother-in-law who was a doctor to the table saying proton therapy is warranted?

MR. ROBERTS: Objection. Improper hypothetical.

THE COURT: Sustained.

BY MR. TERRY:

Q So let's talk, Dr. Ahmad, about what you brought to the table when you were assigned to review Mr. Eskew's claim for proton therapy, okay. So you told us you were a medical oncologist and not a radiation oncologist. So is it fair to say that you are not trained and educated as a radiation oncologist?

A Correct.

Q And you're not an expert in radiation oncology; are you?

A Correct.

Q You're not board certified as a radiation oncologist?

A I'm not.

Q You don't hold yourself out as a radiation oncologist?

A Correct.

Q You don't see patients as a radiation oncologist?

A Right.

Q In fact, you've never treated anybody with radiation, not one person. Isn't that true?

A I have not treated, but I've participated in the care of my patients that receive radiation.

Q Sure. Because the way it works, isn't it -- Dr. Ahmad, is there -- there are -- cancer doctors work in different areas of cancer treatment, right?

A Yes.

Q So a medical oncologist, generally speaking, would be -- would oversee a patient's chemotherapy, medical oncology, medication, right?

A That in addition to the overall care of the patient.

Q Okay. And then a surgical oncologist is a doctor who does surgery to cut cancerous tissue out of a person's body, right?

A Yes.

Q And then a radiation oncologist, on the other hand, is a -- an oncologist who shoots radiation beams into a person's body and hits cancer and hopefully kills it, right?

A Yes.

Q Okay. So you would never attempt, would you, Dr. Ahmad, to go to a surgical oncologist and say hey, I don't think you should use that scalpel, or I don't think you should use that scope, I think you should use this other one; would you?

A No, I would not.

Q Okay. And then likewise, you would never expect a surgical oncologist to come to your clinic and say hey, Dr. Ahmad, don't prescribe that drug for chemotherapy in that dose, prescribe a different one in a different dose; would you?

A I would expect not to.

Q Right. You'd throw the surgical oncologist out on his ear if he tried that; wouldn't you?

A I don't want to speculate what might happen.

Q You wouldn't appreciate it any; would you?

A Yes, correct.

Q Likewise, you would never attempt to try to tell a radiation oncologist what kind of radiation to use to treat a patient's cancer; would you?

A As a clinician, talking of clinical management, I would not.

Q Okay. So in other words, you would never go to a radiation oncology doctor and say hey, wait, wait, wait, wait, don't do proton therapy, I think you should do 3-D conformal radiation therapy or IRMT; would you?

A I would not tell them, you know, what treatment they should consider.

Q Because you don't possess the medical education, experience, and training to do so, correct?

A Correct. As a clinician, I don't.

Q So let me ask you a little bit here. I'm starting to get my stuff scattered everywhere. I want to ask you if you're familiar with a couple of things. If you're familiar with a couple of things. Have you ever heard of a concept called ALARA? A-L-A-R-A.

A I have not.

Q I'm going to switch over to this overhead projector because I've written that down and want to jury to have it in their head here,

Doctor.

UNIDENTIFIED SPEAKER: You've got to turn it on the side there.

MR. TERRY: Thank you, is that good to go?

UNIDENTIFIED SPEAKER: It should be in just a second.

[Pause]

BY MR. TERRY:

Q Doctor, while that happens, while we wait on the technology to boot up, let me ask you a related question then we can jump to that.

Have you heard of a concept called therapeutic ratio?

A I'm not sure what that term exactly means, but seems to sound relative to the dose delivered.

Q Related to what? I'm sorry, Doctor.

A Related to the amount of radiation that is administered.

Q Well, let's do this without, so we don't have to delay.

MR. TERRY: Sorry, Your Honor.

BY MR. TERRY:

Q So Dr. Ahmad, I said the word, the acronym ALARA, A-L-A-R-A, you said you had not heard of it?

A Correct.

Q It stands for a fundamental principle of radiation oncology, which I assume you are not familiar with, right?

A Depends on what it stands for. So --

Q It stands for As Low As Reasonably Achievable. You've heard of it?

A I'm familiar with that general concept.
Q Let me put this up here, so -- As Low As Reasonably Achievable. You see that, Doctor?
A Yes.
Q Do you know how that applies in radiation oncology work?
A In general terms, yes.
Q Now, isn't it true that the principle of As Low As Reasonably Achievable means that you want to keep radiation dose to healthy tissues as low as reasonably achievable?
A Yes.
Q Now, if you're radiating someone, as a cancer patient, providing radiation to them, there's no way that you can keep the radiation dose to healthy tissues at zero, is there?
A Probably not.
Q But different radiation modalities, like protons IMRT, 3D conformal, different modalities have different utility when it comes to as low as reasonably achievable, right?
A Yes.
Q So IMRT is better at as low as reasonably achievable than the previous iteration 3D, right?
A Right, but the intensity of the does is not necessarily corelating with the treatment outcome expected. So yes, generally speaking the lower the dose the better, but it then has to be whether or not that difference is clinically significant.
Q If you have two treatment options one of them is X and one

of them is Y, and X has a lower dose to healthy tissues, and Y has a higher dose to healthy tissues then the one that has lower dose, X, is more compliant with the concept of ALARA, right?

A Yes.

Q All right. And you'd agree with me, too, wouldn't you, that there's no such thing as a safe dose of radiation?

A Across the three modalities you mentioned, correct.

Q Now, I'll ask you about another thing. I said this a moment ago. Therapeutic ratio. You said you didn't know for sure what that meant, but it had something to do with radiation oncology, maybe, right?

A It can be applied in chemotherapy as well, but, yes, I suppose that's what you are saying.

Q So therapeutic ratio is important in radiation oncology, true?

A Yes.

Q And therapeutic ratio is defined as the difference between the amount of dose to the cancer on the one hand, versus the amount of dose to healthy tissues around the cancer on the other. The difference is the therapeutic ratio, right?

A Yes.

Q Okay. So what a radiation oncologist wants to do is to increase the therapeutic ratio, right?

A I would assume, yes.

Q So let's look at it like this. I developed a very high tech thing for you to look at here, Doctor, drawn by me, but I think it may work.

See on the left-hand axis of this little graph I made it says radiation dose.

A Yes.

Q And down here at the bottom it says tumor and healthy tissue.

A Yes.

Q So a higher radiation dose here and a lower radiation dose here, is a good thing, right?

A It depends on what you describe as a good thing. So yes, from the perspective of the dose, yes, lower dose is better. Clinically whether or not that is giving the result that you're looking for; I think is slightly separate from this.

Q Well, that's certainly something that a radiation oncologist would be able to tell us better than you, right?

A Yes.

Q All right. So let's try another radiation dose. Let's say that the radiation dose to the tumor and the radiation dose to the healthy tissue is about the same. That's a worse therapeutic ratio, isn't it?

A Again, I see -- yes.

Q So if you could achieve this therapeutic ratio and avoid a therapeutic ratio that was not as beneficial, then that's what you should do as a radiation oncologist, shouldn't you?

A No. I think it depends on what the use of the differences have shown in clinical trials to show that the dose equals or is reflected in the outcome at the end of it. But that's the ultimate goal that we're trying to achieve, right?

Q Okay. So you would treat a clinical trial instead of a patient?
A I'm sorry?
Q You would treat a clinical trial instead of a patient?
A No. But we gather information from clinical trials.
Q Well, doctors don't treat papers, they treat patients, right?
A True.
Q Okay. So all things being equal, these two therapeutic ratios, the higher and the lower, the higher and the lower, the higher's better, right?
A Yes.
Q All right. And your equivocation about it is well, it may not make any difference, right?
A I mean, not my personal opinion, but it's what the clinical studies show.
Q Do you know how the radiation oncology team at MD Anderson makes decisions about how to implement the basic concepts of radiation oncology, including ALARA and therapeutic ratio?
A No, I'm not familiar with their process.
Q Are you aware that they're highly cognizant of it and they pay close attention?
A yes.
Q And you understand that MD Anderson's one of the top rated, if not top rated cancer center in the whole world, correct?
A Yes.
Q And you have respect for that as an cancer center down in

Houston, right?

A I do.

Q And you understand, don't you, that the doctors that work there are top notch.

A Yes.

Q And before this case, had you ever heard of Dr. Zhongxing Liao?

A I have no idea.

Q Have you learned anything about her in the course of this case?

A From what I heard, I guess from you or others.

Q In your deposition you first learned?

A Yes.

Q And you understand that Dr. Liao is a world-renowned lung cancer radiation oncologist?

A That was described to me.

Q You don't have any reason to disagree with that statement, do you?

A I don't know.

Q Now, let's talk about what you know, your level of knowledge about proton therapy. It's true, isn't it that you have no experience providing proton therapy to anyone.

A Right.

Q And there's not a proton center in Las Vegas.

A There was not, as far as I know there's not.

Q There's not one in the State of Nevada as it stands today, is there?

A I don't know what the status is today.

Q There's some in southern California, though, you know about that.

A I would assume

Q And you understand that there are dozens of proton centers all over the world?

A I don't know how many there are anywhere.

Q But you know that MD Anderson has one, right?

A Yes.

Q You know that the Mayo Clinic has one.

A I don't know that.

Q You don't know anybody else who has one?

A Not specifically speaking, correct.

Q And I guess it goes without saying, but let me ask it. You've never worked in a proton center, right?

A I have not.

Q Never seen a proton machine.

A I have not.

Q You don't know how one works.

A I know the general principle of how protons are generated, but I don't know how precisely it works.

Q Let me ask you something quickly about proton therapy and the insurance policy real quickly.

MR. TERRY: So Jason, you pull up Exhibit 4, please. This is the insurance policy sold by the company to Mr. Eskew.

Dr. Ahmad, it's Exhibit 4.

And Jason, I'm sorry, I just have the Bates numbers SHL2629. Sorry, but I don't know the exhibit page number. I've gotten up here with one that doesn't have the exhibit page numbers.

UNIDENTIFIED SPEAKER: Looks like that's 19, 20, 22 at the bottom. See bottom left -- or right I mean.

MR. TERRY: 2629, Jason. So 20 more pages. Ten more. There you go. Thanks.

BY MR. TERRY:

Q Exhibit 4, page 43. And I want to focus on Paragraph 5.18, down there in the lower right-hand corner. Can you see that, Dr. Ahmad? I know it's kind of small print. There it's blown up. Do you see that?

A Yes.

Q Now, you and I can agree, can't we, that proton beam therapy is therapeutic radiation?

A Yes.

Q And if you look at this paragraph 5.18, which is under the section of the policy that defines covered services, you could see in this third bullet point therapeutic radiology services.

MR. TERRY: Can you highlight that, Jason? Thank you.

BY MR. TERRY:

Q You see that?

A Yes.

Q So looking just that far in the policy, you and I could agree to it, that proton beam therapy, because it's a therapeutic radiology service, is covered.

A Therapeutic radiology is, to my understanding, a treatment that's rendered or delivered by radiologist, not radiation oncologist. So it's not clear to me what that implies in the policy.

Q So are you here to say that proton beam therapy is not therapeutic radiology?

A I'm not familiar with that term precisely, because radiology is a radiologist; and radiation oncologist is radiation oncology. But it may be I don't know.

Q Well, do you remember, Dr. Ahmad, back -- we talked about it earlier, I took your deposition back in the summer of 2020 in July of 2020, remember that?

A Yes.

Q And there was a court reporter there, as there is in legal proceedings, tapping down every word?

A Yes.

Q And remember Mr. Roberts and Mr. Gormley, and some other -- you had a lawyer there, too, your own personal lawyer, you remember that?

A Yes.

Q And remember you raised your right hand and swore to tell the truth?

A Yes.
Q Just like you did here today?
A Yes.
Q All right. I want to show you, this is a copy of your --
MR. TERRY: May I approach, Your Honor?
THE COURT: Yes.
MR. TERRY: Jason 59, line 8.
BY MR. TERRY:
Q Dr. Ahmad, I'm going to direct you to page 58 -- I'm sorry, page 59 of your deposition. Oh, it's going to come up on your screen, too, if you like.
MR. TERRY: Jason, if you'd highlight page 59, line 8 through 15, please.
BY MR. TERRY:
Q So Dr. Ahmad, this is printed up in a book form with the Q up here being a question from me and the A down here being an answer from you. Do you use that?
A Yes.
Q The question is:
"Q Well, I mean what's different between what he just said and the statement I'm about to make? Proton beam therapy is a form of therapeutic radiology.
"A Okay. Generally speaking I would answer that it's a modality or it's the type of radiation that is used in therapeutic radiology."
Correct?

