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 7 of 18

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REDIRECT EXAMINATION

BY MR. TERRY:

Q Dr. Chang, do you believe that the treatment of lung cancer with proton beam therapy is theoretical?

A No. We treat patients everyday with proton beam radiation therapy for lung cancer.

Q Is the -- are the benefits of proton beam therapy treatment theoretical to the children that you treat?

A No.

Q Or the --

A It's not theoretical.

Q Or the adults with lung cancer that you treat?

A No. It's not theoretical.

Q Does the literature support the use of proton beam therapy?

A Yes. The literature supports the use of proton beam therapy for the treatment of cancers.

Q Does the --

A The question is the theoretical for how much better than x-rays.

Q Does the literature cited in Sierra Health and Life's proton beam therapy policy support the use of proton beam therapy --

A Yes. The --

Q -- for lung cancer?

A When the policy was pulled I was trying to reference the other paragraphs all of which state that proton therapy is an acceptable

treatment. The question is how much more beneficial with protons is unknown for specific patients as compared to x-rays.

Q Should a --

A And those were all the references that were there.

Q Should a person -- should whether or not a person receives proton beam therapy be determined based on the clinical presentation that a person's condition when their doctor examines them in a clinic, or alternatively should it be treated based on all these papers and stuff?

A So as physicians our duty is to give the best care we can to the patient in front of us with the tools we have available. And if that tool is useable then we will use it.

Q Is that how decision making is done by radiation oncologists in the real world?

A Yes. By physicians in general we treat what is best for our patients with the tools we have available to us.

Q Now there was some discussion of an article that Dr. Liao wrote after -- a couple years after the decision was made to deny proton therapy to Bill Eskew. And so I want to ask you, there's been suggestion here that somehow Dr. Liao's articles represents an opinion by her that proton beam therapy for lung cancer is no good.

A That is correct.

Q Is that an accurate representation of what her article says?

A That is a completely inaccurate representation because the --

Q And tell us why?

A The article was doing a randomized study for patients who

had met two criteria and that's why I specified that it's a subset of lung cancer patients.

Q Okay.

A What the patients first were for randomization were patients that had both an x-ray plan and a proton plan done, like the comparisons that we were looking at.

Q Yes.

A For the patients whose DVHs were equivalent, then they were randomized to protons or x-rays on that study. If they were not equivalent, if the proton one showed better than they were not randomized, they were just treated with protons. Likewise the patients that were enrolled on the study would only be randomized if there was a net coverage of the treatment with insurance and so if a patient were not able to get insurance to pay for the treatment they would not be randomized in that study.

What that led to is the patients that had the equivalent picture, the equivalent DVHs through randomization only had patients that were approved first to get proton therapy covered. Because Medicare covers it what we saw in the patients that were randomized that median age, that is the age a patient's treated with proton therapy was 80 years of age. The patients that were treated with x-ray therapy were 41 years of age. That by itself is a big difference in the overall outcomes of a patient. If I didn't say protons or IMRT or anything, if I just said I'm treating lung cancer and 100 patients are 41 with chemotherapy and 100 patients with protons or with x-radiation and chemotherapy in someone who is 80

years of age there's going to be a survival outcome simply from the age difference.

And because protons is only allowed for the patients that have insurance coverage that led a very, very much older population of patients that had proton therapy as compared to those who had x-rays. And again, that randomization only took place after the DVHs were determined to be equivalent, if they were not they were just treated with proton therapy. And Dr. Liao was the head of the study who knew that as she wrote it that way and she is the one who saw this patient for decision making.

Q Now you've seen Dr. Liao's deposition in this case, right?

A I have.

Q Did she diagnose, or did she opine in her deposition that Mr. Eskew developed grade 3 esophagitis?

A Yes. And she stated that in her discussions with him he developed grade 3 esophagitis.

Q The -- these follow up appointments that we've read, is there anything about the evidence that you've seen, in the records or in the testimony of the family members for the Eskew family that is inconsistent with the idea that IMRT led to cause Mr. Eskew to develop chronic esophagitis?

A No. It sounded like it was very classic for chronic esophagitis, but again difficulty keeping food down or getting food down.

Q And that's your opinion to a reasonable degree of medical

probability?

A Yes.

Q All right. And that's true, is your opinion the same even though Mr. Eskew's weight fluctuated?

A That's correct. It went up when he was able to get the TPN in -- oh sorry. Right after the radiation finishes the acute stuff resolved, he ate and got better. Started decreasing again. Now I agree some of it was likely due to an infection when his weight decreased. They got the infection taken care of, they got him on the TPN. It got better, but it continued to decline after that as he was noted to not be able to keep food down or want to eat.

Q Are you aware of something called the New York Proton Center?

A Yes, I am.

Q Were you aware of it before --

MR. GORMLEY: Objection, Your Honor. May we approach?

THE COURT: Yes.

[Sidebar at 4:58 p.m., ending at 4:58 p.m., not recorded]

BY MR. TERRY:

Q Dr. Chang, you're aware of something called the New York Proton Center?

A Yes, I am.

Q And you've known about it since before this case?

A Yes, I have.

Q Is it widely known in the radiation oncology community?

A Yes. We are aware of the New York Proton Center.

Q And who -- are you aware that United Healthcare is one of the owners of it?

A Yes, we are. That was brought up at a large conference previously when pointing out the fact that their policies are not consistent with the ownership of their proton center in New York, which is opened and stating that they treat all sorts of cancers with proton therapy and the benefits.

Q Do they treat lung cancer at the New York Proton Center that's owned by United Healthcare?

A Yes. And the medical director is one of the lung cancer specialists in the field of radiation oncology.

Q The medical director of New York Proton Center is a lung cancer specialist?

A Yes.

Q Have you seen their website?

A I have.

Q Does it say that they treat lung cancer?

A It does.

Q Does it say why they treat lung cancer with proton therapy?

A Because it reduces the side effects like lung pneumonitis, esophageal toxicity, heart toxicity and so forth.

Q So their website says that it's good to use lung -- proton therapy to treat lung cancer to reduce the risks of esophagitis?

A Well, it's not United --

MR. GORMLEY: Objection. Ambiguous as to their.

THE COURT: Say that again?

MR. GORMLEY: Objection. Ambiguous as to their.

THE COURT: Overruled.

THE WITNESS: It's not the United Healthcare website, it's the New York Proton Center's website that states that.

BY MR. TERRY:

Q Right. And it says that they treat lung cancer with proton therapy?

A Yes.

THE COURT: We're going to take our evening 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 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, the internet or radio.

You are not to conduct any research on your own relating 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 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 are not to form or express any opinion on any subject connected

with the trial until the case is finally submitted to you.

We'll start at just after 9:00 a.m. tomorrow. Thank you.

THE MARSHAL: Okay. All rise for the jury. Leave your notepads on your seats, thank you.

[Jury out at 5:01 p.m.]

[Outside the presence of the jury]

THE COURT: Okay. Who do the parties anticipate calling tomorrow?

MR. TERRY: Matt, who are we going with first?

MR. SHARP: I'm sorry, Your Honor.

MR. TERRY: Shelean Sweet I think is the first one.

MR. SHARP: We have Shelean Sweet, we have Dr. Liao's deposition being read, we have Ms. Amogawin coming tomorrow, right?

MR. GORMLEY: She was Wednesday morning.

MR. SHARP: Wednesday morning for her, so.

MR. GORMLEY: I think Gustavo if you wanted him.

MR. TERRY: Guerrero.

MR. SHARP: Guerrero, and then we have Mr. Prater available in the -- oh Mr. Sweet in the afternoon and Mr. Prater available in the afternoon. Mr. Flood, I'm sorry. There are two Sweets.

THE COURT: All right. So Sweet, Liao, Guerrero, Prater and Flood?

MR. SHARP: Yeah, that's the plan.

THE COURT: All right.

MR. TERRY: Is that clear?

THE COURT: That's very clear. All right.

MR. SHARP: There will be people.

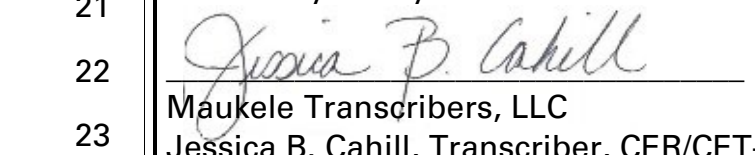
THE COURT: So see you tomorrow.

GROUP RESPONSE: Thank you, Your Honor.

THE COURT: Thank you. Have a good evening.

[Proceedings adjourned at 5:02 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.



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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
TUESDAY, MARCH 22, 2022

RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 5

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		

Las Vegas, Nevada, Tuesday, March 22, 2022

[Case called at 9:05 a.m.]

THE MARSHAL: -- come to order. We're on the record.

All rise for the jury.

[Jury in at 9:05 a.m.]

THE MARSHAL: All jurors present.

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

MR. SHARP: Yes, Your Honor.

MR. ROBERTS: Yes, Your Honor.

THE COURT: Thank you. Please be seated.

Mr. Sharp, are you ready to proceed?

MR. SHARP: Yes. Our next witness -- and I hope I don't mispronounce her name -- Shelean Sweet.

MS. SWEET: Shelean Sweet. Yes.

MR. SHARP: Shelean Sweet. I'm sorry about that.

MS. SWEET: That's okay.

MR. SHARP: I have a problem names.

THE COURT: Ma'am, would you stand and be sworn in by the clerk?

THE WITNESS: Yes, ma'am.

SHELEAN SWEET, PLAINTIFFS' WITNESS, SWORN

THE CLERK: Can you please state and spell your first and last name for the record?

THE WITNESS: Shelean Sweet. S-H-E-L-E-A-N S-W-E-E-T.

THE COURT: Thank you. You can be seated.

THE WITNESS: Thanks.

THE COURT: Mr. Terry, go ahead.

MR. SHARP: Thank you, Your Honor.

THE COURT: Mr. Sharp.

DIRECT EXAMINATION

BY MR. SHARP:

Q Ms. Sweet, nice to see you. Can you tell the Ladies and Gentlemen of the jury what you do for Sierra Health and Life and UnitedHealthcare?

A Yes. I am the director of prior auth or pre-service review.

Q So the procedure that we're talking about today would apply to Mr. Eskew's proton beam therapy claim or any other preauthorization claim?

A Correct.

Q And you were also designated as you recall, to testify on behalf of Sierra Health and Life on certain subject matters?

A Yes.

Q You remember that when I took your deposition?

A Yes, sir.

Q One of those subject matters was the evaluation of Dr. Ahmad; is that right?

A Correct.

Q And one of those other subject matters also included MBO

Partners?

A Yes.

Q And then also I believe, the denial text?

A Correct.

Q I may have missed some in between but as we go through -- so would it be fair to say as the pre-service review director, Sierra Health and Life and UnitedHealthcare had not told you that Sierra Life had a duty of good faith and fair dealing to its insurers?

A That -- yeah. In those particular words, we -- they have not told me that we have a duty of good faith and fair dealing -- sorry. I'm not familiar with that particular term.

Q Yeah. So the answer to my question would be --

A Yes.

Q Yeah. And one of the things that -- just like in the deposition we had -- the Court is recording what we are saying so if we could just -- if I interrupt you, let me know; and if you interrupt me, I'll let you know. But most important thing is to -- so we have a clear recording.

So as I understand it, in 2011, UnitedHealthcare started a business relationship with MBO Partners?

A I don't recall the exact date, but I know that business relationship was started. I just don't recall the exact date.

Q Okay.

MR. SHARP: Your Honor, may I approach?

THE COURT: Of course.

BY MR. SHARP:

Q I put a binder in front of you with some exhibits and within that binder, they'll be some tabs. So if you could go to Exhibit 56?

A Just a minute here. Hold on.

Q I can help you find that if it --

A Oh, no, no, no. I found it. It's just that there's a little ring here that's a little messed up. Sorry. It's going. I'm getting there. Okay. I'm on tab 56.

Q And this is a document called -- entitled master services agreement?

A Yes. I see that.

Q And it's between UnitedHealthcare Services, Inc., and MBO Partners?

A Yes. Okay.

MR. SHARP: Your Honor, I move for the admission of Exhibit 56.

THE COURT: Any objection?

MR. ROBERTS: No objection, Your Honor.

THE COURT: Exhibit 56 will be admitted into evidence.

[Plaintiffs' Exhibit 56 admitted into evidence]

MR. SHARP: And Jason, can you pull up Exhibit 56? The first page and if you could blow up where it says this first paragraph, master services agreement?

BY MR. SHARP:

Q So the master services agreement reads, "This master services agreement is made as of March 1, 2011 between

UnitedHealthcare Services on behalf of itself and its affiliates." And it continues, "and MBO Partners, Inc." Did I read that correctly?

A Yes.

Q And then is it your recollection that Dr. Ahmad also entered into a relationship with MBO Partners?

A Correct. He is part of MBO Partners. Don't quite remember that date either.

Q Before he was part of MBO Partners, he was also consulting with Sierra Health and Life?

A Yes.

Q And Sierra Health and Life also -- there's also an HMO called Health Plan of Nevada?

A Correct.

Q And they're kind of managed collectively, if you will?

A Yes.

Q So the procedures that we're going to talk about today apply equally to Health Plan of Nevada?

A Correct.

Q So if you could go to Exhibit 47? And is Exhibit 47 entitled vendor service contractor's agreement?

A Yes, I see that.

Q And it's between MBO Partners and Physician Legal Consultants?

A Sorry. I'm reading. Oh, yes. Okay.

MR. SHARP: And Your Honor, I'd move for admission of

Exhibit 47.

THE COURT: Any objection, Mr. Roberts?

MR. ROBERTS: No objection, Your Honor.

THE COURT: Exhibit 47 will be admitted into evidence.

[Plaintiffs' Exhibit 47 admitted into evidence]

MR. SHARP: So Jason, if you could pull up Exhibit 47? And if you could pull up the first paragraph?

BY MR. SHARP:

Q So this is a contractor agreement that MBO Partners is entering into with Physician Legal Consultants, right?

A Yes.

Q And is it your understanding that Dr. Ahmad had a company called Physicians Legal Consultants?

A Yes.

Q So --

MR. SHARP: You can pull that down.

BY MR. SHARP:

Q So the purpose -- MBO Partners would submit bills to UnitedHealthcare?

A Yes, an invoice. Yes.

Q And so it was kind of like facilitating the billing process to UnitedHealthcare?

A Correct.

Q So before the contract was entered into, is it your recollection that UnitedHealthcare referred Dr. Ahmad over to MBO

Partners?

A I'm not quite sure how he got there. I apologize for that. I'm just not sure.

Q Let's -- if you could take a look at Exhibit 48?

A Sure.

Q Just let me know when you're there.

A Oh. Yes, I'm here.

Q Okay. And so this is entitled independent contractor referral template? Did I read that correctly?

A Yes.

Q And then on the -- well, as I'm looking at it, on the left side, MBO Partners? Did I read that correctly?

A Yes.

Q And then on the right side is United Health Group?

A Uh-huh.

Q Is that right?

A Correct.

Q I don't mean to be rude, but the -- audibly uh-huh --

A I apologize --

Q No, no, no. That's --

A Am I speaking -- not speaking loudly enough?

Q No, no, no. Uh-huh aren't picked up by the court recorder. That's fine. I mean, you don't live in our world.

So then on the contractor information it's identified as Physician Legal Consultants, Inc., Shamoon Ahmad?

A Yes.

Q And then down on manager information, Valerie Grossjean [phonetic]?

A Yes, that's [Gro-Jahn].

Q [Gro-Jahn]. I'm sorry. And she's somebody with UnitedHealthcare?

A Yes.

MR. SHARP: Your Honor, I'd move to -- I'm sorry. I move for the admission of Exhibit 48.

MR. ROBERTS: No objection, Your Honor.

THE COURT: Thank you. Exhibit 48 will be admitted into evidence.

[Plaintiffs' Exhibit 48 admitted into evidence]

MR. SHARP: Jason, can you bring up Exhibit 48? So Jason, can you bring up the contractor information first?

BY MR. SHARP:

Q And Ms. Sweet, we have -- there is the contractor information, Physician and Legal Consult, Inc., Shamoon Ahmad; is that correct?

A Yes.

MR. SHARP: And Jason, if you could go down to project information?

BY MR. SHARP:

Q So on the project information, it says project title oncology services review program; did I read that correctly?

A Yes.
Q And then over there it says start date, August 20, 2011?
A Yes.
Q So this is the -- from your recollection, this is when MBO Partners was working with UnitedHealthcare?
A Yes, based on this piece of paper. Yes. Uh-huh.
Q Now, on the top it says, "project information consultant is an oncologist who advises plan directors -- plan medical directors regarding oncology services as they relate to member needs and plan benefits." Did I read that correctly?
A Yes.
Q And that was basically a summary of what Dr. Ahmad was doing at the time --
A Yes.
Q -- for Sierra Health and Life and Health Plan of Nevada?
A Yes.
Q And then it continues, "consultant does not make authorization or denial decisions." Did I read that correctly?
A You did.
Q And is that because at that point in time in 2011, Dr. Ahmad was not making those decisions?
A Correct. It appears so, yes.
Q And at some point thereon after that, he started to make denial decisions?
A Yes.

Q If you could move to Exhibit 48?
A Okay.
Q Oh, I'm sorry. Exhibit 49.
A Oh. Thank you.
Q We just had 48 up. And is this document also entitled independent contractor referral template?
A Yes.
Q And does it also deal with Dr. Ahmad?
A Yes.
Q And it has on the contract MBO Partners and United Health Group?
A Yes.
MR. SHARP: Your Honor, I'd move for the admission of Exhibit 49.
THE COURT: Any objection, Mr. Roberts?
MR. ROBERTS: Yes, Your Honor. The start date is 11/1/2016 so object on relevance.
THE COURT: Mr. Sharp?
MR. SHARP: Well, it goes to the scope of their relationship, which we -- on cross, he was brought out that he continued to work for the company, was on the appeals program, etc.
THE COURT: Overruled. Exhibit will be admitted into evidence.
[Plaintiffs' Exhibit 49 admitted into evidence]
MR. SHARP: Jason, if you could bring up Exhibit 49 and just

start with the contractor referral template.

BY MR. SHARP:

Q And again, we have Dr. Ahmad as the contractor information; do you see that?

A Oh. I'm sorry. Yes, I do see that.

Q Okay. Thank you.

MR. SHARP: And then Jason, if you'd go down to project information?

BY MR. SHARP:

Q So this is project information and then it says here, end client project titled consultant; do you see where I'm at?

A Yes, at the top line. Yes.

Q And then it says over here, start date November 1, 2016 to May 1, 2017?

A I see that.

Q Did I read that properly?

A Yes.

Q So at least from your understanding, that between 2011 to 2016, Sierra Health and Life, UnitedHealthcare were satisfied with Dr. Ahmad's performance?

A Yes. And then apologies just because this particular agreement is related to SMA, they had -- they separated the -- their patient volume at the time. So I just want to state that. It's not quite applicable to all of Sierra Health and Life. This is a different -- a different type of a group.

Q That's fine. I mean, I --
A Okay. But, yes. I would --
Q -- SMA is Southwest Medical Associates?
A Yes. Yes.
Q Can you tell the jury what Southwest Medical Associates is?
A Southwest Medical Associates is a physician group, and it has multiple specialties and at this time, they also decided to manage their prior authorization and UM as well. And that's what they were using Dr. Ahmad for. So --
Q So Southwest Medical Associates was managing their own preauthorizations?
A Yes, for a certain product -- the Medicare product.
Q Through Dr. Ahmad --
A Yes.
Q -- or in part --
A Or just he -- in part, yes.
Q And so Southwest Medical Associates is an entity within the United Health Group that provides medical care?
A Yes, sir.
Q Okay. In any event, my point was that at least as of 2016, UnitedHealthcare, Sierra Health and Life were satisfied with Dr. Ahmad's performance?
A Correct.
Q If you could go to Exhibit 50?
A I'm here.

Q And this is again another independent contractor referral form?

A I see that, yes.

Q And it's between MBO Partners and United Health Group?

A Yes.

Q And the start date on that form is February 28, 2017 through February 28, 2018; did I read that correctly?

A Correct.

MR. SHARP: Your Honor, I move for the admission of Exhibit 50.

MR. ROBERTS: No objection, Your Honor.

THE COURT: Exhibit 50 will be admitted into evidence.

[Plaintiffs' Exhibit 50 admitted into evidence]

BY MR. SHARP:

Q And so it would be fair to say that as of February 28th, 2000 and -- or February 28, 2017, Sierra Health and Life, UnitedHealthcare continued to be satisfied with Dr. Ahmad's work?

A Correct.

Q And in fact, at one point, didn't Dr. Ahmad go to work for Optum?

A I can't speak to exactly when he did. I know he stopped working for us and I can't speak to his other endeavors. I apologize.

Q He came to be an employee within UnitedHealthcare Group, right?

A Yes. I -- yes.

Q When that happened, you don't recall?
A No.
Q Now, I want to talk about --
MR. SHARP: Can we bring up Exhibit 7?
BY MR. SHARP:
Q Exhibit 7 is an invoice -- so Exhibit 7 is an invoice to UnitedHealth Group; is that right?
A Oh. Yes.
Q And a description is employer and individual oncology service review program?
A Yes.
Q Now, this -- in terms of the reviews that Dr. Ahmad was performing for Health Plan of Nevada and Sierra Health and Life, as I understand it, he would submit time cards to you?
A He did start submitting time cards to me. I don't think he was submitting time cards to me at that time.
Q Okay. So who would be getting his time cards as of March 29, 2016?
A I believe -- I do not know who that was. It -- just based off of who signed the form or who completed the form, it may have been Roberta Junia [phonetic].
Q Is she somebody working for Sierra Health within the Sierra Health and Life area?
A Yes.
Q Okay. And at some point, you became responsible for

reviewing time records?

A Correct.

Q And as I understand it, those time records were not billed down specifically per review?

A Correct.

Q Now, that was part of the system that had been implemented by UnitedHealthcare?

A Yes, it was implemented by -- well, not by me. Is that fair --

Q Yeah. In other words --

A -- UnitedHealthcare. So somebody.

Q It would be no skin off your back if UnitedHealthcare said Dr. Ahmad, we want you to split out your reviews on a per review basis?

A I would comply with whatever process they -- they told me to adhere to.

Q So if we --

MR. SHARP: Jason, if you could just pull up the reviews.

BY MR. SHARP:

Q So for example, where it says two one sixteen approved by June -- by Roberta Young, 11 cases; do you see where I'm at?

A Yes, I see it. Thank you.

Q So that -- what we are seeing here was part of the policies and practices that were adopted by UnitedHealthcare?

A It looks to be part of his time -- whatever he submitted for time at the time, yes.

Q Yeah. And my only point is is that the submission as it exists

before you in Exhibit 7 is consistent with the policies and procedures that were adopted by Sierra Health and Life and UnitedHealthcare?

A Yes.

Q And you weren't the person that adopted those policies and procedures?

A I was not.

Q You're the person that in some respects may implement them?

A Correct.

MR. SHARP: You can take that off.

BY MR. SHARP:

Q Now, in your role as the pre-service review director, do you from time to time have the responsibility of reviewing the agreement of coverage?

A Correct.

Q And when we say the agreement of coverage, that's the insurance contract between the insured and Sierra Health and Life?

A Yes, sir.

Q And in the course of your job, you've become familiar with the definition of medically necessary as contained within the agreement of coverage?

A Yes.

MR. SHARP: Can you bring up Exhibit 4? And can you go to page 2624 -- or no, sorry. Page 38? And if you could blow up managed care through section 3.1?

BY MR. SHARP:

Q And Ms. Sweet, if you have a hard time seeing this on the computer screen, there are binders back there. I can help you find the physical paper --

A Thank you --

Q -- just so you know.

A Okay. Thank you.

Q So section 3 says this section tells you about SHL's managed care program and which covered services require prior authorization; did I read that correctly?

A Sorry. I'm just looking for the word. Oh, yes. At this top line here. Thank you.

Q Did I read that correctly?

A Yes, sir.

Q Thank you. And then it says HSL'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; did I read that correctly?

A Yes.

Q And medically necessary is capitalized because that's a term within the contract?

A Not quite sure why they capitalized it. But it's a term -- this is a contract and it's a term in it so --

Q That's fair.

A Yes.
Q You don't -- you don't write the contract --
A Correct.
Q -- is that correct?
A Correct.
MR. SHARP: And let's go, Jason, to -- so let's go to Exhibit 4, page 47. And go down to section 6 and just bring up section 6.1.
BY MR. SHARP:
Q And this section says, this section tells you what services or supplies are excluded from coverage under this plan?
A Correct.
Q Did I read that correctly?
A Yes, sir.
Q And so as you understand it, there are certain services that are covered and certain services that are not covered?
A Yes.
Q And a service that is not covered is referred to as an exclusion?
A Correct.
Q And so when the pre-service review people determine that a prior authorization request is seeking information that is not medically -- or seeking a procedure that is not medically necessary - with me so far?
A Almost. I'm sorry. Could you repeat that --
Q Yeah. Let's just --
A -- that first part there?

Q -- let's just take it as an example.
A Okay.
Q -- Somebody submits a prior authorization request and it's denied as not medically necessary.
A Yes. Okay. I follow you.
Q That means that particular procedure is a non-covered service?
A In a sense. And I'll -- if you don't mind, if I could add a little bit more explanation?
Q Sure.
A Okay. so under the covered service section, services are covered or approved by the health plan if they are medically necessary. Under the exclusion section, it's -- it's an explicit non-covered item as outlined in the -- in the list below. So there is not really a medically necessary -- a medical necessity review per say; it's more something is on this list of exclusions, and it's denied as not a covered benefit.
Q Okay. So let me just focus then on -- it says, complications resulting from a non-covered services, or services which are not medically necessary?
A Yes.
Q Okay. So you're department determines which services, in part, when it's a prior authorization, as to which services are medically necessary or are not medically necessary?
A Correct.
Q And so this section says services for which coverage is not

specifically provided, in this -- well, let's just do this. Services which are not specifically provided --

MR. SHARP: Highlight that, Jason. Sorry.

BY MR. SHARP:

Q -- or services which are not medically necessary. So what's being instructed to the insured here is if you have a service which the prior authorization people determine is not medically necessary and you go forward with that service, and there are some sort of complications, those complications are excluded, correct?

A Oh. Yes.

Q And so that's another reason why or one reason why Sierra Health and Life wants to make sure that it does a thorough job in determining whether a service is prior authorized or denied, fair?

A Yes. We do review -- correct.

MR. SHARP: Jason, let's go to -- let's go to page -- Exhibit 4, page 65. And if you go down to this section at the bottom and I don't know if you can pull up this part to make it all fit. The part right over here. No, below that. There we go. You got it. No, no. Take out this. No, I'm sorry. You have it right.

BY MR. SHARP:

Q So I have in front of you the definition of a pre-service claim; do you see that?

A Yes, sir.

Q And a pre-service claim says -- "means any claim for benefits under a health benefit plan with respect to which the terms of the plan

condition receipt of the benefit in whole or in part on the approval of the benefit in advance of obtaining medical care." Did I read that correctly?

A Yes.

Q And one of the things that the prior authorization department does is determine approval of the benefit in advance of obtaining medical care?

A Yes.

Q So with respect to this agreement of coverage, we can say a prior authorization is a pre-service claim?

A Yes.

MR. SHARP: Now, Jason, if you could go back to medically necessary. It's a page up. Exhibit 4, page 64. And if you go to 1355.

JASON: 64?

MR. SHARP: 13.66. Right here. And if you blow up medically necessary.

BY MR. SHARP:

Q And I'm showing in front of you the definition of medically necessary, correct?

A Yes.

MR. SHARP: And then if you go -- knock that down. And then put this paragraph --

BY MR. SHARP:

Q And it says here, this is the second paragraph of the definition of medically necessary, right?

A Yes.

Q So this is telling -- this provision is telling the insured these are the things that Sierra Health and Life may consider when determining whether something is medically necessary?

A Correct.

