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 12 of 18

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

BEFORE THE HONORABLE NADIA KRALL
DISTRICT COURT JUDGE
TUESDAY, MARCH 29, 2022

RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 10

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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FOR THE PLAINTIFFS	MARKED	RECEIVED
None		

FOR THE DEFENDANTS	MARKED	RECEIVED
None		

Las Vegas, Nevada, Tuesday, March 29, 2022

[Case called at 9:00 a.m.]

[Outside the presence of the jury]

THE MARSHAL: Come to order. The Honorable Nadia Krall presiding.

THE COURT: Good morning.

MR. TERRY: Good morning, Your Honor.

MR. SMITH: Good morning, Your Honor.

THE COURT: Good morning.

MR. ROBERTS: Good morning.

MR. TERRY: A couple things real quick, Judge. We're working on the displays in the courtroom, but the two sides of IT people have been trying to get something going and it work, and we hope it works out for you as well.

But in any event, more substantively we wanted to let you know that there had been some back and forth between the parties with regard to the substance of Dr. Kumar's testimony here today in light of the Court's previous ruling with regard to after acquired evidence. Specifically what I mean when I say that is the reliance on evidence that was not in the possession of or relied upon by Sierra at the time of the denial of the claim on February 5 of 2016. Court had previously ruled that such evidence would not come into evidence.

That ruling, in our estimation, applies particularly to Dr. Kumar in certain respects with regard to his testimony. Mr. Roberts has

made representations to me about what they intend to ask Dr. Kumar to testify about. I think that some of the concerns that the Plaintiff's had with regard to that topic have been addressed by that interaction that Mr. Roberts and I have had.

However, we want to point out to the Court that there may be some instances where there's some grey area with regard to that as you might imagine because of the -- sort of the complexity of the issue. And so we just wanted to advise the Court that there may be some need for us to address some topics with regard to that throughout the course of the testimony. But overall I think we've sort of navigated as best we can with an agreement, and we just want to let you know that.

THE COURT: Thank you, Mr. Terry.

MR. TERRY: Is that fair enough, Mr. Roberts?

MR. ROBERTS: Yeah. That is fair enough. And specifically, you know, partly because we were able to cover Dr. Owens, we've eliminated any opinions regarding whether or not the decision was correct, and we are mainly using him as a causation witness. That in his opinion the use of IMRT instead of proton beam is not what caused his side effects and that his side effects were not as severe as they could have been. That's the primary purpose of him.

But with regard to their objections, I think that we're not -- I think we're on the same page, he's reviewed my slides. But we would like to point out that we think Dr. Chang among others has opened the door to post decision testimony regarding the efficacy of proton beam therapy. Dr. Chang testified to hundreds of studies. They have produced

the 2022 website from the Proton Beam Center. They over our objection have produced our 2018 policy. So we think any limitation to evidence strictly at the time of the decision has long ago been waived.

THE COURT: At this point the Court sees the Plaintiff opened the door to that issue.

MR. TERRY: Can we just take it up as we go along?

THE COURT: Oh we can take it up as we go along, Mr. Terry.

MR. TERRY: That will be fun.

THE COURT: Yeah.

MR. TERRY: We'd enjoy that very much. I can see that you would too.

THE COURT: I would. Thank you.

MR. TERRY: Thanks.

THE COURT: Oh Mr. Roberts, one thing. When you were standing up in front of the TV the jury couldn't see the TV. But for whatever reason when Mr. Sharp was in front of the TV they could see the TV just fine.

MR. SHARP: I think there's a problem with that. It's a benefit of being, you know, a little short or --

THE COURT: Yeah.

MR. SHARP: -- vertically challenged --

THE COURT: Yeah.

MR. SHARP: -- as they say, right, Your Honor?

MR. TERRY: That's kind of a gratuitous shot at Mr. Sharp first thing in the morning, Judge.

MR. SHARP: I thought it was a compliment --

THE COURT: It was a compliment.

MR. SHARP: -- Mr. Terry.

MR. TERRY: Okay. I should have seen it, I'm sorry.

MR. ROBERTS: So that's when I was over --

COURT RECORDER: She was just saying you need to stand to the side of it is all. If you could just probably just stand on the side of it maybe when you're showing stuff.

MR. ROBERTS: Okay.

COURT RECORDER: That'll help a little bit too.

MR. ROBERTS: Yeah. That makes sense.

THE COURT: Just stand in front of Ms. Burgener.

COURT RECORDER: Yeah. So I can't see anything. That'd be great.

THE COURT: Yeah.

COURT RECORDER: No. But Mr. Sharp I think was more to the side and not standing directly in front of it most of the time, so I think that was the difference too.

MR. ROBERTS: Okay. Very good. Thank you.

COURT RECORDER: He said everybody's here.

MR. ROBERTS: Thanks for the heads up.

COURT RECORDER: I do what I can. Everybody's here, Judge.

THE COURT: Okay. We're ready? Are the parties ready for the jury?

MR. TERRY: Yes, Your Honor.

THE COURT: Thank you.

MR. ROBERTS: Your Honor, would you like a copy of the PowerPoint just in case at any point you -- I'm in your way or you can't see the slide?

THE COURT: That would be great.

MR. ROBERTS: Permission to approach?

THE COURT: Yes. Thank you. Do we have Dr. Kumar here?

MR. ROBERTS: Yes, Your Honor. This is Dr. Kumar right here.

THE COURT: Okay.

[Pause]

MR. ROBERTS: Yes. Dr. Kumar, you can take the witness stand.

DR. KUMAR: Sure.

THE COURT: So we're going to bring the jury in and once the jury comes in then the clerk will swear you in.

DR. KUMAR: Okay. Can I sit down?

THE COURT: No.

DR. KUMAR: Okay. Just asking.

THE COURT: The jury's about to come in otherwise I would say yes.

[Pause]

THE MARSHAL: All rise for the jury.

[Jury in at 9:07 a.m.]

THE MARSHAL: Okay. All jurors are present.

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

MR. ROBERTS: Yes, Your Honor.

MR. SHARP: Yes, Your Honor.

THE COURT: Thank you. Please be seated. Mr. Roberts, will you call your next witness?

MR. ROBERTS: Yes, Your Honor. The Defense calls Dr. Parvesh Kumar.

THE COURT: Thank you.

THE CLERK: Please raise your right hand.

PARVESH KUMAR, DEFENDANT'S WITNESS, SWORN

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

THE WITNESS: Sure. Parvesh Kumar, P-A-R-V-E-S-H and the last name is K-U-M-A-R.

THE CLERK: Thank you. You may be seated.

THE WITNESS: Thank you.

THE COURT: Thank you. Mr. Roberts.

MR. ROBERTS: Thank you. Audra, could we have the first slide?

DIRECT EXAMINATION

BY MR. ROBERTS:

Q And Dr. Kumar, one of these TV's is out of order this morning, we're trying to get it fixed. But I will do my best to -- can you

see this okay?

A Yes, thank you.

Q Okay. I'll try to stay out front of it. Just wave me off if I get there, okay? So the first thing we'd like to do just with our other experts -- well, are you here as an expert witness?

A Yes, I am.

Q Okay.

MR. ROBERTS: And can we see the first slide, Audra?

BY MR. ROBERTS:

Q What I'd like to do with you, sir, first is just to walk through your education, your experience, your professional career to put your opinions in context and lay a foundation for you to give expert opinions in this matter.

A Sure.

Q Is that okay?

A Sure.

Q And you've reviewed this broad summary of your qualifications?

A Yes, I have.

Q Is this fair and accurate?

A Yes, it is.

Q So you've spent over 30 years as a board certified radiation oncologist?

A 32 years, that's correct.

Q Okay. And the jury's heard from Dr. Cohen, Dr. Chang, Dr.

Liao. Is that the same specialty as those three physicians?

A Yes, it is.

Q You've been the chair at the Department of Radiation Oncology at top universities, which we'll get into later. Is that fair?

A Yes, I have.

Q And you've had a leadership role at nationally recognized cancer centers?

A Yes, I have.

Q Let's start with your education, how about we start with medical school?

A Sure.

Q Where and when did you go to medical school?

A I went to University of Kansas School of Medicine after I graduated from chemical engineering at the University of Kansas in Lawrence. And I graduated medical school in 1986.

Q And what was your undergraduate degree in?

A Chemical engineering.

Q Okay. The Plexiglas makes it a little hard for me to hear you. Right up there with the lights on it is the mic, if you could lean into that a little bit that might be better.

A How's that, is that better?

Q That is. That's much better.

A All right.

Q Thank you, Doctor. So did you do a residency, anything like that after medical school?

A Yes. I did my residency at Thomas Jefferson University Hospital in Philadelphia from 1986 to 1990.

Q Did you know Dr. Owens when you were there?

A No, I didn't. But I know he went to U Penn and did his residency in family medicine there at Thomas Jefferson.

Q Did you hold any positions?

A Yes. During my senior year I was chosen to be the chief resident of the radiation oncology program and I was also given the honor of being the American Cancer Society fellow.

Q What does the chief resident do?

A Well, we had a rather large residency training program and as chief resident your role is to serve as an intermediary between all the radiation oncology faculty, the chair of the department and the residence to make sure that our training and education is optimized including our clinical experiences.

Q Thank you, sir. Where did you go after you were the chief resident at Thomas Jefferson?

A I was given an opportunity to have a leadership role at St. Jude Children's Research Hospital and University of Tennessee School of Medicine. I was given the opportunity to lead the radiation oncology program for the University of Tennessee at the VA hospital, as well as have a joint appointment at St. Jude Children Hospital. At that time it was a combined program between University of Tennessee and St. Jude Children's Research Hospital.

Q And how long were you there at St. Jude's?