A Yes, I see that.

Q And it's also true, is it not, Dr. Ahmad, that 3D Conformal radiation and IMRT are also forms of therapeutic radiation?

A Therapeutic radiation, yes.

Q And Proton Beam therapy has been used to kill cancer in humans since the 1950s, did you know that?

A It's been around for a while, yes.

Q And the FDA approved devices that deliver Proton treatment to humans in the1980s, did you know that?

A Long time ago, yes.

Q Did you now that hundreds of thousands of patients have been successfully treated worldwide with Proton Beam therapy?

A I would assume that's correct, yes.

Q Did you understand that MD Anderson successfully treats patients with lung cancer with proton therapy on a regular basis?

A I'm not familiar with what they do.

Q Are you familiar with the fact that there are hundreds of published articles supporting the safe and effective use of proton therapy to kill cancer in human beings?

A Certain types of cancers, yes.

Q Do you have any opinion that proton therapy is a sham of some kind?

A No. Not [indiscernible].

Q Rip-off? A money grab? Anything like that?

A No.

Q You don't hold any opinion that the people who own proton beam centers are somehow grabbing money out of the system unfairly?

A I cannot speak to that.

Q You certainly didn't deny Bill Eskew's claim for proton therapy based on any belief like that, did you?

A No.

Q Okay. So we were talking, started off talking about what you brought to the table. You told us now sort of your medical background and what you know about proton therapy, correct?

A Yes.

Q Okay. Now, at the bottom, at the core of all of this, what you did in this case, Dr. Ahmad, is you denied an insurance claim, right?

A I made a medical management decision which was a denial, correct.

Q Right. And what you told Bill Eskew was that there was no coverage for proton therapy under his insurance policy, right?

A For the diagnosis of the services in question, yes.

Q Okay. So you told Mr. Eskew there was no coverage under his insurance policy for proton therapy, right?

A I'm not sure what coverage precisely means, but it was felt not to be medically necessary, which --

Q If I use the word coverage in this context you're not even sure what that means?

A No, I understand what coverage is.

Q Okay. What is coverage?

A Whether or not the requested service is going to be paid.
Q Okay. And you determined that it wasn't.
A Yes.
Q As part of the system at UMC.
A Part of the UM process, yes.
Q All right. So you weren't out on an island on your own doing things differently than anyone else at UMC, were you?
A Can you repeat that again? I'm sorry.
Q Yeah. You weren't out, off the reservation, so to speak, doing things your own way at UMC, you were dint it the way the company wanted you to do it, right?
A Sort of, yes.
Q Sort of?
A I mean I was making UM decisions based on the general principles of what we did.
Q And the company was happy with your work.
A I can't say they were -- I mean they did not -- they continued to use me, so I'm assuming that's the case.
Q They continued to pay you, they continued to send you more business, right?
A They sent me cases to review, yes.
Q And then they even hired you on fulltime.
A I don't know that there's a relationship between the two.
Q That's what happened.
A I was hired because I decided to go fulltime.

Q You decided what?
A I said I was hired fulltime because that was my decision to become fulltime.
Q And they were willing to hire you fulltime.
A Yes.
Q Okay. Nobody ever called you on the carpet or criticized you or rapped you on the knuckles over this claim, right?
A No.
Q And you've continued to handle claims just like you've handled Bill Eskew's ever since, right?
A I've continued to review claims --
Q Right.
A -- for coverage, yes.
Q And you haven't changed the way you do that?
A No.
Q Nobody at UHC has told you to change the way you do that.
A I mean there are -- there is guidance that comes periodically; but no. Generally speaking, yes, the process is the same.
Q And the fact of the matter is, Dr. Ahmad, you're going to continue to do things, handle claims just like you handled Bill Eskew's until somebody tells you to do it differently.
A I mean I don't want to speculate on that. I have my way of reviewing claims and I will keep on doing that.
Q You're only going to change the way you review claims if somebody in your chain of command tells you hey, we got to do things

differently, right?

A Possibly.

MR. TERRY: Now, let's pull up Exhibit 5, Jason, please.

BY MR. TERRY:

Q Dr. Ahmad, Exhibit 5 is the administrative file, I think, UHC calls, I call it a claim file. You call it administrative file?

A Either. I don't have a name for it.

Q Okay.

MR. TERRY: Let's pull up, if we can, Jason, page 33 of Exhibit 5. Okay. Let's pull up the top part, Jason, just the top, pick up that [indiscernible]. Come on down a little bit. There you go.

THE COURT: Has 5 been admitted yet?

MR. TERRY: Any objection to 5?

MR. ROBERTS: No objection.

MR. TERRY: Sorry.

THE COURT: Exhibit 5, will be admitted in evidence.

[Plaintiffs' Exhibit 5 admitted into evidence]

BY MR. TERRY:

Q Exhibit 5, page 33, so this is a letter contained in the claim file, Dr. Ahmad, it's from, as you can see at the top right corner, Sierra Health & Life, United Healthcare Company, and it's written to William T. Eskew, that's Bill. February 5, 2016.

See what we're talking about?

A Yes.

MR. TERRY: Now, Jason, reduce that, please, could you skip

to the last page? That sort of would be page 35, down two pages, please. Thank you.

BY MR. TERRY:

Q And you see here, Dr. Ahmad -- if you blow up the signature there, please Jason -- there's the signer of that letter to Bill Eskew is you, right?

A Yes.

Q Shamoon Ahmad, M.D., medical director, United Healthcare Nevada. Do you know who United Healthcare Nevada is?

A That the name of the insurance, right?

Q Okay. It says medical director. It says you're a medical director for United Healthcare Nevada, right?

A Yes.

Q Were you a medical director working for them at that time or were you an independent contractor?

A I was an independent contractor.

Q It doesn't say that in here anywhere, does it?

A I don't think.

Q Okay. Now, then the truth is, Dr. Ahmad, at the end of your work on this claim, before this letter went out, it's true to say that you never saw the letter before it went out, right?

A I don't recollect if I saw it or not.

Q It's also true to say that you didn't sign the letter before it went out.

A Correct. I did not physically put the stamp.

Q That is an electronic stamp signature on there, right?
A Yes.
Q Now, let's look at what the letter say, real quick.
MR. TERRY: Jason, go to page 33 of Exhibit 5, please. Pull up this, yes.
BY MR. TERRY:
Q The first paragraph of the letter says: Dear William G. Eskew. We reviewed healthcare services requested for what? First sentence.
A Do I see that?
Q Yes. What's it say. We reviewed healthcare services requested for what?
A For coverage.
Q Coverage. Under the terms of what?
A Health benefit plan.
Q Okay. Stop right there. When you say health benefit plan, you're talking about the insurance policy right?
A Yes.
Q Okay. Now, the truth is, Dr. Ahmad, before you wrote this letter that says, we reviewed healthcare services request for coverage under the terms of your health benefit plan, the truth is, you never read it. You never read the plan.
A This particular plan, correct; but I'm very familiar with what the languages are in these plans.
Q Bottom line is you didn't read Bill Eskew's contract with Sierra Health & Life before you wrote in here, services requested for

coverage under the plan -- services requested for coverage under the terms of the plan are not covered. Right?

A Correct.

Q And you're okay with that?

A Yes.

Q Okay. Now, let's take another little quick breeze through this letter here. On the second line -- right here, Jason -- it says, what's that word covered? You see that second word, the second time it says covered, Doctor?

A Yes.

Q Then down here it says not covered, see that?

A Yes.

MR. TERRY: Increase this, Jason, and pull up this box on the first page, please, the whole box, if you will.

BY MR. TERRY:

Q It says, we have determined that proton beam radiation therapy is not what?

A Not covered.

Q Okay. So -- go on the second page, Jason -- up here in the first multi sentence paragraph, at the very end right here, it says, not what?

A Not covered.

Q Then -- minimize that, Jason, right here pull up this paragraph -- we will -- what's that say, Dr. Ahmad, we will not what?

A Excluded service.

Q We will not what?
A We will not cover.
Q Okay. Then so I guess my point with all of that exercise is to show that you made it real clear that on behalf of the insurance company, pursuant to the system that they have there, you were telling that family no coverage under the insurance policy, right?
A I made the UM decision which then translates into that, correct.
Q Are you aware of the insurance industry's standard for how to fairly and in good faith read and interpret an insurance policy? Not a medical policy. Not a medical guideline, I'm talking about an insurance policy.
A I'm aware of the general principles of --
Q Okay.
A -- of fair review as what you mentioned.
Q Are you familiar with the principles of how policy language is to be interpreted?
A As it pertains to my work, yes.
Q Okay. But it doesn't pertain to your work if you don't read the policy, right?
A I mean I'm familiar with the policy, but correct.
Q Can you recite to us what the policy says, you have it your head?
A No, I cannot.
Q Okay. Now, let's go -- let's do this. Let's talk about what you

did on Mr. Eskew's claim. Okay? So let's get some general housekeeping terms out there and the new can kind of talk about the specifics. What we know is that you would do these reviews after or during or in addition to your oncology practice, right, back in 2016?

A Yes.

Q Would you do it at the end of the day?

A I mean it could be any time during the day.

Q So maybe you'd see a patient, if you had a break between patients you might go do a couple of cases and then go see another patient, that kind of thing?

A I mean it's possible, but generally there was time to do the reviews.

Q Okay. So you received the claims that you handled, including Bill Eskew's claim, by computer, right?

A Yes.

Q You didn't get a package in the mail with documents, you got something on the computer, right?

A Correct.

Q Then you knew that you had a claim to review, and you have a number of them to review, right?

A Yes.

Q You can see them on the UHC computer system that you have access to.

A I mean I would see them, yes.

Q Okay. So then like with a claim like Bill Eskew's you could

open it up, pop up the documentation and read it on your computer, right?

A Yes.

Q And contained in that documentation would be a communication from somebody at the company sending over the question that they had for you to answer.

A It would be the review coming in.

Q Okay. So there would be some communication from a nurse at UHC, right?

A Yes.

Q And then attached to whatever communication they sent you or attached to the file on the computer would be documents that you needed to review?

A Yes.

Q All right. And included in there, with the various things, for instance in this case -- Jason, could you pull up Exhibit 5 from page 9, please? Can you just blow it up, just blow up the top half, just that there. Okay -- So this would be a letter, this is a fax cover page, actually, from MD Anderson, right?

A Yes.

Q Okay. Now, you know who MD Anderson is, so when you saw that, you knew that it was good doctors in a good hospital sending in this request, right?

A Yes.

Q You certainly didn't think the opposite, did you?

A I did not.

Q Okay. So this is a fax cover page, and right here it says, what, urgent prior authorization.

MR. TERRY: Jason, can you highlight that, please?

BY MR. TERRY:

Q Urgent prior authorization. And so that means it was time sensitive as far as you were concerned, right?

A Yes.

Q And you knew it was a prior authorization request meaning that the policy holder was looking to get treatment, but was looking for authorization from the insurance company to get it, right?

A Yes.

Q Okay. Looking at here, Zhongxing Liao, from the Proton Therapy Center, do you see that?

A Yes.

Q All right. So you knew it was Dr. Liao, but you didn't know anything about her at that point.

A Correct.

Q Okay. Now, attached to that letter were a number of things. I wanted to talk to you about them. Attached to that letter or attached to that fax cover sheet is a letter -- so Jason, if you could go down to two pages. Yes, there. -- so this is a letter -- do this one right here -- this is an urgent letter of medical necessity, right?

A Yes.

Q Okay. It's sent to United Healthcare, Sierra Health in Las

Vegas, and it makes its way to you through the UHC system, right?

A Yes.

Q Okay. Now, there's a letter that goes this page and another -- so skip to the next page, Jason -- there's the second page of that letter, that's one of the things that came in the packet to you, right?

A Yes.

Q Okay. Then let's go to the next page, from that page through SHL346, so from 32 to 46 are medical records --

MR. TERRY: If you give us, like, scroll through those, Jason, to the end of the medical records, just scrolling through, we'll talk about more in a second, that were attached to the MD Anderson letter, the urgent letter of medical necessity, right?

BY MR. TERRY:

Q Do you see those?

A Yes.

Q Okay. So you read those carefully, right?

A Yes.

Q You gave them the due consideration they deserved, right?

A Yes.

Q Because you knew from the letter --

MR. TERRY: Jason, go back to the third page of Exhibit 5, please.

BY MR. TERRY:

Q You knew from the letter that this case involved a serious situation from the policyholder, right? Third page of Exhibit 5 -- no I take

that back 11th page, I'm sorry.