Q And it says Sierra Health and Life may give considerations to any and all of the following, right?

A Yes.

Q And then down at the bottom --

MR. SHARP: Could you highlight this final bullet point?

BY MR. SHARP:

Q -- it says inclusively, other relevant information obtained by Sierra Health and Life?

A Yes, it says that.

Q So one of the things that Sierra Health and Life has taught you and the pre-service review department, is that they are free to obtain relevant information relating to the prior authorization?

A Correct.

Q And so in other words, the whole process of this prior authorization is a non-adversarial process?

A Yes, we're not -- we're not opposed to anyone -- where reviewing a case objectively, yes.

Q In fact, you're working in part for the insured member, right?

A Yes.

Q You're trying to help them obtain the insurance benefit?

A Yes, we are reviewing services so that they can obtain

services, yes.

Q Yeah. Insurance benefits, right?

A Insurance benefits. Yes.

Q And so it would be fair to say that your expectation of Dr. Ahmad is that he would understand that one of his roles is to help the insured obtain the benefits under the policy?

A Right. To provide an accurate review and help members obtain services that you know, meet this definition here, yes.

Q And certainly, you're not here to suggest that Dr. Ahmad could not contact another provider and request medical information to answer any questions he may have?

A He's free to contact anyone to review a case, yes.

MR. SHARP: Jason, you can pull that down right now.

Your Honor, may I approach?

THE COURT: Yes.

BY MR. SHARP:

Q And I'm going to show you -- take out Exhibit 14.

A Okay.

Q I have in front of you Exhibit 14, and it's captioned utilization management policy?

A Yes.

Q And attached to it are a number of different policies?

A Correct.

Q And you're familiar with those policies?

A Yes.

MR. SHARP: Your Honor, I'd move for the admission of Exhibit 14.

MR. ROBERTS: No objection, Your Honor.

THE COURT: Exhibit 14 will be admitted into evidence.

[Plaintiffs' Exhibit 14 admitted into evidence]

MR. SHARP: Jason, can you pull up Exhibit 14, page 11, please? And if you could pull up first, just this decision-making hierarchy?

BY MR. SHARP:

Q So this document is entitled decision-making criteria hierarchy; is that correct?

A Yes.

Q And the first point is evidence of coverage, certificate of coverage for agreement of coverage documents and benefit plan summaries; do you see that?

A Yes.

Q And so in this particular case, we're talking about an agreement of coverage, right?

A Correct.

Q But the other names there are just different names for insurance contracts?

A Yes.

MR. SHARP: And then the last paragraph -- or the last sentence -- or the next to the last sentence where it starts with once. Actually, if you go to the paragraph and the sentence above that, Jason.

BY MR. SHARP:

Q So the first step on the prior authorization is determining whether -- determining if the requested service or procedure is a covered benefit is the first step in the decision-making process; did I read that correctly?

A Yes.

Q In other words, you're making sure that the specific item being requested is not excluded from coverage?

A Correct.

Q Next sentence reads, "Once it is determined that a service or procedure is a covered benefit, then the review for medical necessity follows." Did I read that correctly?

A Yes, sir.

Q Then it says if a requested service or procedure is not a covered benefit, the adverse benefit determination is made at this point and no further review is required?

A Correct.

Q So again, that's if the review comes in, it's excluded from coverage, then the client is denied?

A Yes.

Q Okay. So now we go to the next -- and the next hierarchy is number 2, HCO protocols?

A Yes.

Q And it says -- so this is the second step that one takes in the coverage hierarchy, right?

A Correct.

Q And it reads, HCO protocols are internally created exception protocols since they are the richer or the more restricted than the MCGTM care guidelines, they need to be reviewed first; did I read that correctly?

A Yes.

Q And then the next step -- step 3 is in the absence of an HCO protocol, the MCGTM care guidelines are used to determine medical necessity?

A Yes.

Q Is that correct?

A Correct.

Q And medical necessity is a different -- it's just a different way of saying medically necessary?

A Correct.

Q And so when we say the --

MR. SHARP: Pull that back up.

BY MR. SHARP:

Q So this terminology, MCG care guidelines, those are the -- those are the guidelines, or we've been referring to them as corporate medical policies that are developed by Sierra Health and Life and UnitedHealthcare?

A So the MCG care guidelines are developed by a separate company from UnitedHealthcare.

Q Okay.

A And the HCL protocols are the ones that are developed by UnitedHealthcare.

Q Oh, I'm sorry. So the top one is when we say internally created exceptions protocols?

A Yes.

Q So if we could go to page 14-22, and under 1.0. And this section reads, "The purpose of the policy is to ensure that nonbehavioral health and behavioral health utilization management decisions are made in a timely manner to accommodate clinical urgency of the situation and to minimize any disruption of the provision of healthcare." Did I read that correctly?

A Yes.

Q If we could go to page -- Exhibit 14 at page 25. And if we go to 3.14. So if we go -- it reads -- do you see where I'm at?

A Yes, I do.

Q And this section, 3.1.12.4, reads, "Notifications to members and practitioners on urgent and current decisions will be made by phone within 24 hours, and for urgent preservice decisions, within 72 hours." So a preservice decision is another way of saying a preservice claim?

A Correct.

Q And then, the section continues, "If the determination is adverse, phone notification will be followed by written notification of the decision within 72 hours." Did I read that correctly?

A Yes.

Q And then, we go to the next section. And it says -- 3.1.12.4.1

says, "A minimum of two attempts by phone will be made to contact commercial, Medicare, and Medicaid health plan members in the first 72 hours of the receipt of the request."

A Yes.

Q Did I read that correctly?

A Yes, you did.

Q And then it continues, "All verbal attempts as well as the outcome of each attempt is documented in the file," correct?

A Correct.

Q And if there's a message that's left, the file will document when that occurred.

A Correct.

Q And then the next one says -- and this is 3.1.12.4.2 -- "For commercial, Medicare, and Medicaid members, if the determination is favorable and verbal notification to the member is successful, written notification is not required." Is that right?

A Correct.

Q So if the claim is approved, notification is provided verbally to the insured. Or at least they attempt to provide it.

A Correct.

MR. SHARP: Now, let's go to the next paragraph, Jason.

BY MR. SHARP:

Q So 3.1.12.4.3 says, "For commercial, Medicare, and Medicaid members, if the determination is unfavorable, written notification is sent to the member via United Postal Service"?

A Yes.

Q "On the same day the decision was rendered if the verbal notification was unsuccessful."

A Yes.

Q Did I read that correctly?

A Yes.

Q If we could go to the next page. If we could go to 3.17.1 [sic]. So it says, "For urgent preservice decisions for commercial members, if the health plan is unable to make a decision due to lack of necessary information, the health plan my extend the timeframe once for up to 48 hours." Did I read that correctly?

A Yes.

Q And this type of program that we're going through, these things are available to people like Dr. Ahmad?

A Correct.

MR. SHARP: Now, if we go to the next page, Jason, page 27. If we go down to 3.1.19.

BY MR. SHARP:

Q So this reads, "If the request for healthcare services comes from a practitioner, the health plan sends the request for additional information to the practitioner. However, the plan notifies the member and the practitioner if it makes a decision to deny services." Did I read that correctly?

A Yes.

Q And so if the doctor's office makes a request for

preauthorization, Dr. Ahmad, any other medical director is free to request additional information from that doctor?

A Yes.

MR. SHARP: If we could go to --

MR. SHARP: Strike that. Sorry, Jason.

BY MR. SHARP:

Q So let me tell you just a little generally how it's beginning to -- you can take that down -- if we kind of transition to the actual how the process works. So if a physician's office or a hospital or whomever submits a request for prior authorization, it contains what's called CPT codes.

A Yes. They would submit with CPT codes, yes.

Q And tell the ladies and gentlemen of the jury what a CPT code is.

A Sure. So a CPT code is a specific number assigned to a service that a doctor or any provider wants to give to a member. How they bill is they'll use that specific number associated with that service to bill for that -- whatever service that they provided. A prior authorization request could be submitted with one CPT code or multiple CPT codes, just based off of what they want to do for a particular member.

Q And so as I understand it, the first step is the request comes in, and somebody is tasked with reviewing the CPT code.

A Correct. They -- the request can come in -- the provider could call in the request or they could fax the request to us, in which case, the -- we call it a clinical administrative coordinator. They are the

nonclinical staff who actually enters the information in the computer. So -- into our computer system so that the case is built so the provider can -- like, to tie it to the claims that the provider would be submitting.

So they'll gather the information from the provider if it's via phone or fax, or providers could also submit through our internet or our web portal. In those cases, the case would already include the CPT codes and whatever information they would like to include in the request.

So the clinical administrative coordinator would either build the case fully in the system or receive the case through the web portal. But they would be the first point of contact for any prior authorization received from a provider's office.

Q And certain CPT codes are identified within the system to give authorization?

A Correct. The clinical administrative coordinators can approve certain CPT codes or providers without clinical review.

Q And the CPT -- the people that are inputting the CPT codes, they're not medical professionals?

A Correct. They do not -- they're not medical professionals.

Q So let's just say as an example, you have CPT code 1, and it comes into the preservice review, the code is typed in. The system says that's something that's medically necessary.

A So the system wouldn't say it's medically necessary. The clinical administrative coordinators have a list of services and conditions in which they could approve at their level.

Q Yeah. Somebody higher up the chain --

A Yes.

Q -- provides a list of CPT codes that are considered medically necessary?

A Yes.

Q And that decision, assuming the office person makes that -- the CPT code 1, and then send whatever it is, a book or on a computer, says that particular code is medically necessary?

A Yes, they could say that.

Q And that would be done without regard to whether the doctor really intended to provide the service for a proper medical reason?

A They would not be able to determine what the provider's intent was, nor would I. But yes. If it's on the list and it meets the rules, they would approve at their level.

Q So somebody above you at some level has made that determination, which codes get -- can get the approval by the first step.

A Yes.

Q Then, there -- as I understand it, there are -- if the CPT code doesn't authorize, the first review -- the first, the clerical person -- I don't know if they're clerical. I mean, I don't mean to insult that person. But they're not medical professionals?

A Usually. Clerical is not an insult, either.

Q Okay. It was suggested in opening statements it may be. That's fine.

A Okay.

Q That's why I brought it up. In any event, it gives -- there are certain CPT codes that the clerical staff can approve. Right?

A Yes. Certain CPT codes, nonmedical personnel can approve. Yes.

Q Cannot?

A Oh, cannot. I apologize.

Q Yeah.

A Yeah. So certain things need to be forwarded on for clinical review.

Q So if it's a CPT code, so we'll use my example. CPT 1 comes in, and it's one that can't be approved, right?

A Correct.

Q You follow me so far?

A Yes. Following you.

Q Then it goes to the nurse review.

A Yes.

Q And at that point, the nurse reviewers, they -- there's certain things they have discretion to approve?

A Yes.

Q Okay. And that's based on CPT codes?

A Based on CPT codes, whether a provider is in network or out of network for certain services, and medical policy review. They can approve at their level.

Q So like for example, if the medical policy says it's medically necessary, the nurse could approve?

A Right. Provided certain conditions are met, that's what the medical policy outlines. If those conditions are met, then a procedure could be approved at nurse level.

Q And there are certain medical policies that say a certain procedure is not medically necessary.

A Correct.

Q And in that instance, the nurse transfers the review to the medical director.

A Yes. She would forward on to the medical director.

Q And in 2016, for the oncology review, the medical director was Dr. Ahmad?

A Yes, sir.

Q And there were other medical specialists that are -- have been retained by Sierra Health and Life and UnitedHealthcare.

A Yes, there are other medical directors.

Q And it just depends on the specialty as to which one gets which case, right?

A Correct.

Q And are you generally experienced with the work of these other medical directors other than Dr. Ahmad?

A Yes. I'm familiar with their work.

Q And you're generally familiar with the work of Dr. Ahmad?

A Yes.

Q And would you say that Dr. Ahmad treats the members with the same fairness and impartiality as all of the medical directors do?

A Yes. He's not changing the way he reviews based off of any particular case.

Q So as we go through the file today, and Dr. -- and what happened in Mr. Eskew's claim, we can all agree that any medical director utilizes the same fairness and impartiality?

A So the same process applies, so yes, the same expectations would be there for any medical director.

Q Now, let's pull up Exhibit 24. And this is the proton -- Exhibit 24, proton beam radiation therapy policy. Do you see that?

A Yes.

Q And I take it you're generally familiar with it?

A Yes.

Q If we go to page 2, and if we highlight this portion. And it says, "Proton beam radiation therapy is unproven and not medically necessary for treating all other indications, including but not limited to," and then there's multiple bullet points. Do you see that?

A Yes.

Q So Exhibit 24 is an example of a medical policy that says it's not medically necessary and it would go to a medical director?

A Correct.

Q And it's your understanding that the medical policies and the application of those policies are discretionary with the medical director?

A Right. He can review the case against the medical policy and if there -- and make a decision based off of the medical policy or any extra information that he may have, yes.

Q Mine's a little broad.

A Oh, pardon.

Q We can take any one of these cancers, whether it's lung cancer, bladder cancer, it doesn't matter. Just take one of the cancers that's listed in those bullet points. The medical director can say, as I understand it, that I'm going to overrule the medical policy and determine in this instance, the proton beam therapy is medically necessary.

A That could be one of his decisions. Yes.

Q And that's the discretion, as you understand it, that UnitedHealthcare has applied.

A Yes.

Q So at least from your understanding, in order to really fairly apply these policies, you have to consider the individual treatment, conditions, clinical picture that is presented to the treating physician.

A That is part of the process, yes.

Q Because there may be instances where for a particular patient, proton beam therapy is proven and medically necessary?

A I wouldn't go that far to say it's proven and medically necessary. The medical director could approve it. This particular instance or this policy is based on scientific outcomes, so to say something is proven means that scientific outcomes support that. So he could say despite the scientific outcomes, I'm going to approve it.

Q In other words, for that person, for that particular member, proton beam radiation therapy is medically necessary?

A He could say that.
Q But he'd have to say that in order to preauthorize it, correct?
A Correct.
Q Now, are you familiar with any kind of standard within Exhibit 24 that tells us how somebody like Dr. Ahmad is supposed to utilize his discretion?
A Is this Exhibit 24?
Q Yeah. The proton beam radiation therapy policy.
A Okay. It's not outlined here as to how he would make an exception. The intent of the medical policy is to share scientific outcomes. So there wouldn't be information about varying from scientific outcomes in this policy.
Q So you're saying -- so just to wrap back, you're saying that nothing within Exhibit 24, which is the proton beam therapy policy, will tell us how Dr. Ahmad or any other oncology medical director is supposed to utilize their discretion?
A The -- not in this policy that I have read. And I'll just say there could be a couple words in there I might have missed. But the intent of medical policy is to share scientific outcomes. So it wouldn't say you can vary from scientific outcomes if X, Y, Z. It wouldn't say that.
Q But none of those policies would?
A I don't think they would.
Q Okay.

[Pause]

MR. SHARP: Jason, could you pull up Exhibit 75?

BY MR. SHARP:

Q So I've got Exhibit 75 in front of you, and it's the intensity modulated radiation therapy, IMRT, policy. Do you see that?

A Yes.

Q And the next page -- down here at the bottom. And it says, "IMRT is medically necessary for treating the primary sites of the following diagnoses." Do you see that?

A Yes.

Q And if you could go to the next page. And it lists a number of cancers that are considered medically necessary, right?

A Yes.

Q And lung cancer is not within that.

A I see that.

MR. SHARP: And now, Jason, if we could go to the next paragraph here.

BY MR. SHARP:

Q And it says, "IMRT may be covered for a diagnosis that is not listed above as medically necessary when at least one of the following conditions is present." Do you see that?

A Yes.

Q And then, there are two bullet points listed.

A Yes.

Q So at least with regard to IMRT, there's a specific standard that the medical director must follow in order to exercise his discretion.

A Correct. And this would still be based on the scientific

outcome. So you're saying that this process is still, you know.

Q All right. And I'm not saying it isn't.

A Okay.

Q I'm just -- you had said it is typical, like Exhibit 24, to not outline what the -- how the medical director is going to exercise discretion.

A Outside of medical policy is what I meant, right?

Q Okay.

A So this is in the medical policy, so this would be within that same argument.

Q So with regard to how proton beam therapy and IMRT is treated, the medical policy for IMRT specifically outlines how Dr. Ahmad is supposed to utilize his discretion?

A So there is a difference. They're both based on scientific outcomes. So the directions would be related to that. I can't necessarily speak to the studies for each one. I know that they are summarized. But the directions in medical policy would be based on the scientific outcomes of each study. I can't really say they all have to look the same for them to be relevant.

Q And I understand --

A Okay.

Q -- that you don't write these medical policies.

A Correct.

Q So I mean, you're not -- you're just the person implementing them, right?

A Correct.

Q And how they come up with these policies is not part of your job.

A Correct.

Q But the information they consider in adopting these policies, that's not part of your job?

A Right. I'm not handing them studies or anything.

Q I'm just pointing out that in order to exercise discretion and approve a diagnosis not listed as medically necessary, the medical director has to find these two bullet points.

A Yes.

Q So it provides, at least, would you agree with me, some direction and predictability to make sure the medical directors' decisions are consistent, fair, and impartial?

A I can't speak to the intent, but it does say up here, "The diagnoses not listed above as not medically necessary." So it has the medical necessity criteria for him to review and make a decision.

MR. SHARP: Jason, can we go to Exhibit 5?

BY MR. SHARP:

Q And Exhibit 5 is the preservice claim file for proton beam therapy?

A Yes, I see that.

Q And you've reviewed this file?

A Yes.

Q I'd like to kind of go through this file with the jury and

yourself.

A Sure.

MR. SHARP: And Jason, if we could go to the first note here, 236.

BY MR. SHARP:

Q So this is a note that's been entered by L. Hamel 15 [phonetic], right?

A Correct.

Q And I take it she's -- is she the first person that's going to see the -- where is she within the group of the preservice review?

A Sure. So she would be part of the intake team.

Q Okay. So she's noting on the intake that Dr. Zhongxing Liao, radiation oncologist, has requested a service.

A Yes.

Q And at that point, somebody would have checked the CPT codes?

A Yes. They would have been provided at that time.

Q And then, the disclaimer known. So that's somebody saying we've made some sort of disclaimer known to the provider.

A Correct.

Q And it says, "Routed to RN for review clinical." Did I read that correctly?

A Yes.

Q And so when somebody inputs the note, is that time stamped?

A Yes, it is.
Q So in other words, can somebody come back and change this note?
A No.
Q Once it's in, it's in?
A It's in.
MR. SHARP: Okay. So if we could go to the next page, Jason.
BY MR. SHARP:
Q And this is a note, the February 4, 2016, note, 3:21, and that was inputted by Nurse Amogawin?
A Yes.
Q And she was somebody working in preservice review at that time?
A Yes.
Q And she was a nurse?
A Yes.
Q And so she inputs notes. And it says, "UG Choice plus National PPO, domicile." Do you see that? Did I read that correctly?
A Yes.
Q And then she notes down at the bottom, "Type, IMRT."
A Correct.
Q "Number of fractions, 30. Energy per dose, 220/200 CGY." Did I read that correctly?
A Yes.

Q And I want to go back down here, "Total energy, 6600-6000 CGY." Did I review that correctly?

A Yes.

Q And somebody like Nurse Amogawin would obtain that information from the medical records?

A Correct.

MR. SHARP: And so if we go to Exhibit 5 at 9, and if you pull up this -- first just pull up the fax header.

BY MR. SHARP:

Q So it says this was received at 17:56 on February 3rd?

A Yes.

Q And I'm thinking that's in Texas, so they're two hours ahead of us?

A Correct.

Q So it's 3:57?

A Yes.

Q Okay. In any event, Nurse Amogawin would be noted that this is an urgent prior authorization, right?

A Yes.

MR. SHARP: And then, go to the next page. Next page. And if you could pull up urgent letter of medical necessity.

BY MR. SHARP:

Q And this would be informing -- this letter, Exhibit 25, page 11, would be informing Sierra Health that this letter of medical necessity is presented on behalf of your member, Mr. William Eskew. "We are

requesting certification of CT simulation and 30 treatments of proton radiation therapy for over six weeks for a 64-year-old male diagnosed with a stage 4 malignant carcinoma with squamoid features, primary site undetermined." And Nurse Amogawin would be expected to review that information?

A Yes.

Q So if we could go to -- back to page 2 of Exhibit 25.

MR. SHARP: Page 2 of Exhibit 25. You got it. And I want to pull up the --

THE COURT: Is 25 admitted?

MR. SHARP: 5. I'm sorry.

THE COURT: Okay.

MR. SHARP: Thank you for correcting me. I'm sorry. If we could go to 7. Page 7 of Exhibit 5. And if you could just pull up this email, Jason.

BY MR. SHARP:

Q So this is an email that Ms. Amogawin sends to Dr. Ahmad, right?

A Correct.

Q And that email was sent at 4:20 p.m.?

A It says 4:48.

Q Oh, I'm sorry.

MR. SHARP: Go to the next page. I'm sorry. Page 7. Yeah. Let's blow that back up. I must have said it wrong.

BY MR. SHARP:

Q So on February 3rd, Dr. Amogawin -- or Nurse Amogawin sends to Dr. Ahmad the request for review.

A Yes.

Q And she writes, "Hi Dr. Evans." Who's Dr. Evans?

A Another medical director.

Q If we go to the next page, right here, authorization. It says, "Authorization request for radiation therapy, IMRT radiation treatment." Did I read that correctly?

A Yes. In the body of the email, it says that. And then at the top, it says, "Servicing facility," and then "proton beam."

Q Well, it says proton therapy center.

A Proton therapy.

Q But radiation type, IMRT, right?

A Yes. Under request, yes.

Q She just took the same information that she'd inputted into the file and put it into an email, right?

A Sure. It seems that she may have copy-pasted, yes.

MR. SHARP: Okay. Now we'll go to page 6. And if we can pull up the February. Hold on a second. Go above that, Jason. Go on up. So if you could go down one more. Go down. It starts here with 6 and 7 side by side. Well, just start here and then we'll go to page 7. Go down at the original message.

BY MR. SHARP:

Q And it says -- at this point, this is the February 4, 2016, message that has a GMT time on it. So somehow it was transferred

from Pacific standard to GMT.

A Sure.

Q And you understand that that's about seven hours earlier, if we went back seven hours?

A Okay. Yeah. I'm unsure how that occurred.

Q In any event --

A I see the time there.

Q -- this is the second email. And if we go to the next page, and so this is the communication on the second page to Dr. Ahmad. And Nurse Amogawin writes, "Correction. Request authorization request for radiation therapy, IMRT versus IMPT radiation treatment." Did I read that correctly?

A Yes.

Q And the IMPT, your understanding is that's proton beam?

A Correct.

Q And so Nurse Amogawin made a correction to Dr. Ahmad, right?

A Looks like a correction in this email, yes.

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

Ladies and gentlemen, you are instructed not to talk to each other or with anyone else about any subject or issue connected with this trial. You're not to read, watch, 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, and/or

radio.

Do not 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 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 it is finally submitted to you.

So we'll take a 15-minute recess and come back at 10:45.

[Jury out at 10:32 a.m.]

THE COURT: All right. We'll come back at 10:45.

[Recess taken from 10:32 a.m. to 10:47 a.m.]

THE COURT: All right. The parties ready for the jury?

MR. SHARP: Yes.

MR. ROBERTS: Yes, Your Honor.

THE COURT: Thank you. Please be seated.

[Jury in at 10:47 a.m.]

THE MARSHAL: Okay. Jurors are all present.

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

MR. SHARP: Yes, Your Honor.

MR. ROBERTS: Yes, Your Honor.

THE COURT: Thank you. Please be seated.

BY MR. SHARP:

Q Ms. Sweet, when we took our break, we had Exhibit 5, page 7 up, just confirming that the request made by Ms. Amogawin was IMRT versus proton beam radiation treatment; is that right?

A Yes.

MR. SHARP: And then, if we could go to page 2 and pull up this bottom section. If you could go above that, Jason. Could you go a little above where Nurse Amogawin's user ID. So where it says notes. Yeah. There we go.

BY MR. SHARP:

Q And so this is an entry that Ms. Amogawin made on February 4, 2016, at 3:21 p.m., right?

A Correct.

Q And it's -- so she's basically just cutting the email and pasting it into the system?

A Right. She's copy-pasting the email into the system.

Q Yeah. Okay. So she received the email on February 4, 2016, at 3:12. And down at the bottom, it says, "The requested procedure does not meet current HPN policy. Decision: proton therapy and all associated codes are not covered and are denied." Did I read that correctly?

A Yes.

Q And you would agree with me that in the text of this email, there is no reference to Dr. Ahmad's analysis of the medical records?

A There is no summary of medical records in this email.

Q No indication of medical records.

A No. No mention of medical records.

Q And there's nothing in this email that would indicate that he reviewed medical literature?

A There's no mention of medical literature.

Q Now, in the next -- if we go now to Exhibit -- page 5, Exhibit 5. And down at the bottom. So Nurse Amogawin sends an email to Dr. Ahmad; is that right?

A Correct. This -- yes.

MR. SHARP: Next page, Jason.

BY MR. SHARP:

Q And she said, "Hi, Dr. Ahmad. This case is for proton beam. Can you please send me an updated denial text with correct protocol? Attached is the UHC/KL protocol. Please send me an edited denial note text." Did I read that correctly?

A Yes.

Q So Ms. Amogawin provided a copy of the medical policy that Dr. Ahmad should have cited to?

A Correct.

Q Now, if we go back to the next page, and to the next. This, page 6, and the 2/4 email. And this email is dated -- is sent February 4, 2016, at 4:20 p.m. And he says, "The current summary, metastatic cancer to lung, unknown primary requested procedure does not meet current HPN policy decision and proton therapy and all associated codes are not covered and are denied." Did I read that correctly?

A Yes.

MR. SHARP: And if you could go back, Jason, to pull up the page 2, the 3:21 entry? And I want them side by side. It doesn't matter which one first. I want the page 6, the February -- or page 6, the February 4 email next to that. Okay. So if you pull up this email. And then, can we pull it side by side with this email, February 4th? Okay. This email here, the February 4.

BY MR. SHARP:

Q So we have two emails from Dr. Ahmad, one sent at 3:12 p.m. and one sent 4:20 p.m., and they're substantively identical, correct?

A Yes. They're both denials.

Q Well, they're both referencing an incorrect policy, medical policy.

A Yes. They're both referencing HPN policy.

Q Well, they're representing -- do you understand that ONC006 does not deal with proton beam?

A Yes. Actually, if you could pull up the -- I didn't look at the number of the policy that we looked at earlier, but okay.

Q Well, they're both here. On page 2, criteria used, ONC006. Do you see that?

A Yes.

Q And then, on the 4:20 p.m., it's the same policy cited.

A Yes. I see that, yes.

Q So we have two emails where Dr. Ahmad is referencing the wrong policy.

A Yes.

Q And you would agree with me, then, both emails, there's no reference to his analysis of the medical records for any literature you reviewed?

A In the 4:20 p.m. email, there is a case summary citing the diagnosis and the lung to unknown primary. And that sentence is not in the first window.

Q Okay. So he added in the second one, he added "Case: metastatic cancer to lung, unknown primary"?

A Yes.

Q So he added a phrase.

A Correct.

Q So he sent two emails, but neither one of them reference any analysis of the medical record.

A There's not a full, detailed review of his medical -- of what he reviewed in the medical records. Correct.

Q There's not any evidence in either email that he even looked at the medical records.

A The diagnosis is here.

Q So beyond the metastatic diagnosis, is there any evidence that he reviewed the medical records?

A No.

Q In those two emails?

A Not stated here, no.

Q And what we're dealing with in terms of the procedure, this is not unusual that the doctor doesn't cite to the medical records?

A The expectation is a case summary. So one would review medical records and provide a summary of what he did. So this is a case summary.

Q Okay. My question is a little different. If we picked up 50 files, preauthorization files with denials, they would all have the same basic substance. There's no evidence in either one that the medical records were reviewed.