A I was there from 1990 to 1998.

Q Tell us about what your duties and responsibilities were at St. Jude's Children's Hospital?

A So I saw patients there obviously. I treated pediatric patients with radiation therapy. I also did a lot of research, I actually did a lot of research in leukemia -- you know, St. Jude is known for essentially finding a cure for pediatric leukemia. So I actually did a lot of research in leukemia as well as some other tumors like -- you know, so the rhabdomyosarcoma tumors. So I was mostly engaged in research as well as seeing pediatric patients.

Q And did you listen to Dr. Chang's testimony?

A Yes, I did.

Q Did he testify he also spent some time at St. Jude's?

A I believe he did a fellowship at St. Jude for four months.

Q And how long were you there, sir?

A I was there eight years.

Q And were you a professor there?

A I was -- I started off as an assistant professor and then eventually was promoted to associate professor and then associate professor with tenure at University of Tennessee with a joint appointment at St. Jude Children's Hospital.

Q Where did you go after you left St. Jude's?

A I was recruited to be the founding chair of the department of radiation oncology at Rutgers Robert Johnson Medical School in New Brunswick, New Jersey.

Q Tell us about what your duties and responsibilities were at Rutgers?

A Well, you know, when you're trying to start a new department and new program your responsibilities are pretty well anything and everything. So I established the clinical infrastructure. I recruited a radiation oncologist as well as physicists to start the clinical program. When I started we had one facility, when I left eventually five years later we had three facilities. We went from essentially two linear accelerators to about six or seven linear accelerators. I also set up the research infrastructure because we were engaged in research at that time and still now Rutgers Robert Johnson Medical School was affiliated with the Cancer Institute of New Jersey, which was a NCI designated cancer center just the way St. Jude is also an NCI designated cancer center.

Q About how many NCI designated cancer center are there?

A Currently there are approximately 72 NCI designated cancer centers.

Q Is MD Anderson also one?

A Yes, it is.

Q Were you a professor at Rutgers?

A Yes, I was. I was promoted from associate professor to full professor with tenure.

Q Are there any special qualifications in order to be a tenured professor at a major university in the medical school versus in other parts of the school?

A Yes. You know, I've been very privileged and fortunate to have been given that honor. I've been professor now at six medical schools. And the requirement -- there's a little bit of variability as you go from one medical school to another one, but the common thread is that you pretty well have to be nationally or internationally recognized for your contributions to your field. And that's pretty well a standard minimal requirement.

Q How long were you at Rutgers?

A I was there five years.

Q When did you leave, do you recall the year?

A 2003.

Q And where did you go when you left Rutgers?

A Yeah. I left Rutgers in April 2003 and I started at USC, University of Southern California and Keck School of Medicine in Los Angeles in early May of 2003. And I remember that as if it were yesterday because my wife's from LA and she was so happy that we were going back to her hometown.

Q And what made you move from Rutgers to the University of Southern California?

A Well, number one, two and three my wife. And we were always going back -- whenever we had vacation we were always getting on the airplane for New York, New Jersey to -- going to LAX. So I knew I'd at least, you know, ten hours round trip four times a year by doing that and my wife would be a lot happier. Plus it was really a phenomenal opportunity to head up a -- USC actually recruited me to be

their chair of the department of radiation oncology, I was quite honored. You know, they had over 20 applicants for that very prestigious position, but they told me I was the only unanimous selection. So I thought it was a privilege and an honor to be asked to be in leadership role for USC Med School.

Q So what were your duties and responsibilities as chair -- was it chair of the department of radiation oncology?

A That's correct. So we ran a couple of facilities. We ran the North Cancer Center Hospital as well as the LACUSC Medical Center, which was next door. So I was in charge of the entire radiation oncology program both at USC and LACUSC County Medical Center. I was clinical service chief as well as being the medical director for Norris Cancer Center Hospital.

Q And what is Norris Cancer Center and how does that relate to USC Keck?

A So, you know, at each medical school they had their own, especially, you know, the prestigious medical schools, they tend to have their own cancer centers and they tend to have unique names, like in New Jersey it was Cancer Institute of New Jersey. At USC it was Norris, it was named after the Norris family who made a large contribution.

And again, the Norris Cancer Center is also and still is an NCI designated comprehensive center. In fact it was one of the original seven NCI designated cancer center when Richard Nixon signed the National Cancer Act in 1972.

Q Did you teach at University of Southern California Medical

School?

A Yes, I did. We taught medical students, and we also had a residency training program.

Q And were you in charge of the residency training program?

A Well, my job was to make sure that their residency program ran smoothly, so I selected the residency training program director. And you know, I was proud to say that when I started -- at that time the residency training programs and radiation oncology were ranked nationally, they don't do that anymore. But if I remember correctly the USC's program wasn't doing well when I was recruited so one of my charges was to improve the performance of the residents.

And you have to understand that in radiation oncology you have to take four exams to board certified. You have to take three written exams, one in radiobiology, one in physics, one in clinical service. And then if you pass all three of those exams then you have to take an oral board exam in Louisville, Kentucky in front of, you know -- and you know, it's a half a day exam and then if you pass -- only if you pass the oral board exam do you become board certified.

So the residents at USC weren't doing well, we were ranked number 58. Then eventually when I did leave USC we were ranked number 33, so we had significantly improved.

And I also set up the Los Angeles city wide mock oral board exam because I realized that most of the residents were failing because they weren't doing well in the oral board exam. So maybe it would be helpful for them to get practice, kind of like a simulation practice. Because you

know, it's fairly stressful for a resident to -- I mean, you're asked, you know, 400, 500 questions in about half of a day. So if you're not prepared for that and if you haven't practiced you're not going to do well.

So I started the Los Angeles city wide mock oral board exam. And so I asked UCLA, UC Irvine, Kaiser Permanente and a private practice group to be part of that. And so every spring we would all get together and there would be about 20 faculty members from those medical schools with 20 residents or so, and we would give them a mock oral exam. And I can tell you it was the only time that USC and UCLA got along, so.

Q Thank you, Doctor. How long did you stay at University of Southern California?

A I was there for seven years.

Q And what year did you leave?

A I left 2010.

Q Where did you go in 2010?

A I went back to my alma mater because the dean at KU Med School I'd actually met her in 2004 in LA when she was doing the fundraiser a year after I arrived at USC. And I remember meeting her explicitly because my favorite team the Kansas City Chiefs were playing the Oklahoma Raiders that day and I had to miss that game just to go and meet her. And so she asked me if I was interested in being chair there, and that was 2004. I said, thank you, but you know I just arrived at USC. But they were very persistent and eventually they made an offer I

couldn't refuse. And the honor and the privilege of going back where you went to med school and heading up a program was something that I just couldn't pass up.

Q So you were a Jayhawk in med school?

A I was a Jayhawk in med school and this year is a good year to be a Jayhawk because we made it to the final four. Let's see what happens in the next week.

Q Thank you, Doctor. So what was your position when you moved to Kansas?

A I was again the chair of the department of radiation oncology. I was also the clinical service chief. I was also the medical director for radiation oncology. And I was also the associate director for clinical research for the KU Cancer Center because -- I was recruited with two charges. One was to rebuild the department and the other one was to help KU get NCI cancer center designation.

Q Did they have that certification when you arrived?

A No. They didn't. In fact they'd been trying to become an NCI designated cancer center for almost 30 years. They started in the early 1980s and unfortunately that efforts didn't succeed. And then they restarted again in early 1990s and that effort also sputtered. And so they started in again early 2000 and the third time was a charm. And you know, my -- you know, I'm proud to say that I was one of the key integral leadership members to help them get the NCI cancer designation because I was in charge of all the clinical trials that we were doing at the cancer center.

Q Tell the jury a little bit about clinical trials and what it means to be in charge of one at a university like that?

A Well, look, I mean, you know, first I think the question is, why do we care about clinical trials? I mean, this is how we find cures for diseases. I mean, if you look at what's happened in the cure rates for cancer in the last five decades, you know, we've gone from an overall cure rate of about 50 percent for all cancers to almost 65 to 70 percent.

How did that happen? Well, that happened because we were doing clinical trials. Good example is at St. Jude Children's Research Hospital. When they got in the business of doing clinical trials for leukemias, the cure rate was only 10 percent, and it was considered a fatal disease. Now the cure rate for leukemia is about 85 to 90 percent.

So clinical trials is how we establish new ways of treating cancers. It's -- you know, you compare essentially if you do, you know, a phase one trial, and you might have heard this previously, where you look at the safety of a new drug. Phase two trial is you maybe look at the efficacy. But a phase three randomized trial is the gold standard where you're comparing the current standard of treatment to a new way of treating a patient. And that new way if it's better and, you know, less toxic or better survival, then that becomes the new standard of care and that's how we improve cure rates.

So clinical trials is where the rubber hits the road. I mean, that is how we make advances in cancer.

Q So what was your role in the clinical trials that were being done at the University of Kansas during that time when you were chair?

A Well, my other role in the cancer center was I was associate director of clinical research for the KU Cancer Center, so I was in charge of all the clinical trials. We were doing approximately 110 to 120 clinical trials annually. So we're enrolling patients, so my job was to make sure that entire clinical trial enterprise ran smoothly in terms of making sure that the clinical trials were safe, they were meeting their accrual goals and, you know, helping the junior faculty and other faculty conduct the trials. And so, you know, it was taking care of the whole clinical trial enterprise.

Q How long did you stay at Kansas?

A I was there from 2010 to 2016.

Q And where did you go in 2016?

A I came back to the west coast. My family unfortunately had a difficult time adjusting to the Midwest, so we wanted to get back to the west coast. So I actually came right here to Las Vegas, Nevada at the University of Nevada, Las Vegas.