So what we have here is a letter --

MR. TERRY: pull up the body of it, if you don't mind, Jason.

BY MR. TERRY:

Q What we have here is Dr. Zhongxing Liao of MD Anderson saying that she is presenting a letter of medical necessity on behalf of Bill Eskew. It says, we are requesting certification of CT simulation and 30 treatments of proton radiation therapy. We'll stop right there. Do you know what the CT simulation part of that is?

A Yes.

Q Do you know what that means?

A Yes.

Q Okay. And do you know why three's 30 treatments?

A That would be the prescription that they decided [indiscernible].

Q Okay. So to get the right amount of radiation into Bill's body, he needed to go under the radiation machine, the proton machine, 30 different occasions, correct?

A Yes.

Q The same would have been true of IMRT, true?

A The numbers may be different, but correct.

Q Okay. So over six weeks, for a 64-year-old male diagnosed with a diagnosis of stage iv malignant carcinoma -- what's that?

A It's a description of the cancer.

Q Cancer -- with squamoid features. What does that mean?

A Again, it's the description of the type of cancer.
Q It's the type of cancer cells in the tumor, right?
A Yes.
Q They're sort of squamoid cell like at least, right?
A Correct.
Q Okay. Primary site undetermined, right?
A Yes.
Q Okay. Now, it goes on to say he is being considered for concurrent chemoradiation therapy using proton therapy to what?
A To maximize local control.
Q Meaning to max -- what's that mean when you say to maximize local control with oncology department?
A To try and treat the tumor as best as possible.
Q Okay. All relevant clinical has been reviewed, says Dr. Liao, and this patient is meeting eligibility criteria for treatment with proton beam therapy. See that?
A Yes.
Q So you can tell from this paragraph, just so far, that Bill Eskew has lung cancer, it's stage 4, and Dr. Liao of MD Anderson thinks that he needs proton therapy, right?
A Yes.
Q This says please see supporting clinical information attached. Do you see that?
A Yes.
Q And that's what we scrolled through quickly a moment ago,

there's a bit of it. Now, let's go ahead this next paragraph, Dr. Liao talking to you now, or MD Anderson, radiotherapy is an accepted plan of treatment for lung carcinoma. See that?

A Yes.

Q Agree or disagree?

A Agree.

Q Okay. Radiotherapy employing proton beam instead of photons -- photons is IMRT or x-ray, right?

A Yes, correct.

Q Is able to provide the optimum dose to the targeted area without causing potentially serious normal tissue complications. True statement?

A It must be, she wrote that, yes.

Q It must be because she wrote it. Okay.

Now, it says especially to the part -- what's it say next?

A Esophagus.

Q Esophagus, spinal cord and normal lungs. Additional radiation dose to these structures -- including esophagus, right?

A Yes.

Q Additional radiation dose to the esophagus, let's read it that way, puts the patient at risk for costly side effects. Do you see that?

A Yes.

Q Including a number of different side effects there, right?

A Correct.

Q So you knew from Dr. Zhongxing Liao, MD Anderson, that

she was concerned that using photons instead of protons, IMRT as to the proton therapy, would cause side effects with Mr. Eskew.

A The way I read this is that this was accurate for what she prescribed, the proton therapy. I'm not sure that this tells me that IMRT would or would not be comparable in further aspects.

Q Did you ask her?

A No, I did not.

Q Did you ever conduct a phone call?

A Nothing.

Q Did you send her an email?

A That's now what we -- I had the record so there was no reason to call.

Q You had everything you needed.

THE COURT: Counsel, we're going to take a 15-minute recess.

MR. TERRY: Yes, Your Honor.

THE COURT: Ladies and gentlemen, you ae instructed not to talk with each other or with anyone else about any subject or issue connected with this trial.

You're not to read, watch, listen to a report of or commentary on the trial by any person connected with the case, or by any medium of information including, without limitation, tv, internet or radio. You are not to conduct any research on your own relating to this case such as consulting dictionaries, using the internet or using reference materials. You're not to conduct any investigation, test any theory of the case,

recreate any aspect of the case, or in any other way investigate or learn about the case on your own.

You are not to talk with others, text others, Tweet others, Google issues or conduct any other kind of book or computer research with regard to any issue, party, witness or attorney involved in this case. You are not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

We'll come back at 2:45.

THE MARSHAL: All rise for the jury.

[Jury out at 2:31 p.m.]

THE COURT: We'll come back at 2:45, counsel.

MR. TERRY: Thank you, Your Honor.

MR. ROBERTS: Thank you, Your Honor.

[Recess taken from 2:31 p.m. to 2:45 p.m.]

THE COURT: Are the parties ready?

MR. TERRY: Yes, Your Honor.

MR. ROBERTS: Yes, Your Honor.

THE MARSHAL: Ready for the jurors to come in?

THE COURT: Yes.

[Pause]

THE MARSHAL: All rise for the jury.

[Jury in at 2:47 p.m.]

THE MARSHAL: All jurors present.

THE COURT: Thank you. Do the parties stipulate to the presence of the jury?

MR. TERRY: Yes, Your Honor.

MR. ROBERTS: Yes, Your Honor.

THE COURT: Thank you. Please be seated. Counsel, please proceed.

MR. TERRY: Thank you, Your Honor.

BY MR. TERRY:

Q Are you ready, Dr. Ahmad?

A Yes.

Q Okay. Let's return if we can to the urgent prior authorization request from MD Anderson to UHC or Sierra that made its way to you. We talked before the break that there had -- there were some records, medical records from MD Anderson, medical records of their treatment of Mr. Eskew attached to the medical -- letter of medical necessity, right?

A Yes.

Q And let's take a look a couple of those things just to orient ourselves to what we're talking about.

MR. TERRY: So can we pull up Exhibit 5, page 15 please, Jason?

BY MR. TERRY:

Q Now this is what a medical record from MD Anderson sort of looks like if you're here, Dr. Ahmad. Do you remember seeing things like this before?

A Yes.

Q Okay.

MR. TERRY: So let's blow up this top portion there, Jason,

please. There you go, thank you.

BY MR. TERRY:

Q So this is a consultation note, January 27, 2016 and it is a consultation with Dr. Liao, were you aware of that?

A Yes.

Q Okay. And so in this consultation note Dr. Liao assesses Mr. Eskew, you're aware of that?

A Correct.

Q And she reviews some scans, CT scans, MRI, that kind of thing and comes up with a working diagnosis and a plan, do you recall that?

A Yes.

MR. TERRY: And let's look at page -- the next page, Jason. Yes. Here, down here at the bottom, please.

BY MR. TERRY:

Q So here is Dr. Liao giving her working diagnosis. Meds -- or the pathology usually we say that first. The pathology shows metastatic carcinoma with squamous features, do you see that part?

A Yes.

Q And then under that it says, "working diagnosis, stage four non-small lung cancers most probably squamous cell carcinoma", et cetera, see that?

A Yes.

Q All right. And then she comes up with a plan. Then next sentence impression -- or the next paragraph, impression and plan. It

says, "I recommend a course of oral aggressive consolidated chemo radiation therapy". That means she recommends both chemo and radiation, right?

A Correct.

Q Consisting of six weeks of radiation therapy with concurrent chemotherapy, right?

A Correct.

Q Okay. So that was January 27 of 2016 that Dr. Liao made that note after she saw Mr. Eskew in Houston, right?

A Yes.

Q Okay.

MR. TERRY: Now let's skip forward in Exhibit 5, Jason. And it'll be SHL332. So about three pages up from there. Yes.

BY MR. TERRY:

Q So here at the top of this page we see a note that's made on February 1st of 2016, do you see that?

A Yes.

Q So this would have been something that would have been in your possession at the time that you made the decision to deny proton therapy for Mr. Eskew, right?

A Correct.

Q Okay. Now Dr. Liao is the author of this note as well, right?

MR. TERRY: If you look at the next page, Jason.

BY MR. TERRY:

Q Dr. Liao is the author of the note, do you see that, Dr.

Ahmad?

A Yes, I do.

Q Okay.

MR. TERRY: Now go back up the first page, Jason, please. Thank you.

BY MR. TERRY:

Q Here Dr. Liao says, "here's a history of Mr. Eskew's condition. He's a 64 year old male diagnosed with right squamous cell carcinoma malignant neoplasm of upper lobe" that means a part of the lung, right?

A Yes.

Q "Unspecified bronchus or lung", see that? Now Mr. Eskew had a tumor in his lung, and he also had what's called a mediastinal tumor, right?

A He had lymph node involvement there.

Q Right. And what's the mediastinum?

A The middle portion.

Q It's the area of your chest between your lungs?

A Yes.

Q Okay. So he had a tumor between his lungs too, right?

A Yes.

Q All right. Okay. So Dr. Liao then makes this statement here, the goal of treatment.

MR. TERRY: Would you highlight that please, Jason?

BY MR. TERRY:

Q Goal of treatment says, "curative", right?

A Yes.
Q Did you have any reason to dispute that Dr. Liao had a curative intent in her treatment of Mr. Eskew?
A No. It's right there.
Q And you didn't have any reason to believe that Dr. Liao was wrong in thinking that she could cure Mr. Eskew's cancer?
A I mean, it's in the future we don't know that, but that was the intent, correct.
Q Right. And you didn't have any reason to believe back in 2016 that she was wrong about that, did you?
A Well, we had a situation where metastatic lung cancer, which --
Q Yeah.
A -- is advanced cancer, so that is part of the records.
Q Well, sure. No question he had a metastatic lung cancer, but Dr. Liao thought that the treatment could be curative that's why she wrote it there, correct?
A Correct.
Q And you don't have any bases as a medical oncologist to dispute that Dr. Liao could cure Mr. Eskew, do you?
A But like I said, I mean, that would be trying to figure out what the future holds, so the treatment -- the intent can be curative whether or not that pans out obviously time tells.
Q I guess what I'm getting at, Dr. Ahmad, and I don't mean to quibble with you, but I'm just trying to get in your head back in 2016. So

is it true to say, Dr. Ahmad that you did not deny proton therapy to Mr. Eskew because you thought he was going to die anyway?

A Correct.

Q So there's a difference between curative treatment and palliative treatment, right?

A Yes.

Q Curative treatment is designed to cure, that's the reason for the word curative, right?

A Right, yeah.

Q Palliative is designed to palliate, right?

A Correct.

Q Which means to lessen the symptoms?

A Yes.

Q Right? To make someone have a better quality of life?

A Right, probably.

Q And you don't deny care or deny the coverage for care that your policy holders need because it is palliative, do you?

A No.

Q Insurance companies pay for palliative care all the time, don't they?

A Yes.

Q And it certainly doesn't say anywhere in the insurance contract that we only pay for care if it's guaranteed to cure, right?

A I don't know if it's in there, but correct.

Q So it's never part of your thought process back in 2016, oh,

this guy's going to die anyway, I don't need to pay for, or the company didn't need to pay for proton therapy, was it?

A No.

Q All right. And if you made the claim decision to deny the man his treatment because you thought he was going to die anyway, that would be the wrong thing to do, wouldn't it?

A Correct.

Q All right. Thank you. Now let's look at something else in this record. You told us earlier that you don't know how the radiation oncology team at MD Anderson goes about trying to implement the concept of ALARA, as low as reasonably achievable, right?

A Correct.

Q And you don't know how they go about trying to make sure that whatever treatment they give maximizes the therapeutic ratio, right?

A Correct.

Q Okay. So have you ever heard of comparative planning in this context?

A Yes.

Q Okay. Have you ever participated in comparative planning, like preparing the comparative plan?

A No. I have not.

Q You're not qualified to read a comparative plan, are you?

A I can read one.

Q You can? Do you do that as a regular part of your practice?

A If one is provided, yes.

Q And you feel confident that you can read a comparative plan?
A Generally they're simple to understand, but, you know, again it depends on the documents that's provided.
Q Okay. Well, let's look and see -- because we've heard said here in this courtroom this morning that you didn't have the opportunity to review a comparative plan from Dr. Liao, do you agree with that statement --
MR. ROBERTS: Objection. Misstates openings.
THE COURT: Sustained.
BY MR. TERRY:
Q Did you have an opportunity to review a comparative plan from Dr. Liao?
A If one was included I would have looked at it.
Q Okay. And the only way you would have had an opportunity to review it is if it was included in this package of stuff that was sent to you?
A Correct.
Q Okay. Because there's no other way you can get the information?
A I mean, the requested provider is submitting the application of the request, so they sent whatever they felt was necessary.
Q Okay. But isn't it true that you as a utilization management reviewer at UHC can ask the treating physician if you think you need some more information?
A I can.