A So there is varying amounts of how you can explain you reviewed the medical records. So I can't speak to every single file. The expectation is medical records are reviewed and you supply a case summary because the medical records are going to be in the file.

Q Okay. Aside from this sentence in the case summary, there's no substantive analysis in the medical record?

A I can't speak to what he analyzed in the medical record. It's not reflected here.

Q And that's typical when you review denials?

A Yes. It would be you would cite what doesn't meet per medical policy, based on your review.

Q So it is typical in a policy, the preauthorization policy, to not include an analysis of the medical records?

A Yeah. Just the summary.

Q And that's the policy that was implemented by Sierra Health and Life and UnitedHealthcare?

A Right. It's our department process, is you provide a summary. People can review the medical records to form their own

opinions if they're going behind you to see what you decided.

Q Well, all this summary says is that, the metastatic cancer lung, unknown primary.

A Sure.

Q Right?

A So that would be the case summary, and somebody could review the medical records to make their own decision, yes.

Q But my question is a little different, because he's supposed to substantively -- he meaning Dr. Ahmad -- is supposed to substantively evaluate the medical records, right?

A He is supposed to review the medical records and he -- you know, that's part of our departmental process. But we don't have to spell out every single detail that we reviewed because the medical record is there for anyone to form their opinion.

Q I appreciate that the medical record is there.

A Yes.

Q But the person making the decision and the analysis is the medical director, correct?

A So the medical director and the nurse both review, yes.

Q I know they review. But my point is I think it's -- you would agree the medical director is the one who denies the preauthorization, right?

A Yes. He does make the decision to deny.

Q And he's the one whose thought process is relevant to the reasonableness of the denial?

A Yes. The denial is -- the denial will follow his decision, yes.

Q And it's typical in the file that the thought process utilized in the evaluation of the record is not documented in the file.

A The thought process is outlined here. The member has a diagnosis that's not covered in the medical policy.

Q I understand that. But I'm talking about the medical records which he's supposed to evaluate in exercising his discretion, right?

A Yes.

Q And when we get a file, there's no evidence of how he exercised his discretion with respect to the evaluation of the medical records.

A He -- the fact that the diagnosis is there shows that he reviewed it. The medical records support the diagnosis.

Q Okay. So in any event, the one sentence that he references, metastatic cancer to lung, unknown primary, that's sufficient in the system that UnitedHealthcare has adopted to document that the doctor actually reviewed the medical records?

A Yes.

MR. SHARP: If we go up to the next page -- well, let me go to -- Jason, if you could go to page 5 -- Exhibit 5, page 3. And if we give her the top entry first.

BY MR. SHARP:

Q So once the denial comes in to Nurse Amogawin, the file is transferred to the adverse benefit determination team?

A Yeah. The adverse determination team, yes.

Q And none of the people on the adverse determination team are medical doctors?

A Correct.

Q Now, received call at 8:23:42 a.m. on February 5, 2016. It says she, "received a call from Adele at Proton Therapy Center, Houston, Texas. Denial reason, informed her of med director denial reason, physician to physician communication, rights good for 14 days from the date of denial notification and appeal rights." Did I read that correctly?

A Yes.

Q And this would be consistent with the process?

A Yes.

Q Now, you would agree with me that there's no indication in this file that anyone attempted to contact Bill Eskew?

A I did not see any. I don't recall calls to the patient. No.

Q So you agree nobody tried to call Bill Eskew?

A Yes.

Q Okay. Now, the next entry. Let's go to February 5. And we got February 5, 2016, at 11:57. Mr. Guerrero makes an entry.

A Correct.

Q And he's the person at this time charged at the adverse determination team. Is that how it's referred?

A Right.

Q So the adverse determination team, Mr. Guerrero is one of the people who writes the denial letters?

A Yes.

Q And he says, "Denial letter is hand typed from template with text below." And he sets forth the text of the denial letter, right?

A Yes.

Q Which he obtained from the medical policy?

A Yes. It's a mixture of the medical policy and the case, yes.

Q So as we have proceeded today, you would agree with me that the basis of the denial is the medical policy?

A Yes.

Q And there's nothing in the emails that we've reviewed that anyone, directly or indirectly, considered the actual terms of the insurance policy, the agreement of coverage?

A I do not agree with that. It's not cited, but the medical -- we reviewed the medical necessity process earlier, and it was applied to this case. So they didn't review the agreement of coverage because they recognized the definition of medical necessity. Radiation therapy is not listed as an exclusion, so it would require medical necessity review.

Q Yeah. Okay. I agree with you. My question is a little unclear. My question is specific. There's nothing in the documents we have reviewed today to evidence that anyone, Dr. Ahmad or otherwise, picked up the agreement of coverage and looked at the definition of medically necessary?

A It's understood. They wouldn't need to review the definition of medical necessity because it's -- the review is a medical necessity review. So they wouldn't need to look at the definition every time they do one.

Q Because your assumption is the definition that's utilized to create the policy is the same that's in the agreement of coverage?

A Yeah. How we operationalize a medical necessity review would be the same for any plan document. We're looking at a request based off of medical policies which are based on scientific literature and determining if they are appropriate or not.

Q My question was a little different and I just want to make sure it's clear.

A Okay.

Q Your assumption is that the people who created the medical policies used the same definition of medical necessity or medically necessary as is contained in the agreement of coverage?

A Yes, that would be my assumption.

Q And that's the reason -- one of the reasons that people don't need to demonstrate that they've reviewed the actual agreement of coverage and the definition of medically necessary?

A Yes.

Q So let me go -- do you have Exhibit 14 in front of you in the binder, Ms. Sweet? Do you have Exhibit 14?

A Oh, sorry. 14?

Q Yes.

A Yes.

Q And I'm sorry, not Exhibit 14. It's Exhibit 13.

A Okay.

Q And this is -- just let me know when you're there.

A Oh, I'm there.

Q And this is a document entitled UnitedHealthcare Policy and Procedure?

A Yes.

Q And it says, "Hierarchy of Coverage Review." Did I read that correctly?

A Yes.

Q And this is to your knowledge a document that's created by UnitedHealthcare?

A Yes.

MR. SHARP: Your Honor, I would move for the admission of Exhibit 13.

THE COURT: Any objection?

MR. ROBERTS: Just a second, Your Honor. I'm checking my chart. I apologize. No objection, Your Honor.

THE COURT: Exhibit 13 will be admitted into evidence.

[Plaintiffs' Exhibit 13 admitted into evidence]

MR. SHARP: Jason, could you pull up Exhibit 13? Okay. So this, just pull up this first part so the jury can see the Hierarchy of Coverage Review. And then, if you go to the purpose.

BY MR. SHARP:

Q So the jury understands, you're not the person that creates this hierarchy of coverage?

A No, I am not.

Q This is a different part of the company.

A Yes. Correct.

Q Okay. So, "The purpose of this document is to define the hierarchy of coverage review to ensure a transparent and consistent approach with UnitedHealthcare. When applying this document to UnitedHealthcare affiliate entities, please remember that there are variations in the use of terms and language across different plans." Did I read that correctly?

A Yes.

Q And one of the affiliates would be Sierra Health and Life and Health Plan of Nevada.

A Correct.

MR. SHARP: If we could go to the next page. And Jason, pull up utilization review guidelines.

BY MR. SHARP:

Q And utilization review guidelines. It says, "Utilization review guidelines may be used to determine," do you see that?

A Yes.

Q And down at point 3, it says, "Level of care or site of service, e.g., office, outpatient, observation, or admission." Did I read that correctly?

A Yes.

Q And, e.g., would be examples of the level of care or service, right?

A Right.

Q And in your knowledge, proton beam therapy, IMRT, they're

both done outpatient.

A Yes.

Q So in terms of that level of service, it's the same.

A Yeah. So they would both be done outpatient. Yes.

Q Yeah.

A Yes.

Q So you agree with me the level of care for both proton beam therapy and IMRT is the same.

A The place of service would be outpatient, so that would be determined as a level of care. So in that respect, they're the same.

Q Yeah. And there's nothing here about saying level of care means type or procedure?

A Nothing here.

Q In other words, like, you could have a surgery at inpatient or outpatient, but they're the same surgery, right?

A Right.

Q The level of care is whether the patient needs inpatient or outpatient, right?

A Right. That's what it's referring to here, yes.

Q And that's the definition you've always utilized working for Sierra Health and Life?

A Right. For level of care. And just, it looks like this portion here is related more to admissions than to all-out patient services, except for this outpatient, observation, or admission.

Q All right. That's fine. I'm just --

A Okay.
Q I'm just focusing on what level of care means.
A Sure.
Q Okay.
A So from my experience, level of care refers to this -- where a person is receiving services, whether it be outpatient, observation, or inpatient, yes.
Q Okay. And you're very experienced in this kind of stuff?
A Yes.
Q Okay. So if we could go to the next page.
A Okay.
Q And we have coverage review. So this is what -- as I understand it, what UnitedHealthcare is doing is they're saying this is a typical policy that we might sell. The terms of how medically necessary is defined.
A Yes. That's -- it's their definition or some of the same.
Q So it applies to commercial, which would include agreement of coverages, right?
A Correct.
Q So this is kind of the form definition that UnitedHealthcare has, to your knowledge?
A Yes.
Q And then, there may be individual variations within each agreement of coverage?
A Yes, there could be.

Q And so on this particular form policy, there's a provision that says, "Not more costly than alternative drugs, services, or supplies that is at least as likely to produce equivalent therapeutic or diagnostic results as a result as to the diagnosis or treatment or your sickness, injury, disease, or symptom." Did I read that correctly?

A Yes.

Q And equivalent means equal?

A It means equivalent, yes.

Q And it's hard to figure out whether a service is equal -- two competing services are equal without analyzing the individual facts of that patient or that member?

A So here, equivalent would refer to outcomes based on scientific measures.

Q At least as equivalent?

A As far as equivalent scientific outcomes, yes.

Q The same, right?

A Equivalent means nearly the same. Sure.

Q Let me just pose it this way as an example.

A Okay.

Q Let's just say we have two surgeries. Okay? You have you can do the surgery by doing a laparoscopic procedure or you can do the surgery by opening up the person. You got me so far?

A Yes, sir.

Q Which one is equivalent for that member depends upon facts and circumstances the member presents, right?

A So it would be those factors as well as whatever the literature says, yes.

Q Fair enough.

MR. SHARP: Jason, can you pull up Exhibit 4 at 64? I want to pull up the definition of medically necessary. No, just the first paragraph.

BY MR. SHARP:

Q And this is the definition we went over from the agreement of coverage for medically necessary?

A Yes.

Q And the provision, the bullet point that I had showed you from the hierarchy of coverage from UnitedHealthcare that it uses to define medically necessary is not in the agreement of coverage, correct?

A So it's not in this section. No.

MR. SHARP: Well, go down, Jason. Show the -- just pull up the entire medically necessary definition.

THE WITNESS: Correct. That bullet is not included in this section. No.

BY MR. SHARP:

Q In the definition of medically necessary?

A Correct.

Q So the policy that's used to develop the medical policy uses a different definition than what's contained in the agreement of coverage, correct?

A So one bullet isn't there. I wouldn't say that it's entirely

different, though.

Q All right. Three bullet points instead of the fourth that says we can consider which cost is cheaper.

A Right. That part is missing.

Q And again, it's not -- you would have no quarrel if management told you, Ms. Sweet, we want to change the policy and we want to make sure the medical directors are actually reviewing the agreement of coverage our member received. You would not have any quarrel with that?

A So no, I wouldn't argue against a medical director looking at the agreement of coverage. I might argue to say what are they looking for and why would they need to look at the definition of medical necessity every time they review a case.

Q Okay. My question is a little different.

A Okay.

Q You would have no problem with a higher up at UnitedHealthcare to say before you deny a claim, you have to review the definition of medically necessary that's in the agreement of coverage that our insured purchased?

A My issue would be that it would be -- I would question how necessary it would be.

Q You'd do it?

A So I would take -- I would ask questions. I would ask why that would be necessary.

Q So you'd ask questions of why it would be necessary that the

people making treatment -- making decisions on preservice claims should or should not review the medical -- the actual insurance policy?

A Because it is something that we do on a daily basis by reviewing clinical information against medical policy. So it would be unnecessary to look at the definition of medical necessity every time you do a review. It would, like, be like me looking up the definition of nursing every time I did a nursing action.

Q Fair enough. But your assumption was that the people at the corporate level used the same definition of medical necessity that's contained in this agreement of coverage when they adopted the medical policy, right?

A And I don't think they're much different, to be honest.

Q Well, except for the last bullet point.

A Right.

Q That's not there, right? The one about cost. Bring that up. Bring that up.

A Yes, I see the bullet point. And it is not there.

Q I'm sorry, I didn't mean to interrupt you.

A Oh, yeah. I see that the bullet point isn't there. But it's still, you know, I'm not -- we would still be reviewing the case against medical policy. So it doesn't stop somebody from looking at a case against medical policy.

Q Okay. Can we just go back to Exhibit 13 and pull up page 3? Let me just pose it this way. Assuming that the people that developed the medical policy are utilizing the definition of medically necessary as

contained in Exhibit 13, your assumption that the agreement of coverage that Mr. Eskew had used the same definition of medically necessary is incorrect?

A No. So I just want to make sure I'm understanding your question. Are you saying that my assumption that the definition of medical necessity is different between -- is -- that my assumption that they were the same is incorrect?

Q Right. Let me ask it -- it wasn't a good question. Let me just -- we'll just move on. But the agreement is there -- the fourth bullet point that's referenced in the coverage of hierarchy review [sic] that's utilized to create these medical policies is not in Mr. Eskew's agreement of coverage?

A That is not in the definition of medical necessity section. Yes. I didn't see that.

Q Thank you.

MR. SHARP: Jason, can we go back to Exhibit 5 and go back to 3? Go back to Mr. Guerrero's entry.

BY MR. SHARP:

Q So Mr. Guerrero inputs the information for the denial letter, and he obtains that information from a library of denial texts, correct?

A Yes.

Q And do you have in front of you Exhibit 6?

A It is a picture of some language. Am I looking at the right thing? There are pictures?

MR. SHARP: Oh, hold on.

THE WITNESS: Oh, that's 9. I apologize. I was reading upside down.

MR. SHARP: Okay.

BY MR. SHARP:

Q Exhibit 6 is a bunch of blacked out stuff, and if you go through it, does it look like the library of denial text?

A I recall the document. Yes.

MR. SHARP: I mean, if so, Your Honor, I'd move for the admission of Exhibit 6.

MR. ROBERTS: Objection. Relevance. It's 195-page document, most of which doesn't apply here.

THE COURT: Mr. Sharp?

MR. SHARP: Well, I think it all applies to the state of mind of the company and to what is actually being utilized to deny the claim.

THE COURT: Overruled. Exhibit 6 will be admitted into evidence.

[Plaintiffs' Exhibit 6 admitted into evidence]

BY MR. SHARP:

Q And Exhibit 6 is actually an Excel spreadsheet; is that right?

A Yes. It looks like a spreadsheet, yes.

MR. SHARP: Jason, can you pull up the Excel spreadsheet, Exhibit 6?

BY MR. SHARP:

Q So what you're looking at is a PDF version. And I have in front of you the actual Excel sheet.

A Yes.

Q And so what happens is there's a request made. And then, there's a -- like, the beginning of a form template to create the denial text?

A Correct.

Q And there are different conditions. All of these conditions have been blacked out. But if I were to look at it without the black out, it would have different conditions, correct?

A Yes.

MR. SHARP: Now, Jason, if you could just kind of scroll up. Just scroll all the way to the bottom. Well, to where the black stops. Keep going. I want to go all the way to where the black stops. Okay. Right here. And can you shrink it? Okay. Do you see the three? Can you pull that up, the number here? Right here. You can't?

BY MR. SHARP:

Q So do you see where that says 358?

A Do I see it?

Q I mean, if you can't, we can get to it at a later point. I don't mean to strain your eyes. Would you agree with me that there's approximately 358 different types of form denial letters?

A There are. Yes, there's a good number -- over 300 rows in this Excel spreadsheet. Yes.

Q Yeah. Okay. All right. Can you now come back up to where the white is? There we go. So this is the entry for the proton beam radiation therapy denial text.

A Yes.

Q Okay. Now let's go back to Exhibit 5. And so what we can just confirm is that Mr. Guerrero is doing consistent with the what the policies and procedures are at Sierra Health and Life?

A So yes, he is.

Q Okay. Now, let's go to -- have you -- go to Exhibit 73. Now, after -- go to the next page. Now, Exhibit 73 is the IMRT file. Have you had a chance to look at that before?

A So is this a different case than what we're reviewing?

Q Yeah. This is for the IMRT.

A All right. Yeah. I've reviewed it in the past, yes.

Q Okay. So let's pull up this entry here at the beginning.

THE CLERK: Has this been admitted?

MR. SHARP: I'm not sure. I'd move to admit Exhibit 73.

THE COURT: Any objection?

MR. ROBERTS: Court's indulgence.

THE COURT: Of course.

MR. ROBERTS: No objection, Your Honor.

THE COURT: Exhibit 73 will be admitted into evidence. Thank you, Madam Reporter.

[Plaintiffs' Exhibit 73 admitted into evidence]

BY MR. SHARP:

Q Okay. On February 5, 2016, at 2:39 p.m., there's a documentation that a fax was received from MD Anderson.

A Yes.

Q Okay. And you've reviewed the four pages from in this file. Do you see any fax within that file?

A So I did not see any fax in the file, no.

Q Okay. So you didn't see any of the medical records that were attached to this file?

A Correct. It was -- it's -- there were none in FACIS, which is our documentation system. The faxes at that time were stored in a different system.

Q So any of them, we can't --

A Right.

Q Based on what we have, we have no idea what MD Anderson actually faxed to Sierra?

A Correct. It's not in this case. No.

MR. SHARP: And if you go to the next page, Jason, at 3.

BY MR. SHARP:

Q And do you see where Nurse Amogawin enters a note -- let's see. Hold on. These emails can be confusing. I'm sorry. Go to the previous page. Okay. So Nurse Amogawin, down here, 2:53, says she's sending the IMRT radiation treatment over to Dr. Ahmad, right?

A Yes.

Q And that's done at 2:53, right?

A Yes.

MR. SHARP: Now, if we go back to Exhibit 5, and we go to page 3, highlight this entry right up here. User -- no, a little bit higher, Jason. Right there.

BY MR. SHARP:

Q And it says, "User ID, C. Polach." So that's February 5, 2016. And this is for the proton beam therapy policy, right? For the proton beam therapy file?

A Yes.

Q And it says, "Placed line in denied status. Holding letters per NWRN auditor awaiting clarification on med director decision protocol."

A Yes.

Q Did I read that correctly? So that's basically meaning they want the correct denial text from Dr. Ahmad?

A Right. It looks like they were looking for the updated decision, yes.

MR. SHARP: And so if we go to back to Exhibit 5, and at 4:42 -- back to Exhibit 5. I'm sorry, Jason. Exhibit 5, page 5. And this middle entry, here.

BY MR. SHARP:

Q And so this is the corrected denial we went over. That was received at 4:42 p.m., right?

A Yes.

Q And then, go up to the next one. And Lou Ann Amogawin takes -- forwards Dr. Ahmad's denial email over to a number of people, including Mr. Guerrero, correct?

A Yes.

Q Now, if we could go back to Exhibit 73. And on February -- go to page 3. I want to go to this email. So a few minutes

before Dr. Ahmad sends his updated denial on the proton beam therapy, he had sent his approval for IMRT; is that correct?

A Yes.

Q And is there any indication in the record that he ever evaluated the IMRT versus proton beam therapy issue that Nurse Amogawin identified when we -- when she first sent the proton beam therapy request?

A He looked at a request for proton beam therapy and then he looked at a request for IMRT therapy. So yes.

Q So based upon that, you think he did analyze which one was better?

A He reviewed both requests per medical policy and --

Q But we don't know what he --

A -- approved the appropriate one.

Q Would it be fair to say nothing in this letter approving IMRT identifies why he exercised his discretion to approve IMRT?

A In this record, it says lung and metastatic mediastinal tumor, so he looked at some records. Again, it's a case summary based off of his review of records. So yes.

Q Well, do you remember when we went through Exhibit -- the medical policy for IMRT?

A Yes.

Q And it said it wasn't medically necessary for lung cancer?

A For -- proton beam therapy is not medically necessary for -- you said IMRT. I apologize, sir.

Q Do you remember going through the IMRT medical policy?

A Yes.

Q Where it said it's not -- IMRT is not medically necessary?

A It's not -- it said -- well I think you showed me the two bullets and we focused on that. And it didn't say for IMRT that it was inappropriate for lung cancer. For proton beam therapy, that's where you showed me the bullet saying that it was inappropriate for lung cancer.

MR. SHARP: Could we just pull back Exhibit 75? And go to the next page. Well, pull up both pages 1 and 2 side by side. Page 1 on the left. So if you just pull up the IMRT is medically necessary. So yeah, right there. And then pull up this paragraph next to it, this one right here.

BY MR. SHARP:

Q And I know we've been asking a lot of questions, so I just want to make sure that this refreshes your recollection that --

A Yes.

Q -- per the IMRT medical policy, the --

A Right.

Q -- statement of the company is it's not medically necessary.

A Incorrect. So the two bullets that you showed me follow this list of medically necessary diagnoses, but it's not as specific as the proton beam therapy saying that one of these diagnoses is explicitly unproven. So there is a difference between the medical policies.

Q Okay. That's fair enough. IMRT is medically necessary for

the following conditions, and lung cancer is not listed, right?

A Right. It's not listed in this section.

MR. SHARP: And then the next page. Or just delete all those, both of those blow ups. And then, just bring out page 2 up here.

BY MR. SHARP:

Q And it says here, "IMRT may be covered for a diagnosis not listed as above as medically necessary." Did I read that correctly?

A Yes.

Q And so this would be the provision that Dr. Ahmad would need to apply to approve lung cancer, right?

A Right. He would refer to this to approve lung cancer.

Q And so there's nothing in the email we reviewed -- I'm happy to go back to it -- to explain to us why or what Dr. Ahmad reviewed to exercise his discretion to approve IMRT.

A Correct. Aside from the diagnosis and the fact that he put the mediastinal word in there, you know, saying that it's spread to a certain part or portion within the chest wall, then there's nothing there to say, I thought this, I thought that. But then, he does add a bit more of a diagnosis in his summary notes.

Q Okay. So which -- is that what you're saying? I don't mean to put you on the spot.

A Sure. Sure. No. I --

Q We can pull it back up, but.

A So I was just highlighting that his note is a bit different in between the IM -- proton, the proton beam therapy and then the IMRT.

Q In any event, there's not --

A There's not a lot of logic in there. He doesn't go into detail on either decision.

Q He doesn't give logic as to why the discretion -- why he exercised his discretion.

A That is not provided.

MR. SHARP: Okay. Let's go back so I understand to Exhibit 73. If we go to the next page. Next page. And just blow that up.

BY MR. SHARP:

Q And this -- so you're saying the case summary --

A Yes.

Q -- is why he exercised his discretion?

A Yes.

Q So where it says, "As described below, lung and mediastinal tumor, the requested procedure meets current HPN policy"?

A Yes.

Q And that's sufficient to meet the criteria for how he exercised his discretion?

A Yes.

Q And you would agree with me that when Sierra Health and Life was processing the proton beam therapy, they knew about the lung and mediastinal tumor?

A Mediastinal tumor. So the lung and the --

Q Well, here's what I mean. Do you know if that information was provided as --

A When the information was provided for this request where it says the mediastinal tumor.

Q It was also provided as part of the proton beam therapy?

A I didn't compare the medical records between the two cases, so I can't really answer that definitively.

MR. SHARP: So let's go to Exhibit 5, and if we go to page 33. And go down to the bottom.

BY MR. SHARP:

Q This is the denial letter of February 5, 2016. You've seen this before?

A Yes.

Q And down at the bottom, it says, "Generic SHL letter created 12/2011."

A Yes.

Q So this letter -- this generic letter was created December of 2011?

A Right. It's a template.

Q Created December 2011?

A Correct. So just to clarify, this part in the box here explaining what the service is, that's something that changes. But the rest of the letter is a template that was created in 2011.

Q Okay. And then, so if we go down to reason for determination, and this is basically taking Mr. Guerrero's email or entry and putting it into a letter?

A Correct.

Q And the letter was not, to your knowledge, reviewed by Dr. Ahmad?

A Correct.

Q And the fact that it was not reviewed by Dr. Ahmad is typical to the policy at Sierra Health and Life?

A Correct.

Q And the context of what's in this denial letter is not -- you're not critical of what Mr. Guerrero did?

A No. No.

Q He was acting in accordance with the policies and procedures of UnitedHealthcare?

A Yes.

Q And you would agree with me that no specific provision within the definition of medically necessary is cited to in this letter?

A So medical necessity is not defined in this letter.

Q And that's consistent with the policies and procedures of Sierra Health and Life?

A Yes.

Q There's nothing in this letter which would suggest that the application of the medical guideline was discretionary to Dr. Ahmad, correct?

A Correct. It wouldn't say your medical director had discretion to approve or deny. Explaining to the member why something was approved or denied.

Q And you would agree that this type of denial letter that's sent

out is similar to and consistent with the practice for all the denials?

A Yes.

Q And if you go back up to -- and just then identify this. And the denial letter is mailed, right?

A Correct.

Q And are you aware that when people apply for insurance, they provide an email to Sierra Health and Life?

A Yes. There are -- inconsistently, people do provide emails, yes.

Q And you would agree with me as we went through this file, there was no evidence that anybody tried to contact Mr. Eskew?

A Correct.

Q And as far as you're concerned, as we went through this file, what happened was consistent with the policies and procedures at Sierra Health and Life?

A Yes.

Q All right. And those policies and procedures are ones that are adopted by somebody other than yourself?

A Right. They are, yes.

Q And when Dr. Ahmad exercises his discretion to not follow a policy, he needs to document it in the file?

A Correct. Some logic as to why he didn't follow the medical policy would be in the file.

Q When he exercises his discretion?

A Yes. If he's varying from medical policy, he would document

logic behind that. Yes.

Q But when he makes a decision not to vary from the medical policy, that doesn't have to be documented in the file?

A Correct.

Q And one of the reasons -- and you've been taught at Sierra Health and Life that it's very important to document the file, correct?

A Yes.

Q Because the file basically speaks to what happened in the processing of the prior authorization claim.

A Right. It speaks to the decision-making of the case. Yes.

Q Decision-making process?

A Right.

Q It reflects how fairly the member has been treated.

A So it reflects --

Q And it's important because people review these files.

A Right. People do review the files.

Q And people's memory of what happened in a file are much better on February 5, 2016, than March, say, 17, 2022?

A Yes, sir.

Q And when in the course of evaluating and overseeing Dr. Ahmad, nobody goes to his office to say, what is it that you actually documented with regard to Mr. Eskew, or any other insured?

A No. We would not go to his office to ask him what he documented. We would see the documentation in the case file. So that's what we're looking at is the decision-making on each case file.

Yes.

Q Yeah. I understand that.

A Okay.

Q And you get the email back from him saying in this case, denied per medical policy. But my question is a little different. Nobody says to Dr. Ahmad, we want you to save the file so we can evaluate your analysis when you deny this claim?

A We would not have him save the file because the file would be saved by us.

Q So he doesn't have to maintain any records?

A Correct.

Q So in the course of evaluating Dr. Ahmad, the people are only looking at the -- in our case, the proton beam therapy file. There could be another file in another case.

A Right. So that is what people would be reviewing is the notes in the case and the medical information with that case.

Q And Dr. Ahmad is not required to document how much time he spent on a particular file?

A No.

Q And Dr. Ahmad is not reviewed or evaluated by other doctors?

A No.

Q He's not?

A Aside from our audits from the National Committee of Quality Assurance where a physician comes in and reviews denial

records, there wouldn't be another physician formally reviewing a case for Dr. Ahmad.