Q Okay. And where you working when we first contacted you to consult on this matter for us?

A I was at UNLV.

Q Okay. And what was your position at UNLV?

A I was a tenured professor, but most importantly I was recruited to try to salvage this huge national institute of health $20 million grant involving 13 other universities, seven states. It was a research infrastructure grant and the NIH have pretty well told UNLV that they were not going to renew the grant. So I was recruited in 2016 to try

to salvage and renew the grant, which I'm proud to say we were able to submit in 2017. And we got an outstanding score, and we were able to renew that 20 million dollar grant in 2018.

Q Right. And when did you leave UNLV?

A I left last year.

Q And where did you go at that time?

A I am currently at the University Of Missouri School Of Medicine.

Q And what are your duties and responsibilities at the University of Missouri School Of Medicine?

A So I'm focused 100 percent on research. I'm the associate director of clinical and translational research and I'm also the associate direct of clinical sciences for their cancer center.

Q What is translational research?

A So translational is basically you know, simplicity going from bench to bedside. So let's say someone discovers a new drug in the lab and they develop the drug, but you want to see does that drug actually work in human beings with certain cancers and diseases. So that's translational research, where you test a drug from the time it's discovered to the time it's actually tested in humans. And you know, this is where all the phase one, two and three random -- you know, clinical trials come into play.

Q And about how many clinical trials have you overseen at the University of Missouri?

A We have approximately 150 clinical trials that we're doing

annually.

Q And we've talked about your role from St. Jude's to the University of Missouri. I know you mentioned treating patients at St. Jude's. Did you treat patients at any of those other positions?

A Yes. I treated patients obviously at the VA. My research focus was actually on lung cancers when I first started and head and neck cancers. And then I expanded to prostate cancer.

Q And about how many patients do you think you've actually treated over the course of your career in radiation oncology?

A I would estimate, you know, approximately maybe -- certainly more than 6,000 patients. Maybe 6,500 to 7,000 patients.

Q Have any of those been in lung cancer?

A I would estimate about a third were -- had lung cancer. So probably more than 2,000.

Q And are you still currently at the University of Missouri?

A Yes, I am.

Q So let's just recap your leadership roles. How many schools were you the chair of the department of radiation oncology?

A Three medical schools, Rutgers Med School, USC Med School and KU Med School.

Q And what about leadership roles in affiliated NCI designated cancer centers?

A Both at Rutgers Med School as well as KU Med School.

Q Let's switch over to some of your research and speaking. You mentioned that you do a lot of research?

A Yes.
Q That's currently your primary field of interest?
A I'm focused on research, that's correct.
Q The -- one thing the jury heard from Dr. Chang was that a national multi-institutional study just being principal investigator on one of those can make your career, did you hear that?
A Yes, I did.
Q And have you ever been the principal investigator on a national multi-institutional study?
A I've actually been radiation oncology principal investigator on four national multi-institutional clinical trials.
Q Have any of those had anything to do with lung cancer?
A Two of the four were in lung cancer, one was a phase two clinical trial and the other one was a phase three randomized clinical trial and both in lung cancer.
Q So we've heard about phase one, phase two and phase three clinical trials. Have any of your clinical trials, the national multi-institutional ones where you were the PI, have any of those been phase three randomized clinical trials?
A Yes. Two of the four. One in lung cancer and the other one in prostate cancer.
Q Have you ever been invited to speak?
A Yes, I have.
Q About how many times?
A Approximately over 120 presentations nationally and

international.

Q To what types of groups?

A Large research meetings, physician focus groups, but mostly large research meetings.

Q All in the United States?

A No. You know, many have been in the U.S. and Canada, but some of have been in Europe as well Ischia and Japan as well as India.

Q And have any those invited speakerships include lung cancer?

A Yes, they have.

Q About what percentage?

A You know, I'd have to count them up, but I know that probably majority -- big portion of my initially talks in my early career were focused on lung cancer because I was doing a lot of research in lung cancer both nationally as well as institutionally. So a good many were in lung cancer.

Q Have you written book chapters?

A Yes, I have.

Q How many do you say?

A Well, I've lost count, but at least eight book chapters and including a book chapter on lung cancer.

Q What about articles, have you written peer reviewed journal articles?

A Yes, I have.

Q About how many?

A Overall, you know, close to 150 abstract as well as manuscript publications.

Q Have any of those articles been on lung cancer?

A Yes, they have. A good many.

Q You mentioned that one of the reason you were brought UNLV was to save some grant funding that they had?

A Yes.

Q Is grant funding one of those things people look at in your field?

A Yeah. I mean, it's really the gold standard for research if your able to secure grant funding from NIH, NCI or other federal agencies, than, you know, you consider a premier researcher.

Q And how much grant funding have you secured as the principal investigator in a multi-institutional setting?

A Well, you know, I've had many grants, NHI grants, Department of Defense grants, Department of Energy grants, grants from the pharma industry. I've had over $31 million in grant funding in my career.

Q Okay. What's sort of the gold standard in cancer grant funding, what does everyone try to get?

A Well, look if you get one buck of grant funding you're doing good, but you know, because currently if you apply for a big what's called an R01 grant from NIH or NCI your chance of getting that grant funded is less than 10 percent. So only one in 10 researcher actually gets grant funding, so any amount is good.

But for radiation oncologists, you know, typically we're so focused clinically that's not a big area of focus. If you look at oncologists, you know, surgical oncologists, radiation oncologists, medical oncologists most of the grant funding is being obtained by medical oncologists, not radiation oncologists. So you know, if you get -- if you have a few million dollars in grant funding in your career, you know, you're doing good.

Q So you heard Dr. Chang, we established that, right?

A Yes.

Q And you hear he was asked if he ever heard of you before?

A Yes, I did.

Q And he said he hadn't heard of you. But he did give the jury the names of some journals that he read, that he thought were authoritative in the field, do you remember that?

A Yes.

Q Have you ever been published in the journals Mr. -- Dr. Chang says he read?

A Yes. I've had multiple publications in those journals.

Q And you've reviewed Dr. Chang's CV?

A Yes.

Q And whose had more grant funding, you or Dr. Chang?

A Well, look I think the CV speak for themselves. So I think the answer is obvious. I've been very fortunate that, you know -- look when you grant funding the idea behind grant funding is to really help patients. You know, why is the federal government giving you taxpayer

money? And they're giving you hard earned taxpayer money so you can make a difference for patients.

MR. ROBERTS: Just realized I had my phone in my pocket, Your Honor. I just hope I'm not crackling the system.

COURT RECORDER: No. You're good.

THE COURT: Thank you, Mr. Roberts.

BY MR. ROBERTS:

Q Have you reviewed Dr. Liao's CV?

A Yes, I have.

Q And you agree that she's pretty eminent in the field, right, or well recognized?

A Yeah. She's known for proton beam radiation therapy in lung cancer.

Q And have you had more or less grant funding than even Dr. Liao?

A Yes, I have.

Q More?

A More.

Q Significantly more?

A Yes. About two to three times more approximately.

Q So let's go dive a little deeper into your experience with lung cancer. You told the jury that you've treated thousands of patients with lung cancer, correct?

A Yes.

Q And you're researched on lung cancer?

A Yes, I have.
Q And have some of those research studies been NCI studies?
A Yes, they have.
Q What is the NCI?
A NCI stands for the National Cancer Institute and is the agency that is charged by the federal government to find a cure for cancer. I mean, that's their main goal.
Q As part of your experience treating patients with lung cancer and studying lung cancer, do you have any experience with esophagitis?
A Yes, of course.
Q And tell the jury about your experience with that?
A Well -- and you know, unfortunately it's a very common side effect. The majority of the times it's not severe, it's usually grade one or grade two. But occasionally you will see a grade three or worse side effect depending on, you know, the disease that you're treating. But mostly it's associated with lung cancer and head and neck cancers and esophageal cancers. So it's a common side effect that radiation oncologists deal with.
Q Are you familiar with the studies that have been done on the causes of esophagitis and how often it occurs?
A Yes. You know -- I mean, there are many causes for, you know, esophagitis.
Q Have you overseen patients with that side effect?
A Yes.
Q Have you done research in how to minimize it?

A Yes. We've -- they're actually -- I've participated in pharma funded clinical trials that have looked at a similar side effect called mucositis. So mucositis is the equivalent of esophagitis that's happening in your oral mucosa with -- when you give patients head and neck radiation therapy. So the same kinds of drugs that would ameliorate mucositis would also ameliorate esophagitis, so I've participated in some of those trials.

Q Let's move to discuss specific types of radiation therapy. This trial involves IMRT. Do you have any experience with IMRT?

A I've treated tons of patients with IMRT.

Q Are you familiar with the research and science that's been done with IMRT?

A Yes, I am.

Q What about proton beam therapy, are you familiar with that?

A Yes, I am.

Q Have you ever treated any patients with proton beam therapy?

A No, I haven't. But then of course, neither have 99 percent of the radiation oncologists in this country.

Q Have you ever worked in a proton beam center?

A No, I haven't.

Q Have you ever taught students about proton beam?

A Yeah. You know, one third of radiation oncology training involves the physics of radiation therapy. And in the physics of radiation therapy you of course have to know about how protons work, so that's

part of the residency training program.

Q Do you study proton beam therapy and stay up on the studies and articles that are issued regarding it?

A Sure, yes, absolutely.

Q Why do you do that?

A Well, I can tell you in all of my leadership positions one of my goals as chair of the Department of Radiation Oncology was to make sure that we had the latest in technologies. So for example, when I was at Rutgers Robert Johnson Med School I was asked to evaluate the relevance and the necessity of proton beam radiation therapy.