Q And you didn't?

A Correct.

Q All right. Now you knew there was a comparative plan though, didn't you?

A No, I did not.

Q Let's take a look.

MR. TERRY: Let's look at this same page. Jason, would you take this part down, please. And let's blow up right in here somewhere. Down to the bottom.

BY MR. TERRY:

Q Now Dr. Liao -- or Dr. Ahmad, here in this paragraph that begins with axial, do you see that? Axial CT images.

A Yes.

Q Okay. "Axial CT images were obtained through the volume of interest". That means axial CT images were obtained through the tumor, right?

A Correct.

Q Isocenters for treatment planning were placed as per routine. Do you know what isocenters are?

A It would be -- again, I'm assuming that they're the centers of the tumors.

Q I'm sorry, I couldn't hear your, Dr. Ahmad. I'm sorry.

A I'm not sure.

Q Okay. So isocenters for treatment planning, what's treatment planning?

A That is the initially work up including images to determine what the treatment is going to be.

Q So it's planning to determine what treatment you're going to give, right?

A Yes.

Q Okay. Treatment planning were placed as per routine. Images -- you with me so far?

A Yes.

Q Okay. Images were accurately transferred from the CT scanner to the pinnacle treatment planning workstation, do you see that?

A Yes.

Q Do you know what the pinnacle treatment planning workstation is?

A I believe it's a computer system.

Q A computer system, for what?

A For treatment plan.

Q Okay. For preparing the planning, right?

A Possibly, yes.

Q So in the record that you have here, Exhibit 5 Dr. Liao makes a note and she sent it to you, February 1 of 2016 and says, "images were loaded into the pinnacle treatment planning workstation", right?

A Correct.

Q Okay. Now let's go look further into the next paragraph. Picking up at this sentence here that says, "these images". It's the second full sentence of this paragraph here. "These images", do you see

that?

A Yes.

Q "These images were imported in our treatment planning system", that's the pinnacle system, right?

A Yes.

Q Have you ever worked with the pinnacle system before?

A No, I have not.

Q And you couldn't tell us as you sit here now what it does?

A No.

Q Okay. "And based on these images in the treatment planning system, based on these we developed target and avoidance volumes that represent the patient during normal respiration." Did I read that sentence correctly, sir?

A Yes.

Q What are target and avoidance volumes?

A I mean, that would be the part that would be the cancer.

Q I'm sorry, what?

A The target I'm assuming would be the cancer.

Q Yes. What's the avoidance volumes?

A Would be -- I'm not quite sure what they are saying there, but it would be the tissue around it, that area that they want to avoid.

Q Healthy tissues around the tumor that you want to avoid, right?

A Yes.

Q Okay. So according to the documentation that Dr. Liao had

sent to you that you had in your hands when you denied the claim, you knew or could have if you read it that images were imported into the treatment planning system and they used them to develop target and avoidance volumes, right?

A Correct.

Q Okay. Now look right down here, this highlighted part. RUL tumor and MD node. What's that mean?

A That's the primary tumor in the lymph nodes.

Q What's RUL stand for?

A Right upper lung.

Q Right upper lung tumor and what's MD stand for?

A Mediastinal node, I would --

Q The tumor between the lungs?

A Yes.

Q I'm probably saying it wrong. You say mediastinal, I say mediastinal. I say it like --

A Both are correct.

Q All right. So -- okay. Technique, what's it say there under technique?

A IMRT versus IMPT.

Q IMPT is what?

A Proton beam.

Q Proton beam therapy, right?

A Yes.

Q In fact its intensity modulated proton therapy, right?

A Yes.

Q Just like IMRT is intensity modulated radiation therapy?

A Correct.

Q Okay. So a fair reading of this document that was in your hand at the time you made the decision to deny the claim shows that there was a plan -- a comparative plan done, right?

A I mean, they were looking at two types of radiation, so yes. There was a comparative.

Q A comparative plan was done because you can see that they're importing images into the pinnacle treatment planning workstation and developing target and avoidance volumes, right?

A Correct.

Q Okay. So if you wanted to see a comparative plan, it was no secret that one existed, was it?

A Well, this is giving the amounts of radiation they would like to deliver using two different techniques. Like --

Q Okay.

A And obviously each technique is different and different amounts of radiation are delivered based on the technique being used.

Q Do you know what a radiation -- a comparative plan developed by the pinnacle, what's it called, pinnacle treatment planning workstation looks like?

A I mean, it depends on how it's printed out, but this is giving two different modalities of radiation with the total dose that they are planning on giving.

Q Well, what this document tells us is that a comparative plan exists?

A Yes. For the two types of radiation they were planning on using or considering.

Q Right. So it -- this document tells you that there's a plan for IMRT and there's a plan for proton therapy and they're comparing the two?

A I'm not sure about comparison, but there are two plans, yes.

Q Well, I guess that brings us back to you've not been -- you're not familiar with the way MD Anderson operates whenever they compare a patient to determine if IMRT is better or proton beam is better, right?

A No, I'm not. Correct.

Q All right. So if you had questions, if you didn't know the answers couldn't have you reached out to somebody to find out before you made a decision on Mr. Eskew's claim?

A I really didn't have any questions. I mean, I had the information I needed.

Q You had the information you needed?

A Yes.

Q So you didn't need the comparative plan?

A That information is there. Whether we call it a comparative plan or not for two different types of radiation and the doses that they were considering.

Q So anybody that complains about the fact that you didn't

have the comparison plan handed to you by Dr. Liao, you didn't need it anyway, right?

A I think I'm trying to clarify what you are referring to as a comparative plan. So we did not have a comparative plan that showed the different areas where certain modality were presenting certain amount of radiation delivery. These aren't -- this is a plan that -- this tells me the two different modalities that they could potentially use and what the dose they would like to use or recommended doses.

Q So you could have had a comparative plan if you would have asked for one, would you agree with that?

A If they had one, yes.

Q Okay. And you didn't know if they had one because you didn't ask for one?

A Well, I assume what they would have sent me was, you know, what they had, but yes.

Q Okay. So you understand though that is part of your job as a person making denials of insurance claims, you have a responsibility to conduct a full and fair and thorough investigation?

A Correct.

Q Okay. So that's a responsibility of yours not Dr. Liao, right?

A I think it's a shared responsibility for them to send the information that they feel is important in making a decision, especially when there appears not to be coverage for a certain treatment or [indiscernible].

Q So Dr. Liao has the joint responsibility with you to investigate

insurance claims?

A No. That's not what I was implying.

Q The insurance company is the expert on the insurance policies not the treating physician, right?

A Correct.

Q So if you needed more information to make a decision about a claim as serious as proton beam therapy for lung cancer, than don't you think you should have done everything you could to get all the information you needed to make a fair decision?

A I believe I did what I needed to do.

Q Okay. So you had everything you needed, and any talk of the comparison plan we can forget about it, right?

A I didn't say that.

Q Well, then do you need it or not?

A It would be part of the review, so if it was there I would certainly take that into consideration, yes.

Q Okay. But you knew it existed and you didn't ask?

A I don't know that it existed.

Q I'm sorry?

A I said I don't know that it existed.

Q Oh. So you couldn't read this like we just did?

A I did and I think I tried to explain what this means to me.

Q Okay. All right. Let's talk about something else here. So you've told us that you read and analyzed and considered everything that you needed to before you made a decision on this claim carefully

with due consideration, right?

A Yes.

Q And isn't it true that all told, you've told us that in this case that you spent something like 30 to 60 minutes on the claim?

A Correct, that's my recollection.

Q And that's about average for what you spend on claims, 30 to 60 minutes?

A Not all claims.

Q I'm sorry?

A I said that's not the time I spend on all types of claims.

Q Okay. Did you spend more or less time on this one than you normally do?

A It would be more.

Q You spent more time than average at 30 to 60 minutes?

A Yes. Denial claims, you know, take a little bit longer to review.

Q Dr. Ahmad, referring to your deposition that you've told us about and gave us on -- back in the summer of 2020. I want to put in front of you page 77, line 10 through 13. Isn't it true, Dr. Ahmad, that the following question was asked, and the following answer was given by you under oath?

"Q Thirty to 60 minutes, which would have been average time is what you would have spent on Bill's request for proton therapy, right?"

The answer,

"A Yes".

A Correct.
Q So you didn't spend more time on this one than you do on average?
A Yes. If they're approving things they take much less time.
Q Okay. So let me ask you this way, you didn't spend any more time on the claim than you needed to spend, did you?
A No.
Q You didn't spend any less time on the claim than you needed to spend, did you?
A Correct.
Q Now you told us at your deposition that you spent five or six hours getting ready for your deposition, do you remember that?
A I don't recollect, but if I say that then yes.
Q Is it about right?
A Yes.
Q Okay. How many hours did you spend getting ready to come here and give this testimony today?
A Around the same time.
Q Five or six hours?
A Yes.
Q Meeting with lawyers?
A Yes.
Q So all totaled in the defense of this lawsuit it sounds like you spent 10 to 12 hours?
A That sounds about -- that adds up.

Q And you're telling us here today that you spent 30 to 60 minutes on Mr. Eskew's claim decision, right?

A Correct.

Q And you spent all the time you felt like you needed to spend on his claim?

A Yes.

Q And it's important that you do so, isn't it?

A Yes.

Q And you certainly wouldn't want to shortchange the claim by not spending enough time?

A Correct.

Q And anything less than 30 to 60 minutes wouldn't be enough, would it?

A I mean, that's dependent on the case and what we are looking at, but not generalize.

Q This case?

A That's the time I spent on it, yes.

Q Yeah. And if you had spent anything less than 30 to 60 minutes it wouldn't have been enough?

A I can't speculate on that. I mean --

Q What? I'm sorry.

A I said I cannot speculate on what it could have been, that's the time I spent.

Q Okay. So let's put up if we can -- well, let me ask this before I pull this thing up. You'd agree with me wouldn't you that many if not all

of your reviews of UM claims regarding cancer treatment are complex?

A Not all are, some are.

Q Okay. They're not easy ones?

A I mean, I don't know easy versus difficult. It depends on the information presented.

Q Well, isn't it true, Dr. Ahmad, that you've told us -- let me just ask you. Isn't it true that of the amount of time that you spent on Bill Eskew's claim, which you've said is about 30 to 60 minutes, about half of that time you say that you spent researching literature on proton beam therapy and lung cancer?

A I don't recollect how much time I spend doing that.

Q Well, let me refer you to page 79, line 4 through 18 of your deposition. This question was asked, and this answer was given:

"Q How much of the 30 to 60 minutes that you estimate you spent on Bill Eskew's claim did you spend researching and reading medical literature?

"A It's a balance of how complicated the situation is and whether or not that is the general treatment management of a certain type of situation or cancer. So based on that one can, you know, spend the majority of that time doing that. On the other hand if it's simple question and answer, which in this case it's not simple question and answer, because obviously we are looking at a complicated and advanced case, you know. Maybe half and half. That's the best I can say."

So about half?

A That's the --

Q Okay.

A -- estimate I [indiscernible].

Q All right. So you spent about half of the time that you spent on the claim researching you say, right?

A Yes.

Q So if you spent 30 to 60 minutes half of that would be 15 to 30 minutes, right?

A Correct.

Q So the other half of the time that you spent you split evenly between reading the medical records and looking at the medical policy, the proton beam policy, right?

A Yes.

Q So if that's true then you took the other 15 to 30 minutes and you spent about seven and a half minutes on reading medical records and another seven and a half minutes looking at the medical policy on the low end or 15 minutes each doing those two things on the high end, if you spent 30 to 60 minutes, right?

A Correct. And again, as I mentioned before these are just estimates of my recollection of the claim.

Q Well, it certainly wouldn't be very much more or very much less than that, would it?

A It's -- the total time, yes. I'm not sure how it's divided between some of the things you mentioned.

Q So isn't it true that you usually reviewed back in 2016 about

20 to 25 cases a week?

A Yes.

Q All right. 20 to 25 cases a week.

MR. TERRY: So let's pull up Exhibit 7, Jason, please.

BY MR. TERRY:

Q And let's do some math. If we add up the number of cases you did in this week. Remember you told us you can look at each day and see how many cases you did?

A Yes.

Q If you take that and add it up -- see if we can do that and demonstrate what we're doing.

MR. TERRY: Can we -- well, we probably can't do that.

BY MR. TERRY:

Q So the number of cases if you add 11 plus 12, plus 22, plus 15, plus 19. I did the math; you can do it yourself if you'd like. It's 79 cases.