Q And my question isn't about the National --

A Okay. I apologize.

Q But even then, they're not reviewing, like, to determine substantive basis. They're just reviewing to make sure all -- everything has been followed?

A So they would be reviewing the case notes against our medical policy and things like that.

Q Okay.

A They would make sure that things were appropriately decided and communicated to a member.

Q Yeah. In other words, if for some happenstance -- so when you say the National Committee of Healthcare Quality, that's just a company that comes in and says we accredit your organization for how you utilize utilization management?

A I'm so sorry, sir. It's a big deal to me.

Q I'm not saying --

A They really do set industry standards as such, so.

Q And I don't mean to dismiss that.

A Okay. Yeah.

Q I don't. And I apologize. I didn't mean to dismiss what's important to you.

A Sure.

Q But it's kind of like a -- I mean, Jayco [phonetic] is accredited

as a hospital. That doesn't -- you know.

A Right. Yes.

Q I'm just saying that the National Committee of Healthcare Quality, when they -- if they pick up Mr. Eskew's file, they would just be making sure that the medical policy had been followed?

A So they would make sure that their standards are met. So it would be the medical policy, whatever other standards they have set forth. But yes.

Q One of which is the medical policy in the file?

A Yes.

Q And you've reviewed this medical policy -- or this proton beam therapy policy. And your belief would be that conforms with the NCQA standards?

A Yes.

Q And regardless of what NCQA does or does not require, you understand we're in the State of Nevada, right?

A Yes.

Q And that regardless of NCQA, that Sierra Health and Life has an obligation to follow its legal responsibilities to Mr. Eskew?

A Yes.

Q And you're implementing the process with the expectations that others have created a system that complies with the medical policy?

A Yes.

Q And you have a little bit -- you don't handle appeals, right?

A Correct.

Q And as I recall, your knowledge of how appeals are handled was gained from somebody else?

A Yes.

Q So one thing you do know is that the proton beam therapy -- whatever the policy, whatever the file is. Let's just call it Procedure X file. Claim is denied. That file then goes to the appeal?

A If a provider or member actually appeals, then yes.

Q And no other records go with it?

A So the appeals team has access to the full records that we have access to. So they would have access to any clinical information submitted, the emails, the full packet that we reviewed, they would have access to that.

Q Yeah. That's my point. They get that access.

A Yes.

Q And so within that, the appeals department would have no evidence of whatever thought process Dr. Ahmad utilized to not exercise his discretion and overrule the medical policy?

A So they would send his information, the full packet, for another physician to review.

Q And when you say his information, it's just this --

A Same information in the denial file. Yes, sir.

Q And nobody goes out and interviews him, right?

A I can't speak to whether they would or would not, honestly. I couldn't speak to that.

Q Okay. Would you at least agree -- would you agree with this

proposition, that Mr. Eskew, regardless of what rights he had under the policy to appeal, had the right and expectation that Sierra Health and Life would conform with its duty of good faith and fair dealing before the prior authorization was denied?

A Yes.

Q And would you agree with me that Mr. Eskew and every other member has the right and expectation to believe that Sierra Health and Life is going to conform with its duty without regard to whether they file an appeal or not?

A Yes. Decisions are made in an impartial manner as you said. Yes.

Q And nobody has said to you in this case that if an appeal had been filed, suddenly the claim would have been paid?

A There's a review process to an appeal as well.

Q But nobody has told you, geez, if only Mr. Eskew had filed an appeal, we would have approved this prior authorization?

A That's not the way an appeal would work. They would still perform their independent review of medical necessity. It's not guaranteed that he would -- that it would be approved.

Q And your expectation would be that the appeals department would utilize the same fairness and impartiality that was provided to Mr. Eskew in the review of his preauthorization request?

A Right. They would send it to another physician to review.

Q Well, they used the same fairness and impartiality?

A Yes.

THE COURT: Counsel, we're going to take our lunch recess.

MR. SHARP: I was going to say I have no further questions.

THE COURT: Thank you. We'll take a one-hour recess and come back at 1:00 p.m. Ladies and gentlemen, you are 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 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.

Do not 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 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.

And we'll return at 1:00 p.m.

[Jury out at 12:01 p.m.]

THE COURT: Any matters outside the presence?

MR. ROBERTS: Nothing from the Defense, Your Honor.

MR. SHARP: Nothing, Your Honor.

THE COURT: Okay. So we'll return at 1:00 p.m. Thank you.

[Recess taken from 12:02 p.m. to 1:02 p.m.]

[Outside the presence of the jury]

THE COURT: All right. Please be seated.

MR. ROBERTS: So I wanted to notify the Court of an agreement between counsel and hope we have it approved by the Court. And that is that our witness has a hard stop at 2:00 and there's also an expert for the Plaintiff that they need to get on and off today, so we're a little compressed. And we've reached an agreement among counsel that Ms. Sweet can be excused and then we will recall her in our case in chief to pick up with our direct examination and her recross if any.

THE COURT: All right.

MR. ROBERTS: Is that okay?

THE COURT: Yes. Ms. Sweet, you're excused.

THE WITNESS: Thank you.

THE COURT: Thank you.

MR. SHARP: That will save us time because you guys will have gaps.

MR. ROBERTS: Yes.

MR. SHARP: Potentially, I mean.

THE COURT: So who are you calling next then?

MR. SHARP: Myself. No. I mean --

THE COURT: Dr. Liao.

MR. SHARP: And we have.

THE COURT: In live and in person.

MR. SHARP: Well, we do have a doctor --

THE COURT: In a black suit and glasses and a purple tie.

MR. SHARP: We have a Dr. Liao. She doesn't quite look like Dr. Liao, but we do have -- and her name is Nicky McCabb, and she's waiting just to be called. But she's at least a professional reader so we won't bore people too much.

MR. ROBERTS: And she looks more like Dr. Liao than what he does, so.

MR. SHARP: We didn't want Doug to have to put on --

THE COURT: So the parties stipulate to having her deposition being published? Dr. Liao.

MR. ROBERTS: Yes, Your Honor.

MR. GORMLEY: And, Your Honor, we had a couple pending objections to a couple of the questions. If I could -- do we have a few minutes to go over those now?

THE COURT: Yes.

MR. TERRY: I think we're -- I think there's a chance that you've already --

THE COURT RECORDER: I cannot hear you.

MR. TERRY: -- you already ruled on, so it should --

THE COURT RECORDER: Mr. Terry, I can't hear you.

MR. TERRY: I was just saying, Your Honor, there's just a couple of things that -- a couple topics that you've already sort of ruled on and other context that should take you about a second to deal with.

MR. GORMLEY: So we mostly agreed on everything the defense had. We have eight questions that are objected to. Five of them have to with the grade 3 issue that we filed a motion in limine about.

And you know, it's just our position on those that she didn't -- her grade 3 diagnosis for esophagitis was outside the course and scope of her treatment.

THE COURT: What did the Court rule on that issue?

MR. GORMLEY: The Court denied our motion, so I'm just not asking to revisit, I just wanted to say that and preserve that. But there are four other ones that I wanted to raise that are slightly different and those are on -- so if you go to page 79, 5 --12 through 21. The question was, "And do you believe to reasonable degree of medical probability that happened in Bill Eskew's case." And she said, "Actually I do not have any information at the time when he died".

And what's that relating to is the question before that asked, do you believe to a reasonable degree of medical certainty based on your treatment of Mr. Eskew and your knowledge of his symptoms that his radiation esophagitis, his grade 3 radiation esophagitis shortened his life span, shortened his life.

And so she said she couldn't give an opinion as to shortening of life span to a reasonable degree of medical probability because she didn't have the information. And there's four questions related to shortening of life span, so it'd just be our position because she couldn't give an opinion that those sort of buildup questions to that alternate issue are irrelevant and improper opinion testimony.

THE COURT: Where are those other four questions, Mr. Gormley?

MR. GORMLEY: Those are 78, 6 through 13. 78, 15 through

19. 79, 5 through 11. And 79, 12 through 21.

THE COURT: I'm just going to read it quickly.

MR. GORMLEY: Okay.

THE COURT: All right. Question -- the first question page 78 line 6 through 10, the objection is overruled.

The second question State's 78 lines 15 through 18 there is no objection, but if there was it would be overruled.

Next is 79 pages 5 through 11. So page 79 lines 5 through 11 there is no objection to that question on the record, if there was it would be overruled.

And the last one is page 79 lines 12 through 21, that objection is sustained.

MR. TERRY: For which lines, Your Honor? I'm sorry. 12 through 21?

THE COURT: Yes.

MR. TERRY: Okay. 79, 12 through 21.

MR. GORMLEY: Your Honor, would --

MR. TERRY: Ryan can never take no for an answer, Judge.

THE COURT: Yeah, it's true, Mr. Gormley. You've always got to add another issue.

MR. SHARP: Okay. Did you cross that off?

MR. TERRY: I'm going through it not.

MR. SHARP: I've got it.

UNIDENTIFIED SPEAKER: 79, 12 through 21.

MR. SHARP: We have it, we're all good. You know --

THE COURT RECORDER: Cell phones away from the speakers again please. Mr. Roberts, you've got your cell phone behind you.

MR. ROBERTS: I do. Am I buzzing.

THE COURT RECORDERER: No. It's buzzing a little bit because it's close to the speakers though. Thank you.

THE COURT: So how long do you expect Dr. Liao's reading to last approximately?

MR. SHARP: So we -- I'm not sure because -- two, two and a half hours. I'm not really sure.

THE COURT: Okay.

MR. SHARP: It's a big depo and -- but we do have Elliot Flood that I was going to call out of order after the break and I have to inform defense. Can I bring the reader in?

THE COURT: So once the jury comes in you'll be sworn in by the clerk.

MS. MCCABB: Okay.

THE COURT: Are the parties ready for the jury?

MR. SHARP: Yes.

THE COURT: Mr. Roberts?

MR. ROBERTS: Yes, Your Honor. We are. Mr. Gormley will be doing our part of the reading.

THE COURT: All right. Thank you.

THE MARSHAL: All rise for the jury.

[Jury in at 1:11 p.m.]

THE MARSHAL: Okay. All jurors are presents.

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

MR. SHARP: For the Plaintiff, yes.

MR. GORMLEY: Yes, Your Honor.

THE COURT: Thank you. Please be seated. Ladies and gentlemen of the jury, the witness who was just on the stand prior to lunch due to a scheduling issue -- you can be seated. Is going to be recalled later on in the trial. We are now proceeding with the reading of the deposition of Dr. Liao. The witness who is on the stand is not the doctor, she is someone who is going to read the part of the doctor.

So a deposition is a statement under oath. And so it was a statement that was given prior to this case where the doctor was sworn to tell the truth under the penalties of perjury.

And so she's unavailable today so her deposition transcript will read like a play, the question and the answer. So you'll be hearing the question as it was asked when the deposition was taken and then the answer is Dr. Liao gave it as read by the witness here. Does that make sense? All right.

Madam Clerk, can you swear her in?

THE CLERK: Please stand. Raise your right hand.

[Nicole McCabb, sworn]

THE CLERK: Please state and spell your first and last name for the record.

MS. MCCABB: Nicole McCabb.

THE COURT: Can you spell your first name and then spell your last name.

MS. MCCABB: Sorry. Nicole McCabb, N-I-C-O-L-E M-C-C-A-B-B.

THE COURT: Thank you. You can be seated. Mr. Sharp.

MR. SHARP: Thank you, Your Honor.

[The deposition of Zhongxing Liao was read into the record as follows:]

DIRECT EXAMINATION

BY MR. SHARP:

Q Tell us your full name, please, ma'am.

A Zhongxing Liao.

Q Dr. -- excuse me. Dr. Liao, the first thing I would like to do is to learn a little bit about you and your background and have you explain to the jury who you are. Fortunately we have been provided a copy of your CV and so that has given us an opportunity to get some idea of your background. But I would like to talk to you a little bit about that now, if that's okay. So the first thing I would like to do is to ask you some basic questions and then we will work out our way into your CV. So can you tell us, Dr. Liao, what kind of physician are you?

A I am a radiation oncologist specializing in treating thoracic cancers.

Q Thoracic cancers?

A Uh-huh. Thoracic cancers including everything inside of the chest, include lung cancer, esophageal cancer, thymoma and

mesothelioma. That's the normal commonly what type of cancer I specialize in.

Q So you specialize in cancers of parts of the body inside the chest including lung cancer?

A Correct.

Q All right. Now how long have you been practicing radiation oncology, Dr. Liao?

A Since 1999.

Q So 21 years as a radiation oncologist now?

A Yes.

Q Can you tell us if you would have -- if you would where you practice medicine?

A I have been practicing at MD Anderson Cancer Center since I joined the faculty. So 21 years as a faculty at the MD Anderson Cancer Center.

Q So let's talk a little about your education and training as a physician and specifically a radiation oncologist. Can you tell us, Dr. Liao, where you went to medical school?

A I went to medical school in China. My medical school's name is Changsha Medical College.

Q And what year did you graduate from medical school?

A 1983.

Q All right. And then what did you go on and do after you finished your medical school of training and education?

A I did my residency in radiation oncologist in the cancer

hospital in China and then I became attending for about two and a half years. Then I got a fellowship for training in the United States. Then I arrived at the MD Anderson Cancer Center.

Q In what year?

A In 1989.

Q So in 1989 you first came to the United States to train and work at MD Anderson?

A Yes.

Q Okay. So how long -- so you went to medical school for what, for four years?

A Five years.

Q Five years in medical school. Then how long -- how many years did your residency take in radiation oncology in China?

A In China it was three years residency.

Q Okay. Then the next thing you did was come to the United States?

A Yes.

Q And so you've been at MD Anderson training and practicing since 1989?

A Correct.

Q And so you did a fellowship in radiation oncology -- radiation oncologist at MD Anderson; is that true?

A True.

Q How long did that take?

A I started with a research fellow, that was from '89 to about

'93. Then I did a fellowship in clinic for half a year before I officially entered into an internship in Kansas, which was then followed by residency training of radiation oncology.

Q Okay. And so you did your internship at the University of Kansas for a year you say?

A For one year, yes.

Q And then you went on and did a residency in radiation oncologist back at MD Anderson?

A Correct.

Q And how long did the residency last?

A Four years.

Q And after that, after your residency did you become a practicing radiation oncologist at MD Anderson?

A Yes.

Q So all totaled how many years of medical training did you undergo before you became a practicing radiation oncologist at MD Anderson?

A Including China or not including China?

Q Including China.

A Including medical school?

Q Yes.

A So eight years plus another three and a half, almost four years. Then another four years, so five years. So almost like from -- because I entered medical school in 1978, and all the way to 1999, so before all that it was all training.

Q So 20 or 21 years of medical education and training before you began practicing radiation oncology at MD Anderson?

A Yes.

Q And how much of that training would have been specific to the practice of radiation oncology?

A That would be seven years.

Q All right. So you've been working and practicing at MD Anderson ever since, right?

A Yes.

Q All the way up to as we sit here today?

A Yes.

Q Okay. So tell us if you would, Dr. Liao, what do you do at MD Anderson? Do you see patients, do you teach, do you do research, combination of those things. Just explain for us if you would what it is that your job entails at MD Anderson?

A My major task at MD Anderson is patient care, which is 68 percent of what we call effort. Then I also have responsibility for research. I'm actually a director of the clinical research for the division of radiation oncology, so that is considered part of the administrative responsibility. Also we have responsibility for education. I teach lessons to fellows, physicians, scientist all the time. We also have responsibly for research, leading clinical trials nationally for lung cancer specialty and also for other clinical trials. In addition, we are also required that we serve in the community. Community service includes like serving on the introducing committees to help provide otherwise to our leadership. So

usually our job is patient care, education, research, administrative and leadership role as well as the community service.

Q Understood. So thank you, Doctor, for all -- for that explanation. I'm going to pull up your CV so we can kind of go through it some together. I'm going to mark it guys as Exhibit 4 to Dr. Liao's deposition.

And just for the record, Dr. Liao, this CV is 71 pages long. It starts at UTMD -- these numbers down at the bottom of the page, I don't know if you can see that. We lawyers call those bate stamp numbers. That number, UTMDACC through UTMDACC-323. So 70 pages or 71 pages of your CV. So I want to talk to you about this briefly. I can pull out some of it if you -- for -- if you'd like. This is part -- this is the part about your present title and affiliation, do you see that, Dr. Liao?

A I do.

Q So this would be the titles and affiliations that you currently hold at MD Anderson, true?

A True. I guess the only thing I can see right now, I'm not an interim anymore for the director of clinical research. I'm right now official director of clinical research.

Q So your CV shows you as the interim director of clinical research, but as of today you are the actual -- you are not interim anymore, you are the director of clinical research in the department of radiation oncology at MD Anderson in Houston, right?

A Yes.

Q Okay. And that's just one of the list of things that you do

here. And you can see there is a number of them, I'm making little red marks by each one. Those are all things that you are currently involved in doing, true?

A True.

Q Including for instance a number of things, but including the committee chair of the division of radiation oncology, right?

A Yes. Committee chair. I forget which one. Committee chair is the committee chair of the clinical research counter counsel. You can see on the CV that there are two committee chairs listed, one is the clinical research counsel, the other one is the committee chair of the division of radiation oncology. I'm just trying to say that we have many committees, but I'm the chair for two of them.

Q Okay. You are also it says here, a professor in the department of radiation -- radiology oncology. That's the teaching part of you were talking about earlier, right?

A Yes.

Q Okay. So let's move forward in your CV a little and talk about some of the other things that are true of your qualifications here. One of the things at page 2 of your CV, which is the MD Anderson document 254, indicates that you are board certified. You have a board certification from the American Board of Radiology and Radiation Oncology, do you see that?

A Yes.

Q Okay. Can you tell us just briefly, Dr. Liao, what board certification means?

A Board certification means that you need to go to our national board, take written examination and pass that. And then take an oral examination. Have a face to face examination with the examiner and pass that. After that you become a board certified. This is a requirement for our practice.

Q Okay. And I see that you are board certified specifically in radiation oncology. Is that a subspecialty of oncology?

A Yes.

Q Is there -- are there other subspecialties of oncology besides radiation oncology?

A There are medical oncology, there are surgical oncology. Medical oncology certainly has a separate board, but I'm not quite clear about the others.

Q Okay. So a radiation oncologist has a separate board certification based on separate training and education as compared to a surgical oncologist or a medical oncologist. Is that right, ma'am?

A Yes.

Q Okay. So can you tell us, Dr. Liao, in general terms what is the difference between a radiation oncologist and a medical oncologist for example?

A The major differences is we use different modalities to treat cancer. Radiation oncology use radiation to treat cancer; medical oncology uses drugs to treat cancer.

Q So would you hold yourself out to be an expert in medical oncology?

A No.

Q Does medical oncology -- does a medical oncologist have the same education and training as a radiation oncologist?

A No.

Q We'll pull up some parts of your CV, Dr. Liao, just so the jury can understand who you are and what you do. I want to go forward now to page 5 of your CV, which is UTMDACC-257. And this portion of your CV has to do with research, grants and contracts. Do you see that, ma'am?

A Yes, I do.

Q Okay. So now -- so you can you tell us -- there's a listing of a number of grants and contracts that are funded and pending and so on. But can you tell us what this research portion of your CV tell us about what you do?

A My research -- well, I think this area shows the area of my research record. You can see there are research focused on proton therapy. There are research focused on toxicity reducing treatment sensitivity, increasing methodology in radiation oncology.

Q Well, let me ask you this way, there are multiple pages, I think there's six pages of listings of research that you have done or doing now going all the way to page 263 or page -- about six pages deep in research. I'm just curious if you could tell us, Dr. Liao, what is it that your research focuses? What are you -- what do you spend your effort in research working on?

A My research focuses -- you know, scientific term is to what

we call increase the toxicity ratio by increasing the therapeutic ratio. That means we want to raise the control of the tumor at the same time we want to minimize the treatment of cancer therapy related toxicity and the side effects. That way you can enlarge -- increase the ratio of the treatment that you give the patient.

So by doing so to achieve this aim we have, you know, different -- a different approach to do that. For example, you know, we want to minimize the radiation dose to normal tissue. We want to identify tumor markers or biomarkers to find the patient who many develop toxicity. And also fortunately we want to test and demonstrate whether those methodology works or not in clinical trials.

Q Okay. So is it fair to say that the focus of your research is attempting to improve the therapeutic ratio in radiation oncology for thoracic --

A Yes.

Q -- for thoracic cancers?

A Yes.

Q Is it fair to say that one of the focuses of your research is proton therapy and its application in the area?

A Yes.

Q And I take it you've been doing that sort of research for many years?

A You mean proton therapy related research or all the research?

Q That's just the research in general.

A Since I joined MD Anderson in 1989.

Q Okay. So we're talking of 30 years plus you've been doing research in that area?

A Uh-huh, yeah.

Q Now let's go forward in your CV a little bit -- a little more to a page that has number 264, which is page 12 of your CV. And it has to do with the section -- it has to do with the publications of peer reviewed original research article. Do you see that, ma'am?

A I do.

Q Okay. Well, tell us if you would, what this section of your CV relates to as it describes the work you do at MD Anderson.

A The publication record is a record basically of my research and the fact that this research has been published in peer reviewed articles -- journals, means that the search has been accepted by peer review.

Q Are these articles that you write, do they relate to research projects that you do that you described for us earlier?

A Yes.

Q So do these articles allow you to write up these research projects and publish them so that other doctors can read them?

A Yes.

Q And are these journals that you published articles in, are they reviewed by doctors all over the world?

A It depends on the articles of the journal, but usually yes.

Q Okay. So let's take a look real quick and see how many times

you've done what we're talking about here. I want to pull up as an example, here is number one. Here's a list of articles that you have written, here's number one. As you can see they are numbered. Do you see that over there at number one?

A Uh-huh, yes.

Q Okay. So if we skip forward through the pages, the listings of the articles that you have written and published -- I'm trying to get to the end of the list here. There is the end. How many articles have you participated in authoring and published in peer review journals?

A Now I think it's more than 332, but you know, my CV says -- yeah. My CV says 332.

Q Okay. So as of the time of this CV that we're looking at, this resume of yours that we're looking at there are 332 times that you had published in peer review journals. But since this CV was prepared there has been a few more?

A Yes.

Q Do you know how many more?

A I cannot tell you exactly, at least two or three more I think.

Q Okay. All right. So when you conducted the research that is reflected in your published articles that reflect the research you have done at MD Anderson, are you conducting this research with other doctors from around the world?

A Yes.

Q So is it fair to say that you have been -- that you've contributed to the body of the world's medical knowledge on the

research topics that you have worked on?

A Yes.

Q Okay. Then at the bottom of this same page in your CV there is the word abstract. There's a list of abstracts in your CV, can you tell us what an abstract is?

A The abstracts are the research project that we have either some preliminary data that we want to report on the conference, and they are abstract on the conference. So those abstracts mean that we have submitted them to a conference to be presented.

Q Okay. So these would be research projects that you would present at conferences to other doctors so they could get the benefit of your knowledge, right?

A Yes.

Q All right. So if we look forward in your CV to page 50, that's the end of the list of abstracts that you have listed. I want to see how many there are. This says 201, is that still roughly accurate?

A Actually I don't think so. What happened is that the CV gets too long, so we only list five years abstract. So many abstracts that were presented in conferences are not included in this CV.

Q Okay. So this would only be the last five years' worth?

A I believe so. I need to go back and confirm that.

Q But at least we know that within the last five years you have prepared and presented 200 abstracts at conferences?

A Yes.

Q And just below that part of your CV on page 302, which is

page 50 of your CV. It says books, chapters. So is that what it sounds like, chapters and books?

A Yeah.

Q Have you written or participated, collaborated on the writing of chapters in textbooks?

A Yes.

Q Books that are used to teach other doctors when they are studying radiation oncology, is that what the books are about?

A Yes.

Q How -- then how many, see if we can see how many of those there are. We're looking on page 51 of your CV. It looks like there are 16, is that still roughly accurate?

A Yes. I think we had a few more, but they took out a lot.

Q Okay. Then let's look at page 52 of your CV, which is page 305. There's a section here -- I'm sorry, 304. There's a section here that is referred to falls under teaching. So this would be a listing of the classes or courses that you teach at MD Anderson?

A I'm sorry, I lost the screen share. Okay. Now I see it. Good.

Q Okay. So this is the -- this is a listing of the courses or classes that you teach at MD Anderson to other aspiring physicians?

A Yes.

Q All right. And one of those is currently you are teaching a class on multi-modality therapy cancer of the esophagus, for instance. That's one of the things you are doing, right?

A Yes.

Q So does teaching -- so does the teaching that you do focus on radiation oncology in the thoracic area?

A Yes.

Q Including lung cancer?

A Yes.

Q Including proton therapy for lung cancer?

A Yes.

Q All right. Now I want to skip ahead to page 57 of your CV. There's a section there that is referred to as conferences and symposia. I want to make that a little bigger, organizations of conferences and symposia, including chairing's. This section. So there is a list in here of such conferences; is that accurate?

A Accurate.

Q And so tell us if you would with these conferences, what involvement you would have -- had in these conferences at least in general?

A There are two types of involvement, one is a presenter for abstract, you know, the abstract we went through. Another major goal for us to participate is to help organizing the satisfaction conferences according to each different topic, where we usually go to the site of the conference and try to moderate -- interact with the audience.

Q Okay. And I counted the number of these conferences and symposia that are listed here. You don't have them numbered in your CV, but there are 38 listed. 38 conferences or symposia that have presented at or organized. Does that sound true for the last five years or

so at least?

A True.

Q Okay. Now let's look at page 58 of your CV, which is page 310. Pull this up for you. This section is called presentations at national or international conferences invited. Do you see that?

A I do.

Q Tell us what that means, ma'am?

A Those are conferences that actually specifically invited me to be an invited speaker for a specific topic.

Q So you've been invited to speak at presentations nationally and internationally to speak to other physicians?

A Yes.

Q And you've traveled around the world doing that?

A Yes.

Q Where are some of the places that you've been to speak?

A I've been to China, Africa, Europe. Many countries in Europe, almost all. Not South America. Almost all other countries.

Q Okay. So I didn't -- well, your CV doesn't number the times that you've been invited to speak at conferences nationally or internationally. But I counted them up and it's well over 100. Does that seem accurate to you?

A Yeah. Yes.

Q So Dr. Liao, you stay very busy with your research and publishing, but it sounds to me like you -- what you told us earlier that about two thirds of your time is spent with actual patient care; is that

true?

A True.

Q So you have patients that you treat, right?

A Yes.

Q Let me ask you this before we move away from your CV. Do you practice in a group of thoracic radiation oncologists at MD Anderson?

A Yes.

Q Approximately how many radiation oncologists are there in your group?

A We have 11.

Q In your opinion, Dr. Liao, is MD Anderson's radiation oncology thoracic group one of the top such groups in the world?

A Yes.

Q I'm sorry, Dr. Liao?

A Yes.

Q Has MD Anderson radiation oncology thoracic group published as much or more literature on the treatment of thoracic cancers with radiation than any other group in the world?

A I would say at least as much. I never compared them. I don't know how many other people in the population, but in the population a lot of papers.

Q Would you say that the radiation oncology thoracic group at MD Anderson is a world renowned group?

A Yes.

Q And I'm going to ask you this, not to embarrass you or make you feel immodest, but would you consider yourself to be a world renowned oncologist -- radiation oncologist when it comes to the treatment of lung cancer?

A Yes.

Q Okay. So you've spent a substantial portion of your career at MD Anderson Cancer Center in Houston. I think that's fair to say, isn't it?

A Yes.

Q Is MD Anderson a cancer center of excellence?

A Yes.

Q What does that mean, ma'am?

A We are number one cancer center.

Q Does anyone, does any organization or publication rank cancer centers around the world?

A There are many agencies that rank the cancer center in the world.

Q Where does MD Anderson rank?

A MD Anderson ranked number one.

Q So do you -- I want to ask you about the patients that you see at MD Anderson. Do you find that you have patients referred to you or patients seeking out your treatment from all over the world?