Q And tell me what that process involved to evaluate that for the Rutgers Medical School?

A Well, the pretty significant comprehensive rigorous process. Of course I did all of my due diligence, but then we actually did a site visit in early 2000 to Loma Linda Medical Center and on that, I still remember of the trip, the president of the university was on that trip, so was the dean of the medical school as well as the CEO of the hospital to evaluate the possibility of bringing a proton beam to Rutgers Robert Johnson Med School.

Q Okay. Ultimately did you decide to bring the proton beam therapy to Rutgers?

A No. We didn't.

Q Have you ever evaluated -- done that type of evaluation of proton beam therapy and the possibility of opening a center for anyone else other than Rutgers?

A Yeah. Not as much formally, but informally ever single medical school that I've been at, you know, they've asked me to evaluate, you know, the possibility of getting a proton beam certainly informally.

Q And was the answer different at any other university?

A No. It wasn't. The answer was no.

Q And why was the decision made not to open a proton beam center at those universities?

A Well, mostly the science still doesn't really support the expenditure of that kind of capital for equipment that has yet to show, you know, better outcomes than photon based linear accelerators.

Q So I think we've broadly covered all of your qualifications and work history. Let's go to the time when I first called you about this case. What work did we ask you to perform as a consultant for us?

A Well, you asked me to review all the medical records for Mr. Eskew, as well as the records from MD Anderson Cancer Center, as well as the depositions of a few folks, as well as the expert witness reports.

Q And you wrote a report for us including the rebuttal of certain opinions from the Plaintiff's experts the jury has heard from; is that correct?

A That's correct.

Q So before we get into the specific opinions that you formed in reviewing the records and other reports in this case, let's talk about your role here today. You confirmed you're an expert witness. Are you being compensated for your time that you spent working and studying

on this case?

A Yes, I have.

Q And how much have you charged us per hour up until today?

A I charge $800 an hour.

Q And approximately how many hours have you put in on the case?

A I haven't counted all the hours, but I would estimate we're probably close to, you know, probably more than 80 hours. It doesn't include the last several days. But, you know, that's just an estimation.

Q So you're total compensation is fair to say is in excess of 50,000 bucks?

A Yes.

Q And what about for trial, do you charge by the hour for your trial time?

A No. Because it's unpredictable, you know, how long my testimony will go. So I just have a half a day rate and a full day rate because, you know, I have to travel from out of town and go back. So I just have a standard rate because I don't like to charge for travel time and all of that stuff.

Q And does the flat rate you charge for half day and full day include your travel time from Missouri?

A Yes.

Q Is that a standard rate, more or less than you usually charge?

A It's the same standard rate that I always charge.

Q How often do you work as an expert?

A Not that often. You know, probably I maybe average at most maybe one case a year.

Q When was the last time you served as an expert at trial?

A More than a decade ago.

Q Do you ever turn down opportunities to serve as an expert?

A Sure, absolutely.

Q And what about this case, why did you accept this case?

A Well, I thought this case had a lot of validity to it.

Q Have you testified in court as an expert on radiation oncology?

A Yes, I have.

Q And what -- you know, as you know we both work for Sierra Health and Life the Defendant in this matter. Have you ever consulted with them before this case?

A No, I haven't.

Q Have you ever consulted with any other affiliate of Sierra Health and Life under the UnitedHealthcare Group?

A No, I haven't.

MR. ROBERTS: Audra, could we have the next slide?

BY MR. ROBERTS:

Q So could you give a brief overview of the opinions that you formed in this matter after reviewing all of the files and materials you indicated that you went through?

A Sure. And I'm going to -- at this time I'm going to ask you kind of get out of the way.

Q You should have that on your screen --
A Okay.
Q -- but you may not.
A It's not on the screen.
Q Okay. Because of the jimmy rig we did this morning.
THE COURT: We can?
THE CLERK: We can't do this screen.
THE COURT: Well, push it closer to the jury. It won't go?
THE CLERK: Can you push it that way? Yeah, but like pull it back a little bit and push it that way. No. Push it that way.
MR. ROBERTS: Actually I've got a hard copy. I may be able to give this to the doctor.
BY MR. ROBERTS:
Q Would that help, Doctor?
A Sure. Yes. Thank you.
THE COURT: Ladies and gentlemen of the jury, can you see that screen?
UNIDENTIFIED JUROR: Sometimes depending on the size of the font and number of words on the page.
THE COURT: Can you see that right now?
UNIDENTIFIED JUROR: Yes. That one's all right.
THE COURT: Can you tilt it just a little bit, marshal?
MR. ROBERTS: May I approach the witness, Your Honor?
THE COURT: Yes, Mr. Roberts.
THE WITNESS: All right. Thank you.

BY MR. ROBERTS:

Q Okay. Could you go through and just give a brief overview of the opinions you formed in this matter that you're going to talk to the jury about today?

A Sure. I mean, the first one is obviously, you know, Mr. Eskew's stage four non-small cell lung cancer. And, you know, unfortunately he was diagnosed with a pathological fracture when he was playing golf and that's how they -- his treating physicians discovered he had a non-small cell lung cancer of his right upper lobe. So I'll talk about what that means in terms of having a stage four non-small cell lung cancer and the prognosis for that.

And then the use of IMRT certainly did not cause any side effects that would have also been caused by proton beam radiation therapy. And it was totally completely appropriate to use IMRT for Mr. Eskew. The --

Q And one of the things that, you know, we've seen in the pre-instructions is the jury's going to have to decide whether or not the denial of preauthorization for proton beam therapy caused the damages to Mr. Eskew. Are you here to assist the jury in deciding that question?

A Yes, I am. The third opinion is that there's no evidence that Mr. Eskew had grade three esophagitis and we'll certainly talk about that. And the fourth one is that, you know, proton beam radiation therapy was not indicated for Mr. Eskew.

Q Okay. Let's go step by step in detail for each of these four opinions, okay?

A Sure.

MR. ROBERTS: Audra, can we have the next slide, please?

BY MR. ROBERTS:

Q Okay. Let's -- well, we can see this a record from -- cited in your report, but this is from the Comprehensive Cancer Center here in Nevada. The date of diagnosis was shortly after he broke his arm playing golf. What was the stage at the first time Mr. Eskew's cancer was diagnosed?

A He's diagnosed with stage four non-small cell lung cancer. And stage four in this case means that it's spread outside the lungs, and it had gone to his bone and that's why this was a stage four non-small cell lung cancer.

Q And on the scale of cancers, where does this fall?

A Well, this is the most advanced because the cancer had unfortunately metastasized from his lung to the bone.

Q And does the National Cancer Society cite survival rates by stage at diagnosis?

A Yeah. And I think what you're saying and maybe this is probably a slide that the jury is having a hard time seeing. But the American Cancer Society has survival outcomes at five years, meaning if you're diagnosed with this stage of cancer what is your chance of being alive at five years. It's called a five year survival.

And you probably can't read it, but I'll read for you. For lung and bronchus for all stages it's 19 percent. For local, meaning it's confined to the lungs it's about 57 percent. For regional, meaning it's gone to the

lymph nodes, it's gone from the lungs to the lymph nodes it's about 31 percent. And from distant, meaning it's spread outside the lungs it's five percent. So your chance of being alive at five years is five percent if you have stage four lung cancer.

Q And this is stage four diagnosis?

A That's correct.

Q So the jury's heard testimony about stage one, two, three and four cancers --

A Yes.

Q -- previously from another witness. How does this relate to those stages, local, regional and distant?

A So again, local is it's confined to the lung where it started. Regional is it's gone to the lymph nodes from the lungs. And distant is it's gone to like the bone and other parts of the body.

Q And is distant exactly the same or somehow different from stage four metastatic?

A Distant in this case means stage four.

Q And you said that this five percent for metastatic lung cancer stage four diagnosis, five percent of the people are still alive after five years?

A Overall, and I think that's being optimistic because unfortunately stage four non-small cell lung cancer is incurable, there's no cure for it.

Q And is there some other indication that you might look for to see if someone like Mr. Eskew would have been in this five percent out

of 100 percent who had a chance of survival of five years?

A I'm sorry, could you repeat that question?

Q Yes. Is there something else that you might look for --

MR. ROBERTS: And actually, Audra, can we go to the next slide?

BY MR. ROBERTS:

Q And I believe that you cited a study in your report?

A Yeah.

Q And --

A So I think -- and I see the question you're answering, thanks for the clarification. I -- look Mr. Eskew unfortunately not only did he have stage four lung cancer that had metastasized to his bone at diagnosis, you know, he was treated with chemotherapy right afterwards. He was --

MR. ROBERTS: Audra, could you blow up the nature of Mr. Eskew's cancer? Just that first third. So maybe people could read that more easily.

A So he was treated with, you know, what's called carboplatin has based chemotherapy for six cycles from essentially August of 2015 to December of 2015. Then he had another PET scan in January and that PET scan showed unfortunately that he did not respond to the chemotherapy. His disease was actually getting bigger. So that's called, you know, progressive disease, so you're failing the chemotherapy and that unfortunately is a very bad prognosis, and those patients tend to do the worst.

And so this trial that we referenced actually refers to patients just like Mr. Eskew who got a first line of chemotherapy, they didn't do well the disease continued to grow, continued to get bigger. So then you have to try to find some way of still helping those patients. So this clinical trial looked at a new drug combined with docetaxel that was experimental arm -- again this was a phase three randomized trial.

So the standard for those patients who failed carboplatin based chemotherapy is docetaxel. So here docetaxel is the control arm, and the experimental arm is this new drug Socometh [phonetic] with Docetaxel. And even in this trial it shows that patients only lived another 10 and a half months.