A I believe you

Q Okay. So if you were handling 20 or 25 a week back then, how in the world did you end up handling 79 in this week?

A I think I said that several times before that equal average numbers and it varied a lot.

Q So the average of 20 to 25 was way off on this week because you did 79, right?

A That's correct.

Q You did three times as many as you normally do?

A Yes.
Q How'd that happen?
A I don't know.
Q So it just so happened that Bill Eskew's claim came to you during this week when you were handling three times as many claims as you normally do?
A It did.
Q Okay. So let's do some more math. If you take 16 and half hours --
MR. TERRY: If you'll highlight that, Jason.
BY MR. TERRY:
Q And you divide it by 79, you get about 12 minutes per claim.
A Well, I mean, as a global average yes. But that does not mean that that's the average time per claim.
Q So it could be that you spent like an hour Bill Eskew's claim out of that 16, 16 and a half?
A Correct.
Q In which case you would have done all 78 of these other claims in 15 and a half hours? Maybe. Is that what you're saying?
A Yes.
Q Okay. Or it could be that you spent about 12 minutes on each one, right?
A That's not the case.
MR. TERRY: Let's look at -- Jason, pull up Exhibit 79, please. No. Hang on.

MR. ROBERTS: No objection, Your Honor.

THE COURT: Exhibit 79 will be admitted into evidence.

Plaintiffs' Exhibit 79 admitted into evidence]

MR. TERRY: Now blow some of this up at the top here.

BY MR. TERRY:

Q You can see right here at the top center it says, MBO Business Center, do you see that?

A Yes.

Q Now this is a big, long document, there's like a 180 pages of time entries for you on various days. But I want to go to page 69.

MR. TERRY: Let's blow this up right up here.

BY MR. TERRY:

Q So we know that you did your work on Bill Eskew's claim on the 4th or 5th of February of 2016, right?

A Right.

Q So on those days you spent -- you wrote down anyway three hours and three and a half hours on those days, right?

A Yes.

Q If you do the math on the number of claims that you handled on those days, it works out to about 12 minutes. Are you aware of that?

A I mean, I'm sure the math is correct.

Q All right. So despite the fact that the math would tend to indicate that you spent about 12 minutes, you're saying as you sit here now today five years later almost -- well, six years later. Five years, six years? Six years later that you remember that you spent 30 to 60

minutes, out of all these claims you remember that?

A Well, I think what I said was denials take longer, hematology cases are very short, and approvals are very short.

Q So --

A So yes. We can look -- we have looked at the average number, but that's just an average if you calculate everything. Individual cases may be much shorter or could be longer.

Q Okay. So were any of these other claims out of the 80 that handled that week were they denials or were they all just approved?

A The majority were approved.

Q I'm sorry?

A The majority were approved.

Q Okay. How do you know that?

A I did the work.

Q I'm sorry, I couldn't --

A I said I did the work, so.

Q But you remember that you approved a majority of the claims during the week of February 1st and February 5th of 2016?

A In general the approval numbers are very high, just any week of the month or year.

Q Are you as confident of that statement as you are with the fact that you handled 20 or 25 on average a week?

A No. I mean, you mentioned the number, so that's correct.

MR. TERRY: Let's pull up if we can Exhibit 5, Jason.

BY MR. TERRY:

Q Dr. Ahmad, Exhibit 5 is the claim file or administrative file, whatever it's called in your parlance. I call it a claim file. And in there, there are emails that you sent back and forth with the nurse, a lady named Lou Ann, I'm going to say her name wrong, I think it said Amogawin, but it may be Amogawin. I just don't remember, sorry. But there are emails between you and her, correct? Do you remember those?

A Yes.

MR. TERRY: Jason, let's pull up Exhibit 5, page 7, please. So let's blow up this part right here.

BY MR. TERRY:

Q This would be the first email as I see it, and tell me if I'm wrong, between you and UHC about Bill Eskew's claim? Is that the way you see it?

A I cannot say this was -- you know, what sequence this was in, but I see what you are showing.

Q Okay. So ultimately though let's just put it this way, you ended up determining that --

MR. TERRY: And go to page 6 of Exhibit 5, Jason.

BY MR. TERRY:

Q You ended up determining that there's no coverage. After having done what you've described for us, researching medical literature you say, spending 30 to 60 minutes you say and reading the submission from MD Anderson and also -- anything else?

A I think you've covered.

Q Okay. On page 6 you say here -- this is your original denial of the claim. It's February 4th of 2016 at 4:20 p.m. and it says that you're the reviewer. Criteria you used is ONC006. Effective date of the criteria. And then it says right here --

MR. TERRY: Highlight this.

BY MR. TERRY:

Q NCCN guidelines for radiation therapy version 2016. So you're saying that you looked at that?

A No. I did not look at that.

Q Oh okay. Do you know what it says about proton therapy and lung cancer?

A I don't recollect anything.

Q Would it surprise you to learn that it says proton therapy for lung cancer is a preferred method if there is a curative intent?

A The recommendations change over time, so is that from then or are you saying it's now?

Q Okay. So -- but you didn't look at it, the NC --

A I didn't

Q -- NCCN guidelines? Okay. Now do you know where you came up with the criteria you used ONC006?

A We realized that that was a typo.

Q It was a typo?

A Yes.

Q What does the medical guideline for ONC006 refer to?

A I'm not sure, but I think it was pointed out that this was some

stool test of some type.

Q A what test?

A A stool test.

Q Stool test. It's a fecal DNA medical policy, right? So it wasn't anywhere close to proton therapy, was it?

A Well, the HPN policies for oncology are numbered with ONC and I believe the number -- the correct number was four, but I'm not certain.

Q Okay. But you're telling us that before you even said you were going to deny the claim you read the medical policy carefully or no?

A I did.

Q You just got the wrong number?

A Yes.

Q Okay. But then somebody pointed it out to you, the nurse did --

A Right.

Q -- and then you gave another email that said the same thing just with the proton beam therapy policy mentioned, right?

A I don't remember, but it's there.

Q Okay. So you've told us -- have you -- anything else you want to tell us about what you did before you denied Mr. Eskew's claim?

A No.

Q And as you sit here now, Dr. Ahmad, if you could get in a time machine and go back and do it different, would you?

A Using the same criteria, I would do the same thing.

Q Okay. Because you implemented the system the way it was intended to be implemented, right?

A I was doing a UM review and based on the evidence at the time, it was real supported.

Q Okay. And you're happy with it?

A That's not an emotion I -- word I would use. It was a UM decision, it can be an approval or a denial, it was [indiscernible].

Q Now, are you aware, Dr. Ahmad, that UHC has its own proton center?

A No, I was not aware.

Q Where you aware that they treat lung cancer there?

MR. ROBERTS: Objection. Foundation.

THE COURT: Sustained.

MR. TERRY: Just give me one -- give me just a little bit of grace here, Judge. I may be about finished. I just want to make sure I haven't missed anything if that's okay.

THE COURT: Of course.

BY MR. TERRY:

Q Now, a couple things. You realize, don't you, Dr. Ahmad, that the proton therapy policy, the medical -- corporate medical policy is not a part of the insurance policy, right?

A Correct.

Q In fact, the corporate medical policy is not disclosed to the policy holder; is it?

A Ask the question again. I'm sorry.
Q The corporate medical policy, the one that says proton beam therapy --
A Yes.
Q -- it's not disclosed to the policy holder?
A It's available online.
Q You have to go on -- you have to go online to find it?
A There may be other ways to do it, but it -- it is available online.
Q How are you supposed to find out that it's available online?
A I don't know.
Q Are you supposed to be going online to find a corporate medical policy that you don't know exists? How does that --
A The denial letter has information in there that points to policies that are applicable to the decision.
Q Okay. So there's something in the denial letter, you're saying, that should, you know, the cancer patient at MD Anderson should -- stage 4 lung cancer should read the denial letter, find the corporate medical policy online, read 20 or 30 pages of stuff, and figure out what happened with their claim?
A I mean, I don't -- there are different processes.
Q So do you have discretion to follow or not follow the corporate medical policy?
A Yes.
Q Okay. So you don't have to agree with it is what you're

saying?

A In some circumstances, correct.

Q But you have to have a reason to not agree with it, right?

A Yes.

Q And if you disagree with it and you approve a claim that the corporate medical policy says you shouldn't, then you have to answer to someone about it, right?

A No.

Q Nobody ever comes to you?

A No.

Q Okay. So if you deny a claim or you approve a claim, there's no difference between the way that you are supervised?

A Correct.

Q So you can deny cancer claims all day long and nobody will ever supervise you over it?

A It hasn't happened to me so I cannot speak for others.

Q And this isn't the only proton therapy claim you ever looked at; is it?

A No, it's not.

Q And nobody has ever supervised you at work on making radiation oncology UM decisions for UHC. Is that right?

A I mean, people may have been looking at it so I cannot say -- answer that precisely that nobody has. Maybe somebody has. I'm not aware of it.

Q But it would be unbeknownst to you if they were?

A I mean, the work is periodically reviewed and -- and, you know, I'm not quite sure in what circumstances or for what, but the quality of the reviews I know is -- is -- happens.

Q Oh, it does. So but you don't know who does it or how they do it, right?

A Correct.

Q And certainly nobody ever came to you about Bill Eskew's claim and the way you handled it and said you did it wrong?

A Correct, nobody came to me.

Q Do you know a lady named Anna Butligar [phonetic], a doctor?

A No, I do not.

Q I'm sorry?

A I don't.

Q Okay. Do you know how the corporate medical policies are developed?

A No, not really. I mean, I'm aware of some generalizations, but I don't know.

Q Well, if there's going to be corporate medical policies, you would want them to be honestly developed; wouldn't you?

A Yes.

Q You wouldn't want them to be developed in a system that's corrupted by profit motive; would you?

A No.

Q You'd want the corporate medical policies to be scientific

documents not money documents, right?

A Correct.

Q You wouldn't want the people that are reviewing and developing and drafting corporate medical policies to be looking at the company's bottom line when they're making decisions about medical necessity, right?

A I mean, I can't speak for what the company would want -- would do or not.

Q But you wouldn't want to be involved in a system where the company is saying to people like you who are making medical necessity determinations on behalf of policy holders of this company that the medical policy is a scientific document while at the same time in reality, they're looking at the bottom line of the company when they're deciding whether procedures are medically necessary are not?

A Correct, I would not.

Q You wouldn't want to be involved in a system like that; would you?

A I mean, it depends on what involvement means, but that is not something I would like.

Q So you say that you have discretion on whether to follow or not follow the corporate medical policy on proton therapy. I wanted to show you that.

MR. TERRY: It's Exhibit 24, Jason, if you could pull that up. I think that's agreed to. Don't pull it up yet, Jason. Make sure.

MR. ROBERTS: I think it is, but I just want to --

MR. TERRY: Yeah.

MR. ROBERTS: -- double check.

MR. TERRY: It's the --

MR. ROBERTS: No -- no objection, Your Honor.

THE COURT: Exhibit 24 will be admitted into evidence.

[Plaintiffs' Exhibit 24 admitted into evidence]

BY MR. TERRY:

Q Exhibit 24, Doctor, is the corporate medical policy?

A Yes.

Q And you see up at the top it says, "proton beam radiation therapy"?

A Yes.

Q So it's the -- it's the medical policy for proton therapy at UNC, right?

A Correct.

Q And it's the one that you utilized to deny Bill Eskew's claim?

A If the numbers match, correct.

Q They do. So this is the one on December 1 of 2015, time matches up, right?

A Yes.

Q All right.

MR. TERRY: So go to the second page, please, Jason. Actually, more than that. The [indiscernible] sorry. Second page. You're right. I was right. Yes.

BY MR. TERRY:

Q So you see here, Dr. Ahmad, just pull out -- yeah, that's good. Okay. It says proton beam radiation therapy is unproven and not medically necessary for treating all other indications besides some ones that previously were found to be medically necessary, all other indications including but not limited to lung cancer, right?

A Correct.

Q So according to this medical policy, proton beam radiation therapy is unproven and not medically necessary for lung cancer, right?

A Correct.

Q So it doesn't sound like you have any discretion; does it?

A Well, I mean, the policy says that, and the discretion is that I can disagree with some of things that if there are circumstances that require me to look.

Q So if it's discretionary, why doesn't it say may be instead of is?

A I can't speak to that.

MR. TERRY: So let's look quickly at page 4, Jason.

BY MR. TERRY:

Q Now I want to show you some things in this corporate medical policy from UHC that UHC knows about [indiscernible] because it's in here, okay?

A Okay.