A Yes.

Q And in your experience, Dr. Liao, why does that happen? Why do people come from around the world to seek treatment for their lung cancer at MD Anderson?

A I believe MD Anderson offer -- many times offers hopes and faster treatment for patient. We have -- often have cases that patient was told, okay, you have six months to live. And the patient come to us and then we can treat them and, you know, help them in that situation. We have international patients referred to us as well as from all over the world. From actually United States and from Texas directed to MD Anderson for their cancer care. The reason for that, which I believe is that MD Anderson offers the best treatment.

MD Anderson also offer the best multidisciplinary care. Provide the treatment like clinical trials other areas, other hospitals doesn't have. You know, pretty much like moving the standard of care and then cutting edge of technology and treatment for a patient. I think that's the reason patients come to MD Anderson Cancer Center.

Q Okay. So let's talk for a minute if we can about cancer treatment in general, Dr. Liao. You mentioned earlier that there are subspecialties of oncology and medical oncology, surgical oncology and radiation oncology. And my question of you, is that because there are three basic ways of treating cancer?

A Surgical oncology, medical oncology and radiation oncology are three main treatment modalities. However, we have many, many more ways now.

Q Okay. So is it fair to say that when someone comes to be evaluated for cancer treatment you look to see if you can do surgery, you look to see if chemo will help, and you also look to see if radiation is a proper treatment. Is that a general description?

A Yes.

Q Okay. So tell us if you would, Dr. Liao, from a -- just from a lay standpoint if you can, what is a radiation oncologist? How do you use radiation to treat a person with cancer?

A Radiation oncology by definition is to use different radiation to cure cancer. To help, to cure cancer cells and help cancer control. So radiation includes different types of radiation. We have photons, which, you know, it's what we also call x-ray where we have electrons, protons. We also have neutrons and many different types of radiation.

Q And so is it true to say that radiation energy injected into the human body kills cancer cells?

A Yes.

Q And so is it also true that a radiation oncology's task is to apply the radiation in a way that is most appropriate to kill those cells?

A Yes.

Q So is it true to say -- well, how do you assess a person who comes to you with cancer, lung cancer, let's say to determine if radiation treatment is appropriate at all?

A Well, I see a patient, a patient will complete a staging work up which includes their scans of the chest and PET scans and brain scans. Basically a complete stage work up, including the scans for the whole body and then the biopsy, their function, their lung functions and cardiac functions, their labs. Virtually all necessary medical information for us to understand the extent of the disease. Also the condition of the patient.

After we have this information collected and we see the patient, evaluate the patient, we talk to the patient and examine the patient. Then we have a multidisciplinary conference for a patient evaluation, which actually is part of the standard at MD Anderson Cancer Center. Then during the discussions in the group we'll say, okay. Based on this and, you know, certain treatment will be the recommendation. So radiation oncologist's certainly weigh better aid, it will be radiation policy in this patient or to be copied provided with all the medical information.

Q All right. So once it's determined, Dr. Liao, that radiation and treatment is appropriate for a patient who has lung cancer for instance, is it -- how do you go about determining which radiation method or modality you would use to treat that person's cancer?

A In terms of radiation we have a process that -- first the process is to develop a treatment plan. During the treatment planning what we do is that we map the patient tumor with the normal organs in the chest. Then what we do is weigh -- okay, say this patient needs a comparative, different type of comparative plan to help us decide what would be best. For example, when we have like a patient where we talk about either proton or photon treatment or maybe like other ablation treatment we will actually -- you know, especially for radiation treatment we will have a comparative plan.

Q Okay. So you have -- do you have different radiation delivery methods or modalities at your disposal at MD Anderson?

A We do.

Q And do you look at the various options and determine which one is the best for the patient?

A Yes.

Q And do you do so by the way that you just described, in general way, right?

A In general we're supposed have a comparative plan. Then the plan need to be presented to our thoracic group of radiation oncologist, get a group input and everybody needs to agree on this plan.

Q Okay. So just before we talk about that planning aspect of it, is it true to say, Doctor, that radiation oncologists are the ones that develop these plans as opposed to other kinds of radiologists?

A Radiation oncologists develop the radiation treatment plan.

Q Do you believe that a medical oncologist without radiation oncology training would be qualified to develop or weigh in on comparison plans between different radiation modalities? Go ahead, Doctor.

A No.

Q If someone came to you wanting you to design a chemotherapy treatment plan for a patient, it would not be within your area of expertise, would it?

A No.

Q Okay. So you mentioned photons and protons a moment ago as two of the different ways that you can deliver radiation energy to cancer centers, right?

A Yes.

Q Let's talk for a minute about proton therapy. Just sort of where it comes from and the history of it if we can. Has proton therapy for treatment of cancer been around for a while?

A Yes.

Q And do you know, Dr. Liao, when protons were first used to kill cancer in human beings?

A I don't remember exactly the year, it's been at least -- it's been practiced more than 60 years.

Q 60?

A Yes.

Q And is the technology that is used at MD Anderson to deliver proton therapy to patients, is it FDA approved?

A Yes.

Q And how long has that technology been FDA approved?

A I don't recall that.

Q Okay. Does Medicare pay for proton therapy?

A Yes.

Q Are you aware of how many proton therapy centers roughly there are in the United States?

A The ones that are in practice, more than 62. I think there are more because, you know, on the list I see -- I think I see 92 now, but I think 60 of them are in practice.

Q All right. And have patients been treated for years now at these proton centers around the country?

A Yes.

Q Do you know if it's fair to say that tens if not hundreds of thousands of people have been treated with proton therapy in the United States?

A Yes.

Q Okay. So you mentioned a moment ago that one of the things you do as part of the comparison planning between the various modalities of radiation treatment for a patient is to look at the organs at risk near the cancer; is that accurate?

A Yes.

Q So let's talk about that. You have -- if you have a tumor in your lung, let's say, is it -- what organs can a lung tumor be near that are vital to human function?

A Lung cancer is inside the chest, the heart, the lungs, and the esophagus are all very close to the tumor in a lot of the situations.

Q So if you have a patient with a lung tumor that is near the heart, the healthy lung tissue, the esophagus, for instance, then what is your goal with your radiation planning with regard to those other body parts that are near to the cancer?

A The goal is to deliver enough dose to kill the tumor, but at the same time, minimize the radiation on what radiation does to those organs to -- yeah. To try to minimize the dose.

Q So is the comparison planning that you were talking about doing for a patient and trying to determine which kinds of radiation to use, is that process for targeting purposes?

A Both the treatment are targeting the tumor. I guess I'm not

quite understanding your question.

Q Okay. Thank you for saying that. I want you to tell me because there'll be plenty of times when I ask a bad question. So if you are comparing the -- making a plan for both protons -- or IMRT on the one hand and protons on the other to determine which of those is appropriate for a patient, do you evaluate that on the basis of how accurately you can deliver the radiation?

A We evaluate a plan based on multiple parameters. We look at the tumor coverage. We look at the dose to the esophagus, dose to the lungs, to the heart and to any organs that is in the beam path of the treatment planning.

Q Are there advantages to using proton therapy when it comes to the accuracy of the delivery of the radiation energy?

A The accuracy of the delivery depends on the imaging guidance.

Q On what the guidance -- I'm sorry, Dr. Liao.

A On image guidance.

Q I see.

A Imaging guidance, yes.

Q I see.

A Protons or the delivery and photon, the delivery both are accurate because they have imaging guidance delivery. I hope I understand your question correctly. Delivery is not the treatment; is how you give the treatment.

Q Okay. So I guess what I'm getting at is can protons more

precisely target the cancer while delivering less radiation to the organs around the cancer?

A Yes.

Q How is that Dr. Liao?

A Because protons in comparison with the photons, it doesn't have the accuracy dose. The way you use photons, what happens the photon comes -- for example, it comes from the front while it exits from the back. So in the path of the photon radiation, many organs or tissue that is in front or behind the tumor will get those. Proton's advantage is that it can stop at a certain depth versus the specification of the planning. So in a way, protons can significantly minimize the radiation treatment, radiation dose in the front, and also in behind the tumor during the radiation.

Q That's fine. So let me ask you this. Do you agree with the statement that there is no significant difference in the biological effects of proton versus photons?

A There is a 1.1 ratio of the biological effectiveness. There is a difference.

Q Is it a significant difference?

A It's one percent. Right now we consider there's a one percent difference. 1.1 ratio.

Q So do protons deliver a dose of radiation in a more confined way to the tumor tissue than photons?

A Yes.

Q So after protons enter the body, they release most of their

energy within the tumor region?

A It was designed that way, yes.

Q And do they deliver only a minimal dose of radiation beyond the tumor boundaries?

A Yes.

Q Is it true that utilizing protons results in less collateral damage to the surrounding tissues?

A Yes.

Q I'm sorry, Dr. Liao. What did you say?

A Yes.

Q Is it true that proton therapies may be useful when the targeting volume is in a close proximity to one or more critical structures?

A Yes.

Q Is it also true that proton therapy may be useful in sparing the surrounding normal tissue when -- or is it true that proton therapy can be useful when sparing the surrounding normal tissues that cannot adequately be achieved with photon based radiation therapy like IMRT?

A Yes.

Q So is it true -- let me just ask, is proton therapy a medically accepted therapy to treat cancer in human?

A Yes.

Q Including lung cancer?

A Yes.

Q Is treating lung cancer with proton therapy evidenced-based?

A Yes.

Q Would it be accurate for someone to say that proton therapy is never medically necessary for treating lung cancer?

A No.

Q So have you heard of the term in radiation oncology called ALARA, A-L-A-R-A?

A Yes.

Q What does that mean?

A It's low, possibly achievable.

Q Okay. What -- how does that apply to the concept of delivering as little radiation as possible to healthy tissues? How does that apply in the analysis of proton therapy versus IMRT?

A That is when we compare the two plans and to make sure that we deliver as low as possibly reasonably achievable dose to the critical organs.

Q Is there an accepted principle or fundamental principle in radiation oncology regarding the avoidance of delivering radiation to a healthy tissue?

A Yes.

Q What is it?

A The principle is, minimize the amount of radiation to lung cancer tissue and the critical organs.

Q Okay. So let's talk -- let's say you've got a patient in your practice, a lung cancer patient in your practice at MD Anderson. And you're trying to determine what radiation method or modality you are

going to use to deliver radiation energy to his cancer. You said earlier that you do some scans or images of the chest to locate exactly where the tumor is. Is that what you told us? I'm sorry, Dr. Liao,

A Yes.

Q And why is it important to know exactly where the tumor is?

A Radiation is a way of targeted therapy. So you need to first define your target so that the scan provides us with the information for us to imaging find the treating target.

Q And do you also -- is it also important for you to know what kind of cancer cells you are dealing with?

A Yes.

Q And why is that important?

A Different cancer cells may have different sensitivity.

Q Okay. So when you mean they have different sensitivity, what do you mean with regard to your planning for what modality to use?

A It is affected more on the dose, the modality, because the modality is the principle. Choosing modality is to make sure that you target the tumor and minimize the dose to the normal structure and the critical organ. But the difference in cells may need a different dose of radiation.

Q Okay. I see a certain -- so a certain kind of cancer cell requires a certain amount of radiation energy to kill it?

A Yes.

Q In our case here today, our patient, Mr. Eskew had squamous

cell cancer, right?

A Yes.

Q And how many rays of energy does it take -- how many rays of radiation energy does it take to kill the squamous cell?

A Usually we can see the range. The range of the dose range all the way from 60 gray to we went to like 90 gray. If you're talking about the self-healing, there is a range of the dose. And then what we do in clinic practice is that way we determine what is the proper dose for each patient.

Q Okay. So in our case here with Mr. Eskew, what amount of radiation energy did you deem to be necessary to deliver his lung tumor to appropriately treat it?

A I recall that we wanted to deliver 66 gray to the tumor, but try to minimize the dose. And we went to the planning target of volume to get 60 gray.

Q So you were looking to do 66 gray was your goal?

A To the tumor.

Q Yes. And so I assume is that because you believe that 66 gray radiation energy was sufficient to kill his lung cancer?

A It is an accepted dose that we use in radiation oncology community.

Q So is it true to say that it takes less than 66 gray to kill healthy tissue cells at of the organ at risk near Mr. Eskew's cancer?

A Yes.

Q How many grays of energy does it take to kill normal

esophageal healthy cells?

A Esophagus is a very acute responding tissue. Usually patients are having problem about probably two weeks after we start radiation. That's when the esophageal lining's still having the problem.

Q Okay. So, all right. So the goal is to deliver 66 gray of energy to the tumor, but it sounds to me like you are saying that you do not want to deliver that many grays of energy to the healthy tissue near the tumor, right?

A No.

Q Okay. So let me ask you this. Do you regularly treat lung cancer patients with proton therapy at MD Anderson?

A Yes.

Q Do your colleagues in your thoracic radiation oncology group do so as well?

A Yes.

Q Has MD Anderson as an institution determined that treating lung cancer patients with proton is proven to be saved?

A Yes.

Q Has MD Anderson as an institution determined that treating lung cancer patients with protons is proven to be effective?

A Yes.

Q And proven to be supported by the medical science?

A Yes.

Q Has MD Anderson as an institution determined that treating lung cancer patients with protons is not experimental?

A Correct.
Q And it's not investigational?
A Correct.
Q And do you believe that those things to be true as well, right?
A Yes.
Q Would MD Anderson treat patients with proton therapy, I mean, lung cancer with proton therapy, if it was not proven to be safe and effective?
A No.
Q Would MD Anderson treat lung cancer patients with protons if MD Anderson believed that to do so would be investigational or experimental?
A If that's the situation, then it would be in the clinical trial.
Q And it isn't, right?
A We have trials, but we also treat patients without trials because we can see it is FDA approved treatment.
Q Is MD Anderson alone in the opinion among -- let me ask it this way. Is MD Anderson alone among cancer centers around the world, in the opinion that using proton therapy to treat lung cancer has been proven to be safe and effective?
A No. There are many other cancer centers using protons.
Q Is that a widely accepted position in the radiation oncology community around the world?
A Yes.
Q I'm sorry, Dr. Liao?

A Yes.
Q Do radiation oncologists at other cancer centers of excellence, like MD Anderson treat lung cancer patients with protons?
A Yes.
Q Is that true all over the United States and all over the world?
A Yes.
Q Is it true that treating lung cancer with proton therapy is a standard of care in the medical profession?
A Yes.
Q So let's talk for a moment about your goals when you are treating a cancer patient, what are your goals? Are you trying to -- what are you trying to accomplish when you're treating a cancer patient with radiation?
A We are trying to control their cancer to the widest degree while we try to reduce as much as possible on the side effects of cancer therapy.
Q Sorry. Do you treat lung cancer patients at MD Anderson in an effort to cure them of their cancer?
A Whenever possible.
Q Is part of that goal of your treatment to improve the patient's quality of life?
A Yes.
Q Is part of your goal in treating a cancer patient to extend the patient's life?
A Yes.

Q Is it important, Dr. Liao, as a radiation oncologist to attempt to minimize the stress and anxiety that the cancer patient is feeling as he or she is going through the course of cancer treatment?

A Yes.

Q Why is that important?

A We know that side effect is the stress and either emotional or physical stress of the patient negatively impacts the patient outcome.

Q And you've had experience in your practice at MD Anderson?

A Yes.

Q And have you done some research with regard to the methods for cancer patients to try and manage their distress and mental anxiety?

A Yes.

Q What kind of research have you done?

A We try different research. We try to -- if you look at the med CV, we do some yoga, supportive care, integrative oncology medicine, and help them to deal with stress, not only the patient, but also their caregiver.

Q Okay. So let's talk a minute about Bill Eskew. I assume Dr. Liao you had an opportunity to review at least part of Mr. Eskew's medical records and radiation records at MD Anderson; is that right?

A Yes.

Q Okay. And the record reflects that he was first seen -- well, he was first seen by you in January of 2016. Does that ring a bell?

A It does ring a bell, around that time.

Q So do you recall, have you reviewed any records to indicate that you did an initial consult with him in or around January of 2016?

A Yes.

Q Okay. And so is it true that Mr. Eskew went through a course of treatment and evaluation at MD Anderson that is similar to what you have described to us here today?

A Yes.

Q And so when you first consulted with Mr. Eskew, did you determine he had a cancerous lesion in his body or tumor in his body that was squamous cell tumor?

A Yes.

Q And did you review some images, or PET scan or MRI of his body to see where the tumor was in his lungs?

A Yes.

Q And what did you recommend in the way of treatment for Mr. Eskew? What method of treatment did you recommend?

A In general we recommended a concurrent chemo radiation therapy.

Q Okay. So what is a concurrent chemo radiation plan?

A It means that we give radiation, and we also give chemotherapy.

Q Did you reach that conclusion early on in first seeing him?

A After we evaluated all the patient information and also touched base with the referring medical oncology and the physical oncology chronic.

Q So you determined that Mr. Eskew needed radiation treatment along with chemo, right?

A Correct.

Q And then did you go about the process of trying to determine which modality of radiation treatment would be appropriate for him?

A We go through the standard procedure in our department, reception in our department, you know, simulation then develop the comparative plan, and then we decide which modality.

Q Okay. So stimulation [sic] first and then the comparison plan --

A That's right.

Q -- right?

A Yes.

Q So tell us what is -- tell us what a stimulation [sic] is.

A A simulation is a procedure, basically another CT scan while the patient is immobilized in the treatment position. And then we scan the patient. We also evaluate patient respiratory motion of the lung during the simulation. And then based on the simulation, see the images. We will then map out the tumor and the critical organs inside of the chest. And then this information will be passed on to the dosimetrist for the planning in the development of the plan.

Q You said dosimetrist, right?

A That's right.

Q Can you tell us what a dosimetrist is in lay terms?

A Dosimetrists are a group of experts after which provide

patient information in terms of the targeted volume, the organs that we want to protect and then set the dose of the treatment. They will then use a computer program to develop a plan that can indicate what ought to be the appropriate energy. You know, if it's an MIRT [sic] plan, what angle the entry will take.

For a comparative plan, they do the same for the protons. They will determine like how many angles of the field, and then at each angle, how long the radiation should be, how much radiation should be delivered. And then what ought to be the overall end, the end output of the dose and the volume that will be treated, receive the radiation during the course of the treatment.

Q Okay. So what we know with Mr. Eskew, according to the records is that that process was gone through with him, and ultimately a decision was made by you as to which treatment radiation modality would be the best for him, right?

A Right.

Q And what was your ultimate conclusion about which radiation method of delivery would be appropriate or best for Mr. Eskew?

A We developed a comparative plan, and then there were a few key things that I looked. The most important in his comparison plan is that he had a reduction of the esophageal dose, a lung dose, and heart dose, three very major organs inside of the chest. The proton actually provided more protection. So that was the reason we decided to recommend proton radiation.

Q So I want to talk to you about your analysis of those issues in one second, but let me show you something else first really -- real quickly. This is a document that I'm going to mark as Exhibit 5. I marked Doctor, your CV as Exhibit 4. I'm going to make this one Exhibit 5. And this is a letter that was sent, and it's bate stamp number SHL328. And following, it's a letter that was sent by MD Anderson. Can you see that? Do you see that Dr. Liao?

A Yes, I can.

Q It's an urgent prior authorization for proton -- well, it's an urgent prior authorization?

A Yes.

Q And for proton radiation treatment, do you see that?

A I do.

Q Okay. Following this cover page is a letter that starts out on SHL330, that is signed on page 331. And your signature is on there. Do you see that?

A I do.

Q And the letter sets forth in it, your justification or your reasoning of why protons would be better, doesn't it?

A Yes. I see that.

Q Okay. So we'll have to come back to that letter in a minute, but that was your ultimate conclusion after you went through the process of the comparison plan, right?

A Correct.

Q So now let's talk a little bit about what the compare -- about

the comparison plan. I understand as you've told us here now that the dosimetrist is involved in the comparison planning. And is there anyone else, like maybe a physicist?

A A physicist would check on the quality assure of the plan. Also, the plan needs to -- has to be presented and go through the oncologists of practice in radiation oncologists in the thoracic section.

Q So there would be a group of radiation oncologists would approve a plan before it was put into effect?

A They will review and make corrections, make recommendations. And then eventually we need approval from the POA before we can proceed with treatment.

Q Let me ask you this, is a patient prior comorbidities factor in any way to the analysis of what radiation modality to use?

A Yes.

Q And why is that Dr. Liao?

A Well, if a patient has existing conditions that often will impact on how much radiation that particular organ can tolerate and the way to minimize the toxicity. For example, if a patient had like a lung fibrosis, then definitely there's a big concern for any radiation to the lung. If a patient had a cardiac disease, it's known that the patient has, like, for example, had a heart attack or had like -- heart attack is the major one or any other cardiac issues, they tend to have a high risk to develop a cardiac event after radiation.

Q And were you aware with regard to Bill Eskew about his preexisting heart issues before he came to you to be treated?

A He had a bypass surgery.

Q Okay. So is that the kind of things that you were talking about when you say that prior heart issues raises concerns for radiation oncologists in designing a plan?

A Yes.

Q I'm sorry. Did the fact that Mr. Eskew had preexisting heart issues make him more susceptible to suffering from the side effects related to radiation being delivered to his heart?

A Yes.

Q Is that one of the reasons that you would try to minimize the amount of radiation delivered to his heart?

A Yes.

Q Okay. So let's look at some images that I think may be of use to you. Let me ask you this. Have you had an opportunity to look at some of the images that were from the planning document on the comparison planning documents on Mr. Eskew?

A I have.

Q Let me see if I can show you, I'm going to show you if I can. There are a couple images they're bates labeled 35 and 36. 35 and there's page 36. I'm going to mark these as Exhibit 6. They're Exhibit 6. So what are these images on page 35, Dr. Liao?

A This is part of the planning documentation. Basically on these screen, the two images you see are the axial slices of the CT scan for the patient. And then you can see the -- I don't know if I can point. No. I can't point. But anyway, so the normal tissue is all included in the

scan and also the tumor is included in the scanning. In addition to that, you can see some lines. Those lines are what we call isodose lines of radiation treatment planning. On these particular page I can tell this is -- should I continue? Yeah. Okay.

So on this line, the -- on the lines of the radiation dose, isodose line, meaning that after a course of the treatment, that is how much the dose patient will receive in this particular location. The white line, you can see the white line. That is the 60 gray line, which is what we call the planning pattern of volume to receive radiation. The blue inside that white one is the 66 gray line. That one to specify deliver only to the tumor.

Q So using this image, can you, as a radiation oncologist, tell how much radiation therapy is going to be delivered to the various parts of the body, including the tumor and the things around it if you use IMRT?

A Usually we have to look at the dose volume histogram.

Q Okay. Is -- I'm sorry. Go ahead, Dr. Liao.

A So the way you evaluate a plan, you go through each slide on the image, just like what we just did now. And then we also evaluate the dose volume histogram, which is called a DVH.

Q Let me see if I can figure this out. I'm going to show you something. I think maybe what you're talking about with regard to your IMRT plan. This document is labeled -- bates labeled 905 through 909, UTMACC-905 and 909. And on this 905, you can see that the first page of it says it's a planned summary sheet. You see what I'm talking about,

Dr. Liao?

A I do.

Q And if you look at the last page of that document, 909, there is -- there are some -- there's some data reflected here. It's called region of dose interest statistics. Do you see that?

A I do.

Q So what does this table that we are looking at here reflect with regard to the images that we were just looking at before?

A Can you blow that up a little again?

Q Yes, I can. One second. Let me mark this as Exhibit 7 before I forget. That will be exhibit 7. Yes. Let me blow this up. Make it easier for you to read. Is that good?

A Is that -- that's good?

Q Go ahead, Dr. Liao.

A When we evaluate the plan, we are supposed to go through the actual slices one by one and review the whole thing. And then we come to the summary. When you look at the summary on the right side, it says ROI, which is region of interest. Region of interest includes the target, which is the tumor. You can see, IGTV, ITV and PTV. IGTV is the tumor, which is the blue line on the plan. PTV is what we just described in the white, the white line. PTV is planning, target volume, and the GTV is gross tumor volume. ITV is the microscopic extension of the tumor.

Plus any patient has any physiologic motion of the tumor we will also include in that, on the ITV. And then the number after that is the goal of the prescription. So in this prescription, we wanted the GTV 66

gray and the ITV and PTV 60 gray.

Q So we can tell you -- tell by looking at the 6600, that that's 66 gray of energy; is that true?

A Yes. Or you can say 6600 centigray.

Q So if it's 66 gray and this IGTV represents the tumor, then this shows you that we're shooting for 66 gray or energy to the tumor and then the margins around it, right? Or 60 gray.

A Yes.

Q Okay. So then if you look down on the list of regions of interest, there are other parts of the body or structure that are shown here on this document. Let me pull this up quickly. So you're looking also at the right lung, the left lung, the lungs collectively, the heart towards the esophagus, right?

A Correct.

Q So does this document show us how many grays of energy would be delivered to each one of these parts of Bill Eskew's body if IMRT was used to eradicate his cancer?

A Yes. It shows on the rest of the column.

Q Okay. So looking at that document, you can tell us what each of those structures could be expected to receive in the way of radiation using an IMRT plan. And we can look right there in that mean value, calm and determine it.

A That's right.

Q Okay. Now you had that information at the time you made the recommendations about whether to use protons or IMRT on Bill

Eskew, right?

A Correct.

Q Let's look at something else you would have had in your possession at that point. This is a document, bates labeled UTMDACC-102.

A Yes.

Q And I assume you've seen this before?

A I saw this before.

Q What is this document, Dr. Liao?

A This is what we call a dose volume histogram, DVH. I can tell that this is the proton DVH.

Q So this would be the dose volume histogram. It says at the top of it, that this reflects your study of the proton plan?

A Yes.

Q I'm going to mark this by the way, as I -- before I forget, I'm going to mark it as Exhibit 8. I'm going to show you that set of images. These are bates labeled 108. Going to mark as Exhibit 9. Then there's another set 109, which I'll mark as Exhibit 10. I don't want to tell you what these images are.

Q These are the similar axial slices of the proton treatment plan. So you can see the color code is a little different. You can see on this plan, the green line corresponding to 60 gray, and then the red line corresponding to 66 gray. And again, you can see all the critical organs that is surrounded the tumor.

A Okay. So you -- can someone who knows what they're

looking at when they look at one of these images can tell like you did in the IMRT energy -- image, how much energy is going to be delivered to each one of those parts of the body inside those lines that are color coded to the key?

A Yes.

Q And so the same is true, Exhibit 10, which is page number 109, some more proton planning images?

A Yes.

Q So is it true to say that Exhibits 9 to 10 are images taken from the proton planning process at MD Anderson?

A Yes.

Q So is it true that like the IMRT planning process, these images can be reflected in a document like we were looking at a moment ago, a dose volume histogram for a proton plan, Exhibit 8?

A Yes.

Q So let's talk about what this shows. The colored lines at the top are reflective of what Dr. Liao?

A On the top half of the pictures, it's the dose volume histogram. So you can see, you know, there is a table below the DVH graph that there was a different color line on the DVH line. So a different color represents a different organ, the structure. The structure name next to that line is the structure this line represents. And then if you -- I think the arrangement is a little different, but you know, if you look at the last column, that's a mean dose to each of the structures listed.

Q And this column shows that the amount of radiation dose to

be delivered to each of the -- to the tumor and each of the organs at risk in a proton plan?

A Yes.

Q Okay. And so -- and we can see a list of those organs at risk, the tumor and those organs at risk over here in that column?

A That's right. Yes.

Q So you can look on this document and tell us how many grays of energy are going to be delivered with the proton plan to each one of those organs at risk; is that true?

A The mean dose, yes.

Q What I'm talking about, I made this little chart, and I would like to fill it in with your help. What I'd like to do is to have you tell me what the mean dose of radiation that would be delivered as to each one of those body parts, lungs, heart, spinal cord, and esophagus in gray so I can write those in as we sit here right now. Can you do that with me?

A Yes, I can. Can you add a mean dose?