So in Mr. Eskew essential after, you know, he failed the chemotherapy and from the time he, you know, finished the radiation therapy he only live another 12 months, so. You know, that's why this trial is relevant because the patients in this trial were exactly like what Mr. Eskew was going through.

Q So based on your experience and study, did Mr. Eskew pass early from his cancer?

A No. And you know, unfortunately it was to be expected because patients who are diagnosed with stage four non-small cell lung cancer then who progress on chemotherapy they tend to have the worst prognosis.

MR. ROBERTS: Audra, can we have the next slide, please?

BY MR. ROBERTS:

Q So let's talk about your second opinion, the use of IMRT did

not cause side effects that would not have also been caused by proton beam therapy. And in discussing this just to summarize and remind you, we're going to look at the slide on dose volumes. Concurrent chemotherapy, therapeutical benefits versus clinical benefits. And then we're going to talk about ALARA as that relates to therapeutic ratio, okay?

A Yes.

MR. ROBERTS: Next slide, Audra. So if we can just blow up the first chart.

BY MR. ROBERTS:

Q But if we look here we see these are dose volumes -- labeled dose volumes from MD Anderson comparative study Pinnacle Planning. Where did you get these dose volumes from?

A This is from Dr. Liao's comparative dissymmetry plans.

Q And the Pinnacle Planning, what is that?

A That's the treatment planning system that used to generate these doses.

Q Are these actual doses that someone received in radiation or are these theoretical doses that are being estimated based on various types of treatment?

A Well, the IMRT mean dose is what Mr. Eskew actually received and for instance, 32.05 gray. The proton mean dose is what he would have received, 27.9 gray if he had undergone proton beam radiation.

Q Okay. And these numbers are numbers that were projected

by you or by Dr. Liao?

A Dr. Liao.

Q And then we see this third column here labeled constraint. What is the constraint?

A So constraint is the dose that you don't want to exceed because as long as you stay below the constraint then the -- whatever technology you're using to give the radiation therapy it's safe to do so.

Q So if you're under the constraint it's a safe dose of radiation based on the science and the study?

A That's correct. And it's important to know that these constraints, you know, are something that are arrived from the peer review literature generally, so the constraints tend to be similar throughout the country.

Q Let's look at the first constraint. This is 34 grays?

A Yes.

Q For the esophagus?

A That's correct.

Q Do you agree that 34 gray would be the constraint most commonly used in the industry?

A No. The constraint for the esophagus is actually much higher.

Q And what do the peer reviewed studies indicate is a safe dose of radiation for the esophagus?

A Yeah. It -- you know, you can actually go much higher for the whole esophagus even and -- but it's much higher than 34 gray.

Q Okay. But using the very conservative restraint imposed by Dr. Liao, did both the IMRT and the proton beam projections indicate that the dose was safe to the esophagus?

A Yes, it was.

Q So Dr. Liao's own projections show that dose from IMRT was safe?

A Yeah. Even with such a concentrative constraint estimate IMRT was still safe.

Q And this is important when we look at the next chart, but explain to the jury what mean dose means?

A So that's really the average dose for the whole organ. But you have to remember, you know, esophagus, you know, is a very long structure, so there's going to be portions of the esophagus that are going to get a dose that's lower than the 32 gray, there are going to be portions of the esophagus that are going to get a dose that are much higher than the 32 gray. Same thing with protons. In fact, with protons typically the maximum dose actually tends to be usually much higher than photons.

And so -- and that's because, you know, IMRT is composed of photons and what are photons? Photons are the light coming out of this ceiling, except it's high energy, and you can't see it and it penetrates the skin and causes DNA damage and that's how it kills tumor cells. Protons are actually particles that are coming out of a beam. So they're very different kinds of radiations and it's important to understand that.

MR. ROBERTS: So let's look at the next table, Audra.

BY MR. ROBERTS:

Q And this says, "max dose", both for IMRT and proton beam therapy, correct?

A Yes.

Q And what is the max dose?

A That's the maximum dose that's being delivered either by the IMRT plan or the proton beam plan.

Q So when you say max dose versus mean dose, does the whole esophagus get a max dose or just some portion of it?

A There -- some portions of the esophagus that are getting a much higher dose than the mean dose and that's a point dose. So here if you look at the comparison between IMRT and proton beam radiation the max dose with the proton beam is actually about six percent higher than it is with photons.

And you know, it's important really to appreciate that because the esophagus is a very fragile structure. Majority of the organs inside our body have an outer layer called a serosa, like the heart has the pericardium and it's -- pericardium is a sac that surrounds the heart, and it protects the heart. The esophagus doesn't have this outer serosa protective layer. So the esophagus is very prone to, you know, rupture. And in fact, the higher point maximum doses that you see with the protons can be quite harmful to a structure like the esophagus.

And unfortunately, you know, that's what happened with the former governor of Texas Ann Richards, she was actually treated with a proton beam radiation treatment at MD Anderson, and she experienced rupture of her esophagus which unfortunately lead to her death. So it's

important to appreciate that these maximum doses can have clinical significance.

Q So are these your calculations or are these from Dr. Liao's Pinnacle Planning program?

A This is Dr. Liao.

Q And is the constraint yours or Dr. Liao's?

A That's Dr. Liao's.

Q Do you agree that the peer reviewed literature would indicate a constraint of 80 grays for the maximum dose to the esophagus?

A Yeah. I'm not quite where she got that, but I can tell you -- I mean, you know, I would be very hesitant to push that kind of a constraint.

Q What do you think the constraint -- more conservative restraint on constraint would be?

A Well, you know, in terms of the hot spots, you know, I would try to significantly limit the hot spots because the esophagus is a very fragile structure.

Q Is there another thing the max dose is referred to in your profession?

A I'm sorry, I don't --

Q Is there another name for it?

A The maximally tolerated dose is another way of -- you know, but that usually refers to the whole organ. But there is another types of constraint doses that you can use called maximally tolerated dose and like for the spinal cord it's 45 gray typically, you know. If you stay below

45 gray you know you're going to be pretty safe.

Q So what's a point dose?

A Point dose is -- remember again with protons, you know, when you're giving radiation you're essentially depositing pockets of energy to cause DNA damage. So they're going to be -- and let's say -- you know, you heard of the expression, you know, you're using a let's say a BB gun to deliver the radiation. So they're going to be -- and you're coming from many different angles. So there are going to be some areas in your target volume in which the point -- the BB gun is going to hit at the same spot multiple number of times. So that point dose could be much higher than the rest of the area.

Q And what is a point dose?

A So point dose can be the dose at a single point and in this case the maximum point dose is a dose that is the most amount at a certain point.

Q And the jury's heard some testimony about Bragg peak.

A Yes.

Q Could you explain any correlation between the unique Bragg peak of proton beam radiation and the higher maximum dose and higher point dose received during proton beam therapy?

A Well, it's because of the Bragg peak that you get the higher maximum point doses. That's the physics of proton beam radiation, you can't alter that because the -- you know, the Bragg peak and, you know, hopefully the jury has seen what the Bragg peak looks like. But, you know, it has a low entrance dose, but then it has a much high maximum

point dose. And that's what leads to the dose -- the maximum dose being much higher with the protons than with IMRT.

Q And we're a little limited on our technology this morning, but what I'd like you to do is --

MR. ROBERTS: May I approach, Your Honor?

THE COURT: Yes you can.

BY MR. ROBERTS:

Q Is I'm going to give you a blank sheet of paper and I'm going to ask you to draw what the Bragg peak looks like.

A Okay.

Q And here's a --

A Okay. I --

Q -- a sharpie.

A Okay. So this is --

Q Thank you, Doctor. We'll be able to put this on the ELMO later. So Dr. Chang said that the Bragg peak was part of the physics that allowed a higher dose of radiation to be delivered to the tumor while minimizing the radiation delivered to adjacent structures. Do you agree with that?

A Generally.

Q Okay. And it's a good thing, right?

A Yes.

Q But is there also a bad thing about the Bragg peak and proton beam?

A Well, the bad thing is what you're seeing right there, the

maximum dose is much higher.

Q And is that a result of stacking Bragg peaks from protons coming in from different directions?

A That's exactly right because you're using multiple beams to get at the target volume and when you're using multiple -- you know, multiple beams, you know, they're stacking themselves on top this of this peak one after the next and that's what leads to that higher maximum dose.

Q So the maximum dose here from the proton beam is actually higher to a maximum -- closer to the maximum safe dose than IMRT that Mr. Eskew actually received?

A That's correct.

MR. ROBERTS: Let's go to the next slide, Audra. This one's harder to read, so we may try to --

BY MR. ROBERTS:

Q This is dose volume IMRT, where did this come from?

A This also came from Mr. Eskew's dose volume histogram.

Q And this was generated by MD Anderson and Dr. Liao?

A That's correct.

MR. ROBERTS: Audra, can you try to blow up the chart just starting with region and going down the 4.87 corner. Let's get this as big as we can here.

BY MR. ROBERTS:

Q So in this chart I see a column region, what's that?

A That's the area that's being targeted in case, you know, the --

you know, by the IMRT treatment plan.

Q And in this case are those critical adjacent structures to the tumors that are being treated?

A That's correct.

Q And what is the constraint?

A So constraint is the dose under which you want to stay because if you're under that dose then the radiation that's being delivered is safe.

Q Okay. And this is the same thing that we saw in the prior charts for constraint, right?

A That's correct.

Q And are these Dr. Liao's constraints or yours?

A These are Dr. Liao's. ZL approved is Dr. Liao approved.

Q Okay. And what is this ZL approved and why is it green?

A Well, it's green because green as you would suspect means it's a green light, you're good to go. So the IMRT plan met all the constraints, and it was safe.