Q So let's look. It's under this description of services portion of the -- of that page. What does UHC know about proton therapy? It says, "Unlike other types of radiation therapy that use x-rays or photons,"

that's IMRT, right? X-rays or photons would be IMRT?

A Correct, yes.

Q "To destroy cancer cells, proton beam therapy uses a beam of special particles, protons, that carry a positive charge. There is no significant difference in the biological effects of protons versus photons." Let's talk about that for a second. That means protons and photons can equally efficiently kill cancer cells, right?

A That's what it sounds like, correct.

Q So if you shot a cancer cell with a photon beam, it would kill it? If you shot a cancer cell with a proton beam, it would kill it, right?

A Yes.

Q Okay. But the difference between proton therapy and IMRT is that protons can be delivered more accurately; can't they?

A Yes, correct.

Q So the advantages of proton therapy are that you can kill the cancer more efficiently without radiating organs and healthy tissues at risk around the tumor, true?

A Generally, true. Yes.

Q Okay. So let's just -- let's see if that bears out here. Let's see, start with however, right there on the third line, end of the line. "However, protons can deliver a dose of radiation in a more confined way to the tumor tissue than photons." So that's something we, you and I, can agree on, right?

A Yes.

Q "After they enter the body, protons release most of their

energy within the tumor region." We can agree on that; can't we?

A Yes.

Q "And unlike photons, deliver only a minimal dose beyond the tumor boundaries." We can agree on that, too; can't we?

A Correct, yes.

Q Okay. So pretty advantageous in the right situation?

A Yes.

Q Then the next paragraph says, "The greatest energy released with conventional radiation, photons, is at the surface of the tissue." Like when it first enters the body, right?

A I don't see where you were reading.

Q The paragraph, "The greatest energy released" --

A Okay, I see it.

Q -- "with conventional radiation, photons, is at the surface of the tissue."

A Yes.

Q "And decreases exponentially the farther it travels into the body," right?

A Correct, yes.

Q So it's radiating the tissue between the surface of the body and the tumor, right?

A Correct.

Q And that's not true with protons?

A Well, I mean, there is some energy that goes to normal tissue; but depending on the site and the situation, it would be less.

Q "In contrast, the energy or a proton beam is released at the end of its path. A region called the Bragg peak. Since the energy release of the proton beam is confined to the narrow Bragg peak, collateral damage to the surrounding tissues should be reduced." Agree with that?

A Yes, correct.

Q "While an increased dose of radiation can be delivered to the tumor." That's the therapeutic ration we were talking about, right?

A Right, correct.

Q So this is saying right here the same thing we were talking about earlier protons increase the therapeutic ratio?

A Yes.

Q All right. Now, last thing, last sentence here. "Because of these physical properties," that they -- that we've just talked about, "proton beam therapy may be useful when the target volume," that would be the tumor, right?

A Yes.

Q "When the tumor is in close proximity to one or more critical structures."

A Correct.

Q Critical structures are healthy tissues that are important around a tumor, right?

A Yes.

Q Something like the esophagus, for instance?

A Sure.

Q The esophagus is a critical structure; isn't it?
A I mean, depends on what critical is. One can live without it, but it's critical enough, yes.
Q And -- okay. So "protons may be useful when the target volume is in close proximity to one or more critical structures and sparing the surrounding normal tissue cannot be adequately achieved with photon-based radiation therapy." Did I read that right?
A Yes.
Q So I submit to you, Dr. Ahmad, that that paragraph right there describes Bill Eskew's situation. Do you disagree?
A So that is a general concept and --
Q It applies to Mr. Eskew?
A It may apply, correct.
Q But the -- the truth of the matter is at the time you denied Mr. Eskew's claim, you didn't know where the -- the tumor was in relation to critical structures; did you?
A We did.
Q You did?
A Well, we -- I think did we not look at where the tumors were?
Q Did you -- did you have any images of the tumor to see where --
A No, I didn't.
Q -- it was in relation to the esophagus or --
A I had the description.
Q -- or the heart or the lung or the spinal cord or anything else?

A No.

Q So you didn't know the distance between the mediastinal, mediastinal, tumor in the middle of his chest and his esophagus; did you?

A Correct. I did not.

Q You didn't know the distance between the mediastinal tumor in the middle of his chest and his heart?

A I did not.

Q And yet, you denied proton therapy to the man without knowing that, right?

A Well, I'm aware of the general principles, but --

Q Well, I'm not talking about general principles. I'm talking about Bill Eskew. You denied a man with a tumor in -- a mediastinal tumor and a lung tumor immediately adjacent to his esophagus, his heart, his normal lung tissue, and you didn't even know where the tumors were in relation to those things, right?

A I mean, I'm aware where they are. I just I don't know the exact --

Q You don't know how --

A -- distances.

Q You don't know of the distance between --

A Correct.

Q You didn't know, Dr. Ahmad, at the time you denied Bill Eskew's claim whether proton therapy was the right treatment for him or not; did you?

A I did. Based on the UM review, it was not supported.
Q You didn't -- so Dr. Liao was wrong?
A I didn't say that. That was a treatment decision.
Q And that's different from what you're doing? Right?
A Yes. A treatment decision is -- is different.
Q So what you're saying then I think is that the proton beam therapy could have been the right treatment for this man, Bill Eskew, and yet not covered?
A I mean, the conclusion I made was that it was not the right treatment because it was not supported by the policy or the literature behind it.
Q It wasn't the right treatment; therefore, Dr. Liao was trying to give him the wrong treatment?
A No. For coverage purposes, not what the treatment recommendation was.
Q Well, are you -- are you saying -- when you say that it was not the right treatment, are you saying that it was inappropriate to give proton therapy to Bill if he had gotten it?
A It might have been appropriate.
Q It might have been appropriate. You certainly wouldn't come here and say that Dr. Liao would have committed malpractice if she had done proton therapy on Bill Eskew; would you?
A No, I would not.
Q Now, let's talk about one last topic, and then I'll stop. IMRT. Immediately after you denied proton therapy, then you turn right around

and approved IMRT, right?

A Yes.

Q What evidence did you have that IMRT was the right treatment for Bill?

A Well, it was a treatment that was requested. It met the -- the criteria; therefore, it was approved.

Q It met the corporate medical policy for IMRT?

A That is my recollection, yes.

Q I'm sorry?

A I said that is my recollection, yes.

MR. TERRY: Okay. Well, let's pull that up. Exhibit 75, please, Jason.

BY MR. TERRY:

Q Dr. Ahmad, you might want to get -- this might be easier if you had Exhibit 75 in a -- in our book.

MR. TERRY: May I approach?

THE COURT: Yes, Counsel.

MR. TERRY: I don't want to get in your space, Doctor. Was it in there? Is 75 in there? Oh, here it is. It's in this book, Dr. Ahmad.

THE WITNESS: Should I give this to you?

MR. TERRY: Yes, I'll trade you.

THE WITNESS: Thank you.

MR. TERRY: Yep. 75, please.

THE COURT: Is that one --

MR. TERRY: Yeah, there's no objection to that one; is there?

MR. ROBERTS: 75?

MR. TERRY: Yeah.

MR. ROBERTS: We have an objection to relevance, Your Honor. This is the IMRT policy, and the IMRT request was approved. There's no evidence the doctor reviewed this policy prior to making his denial decision which is at issue here.

MR. TERRY: I'll ask him that, Judge.

THE COURT: Go ahead and ask him.

BY MR. TERRY:

Q Dr. Ahmad, did you review the IMRT policy before you approved IMRT?

A I don't recollect.

Q You don't remember?

A Correct.

Q Would you just approve IMRT without even looking at the corporate medical policy?

A I did in this case.

Q I'm sorry?

A I said I did.

MR. ROBERTS: I'd like to restate my objection, Your Honor. I'm not disputing that. I'm saying it's irrelevant that the policy -- IMRT was approved. There's no dispute as to IMRT appropriateness.

MR. TERRY: This demonstrates the difference between the way he reviewed the proton therapy claim and the IMRT claim. He gave -- he held protons to a much different standard than IMRT. And it

demonstrates that the system with which they review these claims is meaningless.

THE COURT: Overruled.

MR. TERRY: Thank you, Your Honor.

BY MR. TERRY:

Q So what you're saying is that maybe you reviewed and approved the claim for IMRT without ever reading the policy?

A No, I didn't say I didn't read it. I just said I don't remember.

Q Okay. Well, let's look at that IMRT policy, Exhibit 75.

MR. TERRY: We move the admission of Exhibit 75, Your Honor.

THE COURT: It's granted.

[Plaintiffs' Exhibit 75 admitted into evidence]

MR. TERRY: I'm sorry, did you just say it was admitted?

THE COURT: Yes.

MR. TERRY: Thank you.

BY MR. TERRY:

Q Now if you have that in front of you, Dr. Ahmad, I'd like for you to take a look and show me in here this IMRT policy where it says that IMRT is medically necessary for lung cancer.

A I'm sorry, what -- what was --

Q Look at the IMRT policy, Exhibit 75, and point to us where is it that it says IMRT is medically necessary to treat lung cancer?

A It's not listed under the [indiscernible].

Q So what evidence did you have in your possession at the

time you made the decision to say that IMRT was medically necessary in this case?

A I think that was my judgment at the time.

Q Okay. So what you and I both know, though, is that proton therapy is more expensive that IMRT; isn't it?

A I'm not sure what the -- the numbers are.

Q You don't know?

A Yeah, it's more expensive, but I'm not sure that's the case.

Q So you denied the more expensive treatment and you approved the cheaper one, right?

A No, that was based on the -- the review of the policy itself and whether or not [indiscernible] was covered.

Q But you approved this one without even looking at the policy, the IMRT?

A I did approve this one, correct.

MR. TERRY: Your Honor, one -- one moment, please.

THE COURT: Yes.

BY MR. TERRY:

Q Now, at the end of the day, Dr. Ahmad, you and I can agree, can't we, that you are not qualified by medical education, training, or experience to overrule the judgement of Dr. Zhongxing Liao at MD Anderson?

A Are you asking about a treatment decision --

Q Yes.

A -- or a utilization?

Q The treatment decision.

A Correct.

MR. TERRY: I believe that's all I have, Your Honor.

THE COURT: Thank you.

Ladies and gentlemen, we'll take a brief five-minute recess. You are instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You are not to read, watch, listen to any report of or commentary on the trial by any person connected with the case or by any media information, including without limitation, newspapers, television, internet or radio. You are not to conduct any research on your own relating to this case such as consulting dictionaries, using the internet, or using reference materials. You are not to conduct any investigation, test any theory of the case, recreate any aspect of the case, or in any other was investigate or learn about the case on your own.

You are not to talk with other, text others, Tweet others, Google issues, or conduct any other kind of book or computer research about any issue, party, witness, or attorney involved in this case. You are not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

So we'll come back at 4.

THE MARSHAL: Okay. All rise for the jury.

[Jury out at 3:56 p.m.]

THE COURT: Let's take a brief restroom break and come back.

MR. TERRY: Thank you for that, Your Honor.

THE COURT: Thank you.

[Recess taken from 3:56 p.m. to 4:04 p.m.]

THE CLERK: Back on the record.

THE COURT: And Mr. Terry, before we're done, don't leave. I have a question for you.

MR. TERRY: Yes, ma'am.

THE MARSHAL: Rise for the jury.

[Jury in at 4:05 p.m.]

THE MARSHAL: Jurors are all present.

THE COURT: Thank you. Do the parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. TERRY: Yes, Your Honor.

THE COURT: Thank you. Please be seated.

Go ahead, Mr. Roberts.

MR. ROBERTS: Thank you, Your Honor.

Good afternoon. We're going to be going to 4:45 so hang -- hang in there with us for just a little bit longer.

CROSS-EXAMINATION

BY MR. ROBERTS:

Q Good afternoon, Doctor?

A Hi.

Q Before we talk about this case, what I'd like to do in the beginning here is just to give the jury a little bit more of your

background. Is that okay?

A Yes.

Q And tell the jury again how you are currently employed? Who is your job -- what is your job and who do you do it for?

A Oh, okay. I am employed by United Healthcare.

Q And what -- what is your current position?

A I'm in the appeals department.

Q Okay. And how long have you been in the appeals department?

A Almost a year.

Q Almost a year. And I can't help, but I need to go back to one question there that Mr. Terry asked you whether anyone ever reviewed your work. When -- back when you were a medical director making a decision like the one you made in this case, did the policies generally provide for right of appeal?

A Yes.

Q And if someone appealed your decision, did someone review your decision?

A Correct, yes.

Q Was that you? Would you have --

A No.