Q I can add that as we talk through it, if we can, yes. In fact, I want to use the mean dose as the number, is that fair enough?

A Okay.

Q Okay. So Dr. Liao, does this chart that we have now made, does it adequately reflect, accurately reflect the amount of radiation energy that would have been delivered to each one of these organs at risk near or adjacent to Mr. Eskew's lung tumor?

A Yes.

Q Okay. So let's look at these parts of the body and the

radiation energy to be delivered to them and have you explain a few things to us, please. First of all, let's look at the lungs. It's Exhibit 11. The proton plan, according to your earlier testimony would have delivered 11.3 grays of energy to the lung. Whereas the IMRT would deliver 16.1, right?

A Correct.

Q Tell us if you would, Dr. Liao, if that difference in the amount of radiation that would be delivered to his lungs was significant in your medical opinion?

A Very significant.

Q Dr. Liao, is the amount of difference in radiation to be delivered to Mr. Eskew's lung on the proton, the proton plan at 11.43 gray on the one hand versus the IMRT at 16.1 gray on the other significant in your medical opinion?

A Yes.

Q Why?

A Well, first of all, we're talking about mean dose. Mean dose means that this is the dose delivered to the whole lung. Almost a five gray difference in radiation to whole lung is very significant. It will significantly increase patient's risk of radiation associated pneumonitis.

Q And what is radiation associated pneumonitis?

A That's an inflammation after radiation goes through the normal lung tissue.

Q Well, let's talk about that next item on our list, the heart. Is that difference of the five grays with protons and the 14.2 grays with

IMRT significant in your medical opinion?

A Very significant. It's in the heart.

Q Tell us why please, Dr. Liao.

A The heart is an organ that any dose to the heart can cause some collateral damage. With every gray of the minimum dose increase, you have seven percent increase in their cardiac event. So this is almost nine gray difference. It's striking. It's a striking difference actually.

Q And based on what you know about Bill Eskew's prior heart issues, before he came to be treated by you, does this difference in radiation energy to his heart, take on additional significance?

A This is one of the factors where you factor in when you decide on the plan.

Q And you decided on protons in part, because of the difference in radiation?

A This difference in radiation, also in a patient who has preexisting cardiac issues.

Q Yes. Was the risk of the side effects something that you were considering at that time?

A The risk of the side effect in the heart as well.

Q Okay. So let's look at the next item on our list, the spinal cord. Tell us if you would, Doctor, the difference between 9.6 gray to be delivered by the proton plan versus 16.5 gray to be delivered by IMRT was significant in your medical opinion?

A The difference is significant. The biological effect of the

spinal cord injury in those dose range, it is considered acceptable.

Q Okay. You would consider it acceptable?

A Yes.

Q Back to the heart for one second. What kind of complications might you expect in a person like Bill with preexisting heart issues and this difference in the radiation?

A They will have increased risk of pericarditis, which is inflammation of the heart sac. When a patient has pericarditis, what happens is they can have shortness of breath and that would have an impact on their lungs. They can also have injury of their cardiovascular blood vessels. They can also have injury on their heart muscle.

Q Okay. Now let's take -- let's talk about the esophagus. Was the difference in the anticipated radiation to be delivered to Bill Eskew's esophagus of 27.9 grays with proton versus 32 grays with IMRT significant in your medical opinion?

A Yes.

Q Why?

A Because the risk. For instance, of the severe esophagitis is highly correlated with the dose of the esophagus.

Q Well, I mean, there's only a difference of four grays roughly between protons and IMRT, Dr. Liao. How could that be significant in Mr. Eskew?

A I wanted to remind you mean, this is a mean dose. Mean dose means that the whole esophagus is taken into consideration. When a whole organ gets four gray, which is the difference between those two,

that is a significant dose to cause mucosa reactions from the radiation.

Q You said necrosis reaction?

A I said mucosa, because mucosa is the lining of the esophagus, which is the way the target of the esophagus radiations into it.

Q So if these mean doses of 27.9 gray with photon -- protons, excuse me, and 32 grays with IMRT would, based on your experience and medical training, would you expect additional side effects to a patient as a result of that difference?

A Yes.

Q Now you mentioned that this was a mean dose. I want to ask you about -- a little bit about that. These are measurements of mean dose meaning the whole organ. Is that what you said?

A Well, we consider the organ as a whole and the dose to the whole organ.

Q Okay. So would the vocalized dose to the esophagus be higher than the mean dose?

A The mean dose is taken into consideration of the range of the dose. So certainly with a higher mean dose, probably you have a higher dose too.

Q And would there be a higher dose to localized areas of the esophagus as opposed to the whole esophagus, if you were looking at a localized dose?

A Yes, yes.

Q Does that make a difference in the amount of grays to be

delivered by protons versus IMRT even more significant?

A Yes. This is part of one -- this is part of the one of evaluation when we go through each slice to see, you know, whether the dose actually landed.

Q Okay. So I think you said earlier that esophageal tissue is very sensitive to radiation; is that true?

A Yes.

Q Tell us what happens with an esophagus when it gets -- when it receives radiation.

A The esophageal lining, which is the mucosa replaces itself every two to three weeks. So when we start radiation, the regeneration of the mucosa will be stopped. So usually after about two or three weeks into radiation, patients start having issues with the inflammation of the esophagus, meaning that at first they feel like they can't swallow. They have pain or sore throat when they swallow. And then they usually have to change their diet. For example, they used to be able to eat a hamburger, but when they are still having -- start having these symptoms, they have to start eating soup or a softer diet.

And then if the degree of the damage, you know, progresses, they can become very -- like very painful when you swallow and then have to give them narcotic pain medication to make sure that their pain is controlled. And then they can have difficulty to swallow and the pain to swallow. They can't eat or drink, and then they become dehydrated. They can also have like, you know, like long term wise, they can have like a stricture on the esophagus and severe case patient may need a

feeding tube to make sure that they have nutrition. Of course -- was there a question?

Q No, no. I think --

A Okay.

Q I think someone just made some noise.

A Of course.

Q Keep going. I'm sorry.

A Okay. Of course. A patient, if there is a side effects -- if the side effects becomes severe enough, they could even die from the side effects. We know the dose to the esophagus and the effect if that patient develops severe esophagitis can negatively impact on the patient's survival.

Q Okay. So is it true Dr. Liao, that you believe that -- or did you believe that the proton treatment with the values that are shown here on the screen for each of the parts of the body versus the IMRT, which is shown here with its doses to the part of body, which one of those was a better plan for Bill Eskew?

A Based on the enumeration, based on these numbers showing on this table, proton plan is the better plan.

Q Okay. And why would you characterize it as the better plan for Mr. Eskew?

A Because it reduced the mean dose to all the organs listed, especially the critical organs, critical organs, like the long heart and esophagus.

Q Would you -- do you believe Dr. Liao, to a reasonable degree

of medical probability that the application of IMRT to Mr. Eskew as opposed to protons, as you recommended, caused him to have negative side effects that he could have avoided with protons?

A Yes.

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

Ladies and gentlemen, 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 medium of information including without limitation newspapers, television, the internet or radio.

You are not to conduct any research on your own relating 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 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 are not to form or express any opinion on any subject connected with the trial until the case is finally submitted to you.

So we'll come back at 2:45.

THE MARSHAL: All rise for the jury.

[Jury out at 2:32 p.m.]

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

MR. SHARP: Thank you.

[Recess taken from 2:32 p.m. to 2:48 p.m.]

[Outside the presence of the jury]

THE COURT: Please be seated. Mr. Roberts, did you have something outside the presence of the jury?

MR. ROBERTS: Yes, Your Honor. I just wanted to pose an objection to the method of reading the deposition in so far. Reading of depositions is supposed to be flat and neutral. And it's been a tremendous performance so far. Our reader is very skilled. But she's been using hand motions. She's been adding emphasis. She's been adding intonation, emphasizing certain testimony, coloring the neutral presentation of the deposition.

So we would ask the Court to instruct the reader to read with a flat, neutral tone and not add her own intonation and interpretation of the witness' motions.

THE COURT: Thank you. Mr. Sharp?

MR. SHARP: Well, the deposition is testimony. And unless we want the jury falling asleep, she's -- she's reading in a reasonable manner consistent with our case. And she'll do the same thing with Mr. Gormley. I mean, that's why we have her here.

THE COURT: The objection is overruled. The Court finds that the witness' testimony is consistent with the testimony of Dr. Liao. The Court does not find that her intonation, voice, or body language is inappropriate in any manner. The Court finds it to be congruent with the

testimony and the objection is overruled.

Anything else outside the presence?

MR. SHARP: No -- the only thing is we're going to try and see how far we can get through. I pushed Mr. Flood back and I'm pretty -- if we don't go, I'm pretty confident I'll just get him on Wednesday morning.

THE COURT: So she's going to be the only person today?

MR. SHARP: I think so. I mean, we're about halfway through.

THE COURT: Are the parties ready for the jury?

MR. SHARP: Yes.

THE MARSHAL: All rise for the jury.

[Jury in at 2:50 p.m.]

THE MARSHAL: All jurors are present.

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

MR. SHARP: Yes, Your Honor.

MR. GORMLEY: Yes, Your Honor.

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

MR. SHARP: Thank you, Your Honor.

[Reading of deposition of Dr. Zhongxing Liao continued as follows:]

Q Dr. Liao, do you believe that Bill Eskew would have been better served by protons and would have been served that way if UAC

would have approved coverage?

A Yes.

Q So Dr. Liao, are you aware or do you know whether or not Bill Eskew developed adverse side effects after radiation was given to him?

A I was aware.

Q And what are the side effects that he developed, if you can tell us, please.

A He started having problems towards the end of the radiation. Because of the esophagitis, he had pain. He was having difficulty swallowing, so we started to make sure that he got hydration during the treatment before he went home. I recall that after he went home, we started the pain medication for him as well, where he was still in Houston and doing the treatment. I recall that he went home, and he still had, like, symptoms progress to the point that he couldn't eat.

He lost a significant amount of weight. I wasn't clear whether he was admitted to the local hospital or not, but he had pretty severe -- what I would say grade 3 esophagitis after he went home. So that was what I recall.

Q All right. Dr. Liao, is it your belief, based on a reasonable degree of -- your opinion, based on a reasonable degree of medical probability that Bill Eskew developed radiation-induced esophagitis following his radiation treatment?

A Yes.

Q Is it your opinion, based on a reasonable degree of medical

certainty, that Bill Eskew suffered from grade 3 radiation-induced esophagitis?

A Yes.

Q Tell us, if you would, Dr. Liao, what sort of symptoms are to be expected if a patient develops grade 3 radiation-induced esophagitis.

A As I just mentioned, the patient have to be totally off their eating habit. They'll probably just have to take sort of soft diet, liquid. They can become dehydrated and need hospitalization. In addition, they need high-dose narcotic pain medication. In some severe cases, they could require a feeding tube.

Q Okay. So I think you mentioned a moment ago that radiation-induced grade 3 esophagitis can shorten a patient's life expectancy or life span and cause them to die earlier than they otherwise would. Is that a fair characterization of your prior testimony?

A Yes.

Q So let's just be clear, Dr. Liao. Do you believe that to a reasonable degree of medical certainty, that radiation esophagitis, a grade 3 case, can shorten a person's life span?

A Yes.

Q And do you believe, Dr. Liao, to a reasonable degree of medical certainty that the grade 3 esophagitis that Mr. Eskew developed was as a direct result -- was caused by -- the fact that he was treated with IMRT instead of proton therapy as you requested?

A Proton therapy probably would reduce the severity of his esophagitis.

Q And you can say -- so with a reasonable degree of medical probability, more likely than not?

A Yes.

Q All right. Do you believe to a reasonable degree of medical certainty, based on your treatment of Mr. Eskew and your knowledge of his symptoms, that his radiation esophagitis -- his grade 3 radiation esophagitis shortened his lifespan?

A Grade 3 esophagitis will negatively impact on the patient's survival.

Q If the evidence in this case from Mr. Eskew's family is that he suffered from symptoms of radiation esophagitis, difficulty and pain in eating and swallowing and taking his medication, lost weight, et cetera, would that be -- in your experience, would that be consistent with radiation esophagitis, grade 3?

A Yes.

Q Can radiation esophagitis, Dr. Liao, be a chronic condition following radiation treatment?

A Yes.

Q And the higher the grade of esophagitis, does that matter with regard to whether it can be chronic?

A Yes.

Q In what way?

A The most severe esophagitis can eventually cause a scar in the esophagus and cause restriction in the esophagus, which is the kind of -- the chronic late complication of the treatment.

Q Do you believe, Dr. Liao, that the fact that Mr. Eskew was treated with IMRT instead of the proton therapy that you requested shortened his life expectancy?

A I don't know. It's possible because he had side effects, but I do not know his condition when he passed away.

Q Okay. Do you believe that a radiation esophagitis can have sort of a ripple or a cascading effect on a patient's overall health?

A Yes.

Q Does that happen?

A If a patient develops severe esophagitis, as I just described where they cannot eat, they have pain all the time, start losing weight, I mean, they can really just deteriorate in their general condition.

Q Do you believe, Dr. Liao, to a reasonable degree of medical certainty that radiation esophagitis can affect a patient's quality of life?

A Yes.

Q In what way?

A The patient becomes so symptomatic, they suffer from pain, they suffer from being unable to eat. And then, when a patient cannot eat and they become dehydrated, the pain all the time, certainly, that's going to be a huge stress in their daily life, and you know, the mental impact on their quality of life because they cannot have a normal daily function due to the side effects.

Q In your experience treating cancer patients, Dr. Liao, can radiation esophagitis have a negative effect on the patient's overall ability to fight the cancer in his body and ultimately, his outcome?

A Yes.

Q What was that, Dr. Liao?

A Yes. Because a good nutrition is very important for a patient and his general condition to fight cancer.

Q If the evidence in this case was that Mr. Eskew's inability to eat and drink and take his medicine, et cetera, was mentally and emotionally distressing to him, would that be consistent with your experience in treating other cancer patients in your practice at MD Anderson?

A You mean compared to other patients or just Mr. Eskew?

Q Well, is that something you see in your patients, that people who have radiation esophagitis and have inability to eat and drink and take their medicine, does that weigh on them or distress them mentally or emotionally?

A Yes.

Q Would you describe for us what it looks like in a cancer patient, a typical patient that you see?

A In terms of, you know, the side effect of the esophagitis, you can see the patient come to your clinic, basically tell you, okay, Doctor, I'm in pain in my chest. I can't swallow, and when I swallow, there's a knot or something that's blocking in the center of my chest, or the pain feels, like, excruciating sometimes. And the radiation bilaterally on the -- across the chest, sometimes it feels like a heart attack. And when they have really pain to swallow and they cannot swallow pills -- the pills get caught as well. And then I had a patient in the past, like, the pill

cannot go down and wouldn't come up, and then, they really choke on that.

Those are the kind of daily life type of impact on a patient quality of life. But you know, if a patient gets to the point where they really cannot eat anything, which we see in some patients, that basically they cannot drink anything. And after a day or two, over the weekend, and then they come back to the hospital, say, you know, totally dehydrated, they may end up in the emergency room in that situation.

Oftentimes, we also see a patient that when they go back home and they leave the treatment, they kind of collapse because they become dehydrated. They cannot really eat or drink anything, and then really, has to be admitted to the hospital. That is actually one of the kind of situations that when a patient leaves MD Anderson, you may follow up with calls and things like that, I guess. Because the way you're talking to the patient, you have to do this, have to do that, and make sure that you do all this, and let us know. But when they went home, oftentimes, they'd collapse.

Q Do you believe, Dr. Liao, based on a reasonable degree of medical probability and your treatment of Mr. Eskew, that he would have enjoyed a better quality of life following his radiation treatment if he would have received protons instead of IMRT?

A Yes.

Q And would you have used protons to treat Mr. Eskew if it had been approved by his insurance company?

A Yes.

Q What's that, Dr. Liao?
A Yes.
Q Was treating Bill Eskew's lung cancer with protons needed to improve his health condition?
A Yes.
Q Was treating Bill Eskew's lung cancer with protons consistent with his treatment of his illness?
A Yes.
Q Was treating Bill Eskew with protons on an outpatient basis at the Proton Center at MD Anderson the most appropriate level of service that could be safely provided to him?
A I believe so.
Q Was treating Bill Eskew with protons -- would not have been solely for your convenience or his, would it?
A No.
Q Did protons -- did treating Bill Eskew's lung cancer with protons create a likelihood of producing a significant positive outcome for him?
A Yes.
Q Did treating his lung cancer with protons -- was that methodology of treating his lung cancer with protons supported in reports and peer-reviewed literature?
A Yes.
Q Is treating a cancer patient -- was treating Bill Eskew's lung cancer with protons supported by evidence-based reports and guidelines

published by nationally recognized professional organizations?

A Yes.

Q Was treating protons -- or treating Bill Eskew with protons consistent with professional standards of safety and effectiveness generally recognized in the United States?

A Yes.

Q Was treating Bill Eskew's cancer with protons consistent with other radiation oncologists around the country's method of treating cancer patients?

A I suppose so.

Q Plenty of other radiation oncologists do so, right?

A Yes.

Q Okay. So after you head determined that Mr. Eskew needed protons, the request for those, for that coverage, was sent to UnitedHealthcare, the insurance company. Remember, we looked at this earlier. See, I'm showing you Exhibit 5 as the urgent prior authorization request for protons. Do you see that, ma'am?

A I do.

Q So let's look at the letter that goes along with that urgent request. Well, first of all, is it from -- it's from MD Anderson Cancer Proton Therapy. It is to UnitedHealthcare, Sierra Health in Las Vegas, Nevada. And it has information in it about the request that you are making. So let's look at this real quick. This is a letter signed by you, as we noted earlier.

It says, "This letter of medical necessity, presented on behalf of

your member, William Eskew. We are requesting certification of CT simulation and 30 treatments of proton radiation therapy for over 6 weeks for a 60-year-old male diagnosed -- with a diagnosis of stage 4 malignant carcinoma with squamoid features. Did I read that right so far?

A Yes.

Q It says, "Primary site undetermined." Then it goes on to say this: "He is being considered for concurrent chemo/radiation therapy using proton therapy to maximize local control." And that you have, it says, "all relevant clinical information has been reviewed and this patient is meeting eligibility criteria for treatment with proton therapy"' Did I read that correctly so far?

A Yes.

Q And this was the message that you were sending to UHC on behalf of Mr. Eskew?

A Our business center.

Q And then you say, "Please see supporting clinical information attached." So do you understand there was some clinical information sent along?

A Yes.

Q Okay. So now, let's look at the next paragraph because I want to talk to you about this maybe in a little more detail. It says, "Radiotherapy is an accepted plan of treatment for lung carcinoma." We talked about that today, right?

A Yes.

Q And then you go on to talk about how you can target proton therapy more accurately than photons, right?

A Yes.

Q And you mention to them about causing potentially serious normal tissue complications. Do you see that?

A Yes.

Q And then you specifically reference some of the things we talked about earlier. Specifically to the heart, the esophagus, spinal cord, and normal lungs. Do you see that?

A Yes.

Q And then you go on to say that radiating those structures can cause side effects.

A Yes.

Q So you were telling UnitedHealthcare the basis of your belief that protons are best, right?

A Yes.

Q And then you told us here today why you felt that way, right?

A Yes.

Q And so you understand that there was a denial of that request?

A Yes.

Q And were you made aware of that denial?

A Yes.

Q Here's Exhibit 3. This is a copy of the denial letter that was sent to Mr. Eskew. I can tell you there was one sent to you similarly to

this. It is dated February 5, 2016. You can see there at the top. I wanted to ask you, though, about some of the language in this letter. First of all, I'm going to show you who wrote the letter. This is the person -- well, who signed the letter, put it that way. Dr. Shamoon Ahmad, medical director at UnitedHealthcare. Do you see that?

A I see that.

Q Do you know Dr. Ahmad?

A I don't recall that.

Q Have you ever seen him at any of the conferences on radiation oncology that you have spoken at around the world?

A I do not recall that.

Q Have you ever read any radiation oncology, peer-reviewed published literature from -- authored by Dr. Ahmad?

A I'm not sure.

Q Would it surprise you to learn that Dr. Ahmad is a medical oncologist and not a radiation oncologist?

A I see that all the time.

Q How do you feel about that?

A Frustrated.

Q Why is it frustrating?

A It's difficult to explain radiation treatment plan and the rationale of choosing a symptom plan to a medical oncologist.

Q And why is that?

A I feel it's the, you know, necessary expertise and the training of the specialty.

Q Do you feel they have -- they lack the expertise to have a conversation with you that is meaningful?

A I do.

Q Okay. So let's see what Dr. Ahmad says in his letter as the basis for his UHC's denial of proton therapy to Mr. Eskew. Here's what it says. The reason for our determination is, then it says, based upon UnitedHealthcare's medical policy for proton beam radiation therapy, coverage is denied. Your provider asked for a proton therapy that uses a beam of protons and carries a positive charge to destroy cancer cells for you because you have lung cancer. Then it says this, this type of radiation therapy is considered unproven and not medically necessary for treating lung cancer. Do you see that?

A I do see that.

Q Do you agree with that?

A No. I disagree.

Q Do you know -- do you know any radiation oncologist in your circle that you operate in at the highest levels of the radiation oncology practice in the world who believe that to be the case?

A You will have to ask them.

Q Then it goes on to say, this letter from Dr. Ahmad from UHC, there is limited clinical evidence that directly compares proton beam therapy with other types of radiation therapy. Is that a true statement?

A There are comparisons. A lot of the clinical trial is still ongoing, but there certainly has been comparison studies.

Q So after this denial was received, the Eskews were informed

that they did not have coverage for proton therapy, right?

A Well, you know, I got notification from my business office to tell me that the request was denied.

Q So Dr. Liao, you made a decision reflected in the documents not to appeal UnitedHealthcare's denial of proton therapy for Bill Eskew's lung cancer. Do you recall that?

A I do.

Q Can you tell us if you have -- I want to know why that is. So why don't you tell us why is that?

A Based on my experience dealing with denials and appeals from the insurance company, United Health has to be one of them, it's very hard. It's almost impossible to get the case kind of overturned. So the patient has to go through, and their family has to go through, to wait and get all those phone calls and everybody -- and then wait for three weeks. And then still, you get a denial. Then you basically, you just lost a lot of time in starting treatment on the patient.

In this patient's case, I didn't want to waste all this time. Basically, because based on my experience, I don't think I'm going to get the denial overturned by appealing and the patient has been so stressed out just by waiting to hear something, I wanted to get treatment started. In his situation, I really don't think it is right to continue to delay treatment because that is actually another negative impact factor for patient survival, for the disease outcome, the delay of the treatment.

Three weeks of delay, that's just -- it's just not acceptable. It's not to say that in this case, what would happen with three weeks' delay. But

that's the kind of experience we had dealing with this type of appeal, and the denial, and then appeal and denial.

Q Dr. Liao, in your experience practicing medicine at MD Anderson and dealing with these sorts of issues with proton therapy and insurance denials, have you ever had the experience with a UnitedHealthcare policyholder where a request for or denial of proton therapy for lung cancer was reversed on appeal?

A I, personally, I don't recall any case.

Q Is it true, Doctor -- well, Dr. Liao, have you given your testimony here today and your opinion, your medical opinion, based on your medical education, training, and experience?

A Yes.

Q Have you given your opinions here today to a reasonable degree of medical probability?

A Yes.

Q And have you given your opinions here today on the basis of your treatment of Mr. Eskew at MD Anderson for his lung cancer?

A Can you repeat the question?

Q Yeah. Have you given your testimony here today on the basis of your education and experience and your treatment of Mr. Eskew?

A Yes.

[End of reading of deposition of Dr. Zhongxing Liao]

MR. SHARP: Thank you. We don't have -- that concludes our direct, Your Honor.

THE COURT: Thank you, Mr. Sharp. Mr. Gormley?

CROSS-EXAMINATION

[The deposition of Dr. Zhongxing Liao was read into the record as follows:]

Q Good afternoon. My name is Ryan Gormley. As Mr. Terry said, I'm an attorney for the Defendant in this matter. I have a few follow-up questions that I want to ask you based upon your testimony this morning. I want to make clear that we appreciate your time. We know you're very busy and this is an inconvenience in your schedule, but we appreciate you being able to be here today to answer all of our questions. I'll try to be concise out of respect for your time today.

I wanted to clarify one thing from your testimony earlier. It was my understanding you testified that you made the determination to recommend proton therapy after receiving the results from the comparative study, right?

A After I reviewed the comparative study.

Q Okay. So in making that determination to recommend proton therapy, you relied on the results from the comparative study, right?

A Very heavily.

Q Okay. That made sense. And so as a researcher, you've led or coauthored national clinical trials comparing proton therapy and IMRT for treating lung cancer, correct?

A Correct.

Q And based on your experience and everything, all the

experience you testified to this morning, you would still agree, though, that the clinical advantages of proton therapy for treating lung cancer are largely theoretical, correct?

A No.

Q No?

A Because we do have clinical evidence to show that proton therapy reduced toxicity, even though it's not in randomized study. But activity in the database comparison study would show that.

Q Okay. Let me bring up my screen here. Hopefully I can make this work and we will treat this as an Exhibit A for the purposes of this deposition. And can you see my screen, Dr. Liao?

A I do.

Q And is this an article that you wrote for the journal of clinical oncology?

A This is a letter.

Q This is a letter you wrote that was published in the journal of clinical oncology; is that right?

A Correct.

Q Okay. And this was published on July 1, 2018, right?

A Correct.

Q And I want to direct your attention to the last sentence in the first paragraph. It says, her closing remarks shed light on the prospects for future randomized studies that one day measure the clinical advantages of proton therapy which have remained largely theoretical, although progress is being made. Do you see that?

A Can you blow that up a little bit?
Q Can you see that now?
A I see that.
Q Okay. So at the time you wrote this article, was it your opinion that the clinical advantages of proton therapy for treating lung cancer are largely theoretical?
A That was the other person's point of view, not mine.
Q And by other person, you're referring to Rate Mohan [phonetic]?
A No. This is a letter responding to the letter or the editor, I believe. Can you go down and I can see the whole paper? You see Dr. Khan's name mentioned here. I recall this is a letter responding to her editorial to the paper that we published.
Q Correct. This is the letter you wrote responding to her editorial on the paper that you published, correct?
A Correct.
Q And it's your testimony that the last sentence in the first paragraph is you summarizing Dr. Kong's view? If you want to take a second and read the whole paragraph.
A I read that.
Q And it's your testimony that you were expressing no opinion that you personally held in that sentence?
A Can you repeat your question one more time?
Q A couple minutes ago, it sounded like you said in that sentence you were simply summarizing Dr. Kong's opinion and not

providing your own opinion. So is it your testimony that in that second sentence, you were not providing your own opinion on the clinical advantages of proton therapy remaining largely theoretical?

A I'm trying to comment on her remarks on the paper.

Q And that's the goal of this article, correct? Or isn't that the goal of this letter, correct?

A The letter -- the goal of the letter is to present our point of view in response to the editorial Dr. Kong has written.

Q And it is your testimony, though, in this last sentence where it says, which had remained largely theoretical, that was you summarizing Dr. Kong's and not giving your own opinion?

A That was Dr. Kong's point of view.

Q And now, Dr. Liao, I'm going to bring up the other article that I think we just alluded to. Can you see this?

A I do.

Q And you are familiar with this paper, correct?

A Very much so.

Q And you are the lead author on it?

A Yes.

Q And this paper discusses a prospective randomized study, correct?

A Correct.

Q And prospective randomized trials are considered the gold standard when it comes to clinical evidence, right?

A In most of the education situation.

Q And that was the opinion that you expressed in this article, correct?

A Yes, correct.

Q And so in the article, you said that prospective randomized studies are considered the gold standard when it comes to clinical evidence, right?

A Yes.

Q Okay. And this, the study discussed in this paper compared toxicity and effectiveness of proton therapy with IMRT for patients with locally advanced, non-small-cell lung cancer, correct?

A Correct.