Q Are these the projections of what Mr. Eskew would receive as far as amount of radiation to various structures with his IMRT treatment?

A That's correct.

Q And the max dose is the same as the max dose on the other pages?

A That's correct.

Q And what does this show as far as the safety of the IMRT that Dr. Liao prescribed for Mr. Eskew after the proton beam preauthorization

was denied?

A Well, it obviously shows that IMRT plan was very safe.

Q We saw in the previous chart max dose, mean dose for esophagus. There's a new one here. What is that new one V70 gray less than or equal to 20 percent?

A So V70 means the volume of the radiation in the esophagus that's getting 70 gray. And the constraint is it should be less than 20 percent. And here actually Mr. -- there was no portion of the esophagus for Mr. Eskew that was getting 70 gray or more, it was actually zero percent. So this was a very good IMRT plan.

Q And again, the projection that zero percent of Mr. Eskew's esophagus would receive more than 70 grays with IMRT, is that your number or Dr. Liao's number?

A That's Dr. Liao's number.

Q Okay. I'd like to go to the next slide and switch up a little bit and talk about the effect of the concurrent chemotherapy.

MR. ROBERTS: Can you blow up the top left hand portion?

BY MR. ROBERTS:

Q And this is from Mr. Eskew's records. Progress notes signed by Zhongxing Liao on March 1st, 2016 indicating, "The patient will receive concurrent chemo radiation to address their aggressive disease. Additional physician time and effort is anticipated to manage the increased acute toxicity resulting from concurrent chemo radiation".

So first, do you agree with Dr. Liao that you need to expect increase toxicity if you administer chemotherapy

concurrently with radiation therapy?

A Absolutely. I mean, this was the major culprit in causing Mr. Eskew's esophagitis, the use of concurrent chemotherapy with radiation. In fact, if you look at just the x-ray, the photon IMRT based literature and there's a meta-analysis that was done -- published in the Journal of Clinical Oncology, that's one of the reputable journals that we've talked about.

And the meta-analysis actually involved six randomized clinical trials and that meta-analysis showed that if you do concurrent versus sequential chemotherapy with radiation for lung cancer the incident of severe esophagitis increases from four percent with sequential to 18 percent with concurrent.

So it's almost five times higher with the use of concurrent chemotherapy versus sequential chemotherapy when you're not given the chemotherapy at the same time as the radiation.

Q So does people sometimes choose to administer sequential chemotherapy and radiation?

A Absolutely.

Q And that's when one follows the other, but you don't do them both at the same time?

A That's correct. In fact, when you think you have an elderly frail patient and you don't want to subject them to the increased toxicity because they may not be able to tolerate it well, that's a good time to do the sequential chemotherapy and the radiation.

Q Does this phenomenon of concurrent chemo radiation

increasing toxicity, is that just a photon problem or does that also occur when you use proton beams?

A It happens with every kind of radiation including protons.

Q And you mentioned a study.

MR. ROBERTS: Audra, could we -- let's see. The chart there at the bottom, table three.

BY MR. ROBERTS:

Q And is this a comparison of non-hematological toxicities between SPT and IMRT?

A Yes.

Q Okay. First, what's a non-hematological toxicity?

A So that's a toxicity that's not affecting your blood count.

Q Okay. And would esophagitis be an example of that?

A Yes.

Q And what is SPT?

A That's the scatter beam use of proton beam radiation.

Q Is that a newer or older type of proton technology?

A Well, that's probably more the older. You know, the pencil beam is the newer one.

MR. ROBERTS: So Audra could we go to the next slide? I think the doctor's put a few dashes. There we go.

BY MR. ROBERTS:

Q So this is that same table from that study, correct?

A That's correct.

Q And what does this show as far as the toxicity rates for IMRT

versus proton of grade three esophagitis?

A It actually shows that's higher. If you look at the grade three esophagitis rate with protons it's 17.6 percent, with IMRT it's 10 percent. So it's almost -- you know, it's 76 percent higher with protons than it is with IMRT for grade three esophagitis.

Q Let's back up a little bit. Is there a scientific explanation for why concurrent chemotherapy increases toxicity over just radiation alone?

A Yeah. Because, you know, chemotherapy sensitizes the effects of the radiation. So the idea behind giving the chemotherapy with the radiation at the same time is you're going to kill more DNA with using concurrent chemotherapy versus sequential with the radiation. Because radiation works by causing DNA damage. So if you put in the chemotherapy at the same time you're giving the radiation then you're going to cause DNA -- more DNA damage to more tumor cells.

So that's why you do it. But then the flip side they're also causing DNA damage to the surrounding normal cells and their DNA. So that's why you get more toxicity -- acute toxicity at the same time with normal tissue.

Q So now let's look at the fact that concurrent chemotherapy with proton beam radiation had a higher incidents of grade three esophagitis than concurrent therapy with IMRT. Is there a scientific explanation why the use of concurrent proton beam therapy might cause more grade three esophagitis?

A You know, it's an interesting phenomenon and, you know --

and they are many reports that have observed and shown that phenomenon. One reason could be that -- again, you have to understand the physical characteristics of proton beam radiation versus IMRT. Again, IMRT is like the photons coming out of this ceiling, like the light in this room. Protons are actually particles. So you're actually shooting particles at the patient's DNA and at their tumor. But at the same time you're shooting protons, particles in the normal surrounding normal tissue.

So there's a concept called the radiobiological effectiveness, RBE. And the radiobiological effectiveness of protons is actually much higher -- it's actually slightly higher than photons, IMRT. It's estimated to be 10 to 20 percent higher, minimum of at least 10 percent higher. So the good news is that when you're treating a patient with protons you're going to get more bang for your buck to the tumor for the same dose.

The bad news is you're still going to cause more normal tissue damage with protons than you would with IMRT because of the radiobiological equivalence, the RBE because the RBE for protons is about at least 10 percent higher than with IMRT.

Q Do you think this could also be related to the higher max dose someone receives with proton beam therapy?

A Well, absolutely, there's no doubt about that. I mean, that's the other reason. Especially with the severe toxicity that you tend to see, you'll see the -- you know, the peaks in the severe toxicity more with protons than with photons. And even Dr. Liao's own phase two randomized trials show that.

She did a phase two randomized trial that compared proton beam to IMRT in non-small cell lung cancer and the rate of pneumonitis, pneumonia was actually much higher in the proton beam arm than in the IMRT arm even though the normal lungs were getting less dose from the protons. So that's, you know -- you know, so that's not uncommon, you actually can see that with protons.

Q As part of your preparation to write your report and testify here today, did you review Mr. Eskew's medical records?

A Yes, I did.

Q Did you see an indication in those records that Mr. Eskew suffered from grade three esophagitis?

A Never saw grade three esophagitis anywhere.

Q What about grade two esophagitis which is also on this chart?

A Yeah. And as you can see grade two esophagitis rate was actually --

Q Did you see an indication that Mr. Eskew was diagnosed with grade two esophagitis?

A Yes.

Q Okay. And when was that in the course of his treatment?

A That was during the course of the radiation therapy. And if I remember correctly it was a little bit more than halfway into his radiation therapy because up around 3200 centigray, something like that he had no esophagitis at all. Then he developed grade one, then it progressed to grade two. But that was the worse that it ever got was grade two

esophagitis.

Q And that was while he was at MD Anderson?

A While he was at MD Anderson getting the IMRT with the concurrent chemotherapy.

Q Okay. So now let's look at what the studies showed for the incidents of grade two esophagitis with concurrent chemotherapy plus protons and with concurrent chemotherapy plus IMRT. What was the incidents? t's much higher for grade two, right?

A Yeah. I mean, it's much higher, but then you remember, you know, grade two is the patient is moderately symptomatic, they're having some difficulty swallowing. But there's -- you know, they're still doing fine, but they need some help. And so here for IMRT it was 43.3 percent versus 47.1 percent for protons, so slightly higher with protons.

Q And even though the incidents is slightly higher for both grade three and grade two esophagitis with concurrent chemotherapy and proton beam, does that -- when the numbers are a little higher in the studies does that always make a difference to you clinically?

A No. It doesn't. In fact, here if you look at the statistical comparison they're similar. The P value here is 0.6 meaning they're not significant, they're similar and that's what we would see clinically, you know.

MR. ROBERTS: So Audra, could you go to the next page, the conclusion of the authors?

BY MR. ROBERTS:

Q I believe you put that in a slide for us, sir. And this is a

conclusion from that study that we've been referencing with the chart, right?

A Yes.

Q And what was the author's conclusion?

A Well, the conclusions were, and I think -- and again Dr. Liao saw the same phenomenon in her phase two randomized trial. Even though the dose to the normal organs was lower with protons, you know, the -- it didn't necessarily lead to reduction in toxicity. In fact, what we saw in the previous table the toxicity, the rate of grade three and grade two esophagitis was actually slightly higher with protons than with IMRT.

Q So just like this study that Dr. Liao did for Mr. Eskew where the projections, the Pinnacle Planning showed a lower dose to the esophagus, when the treatment occurred no benefit was shown from that lower dose?

A That is correct.

Q And that was with toxicity rate?

A That's correct.

Q And what about improved survival?

A Well, I mean, that answer is very clear, there have been no phase three randomized trials that have ever shown a benefit to using protons over IMRT or photons.

Q Thank you, Doctor.

THE COURT: Ladies and gentlemen, we're going to take a 15 minute recess.

You are instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You're not to read, watch or listen to any report of or commentary on the trial by any person connected with the case or by any medium of information including without limitation newspapers, television, the 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 this trial until the case is finally submitted to you.

We'll return at 10:45.

THE MARSHAL: All rise for the jury.

[Jury out at 10:29 p.m.]

THE COURT: Counsel, any issues outside the presence of the jury?