Q -- handled the appeals as the medical director?

A Correct. It would never be the same person [indiscernible].

Q Okay. So prior to moving to appeals and -- and just is it fair to say for the jury, what do you do in the appeals department? Let's tell

the jury that.

A Well, we look at all the information that was provided. We look at the decision. We look at the various documents pertaining to the decision, and then decide at the second level of -- which is the appeals process -- whether or not the initial decision was accurate, or it should be changed.

Q Okay. So prior to moving into appeals, what position did you hold with United?

A I was a medical director doing initial reviews.

Q Okay. And remind the jury how long did you do that full time?

A Full time for about a year, part time for several years.

Q Okay. So let's go back to you graduated from medical school. What's a residency?

A Residency is the initial three years of training that we get in different fields.

Q And did you do a residency?

A Yes.

Q Where did you do your residency?

A I did my residency in New Jersey.

Q What school?

A Seton Hall University.

Q And as part of your residency, did you -- was that a general residency or did you specialize in particular fields?

A It was internal medicine residency, so it was a specialization

in internal medicine.

Q Okay. Internal medicine at Seton Hall?

A Yes.

Q What did you do after your residency was completed?

A I did my fellowship training.

Q And where did you perform your fellowship training?

A At the Mount Sinai School of Medicine in New York.

Q Did you have any specialties that you studied during you fellowship at Mount Sinai?

A Yes. I did oncology, I did hematology, and bone marrow transplantation.

Q Did you complete that fellowship?

A Yes, all three of them.

Q About what year was that?

A 1998.

Q Okay. So when you completed your fellowship at Mount Sinai in 1998, what did you do next?

A I went into clinical practice here in Nevada.

Q And what was the first firm you joined -- first medical practice you joined when you moved here to Nevada in 1998?

A I joined a group called Comprehensive Cancer Centers of Nevada.

Q Okay. And how long did you work with Comprehensive Cancer Centers of Nevada?

A About six years.

Q Okay. What did -- what did you do then?
A I actually -- in addition to hematology, oncology, I started a bone marrow transplant program.
Q Did you see patients?
A Yes.
Q Did you do anything other than seeing patients at this time?
A I mean, I was doing some of the review -- not at that time, no.
Q But not at that time, right?
A Yes.
Q So when did you start doing some of the part-time review?
A Somewhere around 2009 or '10.
Q Okay. So if my math is correct, between 1998 and 2009 or '10, you had a full-time practice seeing patients?
A Correct.
Q And what field did you practice in during that time?
A Primarily oncology and bone marrow transplantation would be second.
Q So I think we've established you're not a radiation oncologist, right?
A Right.
Q Okay. Tell the jury what you did as far as the management of your oncology patients who needed radiation therapy.
A So our group actually included radiation oncologists and we had radiation facilities on site. So as part of my medical oncology patient management, we collaborated closely if there any for radiation

with one of our radiation oncologists.

Q Did you treat any patients with lung cancer during this period of time?

A Yes.

Q Is that a -- was that a rare disease for you to treat as part of your practice?

A No, it's one of the more common cancers so there were lots of patients with lung cancer.

Q And as an oncology [sic], did you oversee patients' entire cancer treatment who had lung cancer?

A Yes.

Q Did you ever work with radiation oncologists to coordinate care for your patients?

A Yes.

Q Was that a big part of your practice or a rare part of your practice?

A It was quite a big part.

Q We have been talking about proton beam therapy today?

A Yes.

Q Did any of your patients during this time period receive proton beam therapy for lung cancer?

A They did not.

Q Was it available in Nevada if they wanted it?

A Not in Nevada, no.

Q When you started doing preauthorization reviews for United

Healthcare, did you know what fields that you would receive referrals in?

A They were all going to be related to oncology or various parts of oncology.

Q And did you agree to do preauthorization reviews for radiation oncology?

A Yes.

Q And did you feel competent to do those reviews?

A Yes, I did.

Q Could you tell the jury why you felt competent to review radiation oncology even though you could not actually perform those treatments yourself?

A Because part of medical oncology training does include radiation oncology just right at the beginning. In addition to that, treating many patients that required radiation gave me a good experience about what the treatment considerations were. And we had radiation oncology on site, so my work included collaborating with them all the time on a daily basis.

Q Could you explain to the jury again the difference between 3-D radiation and IMRT?

A Yes. So 3-D radiation is the oldest technique or one of the oldest techniques of radiation, and it is -- today it's delivered actually quite precisely as well and appropriate for certain cancers and depending on the location it's a well-established currently used method of -- very effective. IMRT is slightly different even though the particles that give the radiation or deliver the energy to the tumor are similar. But

IMRT, intensity-modulated radiation therapy, by the term or by the name has the capacity using really sophisticated computer programs to deliver radiation extremely precisely to the tumor while avoiding the surrounding tissue. And in fact, the IMRT technique allows different rays to contain a certain amount -- different amounts of radiation targeting different parts of the tumor.

Q So IMRT as you just explained it is designed to increase the therapeutic dose to the -- to the tumor while keeping smaller the amount that goes to surrounding tissue?

A Yes, correct.

Q How long has IMRT been generally used in radiation therapy?

A At least 20, 30 years, if not longer.

Q When you performed utilization review for United Healthcare, did you have an understanding of whether you were making coverage decisions or treating decisions?

A Yes, it was always a coverage decision.

Q And how did -- how did -- define what that is. How does that differ?

A Sure.

Q Could you --

A So the treatment decision obviously is by a doctor in conjunction with the patient and there are preferences involved in that. Utilization management is a tool or a method to control -- well, to try and make sure that the treatments that are being requested are according to

the standards existing at the time. And the decision to approve or deny something is for coverage not denying that the treatment should or should not be given.

Q And you agreed I believe with Mr. Terry that coverage decisions should be based on the coverage that the insurance contract provides to the insured person, correct?

A Yes, correct.

Q You just agreed with that?

A Yes.

Q And you also agreed that you did not go and look at the specific terms of Mr. Eskew's insurance contract when you made his coverage determination in this case, correct?

A Correct. I didn't look at it, but I'm very familiar with the general insurance contract and the contents that pertain to the UM portion of it.

Q Have you ever reviewed a Sierra Health and Life insurance policy before?

A Yes, many times.

Q And is that -- was that something that you did before you made the decision in this case or afterwards?

A It was before and after I reviewed the documents.

Q So how did you know that the provisions of Mr. Eskew's contract for coverage were substantially similar to the ones you've reviewed before?

A Well, like I said, the general standard policies are similar, so I

was relying on my knowledge of that. In addition, we have the reviewing nurses that review those documents as well as far as I know, and they alert us if there is a difference in how we should look at it and whether or not we need to go into more detail in that respect.

Q I'm sorry, did you say alert you?

A Yes

Q Okay. Sorry, with the mask --

A Sorry. Yes, I apologize.

Q -- and I understand the -- you have a pre-existing condition that you have to be cautious, right?

A I appreciate that. Thank you.

Q Okay. But if you could speak towards the microphone, that would be great, Doctor. All right. So let's take a look at the document, and you were shown some pages from the AOC or the agreement of coverage that was provided Mr. Eskew in this case. And I'd like to show you a few of the other pages Mr. Terry didn't show you, okay?

A Okay.

MR. ROBERTS: Riza, could you put up Exhibit 4, page 38. I'll get out of your way.

BY MR. ROBERTS:

Q Okay. This is part of the agreement of coverage. Let's go down to --

MR. TERRY: Your Honor?

THE COURT: Yes?

MR. TERRY: I'd like to object based on your ruling on the

motion in limine regarding after acquired evidence. Dr. Ahmad has said he hasn't reviewed the policy at the -- he did not review it at the time that he made a decision on the claim.

THE COURT: It's overruled. He just testified he'd reviewed it previously.

MR. ROBERTS: So if you could highlight section 3, managed care. Could you include the caption, Riza? Thank you. No, no, down there, section 3. Managed care is in bold. Include that down to the end of 3.3. There you go.

BY MR. ROBERTS:

Q Okay. Managed care. The section tells you about SHL's managed care program. And what -- what I'd like to do is just read this description of the managed care program and have you tell me if that's any different than -- than the other standard policies that you've previously reviewed the work, okay?

So "SHL's managed care program using the services of professional medical peer review committees, utilization review committees, and/or the medical director determines whether services and supplies are medically necessary." Is that consistent with your understanding at the time you did this review?

A Yes.

Q Had you read this prior to doing your review or as part of your review would it have changed any decision you made?

A It would not have.

Q So medically necessary here is it in all caps, right, so let's --

let's go look and see if we can find where that term is defined.

MR. ROBERTS: Riza, could you try page 64. 13.66 through the first three bullet points so we can get nice and big.

BY MR. ROBERTS:

Q So this is Mr. Eskew's medical necessity definition in his agreement of coverage. "Medically necessary means a service or supply needed to improve a specific health condition or to preserve the insured's health and which as determined by SHL is," first bullet point, "consistent with the diagnosis and treatment of the insured's illness or injury. The most appropriate level of service which can be safely provided to the insured; and three, not solely for the convenience of the insured, the provider, or the hospital." So if you had read this prior to making that review of Mr. Eskew's claim, would it have changed any decision you made?

A No, it would not have.

Q Is this consistent with other policy language you've reviewed?

A Yes, it's what I'm familiar with.

Q As you applied it in your work, can you explain to the jury what that second bullet point means, "the most appropriate level of service which can be safely provided to the insured." What does that mean, appropriate?

A It means if there are several different options, then you would use the one that has the most scientific evidence supporting that service. That would be one definition. I'm sure there are others.

Q Will taking the limousine get you to the airport?

A Yes.

Q Is it necessary to take a limousine to get to the airport?

A No.

MR. ROBERTS: Could we also look at page 43, Riza. And what I would like to blow up is the same thing Mr. Terry showed the jury, bottom right hand, "other diagnostic and therapeutic services."

BY MR. ROBERTS:

Q Do you remember when Mr. Terry showed you this?

A Yes.

Q And he pointed out that third bullet point, therapeutic radiology services are listed here under covered services, right?

A Yes.

Q Now, it also has this part up at the top that says, "diagnostic and therapeutic covered services when prescribed by an insured physician and authorized by the managed care program." What does it mean by "authorized by the managed care program"?

A That would be part of the utilization management review --

Q So --

A -- process.

Q So it would be covered if it was part of -- if it was approved by utilization review?

A Correct.

Q And it's approved by the utilization review if it's medically necessary?

A Correct.

Q And it's only medically necessary if it's the appropriate level of service?

A Yes.

MR. ROBERTS: So let's go to -- back to page 64, Riza. 13.63 up at the top.

BY MR. ROBERTS:

Q We just saw that reference to the -- approved by the managed care program, right. Now that's another definition in Mr. Eskew's policy. "Managed care program means the process that determines medical necessity and directs care to the most appropriate setting to provide quality of care in a cost-effective manner." Is that standard in the United policies that you reviewed in the past?

A Yes.

Q So when -- when you were getting asked all afternoon about you were considering costs, you were considering whether proton beam was a lot more than any other therapy or more than IMRT, is cost actually something you're required to consider under the language of the contract between Sierra Health and Life and Mr. Eskew?

A Yes.

Q Is a treatment appropriate if it costs more and has not been proven to be better?

A No.

MR. ROBERTS: Riza, can you go now to Exhibit 5. It's already in evidence. Pull up page 11 for me. All right. Let's go to the

paragraph beginning "radio therapy," and just blow that up. You're -- there you go. Right there.

BY MR. ROBERTS:

Q And this was a paragraph, which Mr. Terry spent some time with you on, right?

A Yes.

Q And Dr. Liao with her request for preauthorization for proton beam therapy indicates here that additional radiation dose to these structures puts the patient at risk for possibly side effects, let's go through them one by one because we didn't really go through them, including pericarditis. Did I say that right?

A Yes.

Q What's pericarditis?

A It's inflammation of the coverings of the lungs.

Q Does that have anything to do with the esophagus?

A No.

Q Myocardial Infarction. What's that?

A That's a heart attack.

Q Does that have anything to do with esophagitis?

A No.

Q Respiratory distress syndrome. What's that?

A Inflammation of the lung leading to shortness of breath.

Q Esophagus?

A No.

Q And I'm going to screw this up again, pneumonitis?

A You said it correct. Pneumonitis is inflammation of the coverings of the lungs.

Q Of the lungs?

A Correct.

Q Esophagus?

A No.

Q To your recollection, did she say anything here that she was worried about the complications to the esophagus?

A No, I don't see that.