Q And at the time this article was published, as far as you are aware, and I would assume you're very familiar and aware of this topic, this was the first prospective randomized study to directly compare IMRT with proton therapy in treating non-small-cell lung cancer, correct?

A Correct.

Q And in the trial, patients were randomly assigned to be treated with proton therapy or IMRT, correct?

A In this trial, the only patient who had a comparative plan when both plans are equally good, then we ran them as a patient. When patient -- the comparative plan -- one plan is better than the other plan, then we use the better plan. So this is actually very important for the design of this trial in the way that we wanted to find out if there's no difference in those or volume to the normal tissue, whether we still need proton, or we can equally protect normal tissue with IMRT. However, if

the comparative plan, you know, if it's better than IMRT and proton plan is better, we use proton to treat patients on the trial.

Q That makes sense and that was going to be my next question. So you knew where I was going with that. But let me ask you this. For certain patients in this randomized trial, the IMRT plan was better, right?

A There are some patients that the IMRT plan was better, and they were treated with IMRT.

Q Right. And so for the patient to be randomly assigned, they underwent a standard radiation plan and procedures to compare IMRT and proton therapy, right?

A They did.

Q And then, they were only randomly assigned to IMRT or proton therapy when both plans met the dose constraint standards, right?

A That's right.

Q And I know you covered this with Mr. Terry. You looked at the median dose constraint volumes. But those constraint standards basically mean safe under the given parameters, correct?

A Can you rephrase your question one more time, please

Q Yes. So in this study, the patients were randomly assigned between IMRT and proton therapy when they met the dose constraint standards, right?

A Correct.

Q And what does dose constraint standards mean?

A Dose constraint standard means that the -- for example, in this trial, the most important thing we looked at was the minimum dose because pneumonitis was the end point of this trial. So we looked at the minimum dose. So there's no difference in the minimum dose in randomized patients.

Q And so when someone meets the dose constraint standards, is the more or less technical way of saying that is the treatment is safe under the selected parameters?

A Based on the population standard, that's kind of acceptable.

Q Okay. And you would agree this clinical trial was ethical, correct?

A Yes.

Q And so in this study, you set out to test the hypothesis that, proton therapy exposes significantly less lung tissue to radiation than IMRT, which thus reduces toxicity without compromising tumor control, correct?

A Correct.

Q Okay. And the results from the trial did not prove this hypothesis, correct?

A The results of this trial did not prove that when you don't have any difference in dose, the proton will be superior to IMRT. I think the mean line dose standard is very important to keep in mind, because that is our daily practice deadline on that dose.

Q And on a percentage basis at one near post-treatment, more of the patients treated with proton therapy than IMRT suffered from

grade 3 or more radiation pneumonitis, correct?

A Two more patients suffered -- I take that back. I don't think it's two more patients. I remember -- I recall six patients from each arm suffered grade 3 or higher pneumonitis and that two of the six grade 3 or higher pneumonitis from the IMRT arm actually was grade 5, which means that patients died from pneumonitis. Six -- zero out of six pneumonitis case from the proton arm was grade 5. They all had grade 3.

Another caveat about this trial is that we don't have, like, equal number of the patients allocated to proton because a quarter of our patient was denied coverage.

Q Okay. And in the trial, you look at the comparative numbers on a percentage basis, right?

A We look at a percentage. We look at, for example, the main line dose, absolute dose. So if you look at this graph, you can see that there wasn't a difference in main line dose and that's the reason we randomized these patients.

Q And 10.5 percent of the patients treated with proton therapy ended up with grade 3 or more radiation pneumonitis, right?

A Correct. They were all grade 3.

Q And 6.5 of the patients treated with IMRT ended up with grade 3 or more radiation pneumonitis, correct?

A Correct. And again, two of them were grade 5.

Q And that term came up earlier in Mr. Terry's examination of the radiation pneumonitis that was one of the side effects, you said,

related to toxicity exposure to a normal lung, correct?

A Yes.

Q And radiation pneumonitis can be fairly serious, correct?

A It can.

Q And it can even potentially be lethal, correct?

A Yes.

Q And the patients treated with IMRT also had a better overall medial survival time, as well, correct?

A There was no significant difference.

Q But so maybe there's no significant difference, but the overall median survival time for the patients treated with IMRT was 29.5 months, right?

A I need to go back to my paper. I quote it in the paper, so it must be right.

Q Do you see the last sentence here on page 1,818 of your paper? That median overall survival times were 29.5 months for the patients in the IMRT group.

A I see that.

Q And the median overall survival time for the patients treated with proton therapy was 26.1 months, right?

A It's correct. In this randomized trial, one big issue is that we can only treat patient with Medicare on proton. That's why about, I believe 25 or 26 patients who randomized for proton couldn't get proton, because their insurance doesn't cover. And the Medicare patient is on average about six -- at least four or five years older than the patient who

are under, like, Medicare age. So certainly, when you compare a younger population with an older population, the older population has a shorter median survival.

Q And do you know if UnitedHealthcare covers proton therapy for clinical trials?

A I do not know. What happened is usually, when we see a patient, we kind of decide what to do and then we submit everything to the business office. And business office deals with that kind of issue. So from what I can tell from our business office is that they have to read very carefully to determine if the policy covers clinical trial or covers certain type of treatment or cover the patient can receive treatment.

Q Okay. And so you agree, though, that the median overall survival time for the patients treated with IMRT was three months longer than the patients treated with proton beam in your trial, right?

A Again, I wanted to emphasize the population. The proton arm, the patient is older.

Q And what was the average age of those patients?

A The median -- I believe the median age was -- with for lung patient, the median age is about 64, 63 -- 64 years old. And the Medicare patient with lung cancer, their median age, usually about 66 or 67.

Q Okay. And just, I will ask the question again. Do you agree that the patients treated with IMRT lived for 3.4 months longer on average than the patients treated with proton therapy, right?

A On this trial?

Q On this trial. Right.

A On this trial, yes.

Q Okay. And do you remember earlier you were mentioning about heart exposure to toxicity?

A Yes.

Q You were looking at that chart that Mr. Terry put together?

A Yes, I do.

Q And you are currently studying the clinical significance of additional toxicity exposure to the heart, correct?

A Correct.

Q And at the end of this paper, which I'm scrolling to, that's where you mention in the middle of the last paragraph, PSPT, referring to proton beam, significantly reduced heart exposure in terms of both radiation dose and heart volume, and its influence on cardiac toxicity and overall survival was under active investigation, correct?

A Correct.

Q Okay. So that the clinical significance of that difference is under active investigation, correct?

A At that time. At the time of this paper publication. But we have a lot more evidence now. The toxicity depends on the dose.

Q And in this paper that we are looking at here that we'll call Exhibit B for this deposition, was published on June 20, 2018, correct?

A Correct.

Q And Mr. Eskew, if you can recall, he was being treated in 2016, correct?

A Even though we did not, you know, have the outcome of the

cardiac toxicity of this trial, we have many, many other publications demonstrating radiation injury induced. So for example, in breast cancer or in other cancers.

Q And do you recall Mr. Terry brought up the prior authorization letter seeking approval for proton beam?

A Can you repeat your question?

Q Do you recall that earlier today, Mr. Terry brought up as an exhibit the prior authorization letter seeking approval of proton beam therapy for Mr. Eskew?

A Yes, I recall that.

Q And I'm going to bring that same letter up here again. And this is that letter, correct?

A Yes.

Q And do you know -- it looks like this was faxed over to Sierra Health. Do you know if that is true?

A I do not know. I think our business office handles that, whether it's fax or mail.

Q Okay. That makes sense. That's not really within your purview, the actual sending of it.

A Exactly.

Q Right. And it's titled, 'Urgent letter of medical necessity,' correct?

A Yes.

Q I think Mr. Terry confirmed it already, but that's your signature, correct?

A Correct.
Q Let me make it -- and you were aware that attached to this letter was 14 pages of medical records?
A I'm not aware of that, but I am aware it's tedious work for the business office.
Q So you were -- so were you involved in the selection of which records they included with this letter?
A I usually provide my medical justification documentation.
Q And you usually provide your medical justification -- what was the last word you said?
A For my recommendation.
Q Okay. But you're not involved in the selection of what records are included with the prior authorization letter?
A No.
Q Do you know who does select those records?
A We review that -- we review the letter. The business office usually is dealing with the actual attach the supplementation and that -- those kinds of things.
Q You review the letter before it gets sent out, though, right?
A I do.
Q Do you recall how long you spent on reviewing Mr. Eskew's letter?
A I would say probably two hours. Two or three hours, maybe. That's kind of the average for the insurance authorization letters.
Q But you spent two or three hours reviewing Mr. Eskew's

letter of medical necessity here?

A I believe we went through the consultation note, I think, and then we went through the comparative plan.

Q And you just testified you went through the comparative plan. Who did you go through the comparative plan with?

A I go through the comparative plan with my group and then I inform the business office which plan I want to recommend and treat. And then, the business office will attach the paper copy or whatever with the letter.

Q Besides these records that were attached, these 14 pages of medical records that were attached to the prior authorization letter, are you aware of any other clinical records that were provided to Sierra Health and Life or UnitedHealthcare in support of Mr. Eskew's prior authorization request for proton therapy?

A Not to my knowledge.

Q Okay.

A I don't recall anything like that.

Q And how long did you spend writing this letter?

A This letter is actually drafted by our business office. We review that and revise it and then finalize it.

Q And besides switching out the name and the dates and the diagnosis, was any of this letter customized for Mr. Eskew?

A Was this letter testified for Mr. Eskew?

Q Customized.

A Customized for Mr. Eskew. His medical records is

customized to him.

Q But besides his medical records, but the actual language of the letter, from 'To whom it may concern' to your signature?

A Can you go up again? I believe there were parts of that that was to him. For example, our prescription goal of the plan, specific information, his diagnosis, all those are customized to him.

Q Right. But besides his diagnosis and his prescription, was anything else customized for Mr. Eskew?

A In this, Mr. Eskew -- I think the -- without causing -- without causing potential serious normal tissue complication, especially heart, esophagus, and the spinal cord and the normal lung, and these were very much like a repeat situation for Mr. Eskew.

Q So that's not -- that second paragraph there, that's not a paragraph that is used in all letters of medical necessity requesting prior authorization for proton beam therapy?

A I am not sure about all the letters. But you know, for the letters relevant to my patient, I review that. And with the case, we modify the letter comparing to the patient's situation. I feel like if you say, like, the heart and esophagus and spinal cord and lung, probably it appeared in a lot of your letters. That is just because those organs are in the chest, and we deal with those organs all the time.

Q And you testified earlier that you're aware that this prior authorization request for proton beam therapy was denied, correct?

A I am aware of that.

Q And you made the decision not to appeal, correct?

A Yes.

Q And I want to bring up a record that was produced by MD Anderson. Go on page 8 of this PDF, which is UTMDACC243. And do you see where it says, emailed MD with denial?

A I see that.

Q Is this showing that the notice of the denial was -- you were notified of that by email?

A The business office probably called me.

Q Do you believe they called you?

A The business office will let me know.

Q But is this showing that they let you know via email?

A Maybe they did, but I don't -- maybe they did. Either they call me or email me or let me -- for certain, they will let me know the decision one way or the other.

Q So Dr. Liao, and I want to bring your attention -- and we will call these pages Exhibit D, UTMDACC390 and some pages after that. These are emails that were produced by MD Anderson, and I want to go down to page 3 of the PDF. Can you see the email there at the bottom?

A I see that.

Q And is that email from Leah Nitsa [phonetic]? I might be mispronouncing her name.

A She was in the business office, I remember.

Q And it says she is a denials management coordinator. Do you know what a denials management coordinator does at MD Anderson?

A They manage all the denials.
Q And managing denials, does that mean that they assist with appeals of denials?
A Yes.
Q And Ms. Leah Nitsa wasn't the only person in that department, correct?
A Correct.
Q MD Anderson had a team that handles appeals of denial prior authorization requests?
A Yes.
Q And Ms. Leah Nitsa sent you this email it looks like at 10:35 a.m., correct?
A It says so on the email.
Q And it says, We have followed up with the insurance, the preview request for PBT. The medical reviewer has denied the requested services for the reasons it does not meet the NCCN guidelines 2016 and the Health Plan of Nevada. Would you please provide us with your availability to time schedule for the P2P to coordinate with the insurance? I have informed the patient of the denial of proton and will start working on the appeal process. Do you see that?
A I do.
Q And you responded to Ms. Leah Nitsa's email 23 minutes later, correct?
A Yes.
Q And in your email, you wrote, Let's stop the appealing and

use the IMRT plan. I don't want to drag for too long. Thank you for all your effort, correct?

A Correct.

Q And prior to sending that email, you didn't review the denial letter sent by Sierra Health and Life, did you?

A I did not review the denial letter, but I got the notification that the case had been denied.

Q Right.

A Again, you know, I didn't want to drag the process for too long because based on my experience with this particular insurance company, I don't recall I have any case that overturned.

Q Okay. And in Ms. Leah Nitsa's email, she uses the abbreviation P2P, do you see that?

A Yes.

Q You're aware that means peer to peer, correct?

A Yes.

Q And you did not make a peer-to-peer call in this case, correct?

A I did not.

Q And you have appeal denials of prior authorizations for proton beam therapy before?

A For other patients, yes.

Q You didn't choose to do it for this one?

A We did not appeal for this one. Again, based on my experience that I never get any case overturned.

Q And is that experience just with UnitedHealthcare or is that common amongst all insurance companies at the time?

A There were a couple of -- one or -- one or two particular. There are insurance companies that actually, you can explain your rationale and get the denial overturned.

Q Okay. And what was the process for doing that?

A The process certainly is to, you know, schedule an appeal and a lot of time. And I -- a lot of time, I think usually the process is, like, for us to wait and give us a time and you can do peer to peer on the first try. Oftentimes, you know, there are times that the peer to peer is still denied proton treatment, and then you make another appeal. So it depends on different insurance companies.

Q And your reasoning for not wanting to appeal this one was because you didn't want to spend the time necessary to go through it and you didn't think it would lead to an overturn?

A The reason I didn't want to pursue the appeal in this case, again, is based on my past experience in a similar peer to peer that, you know, I have not been very successful to get the decision, the denial decision, overturned. And then as a result of that, we just have to wait and wait until the process is over. And sometimes, the treatment -- delay the treatment for three weeks or so, which is just not a good practice.

Q Okay. And after you decided to pursue the IMRT, Heather Bird [phonetic] informed you that the IMRT prior authorization would require preapproval from the insurer also, correct?

A Yes.

Q And she informed you that the approval may take up to 72 hours, correct?

A Yes.

Q And looking at the emails, you responded, thanks, correct?

A Yes.

Q And you didn't object to this timetable, right, 72-hour turnaround?

A There was no other option for this patient.

Q Okay. But you didn't -- I'm just wondering. I see the thank you, but you didn't object in a phone call or any other form of communication, correct?

A I did not object to the form of communication. No, I did not.

Q And were you aware that expedited appeals under Mr. Eskew's health plan have to be decided in 72 hours as well?

A Business office usually will inform us about these possibility. But again, you know, the experience is that you never get an answer within 72 hours and then you have to appeal again and then it drags. On the other hand, IMRT, usually when they say it may take up to 72 hours, you believe you will get an answer the next day.

Q Right. And let me bring up -- I need to share my screen again. And you see this PDF, Dr. Liao?

A Yes.

Q And it starts at UTMDACC24, and that will be Exhibit E for the deposition.

A Yes.

Q Is this the radiation oncology IMRT planning note that Mr. Eskew received treatment under?

A Yes.

Q Okay. And per the top right, this plan was deemed approved as of February 5, 2016, at 2:51 p.m.?

A It looks like so.

Q I want to turn to Bates label 54. And do you see this third column labeled ZL approved, and what does that column represent?

A That represents the population-based dose constraints. Actually, this is what the plan showed.

Q And then, ZL, are those your initials?

A Yes.

Q And so that is saying that you approve those parameters highlighted in green?

A Correct.

Q And where did those standards come from?

A The standards come from the population studies and, you know, the population studies are based on certain level of expectation in terms of associated toxicity.

Q Are those standards universal among all radiation oncologists or can they change a little depending on the provider and the patient?

A It's not universal among radiation oncologists or different centers. For example, in our center, we keep on pushing those dose constraints to optimize. Optimize means that you really have to do a

little better just compared to the other national standards.

Q And this shows that you approved the IMRT for Mr. Eskew as satisfying all those optimized standards, correct?

A Approved to be what he, based on the dose constraint that met our current department requirement at the time. You can see the constraints on the other side, even though it wasn't the optimal plan for all the organs.

Q All of the dose constraints are satisfied, though, correct?

A They met the dose constraints.

Q I will bring up what is going to be treated as Exhibit F, starting with Eskew-MD Anderson 1, and then I'm going to go down to page 16. And earlier this morning, you testified that before Mr. Eskew had received treatment with the IMRT with any radiation, it would have to be approved by the radiation oncology section planning group, correct?

A It's the collage of assurance meeting we have for all of our patients.

Q And that would have been for any radiation plan, correct?

A For any radiation plan, correct.

Q And for Mr. Eskew, as shown here on page 16, this oncology group evaluation took place on February 5, 2016, correct?

A Yes.

Q And why does such a review take place?

A To make sure we're -- the plan is safe, and any patient is correct, and the plan is acceptable.

Q And the review is just not, like, a mere formality, is it?
A No. We review these all the time.
Q And that's because reasonable and qualified medical professionals can sometimes disagree on what is the most appropriate form of treatment for lung cancer?
A Can you say that -- unqualified or qualified?
Q Qualified.
A Yes.
Q And so Mr. Eskew's clinical history, relevant diagnostic imaging, and proposed IMRT treatment was presented to the group, correct?
A Correct.
Q And there was a number of people named there. Were they all medical doctors?
A They are all radiation oncologists in our section.
Q Okay. So all of those people are radiation oncologists at MD Anderson, correct?
A Correct.
Q It looks like there is 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 MD Anderson radiation oncologists including yourself, right?
A Correct, at that time.
Q At that time?
A Yes.
Q And the IMRT plan was approved without dissent, correct?
A Correct.

Q And any dissent that had been made would have been recorded in the medical records, right?

A There would be some recommendation.

Q It would have been written down somewhere, though?

A Some of the discussion gets recorded. For example, if there is a disagreement on medical -- medication modality, or dose, then certainly there will be documentation. In those kinds of cases, like for example, when we have a comparative plan, usually what we do is we show both plans and both plans are good, but the proton plan is better. However, you know, we cannot really use that.

So in this situation, do you all feel like IMRT plan is acceptable? And then we usually kind of go through this. And certainly, the plan was approved. I mean, this plan is -- I still say it's another. It's a pretty good recommended plan. But it's not as good as the proton plan.

Q I want to go back to the prior authorization letter. I'm trying to clarify something in the top paragraph. Do you see where it says, maximize local control?

A I see that.

Q Was your treatment of -- were you treating Mr. Eskew with an intent to cure his cancer or aggressive palliative care?

A In his situation, we should call this consolidating definitive chemo and radiation. Given the situation that he had only bone metastasis, which means that he had only one site of the disease. And again, he had chemotherapy and he didn't have any progression during the chemotherapy, which means that in this situation, he has a good

chance to have a disease-free life after treatment.

Q Okay. And you just mentioned that you take into account no progression from frontline chemotherapy prior to radiation, correct?

A He had -- he had a stable disease or just minimally.

Q But you would agree that medical literature only supports the use of radiation oligometastatic stage 4 lung cancer with the potential curative intent when the patient has a positive response to frontline chemotherapy prior to radiation, correct?

A When a patient consolidating definitive concurrent chemo radiation therapy, if the patient did not show additional, like, site of metastasis, and you know, didn't -- basically didn't have more metastasis, what happened is that when you give chemotherapy, you normally -- what happened is that the tumor will respond in the beginning and then become resistant to chemotherapy, and it grows from the original site. This is actually further indication for local therapy to come in. Sometimes, we even do surgery in those cases. And so in his situation, chemotherapy was considered as the most appropriate local treatment.

Q Okay. I appreciate all that testimony, Dr. Liao. I just want to -- I don't think it quite responded to my question, so I'll ask it again, see if we can get a response. So the question was wouldn't you agree that medical literature only supports the use of radiation to treat oligometastatic stage 4 lung cancer with a curative intent when the patient has a positive response to frontline chemotherapy prior to the radiation?

A I don't quite agree with that statement, especially when you say only. I mean, each patient is different. Each disease is different. You have to look into the situation and then based on your experience and your training and everything and see if the curative intent clinically is appropriate or not.

Q Are you aware of any medical literature that does not support that proposition?

A Medical literature is always in the true side to many things. Other side focus more on the positive one.

Q Okay. Let's -- I will bring back up the medical records here. And do you recall that you first saw Mr. Eskew on January 27, 2016?

A I recall that.

Q And just going to page 8, looking at this top section, do you see where my cursor is?

A I do see that.

Q And this is showing the encounter date, and that's when you would have seen the patient; is that correct?

A I suppose so.

Q Is that what encounter date is meant to represent?

A Encounter date is the dates I see the patient at the clinic.

Q Okay. And it shows your name and that is showing that you wrote the clinical note beneath this heading, right?

A That's right.

Q That's just how their record works here?

A That's right.

Q Okay. And do you recall that prior to your first appointment with Mr. Eskew, that he received a PET scan on January 26, the day before?

A I believe I reviewed it, yes. I think I had the results.

Q And that's referring to that January 26th PET scan, correct?

A I think so, yes.

Q Okay. It was -- I think it was marked already. I think it might be E. And do you see that, Dr. Liao, the laboratory imaging data heading?

A I do.

Q And that PET/CT scan showed there is a subtle focus of increased metabolism in the left femoral head, a subtle focus of increased metabolism is noted in the left anterior superior iliac spine. Do you see that?

A I see that.

Q Okay. And what does that mean, subtle focus of increased metabolism.

A Subtle focus of increased metabolism can be a lot of things. The patient has trauma, the patient has inflammation. It can all show up on the PET as a hot spot. In this situation, discussion certainly would be referring physician and the radiologist. Usually what would happen, to find out how competent, how much they feel like this is really a true metastasis or really something, you know, kind of doubtful, but -- not sure. So those, you know, those, those are what the areas show.

Q Could that be a precursor of cancer spreading outside the

primary tumor location?

A Well you know, he presents with a tumor spread to the bone. He came with a metastasis on the humerus. He had radiation for that.

Q Right.

A Stage 4.

Q But increased metabolism in a different area can be an indicator of a spread of the cancer, correct?

A It can.

Q And at this appointment, you evaluated Mr. Eskew also for participation in a clinical trial, correct?

A I think we evaluate all patients for clinical trial if possible.

Q Okay. Can you recall -- and I'll bring this up, see if this refreshes your recollection. In your note, you have that patient is not eligible for pending protocol due to his stage 4 status. Do you recall what clinical trial you were evaluating him for at the time?

A I cannot recall.

Q And Mr. Eskew wasn't treated as part of the clinical trial, correct?

A He was not.

Q And after this appointment, that's when Mr. Eskew underwent this simulation to develop the comparative plan, right?

A After this consultation, yes, that's correct.

Q And then after the IMRT was approved, you treated Mr. Eskew from February 10, 2016, to March 22, 2016, with IMRT, correct?

A With the chemo, too, yes.

Q Let me go down. Let me go down to page 51 from the records. This shows that the IMRT treatment completed on March 22, 2016, correct?

A Correct.

Q Okay. And when Mr. Eskew was being treated with IMRT, do you actually administer the radiation or does someone else handle that process?

A Our therapy technologists deliver it. They actually turn on the machine and put the patient on the machine and that part of the treatment.

Q And did you meet with Mr. Eskew after each administration of IMRT?

A We meet with our patient once a week at least to assess their treatment process.

Q Can we go to page 32. And again, we talked about this. But this shows that this is an appointment on March 2, 2016, and you're the author of this note, correct?

A Correct.

Q And this is an appointment following the administration of proton therapy to Mr. Eskew?

A He didn't have proton therapy.

Q Or IMRT?

A Can you go back? I think this is our dose summary, right? This is one of the weekly, see?

Q This is one of the weekly appointment notes with Mr. Eskew,

right?

A Yes. Can you see how much dosage he got in that time?

Q Right. And this is an appointment that you have in person with him, correct?

A Correct.

Q And it says, I personally interviewed and examined this patient. That's referring to you, correct?

A Correct.

Q Okay. And then this subjective assessment, that's based on your knowledge and evaluation of the patient; is that right?

A Yes.

Q And is that also true for the subjective toxicities?

A Yes.

Q And is that also true for the assessment?

A Yes.

Q I want to go back up to the subjective toxicities. That's referencing grade levels, right? And you talked about grade levels earlier today?

A I did.

Q And when it comes to determining grade, do you rely on the common terminology criteria for adverse events?

A We do.

Q Now, on page 38, this is the start of your assessment from March 9, 2016, right?

A Yes.

Q And these notes were made based on an in-person evaluation of the Plaintiff?

A That's right.

Q Or sorry, Mr. Eskew?

A Mr. Eskew, yes.

Q And this was also based -- this is the note for your March 16th appointment with Mr. Eskew?

A Yes.

Q In these, the evaluation was also based on your in-person examination of Mr. Eskew?

A Yes.

Q Okay. And on page 51, this is a note regarding an appointment Mr. Eskew had with Lauren Colbert, M.D. (phonetic); is that correct?

A I believe this -- can you go down a little bit? Okay. This is what we call the end of the treatment summary. This is done by Dr. Colbert, who has the -- at the time, this is really our treatment dosimetric summary.

Q So this is a summary that was written by Dr. Colbert?

A Yes.

Q And then next line, this is you saying I saw and evaluated the patient, and we agree with Dr. Colbert's note as documented?

A I saw the patient that week.

Q Okay. And this was you agreeing with Dr. Colbert's note, too, correct?

A Yes.

Q And this was the day after Mr. Eskew had finished his IMRT treatment, correct?

A Correct.

Q Dr. Liao, coming off that short break, we are back on the record now and I want to share my screen again and direct your attention to Bates label 53 of the medical records we have been going through. And this shows that on May 4, 2016, Mr. Eskew saw Eve Huang [phonetic], correct?

A Yes. Medical records.

Q And who is Ms. Huang?

A Ms. Huang, I believe, is the one who took the medical consult.

Q And Mr. Eskew had a follow-up PET scan on May 3, 2016; is that right?

A Yes.

Q And this shows that on May 6, 2016, Dr. Tsai provided a consultation for Mr. Eskew, correct?

A Mr. Tsai.

Q And who is Mr. Tsai?

A Mr. Tsai was a fellow, I believe. Hold on. I'd have to say Dr. Tsai. He was a -- he was a fellow at that time.

Q Was he a radiation oncologist?

A His situation was a little different from a fellow. He was actually attending, but he was doing a retake with us. He was hired by

the Scottsdale Mayo Clinic.

Q Okay. And you mean he was hired but he is not with MD Anderson anymore?

A He is not with MD Anderson.

Q And he is a radiation oncologist?

A He is a radiation oncologist.

Q On page 58 here, it says, imaging review with Dr. Liao as well. Does that indicate that he reviewed the images with you?

A It does indicate that he reviewed the images with me, yes.

Q And then, his note provides his assessment and plan on page 59, correct?

A Correct.

Q And did you agree with his assessment and plan at the time?

A I agree.

Q And looking at the first sentence under Assessment and Plan, do you see where it says, Mr. Eskew's lung cancer was well controlled within the radiation fields in the RUL and mediastinal areas?

A Correct.

Q And RUL refers to right upper lobe, correct?

A Yes.

Q And radiation only targets a certain area, correct?

A Correct.

Q And the IMRT here only targeted the tumor in the right upper lobe, correct?

A And the mediastinal, correct.

Q And that would have also been true for the proton beam therapy, correct?

A Correct.

Q And this shows that the tumor in the right upper lobe and mediastinal areas had a positive response to the IMRT, correct?

A Correct.