MR. ROBERTS: Nothing for us, Your Honor.

MR. TERRY: No, Your Honor.

THE COURT: Thank you. So we'll see you back in 15 minutes.

MR. ROBERTS: Thank you, Your Honor.

[Recess taken from 10:30 a.m. to 10:45 a.m.]

THE MARSHAL: Department 4 come to order. Back on the record.

THE COURT: Thank you. Please be seated. Are the parties ready for the jury?

MR. TERRY: Yes, Your Honor.

THE COURT: Mr. Roberts?

MR. ROBERTS: Yes, Your Honor.

THE COURT: Thank you.

Mr. Roberts, what deposition were you doing today?

MR. SHARP: Amogawin.

THE COURT: What's that?

MR. SHARP: Amogawin if we get to that.

THE COURT: Amogawin.

MR. ROBERTS: We have a deposition of Mr. Palmer, which is a video deposition that we're going to play if we have a TV that we can display it on.

THE COURT: Okay.

MR. ROBERTS: And then we wanted to do a read in of Lou Ann Amogawin.

THE COURT: Okay.

MR. ROBERTS: She's in California.

THE MARSHAL: All rise for the jury.

THE COURT: Thank you.

[Jury in at 10:46 a.m.]

THE MARSHAL: All jurors are present.

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

MR. TERRY: Yes, Your Honor.

MR. ROBERTS: Yes, Your Honor.

THE COURT: Thank you. Mr. Roberts, please proceed.

MR. ROBERTS: Thank you, Your Honor.

BY MR. ROBERTS:

Q Doctor. Okay. So let's transition to your next opinion. We just reviewed a study in Zhen Wei Zou. Is that how you pronounce that?

A Yes.

Q By Zhen Wei Zou, which shows that even the dose volumes for proton were projected to be lower than IMRT. It made no difference in outcome, right?

A That is correct.

Q Okay. So let's go to the next slide. And you've titled this slide theoretical benefits versus clinical outcome, what does that mean?

A Well, essentially this is an evolution of the analysis of how proton beam radiation has evolved from over a decade, from 2008 to 2018. And as you can see, you know, we're still waiting for that -- you know, that phase three randomized trial that shows that protons are better than photons, than IMRT and that has yet to happen.

Q Do you agree that when it comes to toxicity of adjacent organs proton beam therapy has theoretical advantages?

A Potential theoretical advantages as we've discussed. You

can potentially lower the mean doses to the surrounding critical organs, but we also talk about the other aspects of protons where the maximum dose to the surrounding critical organs is usually higher with protons than with IMRT. So there's also that other side of protons as well.

Q And in a way that's theoretical too, right? The higher max dose or higher point dose.

A Well, it is theoretical, but then you would actually see it in patients as well if you were to give the protons.

MR. ROBERTS: Audra, could blow up the title of the article and the conclusions on the left hand side of the page?

BY MR. ROBERTS:

Q Is this an article which you reviewed and supplied to us by, is it Widesott?

A Yes.

Q And this from what years?

A This is from 2008.

Q So what was the conclusion of Widesott in 2008 with regard to proton beam therapy and its theoretical advantages?

A Well, it was essentially looking at the technical aspects of protons and indicated that there are theoretical advantages and the dose distribution delivery of protons.

Q And what -- could review the rest of his conclusions?

A Yeah. Sure I'm happy to read it.

"The use of proton beam therapy in non-small cell lung cancer is mainly based on theoretical advantages and dose distribution. Little

clinical data are available in terms of the number of institutions involved. The number of treated patients and quality of studies conducted, i.e., lack of randomized control trials making it impossible to draw definitive conclusions about its efficacy."

Q Was this an outlier or was this the consensus in the medical community with regard to proton therapy in lung cancer as opposed to other types of cancers?

A This was a systematic review, so it's important to know that. This would meet the higher standard of peer review literature.

Q Is that the same thing as a meta-analysis?

A That's correct.

Q And let's ask you to move forward to 2016. Had the consensus in the medical between change between 2008 and 2016?

A No. It had not.

MR. ROBERTS: Audra, can you pull up the right hand side of the page?

THE WITNESS: And we know it hadn't. I mean, we know that, you know, the Comprehensive Cancer centers here, you know, they have -- you know, where Mr. Eskew was treated. I mean, they use IMRT, but they don't have the capability of protons.

BY MR. ROBERTS:

Q And you also included in your report a letter to the editor from Dr. Liao that was published in the Journal of Clinical Oncology in 2018, and the jury's already seen this. Why did you include this in your report, sir?

A Well, I think it's important to know how things have evolved over a decade, over a ten year period.

Q And where Dr. Liao says, At the end that her closing remarks shed light on the prospects for future randomized studies to one day measure the clinical advantages of proton therapy, which have remained largely theoretical although progress is being made". Do you agree that the benefits of proton therapy were still largely theoretical in 2018?

A That's correct. And this was actually a commentary, just to be clear about Liao's article.

MR. ROBERTS: Court's indulgence just for a second, I lost my spot.

THE COURT: Of course, Mr. Roberts.

MR. ROBERTS: Just a second. Okay. Could we go to the next slide, Audra?

BY MR. ROBERTS:

Q So you stated you reviewed Mr. Eskew's medical records, correct?

A Yes.

MR. ROBERTS: And if we could blow up the bottom right hand side of the screen.

BY MR. ROBERTS:

Q Mr. Eskew's medical records indicate at MD Anderson, "He is in clinic today for staging and discussion of consolidated XRT possibly in the oligometastatic trial. Patient is not eligible for ending protocol due to his stage four status. He has been consented for radiation therapy and

simulation is to be arranged for tomorrow". Could you interpret this note for us from a medical standpoint?

A Sure. Due to Mr. Eskew's stage four non-small cell lung cancer, especially with progressive disease I suspect that he was not eligible for one of their trials looking at proton beam radiation therapy in non-small cell lung cancer. And if that trial was RTOG1308 it would explicitly exclude patients with stage four disease.

Q And why do clinical trials exclude people with stage four disease?

A Well, unfortunately, you know, again their life expectancy is very limited, they tend to have incurable disease and their not likely to see any benefits being -- from being enrolled in such a clinical trial. I mean, if you're going to put a patient in a clinical trial, you know, you have to get informed consent from the patient and in that informed consent you have to be able to tell the patient what is the benefit of going into that clinical trial. But if you have stage four disease you're not likely to see any benefits because of your expected limited short life span.

MR. ROBERTS: Could we go up to the top left, Audra?

BY MR. ROBERTS:

Q And in doing your investigation for your report did you look to see if Dr. Liao was doing a clinical trial that sounded like the one you found in the medical records?

A Yeah. In fact she's currently the principal investigator of an ongoing clinical trial, RTOG1308. This is a very important clinical trial.

MR. ROBERTS: And Audra, can you go -- release that and go back and just try to blow up the summary so we can get that as big as possible? Little letters. There you go. Thanks, Audra.

BY MR. ROBERTS:

Q And what was RTOG1308?

A So this is a clinical trial. So 13 stands for the year 2013. 08 is the trail. And RTOG is the Radiation Therapy Oncology Group. And this is a randomized clinical trial that is evaluating the comparison between using proton beam radiation therapy with IMRT in stage two and three non-small lung cell lung cancer.

Now RTOG it's important to know and it's -- they've changed the name of the group, it's part of NRG now. But RTOG at that time was a standalone cooperative group funded by the NCI. So this is an NCI sponsored clinical trial. And one of the trials that I did RTOG was -- it was RTOG9615 in head and neck cancer. It was a similar trial in head and neck cancer.

So -- but this trial is currently looking to see if -- comparing protons to IMRT to see if protons are better than IMRT or worse, we don't know until we complete the randomized trial for patients with stage two and three non-small cell lung cancer.

Q And the summary for RTOG1308 the principal investigator Dr. Liao, what is the last sentence in that summary?

A It states that, "It is not yet known whether proton chemoradiotherapy is more effective than photon chemoradiotherapy, photon meaning IMRT in treating non-small cell lung cancer".

Q Do you agree with her conclusion?

A Absolutely.

MR. ROBERTS: Audra, could we have the next slide?

BY MR. ROBERTS:

Q The jury heard a lot about ALARA from the Plaintiffs' experts, did you listen to that?

A Yes, I did.

Q What does ALARA stand for?

A ALARA stands for as low as reasonably achievable.

Q Is ALARA a principle you used in treating patients with therapeutic radiation?

A No. It's not. And I think it's very important to understand the concept behind ALARA. In order to understand that you really have to begin the history of how ALARA was established.

ALARA was established 1954 by the national council on radiation protection and measurements in response to the atomic bombings on Hiroshima and Nagasaki. And ALARA is intended to protect -- it's a radiation protection principle, so it's intended to protect the safety of workers who are involved in the care of patients receiving radiation therapy. ALARA is not a radiation delivery concept. Now that's different than the therapeutic ratio. So that's ALARA.

Q And how is the therapeutic ratio different from ALARA?

A Well, the therapeutic ratio is what we use when we are treating patients with radiation therapy. And the objective of the therapeutic ratio is to deliver the highest possible maximum dose to the

tumor and to limit the radiation dose to the surrounding critical organs to a safe dose, to below the maximally tolerated dose.

Q Okay. So below the constraint listed in the charts?

A Yeah. Below the nationally accepted constraints.

Q And based on your review did the IMRT received by Mr. Eskew have a safe dose to his surrounding organs including the esophagus?

A Well, look you don't have to take my opinion for it, I mean, Dr. Liao's own plan confirmed that the IMRT that she gave to Mr. Eskew was safe and it was well below the constraint doses that she established for ionizing radiation.