Q Is esophagitis a known complication of administering chemotherapy simultaneously with any kind of radiation therapy?

A Yes, it's very common.

Q So in this same letter, Mr. Terry showed you that there was a -- information about a software system that MD Anderson used, the pinnacle system, correct?

A Yes.

Q Okay. And in opening statements, which you weren't here during opening statements, right?

A Correct.

Q You didn't see them?

A I didn't.

Q So Mr. Sharp showed the jury some images from the pinnacle system.

MR. ROBERTS: We have any objection to me displaying a couple of those images so that they can place them? Do you know

which exhibit number you used? I know that's an agreed exhibit.

MR. SHARP: Well, do you mean you want him to interpret the --

MR. ROBERTS: I don't. I just want to see if he ever saw them before. If they were in this packet that he got from MD Anderson.

MR. SHARP: I think you know the answer to that, but I don't -- I think --

MR. TERRY: Well, let's stipulate to the fact they weren't in there --

MR. ROBERTS: Okay.

MR. TERRY: -- if you'd like that.

MR. ROBERTS: I would. That would be great.

MR. TERRY: Okay.

BY MR. ROBERTS:

Q So images generated from the pinnacle system showing relative doses of radiation and the tumor and surrounding tissue was anything like that in the packet you got from Dr. Liao of MD Anderson?

A No.

Q Was there anything that you got in the packet that told you wow, this case is different, and Mr. Eskew really needs proton beam therapy?

A No, there was not.

MR. ROBERTS: Could you pull up page 33 for me, Riza?

BY MR. ROBERTS:

Q Now, this is the denial letter which you were also shown,

February 5th, 2016?

A Yes.

Q And you acknowledged that your signature is on it, but you didn't sign it, right?

A Correct. Yes.

Q Were you aware that your signature was being put on denial letters?

A Yes.

Q And even though you didn't review this letter and sign it, did you review the file and recommend denial of coverage for this claim?

A Yes, I did.

Q And do you have a problem with the fact your signature was on there?

A No, I don't.

Q Why not?

A It's consistent with the decision that we make.

MR. ROBERTS: And if you could blow up the last bullet point in the box for me, Riza.

BY MR. ROBERTS:

Q So the jury previously saw this. Does this accurately set forth your reasons for denying preauthorization for proton beam therapy in Mr. Eskew's case?

A Yes, that's correct.

Q And could you read that last -- next to the last to the last sentence to the jury?

A "Current published evidence does not allow for any definitive conclusions about the safety and efficacy of proton beam therapy to treat your condition."

Q Okay. So you acknowledged to Mr. Terry that you knew proton beam therapy was more expensive than IMRT, but you couldn't quantify it exactly. Is that fair?

A Yes.

Q So you knew that it was more expensive, what they were requesting, right?

A Correct.

Q And did you think it was better to justify the additional expense?

A No, I did not.

Q And how did you know that current published evidence does not allow for any definitive conclusions about the safety and efficacy of proton beam therapy to treat his condition, his lung cancer?

A Because the policy has -- I'm sorry, the policy lists its -- lists in there the literature that supports the -- both the proven and the unproven conditions. And my knowledge and experience in -- in oncology I know as well that at that time it was not something that was established as superior or even equal to alternate therapies such as IMRT.

Q Before this request, had you reviewed other requests for preauthorization for proton beam therapy for cancer?

A Yes.

Q Had you previously reviewed the medical policy that you ultimately based your decision on?

A Yes, many times.

Q The whole thing or just portions of it?

A All of it.

Q All of it?

A Yes.

Q And does that policy contain anything other than just the summation that it's considered unproven for the following cancers and has lung cancer listed?

A There's --

Q Is there anything other than that it has to support that conclusion?

A Yes. There are several pages of literature some with quite a bit of detail that actually describe the clinical trials and the results that either support or don't support each one of the listed diagnoses.

Q And which is considered better, non-randomized clinical trial or randomized clinical trial?

A Randomized clinical trials.

Q And at this time in 2016, had proton beam therapy been proven to be more effective in any way than IMRT to the treatment of lung cancer?

A No. It had not been proven, and I don't know if it's even proven today.

MR. TERRY: I'm sorry, I couldn't hear that last part. What --

I'm sorry, Your Honor.

THE WITNESS: I said I don't know if it's even proven today.

MR. TERRY: Thank you.

MR. ROBERTS: So Riza, if you could pull up page 28, Exhibit 5, page 28.

BY MR. ROBERTS:

Q And 28 here do you recognize that?

A Yes.

Q And then next page, 29. So this is a portion of the proton beam policy, correct?

A Yes.

Q And this is in the file, and there's certain things highlighted here.

MR. ROBERTS: Could you blow up that paragraph so we can see the highlights, Riza?

BY MR. ROBERTS:

Q So what's highlighted is "Proton beam radiation therapy is unproven and not medically necessary for treating all other indications including but not limited to" and then lung cancer is highlighted. Is that correct?

A That's what's highlighted, correct.

Q And is that a portion in the policy you cited in your denial letter or that was cited in your denial letter? Do you recall?

A This is the part of the policy that we looked at. Is that what you asked?

Q Yes. Part of the policy you relied on?

A Yes.

Q But it was implied that, you know, United was being inconsistent because it was invested in some proton beam equipment and -- but yet it was denying proton beam therapy here at some point. Let's go back to the first page. And this is the same policy that we reviewed.

MR. ROBERTS: Page 28, Riza. And could you blow up under benefit considerations. No, let's go back to the next page. Sorry. My notes were wrong. Go back to the next page. Okay. Stop there. Under the coverage rationale, I'm in the first three bullet points. There we go.

BY MR. ROBERTS:

Q Did United's medical policy at this time find that all proton beam therapy was not medically necessary for all cancers?

A No, there are those that are listed here as proven.

Q And which cancers according to United's policy had been proven to be appropriate for proton beam therapy?

A Ocular tumors so tumors originating or inside the eye, as well as tumors that kind of fall at the base of the skull which is this area here.

Q When you were applying this medical policy for lung cancer, tell the jury did you think you were applying some cost-based policy that was generating profits even though treatment was needed?

A That's never the case. As a UM medical director, we do not look at the cost as a consideration even though the policy has a

stipulation in there. We look to see the scientific evidence that supports the request or not.

Q Have you ever approved a request for treatment that was not covered by, presumptively covered by, United policy?

A Yes.

Q Have you approved treatments that cost more even though they were not covered by United policy?

A Yes.

Q Has anyone ever criticized you for those decisions?

A No.

Q Now, you were shown a sheet which shows, I guess, over a four year period you made a little under 200,000 a year from United?

A Yes.

Q Is that way more than you could make practicing medicine as an oncologist?

A No, it's not. It's way less.

Q Way less. So you took a pay cut to take your current position?

A Yes.

Q And when you went through and did your preauthorization reviews for this case and others, did anyone tell you how long you can take to do those reviews?

A No. In fact, I was paid by the hour so I could take as much as I wanted.

Q And if you had taken more time, would you have gotten paid

more or less from United?

A More.

Q So United incentivized you to take as much time as you wanted?

A I suppose you can call it that.

Q But were you comfortable at the time that you'd taken enough time to make a fair decision or were you feeling rushed because you had a lot of claims that week?

A No, I think I spent enough time, the appropriate amount of time.

Q Do you have any quotas as to the total number of claims you have to get through every week?

A No, we do not.

MR. ROBERTS: So Riza, can you go down to the letter at page 39, I think? Okay. If you could blow up the notice of appeal rights? Okay. There we go.

BY MR. ROBERTS:

Q So was this part of the denial letter which went to Mr. Eskew?

A Yes.

Q Was a copy of that letter provided to Dr. Liao at the MD Anderson Center?

A Yes, it would have been.

Q And it contained this notice of appeal rights, and we've talked about appeals. It says, "You have the right to appeal any decision

we make that denies payment on your claim or your request for coverage of healthcare service or treatment." If you don't understand the reason, is that one of the reasons you can appeal?

A Is that a question to me?

Q Yes.

A You can appeal for any reason whatsoever.

Q And the last bullet point, can you appeal because you disagree with the denial?

A Yes, that would be the most common reason to appeal.

Q So again, you weren't here in opening statement, but the jury was told that Dr. Liao did not appeal because she didn't have time. She wanted to start treatment immediately. Do appeals take a long time?

MR. TERRY: Objection, Your Honor. Mischaracterizes the opening.

THE COURT: Overruled.

MR. ROBERTS: Let's go to -- let's go to page 36. Could you highlight the "expedited appeal rights?"

BY MR. ROBERTS:

Q The letter indicates that "an expediated internal appeal may be available if a medical condition is such that the time needed to complete a standard appeal could seriously jeopardize the patient's life or ability to regain maximum function. You must request an appeal within 24 hours from receiving that notice. If we confirm that an expedited appeal is needed, we will complete the review within 72 hours of receiving the appeal request or any additional information they

wanted to send;" is that correct? Did I read that right?

A Yes.

Q And you do appeals now. Does United review appeals within 72 hours if it's requested for medical urgency?

A Yes, correct.

Q And this letter is dated February 5th, correct? You remember?

A I -- yes.

MR. ROBERTS: Can you go to page 33, please?

BY MR. ROBERTS:

Q Page 33, letter dated February 5th. Do you know if Mr. Eskew's IMRT treatment was actually started within 72 hours of this denial letter, or did it take longer, or you don't -- you don't know?

A I don't know.

MR. ROBERTS: Okay. Is this a good time to stop, Your Honor? I seem to be a minute over.

THE COURT: Yes, we can stop now.

MR. ROBERTS: Thank you. Thank you very much.

THE COURT: Ladies and gentlemen, as promised, we will not have trial tomorrow or Friday. We'll resume Monday at 9 a.m.

During this time period, you are instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You are not to read, watch, listen to any report of or commentary on the trial by any person connected with the case or by any media information, including but not limited to, newspapers,

television, internet, or radio. You are not to conduct any research on your own relating to this case such as consulting dictionaries, using the internet, or using reference materials. You are not to conduct any investigation, test any theory of the case, recreate any aspect of the case, or in any other was investigate or learn about the case on your own.

You are not to talk with other, text others, Tweet others, Google issues, or conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney involved in this case. You are not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

Ladies and gentlemen, I cannot stress this enough. You have heard today about different types of cancer treatments that you're probably not familiar with. It would be a violation of your oath if over the weekend you were to start Googling these issues. Do you understand that?

We cannot have a situation when you go back to the jury deliberation room and one of your fellow jurors says oh, yeah, by the way, I decided to Google these issues because I wanted to know more about these types of cancer treatments. If that happens, we would have to start this trial all over again from scratch. Do you understand that? If you find out that a fellow juror has violated this oath, you will tell the Marshal, correct?

THE JURORS: Yes.

THE COURT: All right. Thank you.

We will see you Monday at 9 a.m. Thank you.

THE MARSHAL: All rise for the jury.

UNIDENTIFIED SPEAKER: Just leave this here?

THE MARSHAL: Yep, leave all the notepads.

[Jury out at 4:47 p.m.]

[Outside the presence of the jury]

THE COURT: Do the parties have any issues they need to address outside the presence of the jury?

MR. ROBERTS: Not for the Defense, Your Honor.

MR. TERRY: Maybe just a slight change of plans as far as order of witnesses on our side now that [indiscernible]. We anticipate finishing Dr. Ahmad Monday and then going straight to Dr. Chang after that just so you guys know.

MR. ROBERTS: Okay. Would you like Ms. Sweet to be here Monday or do you want to reschedule her?

MR. TERRY: Probably be here Monday, but after Dr. --

MR. ROBERTS: Afternoon?

MR. TERRY: Yeah. I don't know how long Dr. Chang will go, but we put Chang on -- we got to get him on Monday because of his --

MR. ROBERTS: We're going to get him on and off.

MR. TERRY: Yeah, we got to get him on and off Monday.

MR. SHARP: Dr. Ahmad for 9.

MR. TERRY: Yeah.

MR. SHARP: [Indiscernible]

MR. TERRY: Well, we can work out all the details, Your Honor. Just wanted to let you -- give you a heads up. We might have a

[indiscernible].

THE COURT: Thank you, Mr. Terry.

MR. ROBERTS: I should be halfway done, more or less.

MR. SHARP: You can have him up to lunch. I just wanted you to hear the schedule --

MR. ROBERTS: Yeah.

MR. SHARP: -- for 9 a.m.

THE COURT: Off the record.

[Proceedings adjourned at 4:49 p.m.]

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above entitled case to the best of my ability.

Jessica B. Cahill

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