Q And then, after that, it says, he unfortunately continued to have progression elsewhere with oligometastatic suspicions of disease in the left adrenal gland, left humeral head, and left iliac bone. Do you see that?

A Those were the lesions suspicious on the PET.

Q And those were the lesions that were previously suspicious back in January when you first assessed Mr. Eskew, correct?

A We could say that.

Q And this is saying that the cancer had progressed to those areas?

A We needed another -- probably a few more follow-ups to see if those areas have continued to progress.

Q Okay. But this is indicating that. And then you would do follow up to see if they continued to progress?

A There was a suggestion that his lesions were becoming hotter on the PET.

Q And the adrenal gland, humeral head, and iliac bone were outside the area targeted by the IMRT, right?

A Correct.

Q And they would have been outside the area targeted by the proton beam therapy as well, right?

A Correct.

Q Okay. And what we are looking at on page 59 shows that Mr. Eskew had another appointment with Nurse Huang on July 13, 2016, correct?

A Correct.

Q And this was Mr. Eskew's last appointment with MD Anderson, correct?

A I believe so.

Q And can you see the next entry is entitled, death note? Do you see that?

A I saw that.

Q And you were compensated on your work at MD Anderson, I'm assuming?

A Yes.

Q And do you have a salary?

A I do.

Q Are you eligible for any type of financial bonuses?

A What do you mean by bonus?

Q Any compensation on top of your fixed salary?

A We have a salary. We have what we call a faculty incentive, but it's not really incentive. It's based on multiple factors. For example, depends on what type of appointment you have. If you are a clinical clinician, I mentioned a benchmark today. So you have to meet your

benchmark in a way. And again, your leadership position, then lab, and completed your education. Basically, it's based on the incentive -- quite complex scores for doctor incentives.

Q And do you also receive compensation from Varian Medical Systems?

A Compensation? What do you mean by compensation?

Q Just money.

A I have been speakers for Varian, and Varian Medical Systems in this situation usually pay my travels. I think I was speaking for about two years in the past.

Q And that was Varian, V-A-R-I-A-N?

A Correct.

Q Okay. And at MD Anderson, you had a couple roles related to finances, correct?

A Depends on how you define finances.

Q I guess you sat on the revenue cycle advisory committee for three years, right?

A Yes, I did.

Q And you served on the PRS budget and finance committee for about six years?

A Yes.

Q Okay. And in 2016, were you aware that MD Anderson proton therapy center was a for profit business?

A For me at the time, it wasn't. I -- actually, I have to say I'm not quite clear if there's -- if it's for profit or not for profit organization. I

know we have a bottom check. That's about what I know about it."

MR. GORMLEY: That is all for me, Your Honor.

THE COURT: Thank you.

REDIRECT EXAMINATION

[Reading of deposition of Dr. Zhongxing Liao continued as follows:]

BY MR. SHARP:

Q Dr. Liao, Mr. Gormley asked you some questions about a paper that I wanted to show you. Do you see that, Dr. Liao?

A I do. Yes.

Q Okay. So this is the June 2018 paper that you were an author on, the primary author on that. Mr. Gormley was asking you some questions about that, right?

A Yes.

Q And it appeared in the Journal of Clinical Oncology back in June of 2018?

A Yes.

Q So I believe this was made Exhibit D -- no, I take that back. It was Exhibit B during Mr. Gormley's examination. And I thought I heard a suggestion from UnitedHealthcare's lawyer that this paper indicates that proton therapy is not appropriate to be used in lung cancer, or something that you wrote here somehow indicates that proton therapy is not appropriate to be used in lung cancer case. Is that true? Is that what this paper stands for?

A No.

Q Tell me why a suggestion that somehow this paper stands for the proposition that proton therapy is not good for lung cancer, tell us why that's wrong.

A This paper -- again, I want to emphasize in the design of this trial that we wanted to make sure that the dosimetric difference -- because radiation is all about dose and volume. So we know if radiation doesn't touch the tissue, you would not have side effects. So in this trial, we specifically designed the trial in a way that if we were able to see if there was difference in the dosimetric plan or not. If there is no significant plan between the -- I'm watching the proton -- then the randomized patient, and then you will see a difference in certain toxicity.

However, if for the comparative plan, one of them showed much better dosimetric parameters, then you are supposed to use the better plan, which is also the practice, actually, outside of clinical trials in our section. So in this study, if the mean long dose is similar, you don't see a difference in toxicity, even though numerically you see, or maybe it's higher or lower. But this, after the trial, showed no statistical difference in pneumonitis, which is the primary endpoint of this trial.

Q So if someone were to suggest, based on what this paper says, that somehow, proton therapy is not appropriate to be used on lung patient or somehow not appropriate to be used on Bill Eskew, would that be a fair reading or application of what this paper says?

A No.

Q What was your answer, Dr. Liao?

A No.

Q Thank you. By the way, as a practicing patient -- a radiation oncologist, do you treat a patient, or do you treat a paper?

A We treat patients.

Q Yes. Is your training and background in medicine to act as a practicing physician or are you trained somehow as an insurance claims representative?

A I'm trained as a medical doctor.

Q Well, let's talk about your role as a doctor. Do you, Dr. Liao, see yourself in your profession as a doctor who is there to further the interests of the patient?

A Yes.

Q And in this case, Bill Eskew was the patient, right?

A Yes.

Q And there's been some indication here, I believe, by UnitedHealthcare, its lawyers, that because you get paid to do your work at MD Anderson or because the way that MD Anderson is set up and the way that the proton center is operated from a business standpoint, that somehow, you may have a divided loyalty or not have the patient's best interests at heart. So let me ask you this. Dr. Liao, is that true?

A No. Absolutely not true.

Q Tell us why that is not true. Why do you -- what do you do?

A We want to do what is best for the patient, you know? In a -- in a way, another -- actually, a very important point is that each patient is different, and we need to individually evaluate a particular situation of the patient. We do not get compensated by the number of

the patient, the way we treat or number of patient which goes one way or the other. And in most of the cases, we have no idea what kind of insurance they have before we see the patient.

Q So Dr. Liao, are you saying that you did not receive any compensation from MD Anderson that is dependent upon how many patients you treat with proton therapy or IMRT or any other kind of modality?

A Correct.

Q Let's talk about this for a second. You work at MD Anderson, but isn't it true that MD Anderson is part of the University of Texas?

A Yes.

Q And as a result of that, by being an employee of MD Anderson, you're an employee of the State of Texas?

A Yes.

Q So you're a government employee?

A I guess you could say that, yes.

Q So what would you say, Dr. Liao, if someone were to say, well, Dr. Liao is biased. She wants people to get proton therapy when they don't really need it because Dr. Liao gets more money in her pocket if that happens.

A No. That's not true.

Q So who do you think, Dr. Liao, is in a better position to decide whether IMRT or proton therapy was better for Bill Eskew, you or UnitedHealthcare?

A It was me.

Q And as part of your clinical practice and expertise, you compared IMRT on the one hand and proton therapy on this other for Mr. Eskew, right?

A Yes.

Q And you made the medical judgment that protons were better for Mr. Eskew than IMRT, right?

A Yes.

Q And you recommended that Mr. Eskew should have protons, right?

A Yes.

Q And you would have administered protons if UnitedHealthcare had authorized it?

A Yes.

Q Okay. Because UnitedHealthcare did not authorize protons, you administered IMRT, right?

A Yes.

Q And it's true, isn't it, according to your testimony here today, that the fact that Mr. Eskew underwent a course of treatment with IMRT that caused him to have grade 3 esophagitis, right?

A Yes.

Q And had you been able to administer protons to Mr. Eskew instead of IMRT, then Mr. Eskew would not, to the best of your -- to a reasonable degree of medical probability, he would not have suffered grade 3 esophagitis?

A That was my prediction.

Q And that's your opinion as you sit here today, right?
A Yes.
Q Yes. Isn't it that what we have here is a case where a real, live patient, Mr. Eskew, would have benefited from proton beam therapy, right? I'm sorry?
A Yes.
Q And what we also have here is a real-life example of a patient who suffered unnecessarily because he was denied proton therapy. Do you agree with that, Dr. Liao?
A To most, I probably -- I would have to say.
Q So you told Mr. Gormley that the IMRT plan was pretty good, but it was not as good as the photon plan, right?
A Correct.
Q So is it your belief that Mr. Eskew could have received better treatment with proton therapy?
A Yes.
Q And do you think that Bill Eskew deserved that?
A What do you mean by deserve?
Q Do you believe that Bill Eskew deserved to get the best treatment he could?
A All patients.
Q I'm sorry, Dr. Liao?
A All patients deserve the best treatment they can have.
Q So do you believe, Dr. Liao, to a reasonable degree of medical probability that proton therapy provided Mr. Eskew with a good

chance to live a disease-free life?

A Disease-free and toxicity. Those are two different things, right? You know, the reason we want to have proton radiation is to minimize the amount of radiation to the normal tissue and will reduce the risk and severity of the toxicity. The disease part of the management depends on many, many things. Proton therapy is one part of that. There are other factors that you have to consider.

Q Well, your intent in providing proton therapy to Mr. Eskew was curative, right?

A Yes.

Q So do you believe that the best chance that Bill Eskew had to live longer and healthier without suffering needlessly from side effects of radiation was proton therapy?

A I don't think this question is a yes or no question because, you know, again, the survival can be impacted by many things. There's -- this is a different term, in a way. I don't know if I answered your question.

Q Let me try it again, Dr. Liao. Okay.

MR. SHARP: Or, that's you.

A Okay.

Q Do you believe that to a reasonable degree of medical probability that if Bill Eskew had received proton therapy as compared to IMRT, that would have given him the best chance to live a life, a better quality of life, than he did with IMRT?

A Yes. Much better quality of life for sure.

MR. SHARP: And with that, Your Honor, Dr. Liao is concluded.

THE COURT: Thank you. Counsel, will you approach?

[Sidebar at 4:11 p.m., ending at 4:11 p.m., not recorded]

THE COURT: Ladies and gentlemen, we're going to take a quick five-minute break and there's going to be another witness who's going to be attending on the screen.

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 medium of information, including without limitation newspapers, television, internet, or radio. You're 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'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 has been submitted to you.

So we'll take a quick five-minute break, resume, and then we'll end at 5:00.

THE MARSHAL: All rise for the jury.

[Jury out at 4:12 p.m.]

THE COURT: So we'll take a quick restroom break and then come right back.

MR. SHARP: Okay.

MR. ROBERTS: Thank you, Your Honor.

[Recess taken from 4:13 p.m. to 4:19 p.m.]

THE COURT: Are the parties ready for the jury?

MR. ROBERTS: Yes, Your Honor.

THE COURT: Can Mr. Flood hear us?

MR. ROBERTS: Ready for the jury?

MR. SHARP: Yeah.

MR. ROBERTS: Okay.

THE COURT: Mr. Flood, can you hear us? What can we do about his audio? Mr. Flood, we can't hear you.

MR. FLOOD: I've got my audio up.

THE COURT: Hold on. Speak again.

MR. FLOOD: Yes. Can you hear me now?

THE COURT: Yes, thank you.

[Jury in at 4:20 p.m.]

THE MARSHAL: All right. All the jurors are present.

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

MR. SHARP: Yeah.

MR. ROBERTS: Yeah. Yes, Your Honor.

MR. SHARP: For the Plaintiff, yes.

THE COURT: Thank you. Please be seated. Mr. Sharp, will you call your next witness?

MR. SHARP: Thank you, Your Honor. We call Elliott Flood on behalf of the Eskews.

THE COURT: Thank you. Madam Clerk?

THE CLERK: Mr. Flood, will you please raise your right hand?

ELLIOTT FLOOD, PLAINTIFFS' WITNESS, SWORN

THE WITNESS: I do.

THE CLERK: Will you please state and spell your first and last name for the record?

THE WITNESS: Elliott, E-L-L-I-O-T-T, Flood, F-L-O-O-D.

THE CLERK: Okay.

DIRECT EXAMINATION

BY MR. SHARP:

Q Mr. Flood, can you tell the jury what you do for a living?

A Well, I'm a consultant. I do research and consulting in insurance cases, financial and operational results of insurers.

Q And how long have you been involved in the insurance business?

A Most of my career, starting out early in my 20s.

Q And you began as an attorney; is that right?

A Right.

Q And do you also have a degree as an accountant?

A Yes. I have a master's in accounting and a CPA.

Q And how long did you practice in the world of accountants

and attorneys?

A Until 1997, when I went to work as an officer for an insurance company, not as a lawyer or as an accountant.

Q And what insurance company did you go to work for?

A Texas Mutual.

Q And how long were you there?

A Fourteen years.

Q And did you become the vice president of internal audits?

A The last seven years. The first seven years, I was vice president of special investigations.

Q Now, based upon your training and experience within the insurance industry, are you familiar with reviewing insurance company financials?

A Yes.

Q And are you -- within those financials, are you familiar with reviewing corporate organizational charts?

A I am.

Q And are you, based upon your training and experience, familiar with interpreting those corporate charts?

A Yes.

Q And did we ask you to conduct an analysis of the ownership of the New York Proton Center as it relates to the UnitedHealthcare structure?

A Yes. You asked me to research that and report on what the financial filings revealed.

Q As well as the filings with the State of New York with regard to the Proton Center?

A Correct.

Q Okay. So you have in front of you -- well, you should have with you Exhibit 8.

A Yes, I have that in front of me.

Q And the front page of Exhibit 8 is documented the State of New York Public Health and Planning Council Committee Day Agenda, March 26, 2015.

A Correct.

Q Do you see that? And if we go to page 146 of that document.

A Yes?

Q And it's entitled Public Health and Health Planning Council, New York Proton Center?

A Yes.

Q And did you review the documents specifically from page 146 through 163 in forming your --

A I did, yes.

Q And you relied upon those documents in forming your opinion -- [Audio malfunction 4:25:56 p.m.]

A I relied on them combined with my research of the financial filings of United Health.

MR. SHARP: Your Honor, move for the admission of Exhibit 8.

THE COURT: Any objection, Mr. Roberts?

MR. ROBERTS: Your Honor, I'm trying to verify something. I may be confused. I thought Exhibit 8 was the 10k.

MR. SHARP: No. Exhibit 8 is the New York Health physician information.

MR. ROBERTS: Could you give me the Bates range from Exhibit 195?

MR. SHARP: It's Exhibit 8. I'm going to move to admit Exhibit 8. Exhibit 195 is Mr. Flood's report.

MR. ROBERTS: No objection, Your Honor.

THE COURT: Okay. Exhibit 8 will be admitted into evidence.

[Plaintiffs' Exhibit 8 admitted into evidence]

BY MR. SHARP:

Q So I want to go back to your report. And within that report, you have relied upon various corporate charts, if you will. Is that right?

A Correct.

Q So I'd like to go to page 39 of your report.

A All right. I'm looking at it.

MR. SHARP: Would you put that up? Can we put a document up?

THE CLERK: Yeah. It just has to go through BlueJeans. Do you need the link again?

MR. SHARP: No, I mean can I just show the jury while he's testifying.

THE CLERK: I think so, yeah. Let me try that.

MR. SHARP: So I want to go to Exhibit 195, page 39.

THE CLERK: Has that been admitted yet?

MR. SHARP: Well, it's not going to be admitted because it's the expert report. I'm just --

THE CLERK: You usually don't show the jury if it's not been admitted. That's why I'm asking.

MR. SHARP: Well, is he still on?

THE CLERK: Yeah.

MR. SHARP: Mr. Flood, are you still on?

BY MR. SHARP:

Q Was Exhibit -- we're at page 195, Exhibit 39 [sic]. Was that relied upon you in forming your opinions?

THE COURT: Can we put him back on? We can only show him or the document. We can't do a split screen.

MR. SHARP: Okay. I'll just --

THE WITNESS: Well, I attached that document to my report, and I used that to prepare a summary because we have a couple hundred organizations within the United Health company group. And so I used this to prepare my summary, so it was a one-page summary. It's easier to see where the New York Proton Center fits into the United Health Group.

BY MR. SHARP:

Q Okay. So let's begin with what is United Health Group?

A Well, it's one of the larger insurers of health insurance in America.

Q And is it -- and is there a holding company that starts with

United Health Group, Inc.?

A Yes. That's right. There's a what we call parent company. And then there's all the subsidiaries that are owned and controlled by the parent corporation. This is a corporate structure that's common in the insurance industry.

Q And is one of those structures UnitedHealthcare Services?

A Yes. That's what you would call an intermediary subsidiary. So you think about at the very top is United Health Group, Inc., and then underneath that is UnitedHealthcare Services, and then underneath that are other groups. And as you go down that ladder, eventually you get to New York Proton.

Q Well, first I want to just identify where the insurance parts are to United Health Group, and within the chain, if you will, of UnitedHealthcare Services, do we have Sierra Health and Life.

A They might be called siblings. In other words, the parent is actually over a large tree of companies that they own. Sierra is one of them and a different branch. And the New York Proton and ProHEALTH Management, which is operating New York Proton, they are in a different branch. So they're called siblings because they all lead up to the same parent at the top of the pyramid.

Q So on UnitedHealthcare Services is responsible for the insurance part as well as the medical part of UnitedHealthcare Group?

A Well, I assume when you say medical, you're talking about the Optum branch.

Q That is correct.

A All right. So you have another intermediate subsidiary underneath UnitedHealthcare Services. And that's called Optum. And then you go down Optum, you get to the ProHEALTH, Proton, and New York Proton.

Q Okay. And so if we go to --

MR. ROBERTS: Your Honor, I've got no objection to the organizational charts attached as Exhibit 3 to his report, Bates numbered Exhibit 195, pages 35 to 56. I think it helps the jury and I've got no objection to those being used as demonstratives, including the page Mr. Sharp wanted to display.

MR. SHARP: Yeah. The problem is we can't use them because we can't go back and forth, so.

THE COURT: Well, yeah.

MR. ROBERTS: Okay.

MR. SHARP: I appreciate the stipulation.

THE COURT: You can share it through BlueJeans.

MR. SHARP: But that will take some time at this point. Or will it?

THE CLERK: All it has to do is log in.

MR. SHARP: You want to log in to BlueJeans?

THE CLERK: Do you have the link, or do you need it? You need it? I don't know your email, Jason.

THE COURT: Do you need the link?

JASON: Yes. So it would be at my email at jason@e-depositions.com.

THE COURT: Thank you.

THE CLERK: D as in dog?

THE COURT: Yes, depositions. Go ahead, Mr. Sharp.

BY MR. SHARP:

Q Okay. So within the Optum arm, you will find the New York Proton Management Center, is that right?

A I didn't hear the last part of your --

Q I'm sorry. I'll stay here. So you have the Optum arm, and within that is ProHEALTH, Proton Center Management; is that right?

A Yes, that's right.

Q And you reviewed -- as part of your work, you reviewed that the New York Proton Center reports to ProHEALTH Proton?

MR. ROBERTS: Objection to form.

THE COURT: Hold on. What was the objection?

MR. ROBERTS: Objection to form.

THE COURT: Sustained. If you could rephrase the question, Mr. Sharp?

BY MR. SHARP:

Q Yeah. Can you tell me what the relationship is between ProHEALTH Proton, New York Proton, and Optum, Inc.?

A Well, ProHEALTH Proton Center Management is a 100 percent owned subsidiary of United. All right? It goes 100 percent all the way up the ladder. Underneath ProHEALTH Proton Center Management, one of the proton centers that they have an interest in is a 33 percent interest in the -- excuse me, New York Proton Management,

LLC, and then the manager of that LLC in New York.

Q So --

A That's the actual physical center that we're talking about. So the subsidiary is a one third owner of the New York Proton Management and it is also there's an LLC and they're the manager.

Q So ProHEALTH manages the New York Proton Center? Is that --

A Yes. Yes, that's correct. ProHEALTH Proton Center Management, that's the subsidiary that's 100 percent owned by United Health. And that subsidiary has a one third ownership in the New York Proton Center Management, and they're also the manager of it.

Q So they -- so in layman language, that means they operate the New York Proton Center?

A Right.

Q Okay. And then, does the ProHEALTH Medical Management, you reviewed the employee benefit records that were available through the Department of Labor, the Form 5500s?

A I obtained those from industry standard sources, yes.

Q And what did that reflect for you?

A Well, these are public financial filings that they file with the Department of Labor and the IRS for pension plans, specifically the 401k. So the tax return for a 401k is public record because it's a -- it means that it has that legal transparency. And when you look at those, they're -- they report the number of employees that are in their health plan -- excuse me, their 401K, the pension plan.

So that's a way of getting a fix on how many employees are scattered throughout this organization chart with the controlling parent at the top, United Health. But then we have these groups down below. And I -- again, I identified several of the key intermediary subs and I determined the employees located in those -- in those subs. And also, the total employment of United Health.

Q So based upon that, did you reach an opinion that the employees of ProHEALTH Proton and New York Proton were paid by an intermediary subsidiary of Optum, Inc.?

A Well, it's not an opinion. It's what the document shows. And what the documents show is that there was 3,000-some-odd -- everyone -- I mean, well, let me say it this way. There's 150-some-odd-thousand employees in the parent, okay? So they're -- the vast majority of this group are directly employed by the parent. And they work for the different subsidiaries.

Now, Proton -- ProHEALTH Proton had zero employees. Okay? But one of the intermediate groups, Optum had zero, okay, in their filing. But an entity called ProHEALTH Medical Management, which is different than ProHEALTH Proton Center Management. They're different corporations. But the ProHEALTH Medical Management, which is in between ProHEALTH Proton Center, in between, they had 3,000 employees reported on their 401.

So -- and because Optum is above them and Optum has zero, the rest are high above. I've run into that before. It's somewhat of an anomaly. What we know for sure is that the report of Proton -- excuse

me, ProHEALTH Proton Management showed no employees. Where they're coming from, is it the 150 that are in United Health or the 3,000 that are in the other intermediate sub, ProHEALTH Medical Management, we can't determine that. I can't determine that without more information.

MR. SHARP: Okay. I have no further questions.

THE COURT: Thank you. Mr. Roberts?

CROSS-EXAMINATION

BY MR. ROBERTS:

Q So Mr. Flood, how much are you being compensated for your time in this matter?

A Three fifty an hour.

Q And what's the total amount that you've billed and are going to bill on this matter, through today's testimony?

A Well, 4,000-something for my research and -- and efforts through the deposition testimony, which was a lot longer than this testimony. This testimony seems like it's going to be about half an hour, to maybe $175 extra.

Q So how much is that all together, sir?

A I don't know. You'd have to add the number I gave you in my deposition, the 4,400, something like that, plus the time for this trial. The last testimony I did was in the deposition.

Q And now that you've retired, is it fair to say that you spend most of your time serving as a paid expert in legal proceedings? Is that where your consultant work lies?

A Most of it. I do research and writing of papers and reports, I should say. And not all of it generates testimony.

Q Fair to say you've got a long list of cases that you provided to us where you've provided expert testimony in legal proceedings?

A Right, going back to my days working at the fraud unit, looking at corporate structures back then in the '90s. Yes.

Q And over the last several years, what percentage of your time is spent testifying on behalf of plaintiffs suing insurance companies versus the defense side of the case?

A Well, probably 70, 80 percent. Since my retirement. Now, before that, it was 100 percent for the insurance industry, with a few exceptions like the State of Texas or the state bar or -- or maybe a prosecutor in a fraud case.

Q Could you have your report there, right, with your exhibit list and your testimony?

A Yes.

Q Could you give me the name of a case over the last two years where you've been hired on behalf of an insurance company defending a claim?

A The exhibit I have, the filed Exhibit 195, is that what you want me to look at?

Q It's your report, sir. It's marked as Exhibit 195 here in court. But however you maintain your records, it should be the same.

A You want me to take a look at the exhibit that has to do with my testimonial history?

Q Yeah.

A Okay. I'm looking at it. All right.

Q Tell us which case it was that you testified for an insurance company, last two years.

A Well, I seem -- yeah. I said after I retired that I generally, not exclusively, but generally work for people who have insurance. After, you know, when they heard I was retired from the industry, I started getting jobs for, you know, anyone that wanted an insurance question answered. Or accounting issues with insurance, that kind of thing.

Q Right. But you told the jury that 70, 80 percent was for plaintiffs. But in fact, over the last few years, none of it has been for defendants, has it? Insurance company defendants in lawsuits?

A Well, sometimes the insurance companies are plaintiffs, and the insured person is being sued by the insurance company and they're a defendant. That's where the 70, 80 percent comes from is that probably 80 percent of the time, the insured person or corporation -- a lot of them are corporations, but the insured entity, probably 70, 80 percent of the time is the plaintiff. But there's a significant number of cases -- not significant, but a minority where they're a defendant. Okay? So then the plaintiff would be the insurance company.

Q Okay. And in cases where the defendant is an insurance company, have you done any of those last few years since you've retired?

A Yes, since I've -- yes. That's right.

Q Okay.

A That's the majority. That's the majority.

Q Just to clarify, sir. I'm sorry, it may be tough with the screen. You're saying a majority of your testimony has been where you've been retained by a defendant insurance company in a legal proceeding?

A No. It's the opposite. The majority has been where I've been retained by a plaintiff who happened to be an insured.

Q And recently, it's almost exclusively that, right, sir?

A Well, like I said, there's a certain percentage of cases where the defendant has retained me because the defendants sometimes are insured entities, corporations that get sued by an insurance company.

Q Okay. So what you're saying is whether it's plaintiff or defendant, you're always adverse to the insurance company now?

A No. There's some -- some cases where no one is insured, and they just have an insurance issue. Two businesses are suing each other, and they want to know about insurance as an issue in the case, and I can provide information on that. There have been some -- a number of those kind of cases. And then of course, before I retired, it was almost all the insurance industry that I work for, but -- and also some others. That early phase, I also did some forensic accounting work for the State of Texas and criminal prosecutions for insurance fraud and things like that.

Q And it's fair to say you've worked before for the Plaintiffs' attorney in this case? You've done other cases for him, or at least one?

A Yes.

Q Let's take a look at the insurance charts. I mean, excuse me,

the organizational charts that you reviewed and found as a matter of public record for the United Health Group. Can we do that, sir?

A Yes.

MR. ROBERTS: And any objection for me showing this once as a demonstrative?

MR. SHARP: Not at all.

MR. ROBERTS: Audra, do you have the ability to display 195, page 38, for the witness and everyone? Can you read that, sir, or is it just a little blurry to us?

THE WITNESS: I can read it.

BY MR. ROBERTS:

Q Okay. This is Exhibit 195, page 38, which is an exhibit to your report. Do you recognize this?

A Yes.

Q And where did you obtain this organizational chart from, sir?

A That's part of the annual statement for the year 2020, which was the most recently available one at the time that I did the research. I obtained it through the National Association of Insurance Commissioners. They maintain the public records, public filings by insurance companies, and this is the annual statement for Sierra Health. And it reports the entire structure. You'll find Sierra if you scroll down here eventually.

Q Okay. And the red block that we all see on this chart, was that on the copy that you found, or did you add that?

A No. I added those because we've got 20-some-odd pages of

these charts. And they -- if you assemble them, it would take up a wall. But instead, they come in a report, one page at a time. And so you need to trace down. And so I remember I said I prepared a summary and simplified the latter because we're interested in Sierra, and we're interested in ProHEALTH Proton and New York Proton.

And so what I did is I put the red boxes so you could trace down from page to page and see how the chain worked. You see the little arrow there underneath the red box on the right-hand side? It says, "Continued on next page." That's how these things go, is that they keep having continued, continued, you know, 20-some-odd times, you know, until you get through the whole -- the whole organization.

Q Okay. Sir, the first one in the red block, is that United Health Group, Inc. that you --

A Right. That's --

Q Is that the ultimate parent company, according to your research?

A That's right. That's what it is. Absolutely, yes.

Q Is United Health Group, Inc., a licensed insurance company?

A No. They are owner of licensed insurance companies. And also owner of healthcare providers. They expanded into buying up medical practices and things like the Proton Center and so forth.

Q So the first level of the United Health Group is shown by following the line over to the red square on the top right of the page, correct?

A Yes.