Q But if you look at her plans for proton beam they showed a lower mean dose than the IMRT, right?

A That's correct.

Q And isn't a lower mean dose always better?

A Well, we've seen from the literature here today, and again don't take my opinion on for it just because you have a lower dose than IMRT that doesn't necessarily translate into a lower rate of toxicity. We saw that with esophagitis here and they may be due to, you know, maybe you're using concurrent chemotherapy or maybe the radiobiological effectiveness, which is higher for protons than it is for photons could also -- could be potential explanations for that.

So just because you have a lower dose to the surrounding critical organs that doesn't necessarily mean that you're going to have lower toxicity rates.

Q And including other reasons that could have to do with the Bragg peak, the higher point dose and the -- what was that the bio?

A Well, the radio -- the RBE, the radiobiological effectiveness. And again, I think inherently if you look at the characteristics of the proton beam the maximum dose always tends to be higher than that of IMRT. So that again could be another reason why that point maximum dose within the normal surrounding critical organs is also leading to, you know, high rates of toxicity sometimes.

Q So in the medical community do you rely on theoretical benefits, or do you do studies?

A Well, you rely not only on studies, but rely on historical experience. I mean, you have to understand that, you know, with IMRT, you know, it's photon based radiation and we've been giving photon based radiation ever since we developed the concept of using radiation to treat cancers. And so we have a lot of historical experience, decade's worth of historical experience with IMRT. You know, we began a long time ago with 2D radiation, evolved to 3D radiation, then to IMRT. So not only do you rely on the literature, but you know that it's safe because the entire world does it.

Q And, you know, that's an interesting point. Is there a difference in the types of studies that we need to determine if IMRT was safe and effective versus a new technology for lung cancer like proton beam therapy?

A Yeah. You absolutely need randomized evidence because when you compare 2D, to 3D, to IMRT its all photon based radiation and

it's an evolution of the delivery of photon based radiation. But now when you're looking at protons, that's a totally different way of delivering ionizing radiation, you know, it's particulate radiation. So you're comparing particle radiation with light radiation, photon radiation. And so that absolutely requires a phase three randomized evidence to show whether it's better or not.

MR. ROBERTS: Let's move to the next slide, Audra.

BY MR. ROBERTS:

Q And this is opinion three. You wrote, "The records do not support the alleged grade three esophagitis opinion." And I believe you told the jury before you looked at the medical records at MD Anderson and you saw a diagnosis of grade two esophagitis. Can you go through the top line of that and put it into context for us?

A Yeah. So just from my recollection Mr. Eskew underwent radiation from about February to March of 2016 and during that time initially he didn't experience any esophagitis at all, and it was when he was more than halfway into the chemoradiation therapy treatments that he began to experience some grade one esophagitis, which eventually progressed to grade two esophagitis. And that's what's noted in the medical records. The most severe esophagitis that he experienced in the medical records was grade two.

Q Now Dr. Chang compared that initially type of esophagitis during treatment to a sunburn, do you agree with that?

A Yeah. I mean, there are three phases to radiation side effects. You have the acute phase which happens during treatment, then

a couple weeks after.

Q And that's say the sunburn?

A Yes.

Q Okay.

A And then you have subacute phase which is up to maybe four to six months afterwards. And then you have the potential for a, what are called chronic side effects or chronic complications and that's usually four to six months. So there are three different phases acute, subacute and chronic.

Q So based on your review of the records the grade two esophagitis, which was that?

A So that was acute.

Q And what symptoms was he complaining about based on the medical records at MD Anderson during the time period where he was diagnosed with grade two acute esophagitis?

A He was having difficulty swallowing.

Q And does the record indicate that he continued to decline from there or did he do better?

A Yeah, it's interesting. So if you look at his weight history, which I think is very important. Before he began the radiation therapy treatments he was approximately, you know, 187,190 pounds.

Q Okay. So February 10th, that was I believe the day before the radiation treatment?

A Yes.

Q And this an excerpt that you got from the medical records,

correct?

A Yes.

Q And so 85.2, what is that?

A That's kilograms, so approximately 188 pounds.

Q Okay. And that was before he started getting the radiation?

A That's correct.

Q Okay.

MR. ROBERTS: Thank you, Audra. And then let's blow up the encounter date 5/4/2016.

BY MR. ROBERTS:

Q What does this show, Doctor?

A Yeah. So it showed -- now this is well after he finished the radiation. Now if I remember correctly when he finished the radiation therapy treatments he was approximately -- he went from 188 to the last day of the radiation around there his weight was around 180 pounds. But then he continued to lose weight after the radiation, that's the subacute phase. And so May 4th, so that's March, about six weeks after he finished the radiation, you know, he was still, you know, losing weight and recovering from his acute side effects.

Q And do you agree with the record that he had lost a total of about 30 pounds from 188 down to the 158?

A That seems correct.

Q And would that be an uncommon side effect for someone receiving concurrent chemotherapy and radiation of the doses that were being administered at MD Anderson?

A It would not be uncommon at all. Unfortunately, you know, you've got the chemotherapy with the radiation, and this is not unusual to see that kind of a weight loss.

Q And he got 30 fractions and he started about February 11, so how long would his treatment have gone?

A About six weeks.

Q So his treatment as you said had been completed for some time by May 4th, right?

A That's correct.

Q And is there any indication he's already started to recover?

A Yeah. If I remember correctly by the time he got to October 2016 he was back at I believe 180 pounds, or 190 pounds there you go. So he was back to his baseline weight.

MR. ROBERTS: And go back to the other slide.

BY MR. ROBERTS:

Q It says he's gained 20 to 15 pounds the past three weeks. Is that an unusual amount of weight gain in your opinion?

A Well, you know, so Mr. Eskew I suspect had gone through a long period where he was having swallowing difficulty and -- but now he's recovered from all of that. So he's recovered now. What's important to know here is he's fully recovered from his esophagitis. And you know, if you hadn't been able to eat well for like four or five months and, you know, I'm sure you're now ready to chow down on whatever you can get ahold of and that's what he was probably doing, so that's not unusual.

Q And the note, "Energy is improving also. He is back to working as a supervisor at his own car shop", is that also from the same medical record?

A Yes.

MR. ROBERTS: Now let's talk about the bottom half of the slide, starting with November hospitalization, Audra.

BY MR. ROBERTS:

Q The jury's heard about the November hospitalization, was that effected at all -- related at all to esophagitis?

A No. It wasn't.

Q And what did your study of the medical records see there?

A Well, if I remember correctly, you know, he was going through quite a lot at that time. He -- having -- was having some difficulty with his humeral pathological fracture that needed revision. He had developed an osteomyelitis, so he had an infection. So he essentially had sepsis at that time. He was on heavy duty antibiotics. He was also getting immunotherapy at that time. He was getting Keytruda, which is a heavy duty chemotherapy agent that has a lot of side effects including nausea and vomiting.

So he's going through quite a lot at this time. You know, the immunotherapy, the sepsis as well as heavy duty antibiotics that also have their own side effects.

Q Dr. Chang told the jury that he believed that Mr. Eskew was suffering from grade three esophagitis during his November 15th, 2016 hospitalization because of the use of TPN during that hospitalization, do

you recall hearing that?

A Yes, I do.

Q And do you agree?

A I totally completely disagree.

Q What's TPN?

A Total parenteral nutrition.

Q Okay. And describe what that is for the jury?

A Well, this is where you use an IV to give nutritional liquids to the patient because they're not eating. An intravenous injection.

Q Based on your review of the medical records was TPN administered because of esophagitis and related swallowing complaints?

A There's no evidence in the medical records that was he was experiencing esophagitis. Now remember a month early he had totally completely fully recovered from his esophagitis. And so I don't understand how after -- and also remember in that timeframe he finished his radiation more than six months ago and esophagitis is an acute side effect of radiation.

So you finished your radiation at the end of March and now you're fully recovered by October because your weight is back to normal, you're eating well, you're back to taking care -- back to -- fully back to work. So how do you now get esophagitis a month later when you finished your radiation six months ago and you were eating perfectly fine more than a month ago?

Q Dr. Chang said that the initial swallowing problems at MD Anderson were caused by that acute sunburn phase, it got better, but

then the scar tissue started to form, and it was a chronic esophagitis caused by the scar tissue that has now surfaced in November. Do you agree with that?

A I disagree with that.

Q Why?

A There's no evidence of that in the medical record. I mean, I think -- you know, we practice today what we call evidence based medicine. And evidence based medicine means that you arrive at conclusions based on evidence. I wasn't there taking care of Mr. Eskew, neither was Dr. Chang or anyone else. He was being taken care of here in Las Vegas, so the treating physicians knew what was going on with him and there's no evidence in the -- in their medical records that he was experiencing or suffering from esophagitis.

Q Would TPN have been appropriate for any other condition in the medical records?

A Oh absolutely. He was on -- he wasn't eating, he wasn't -- you know, he was on the Keytruda chemotherapy. And he was also again, was experiencing sepsis, so he's not feeling well. And he's also on heavy duty antibiotics. Those are all reasons that could have caused Mr. Eskew to not want to eat.

And unfortunately also I think we learned later on when we repeated the PET imaging, because remember there was a PET scan prior to that, his disease continued to progress. He had developed left adrenal metastases in the summer --

Q What -- explain what that is?

A So you have these glands called the adrenal glands and it's a very bad sign when your cancer goes to the adrenal glands. It's kind of like your approaching end stage.

So in that summer when had -- the summer of 2016 when he had the PET scan his tumor had gone to the adrenal gland. And there were suspicious areas in the January 2016 PET scan that maybe showed some suspicious lesions in the left hip. And the PET scan done during the summer of 2016 confirmed that those suspicious areas were actually real. So his disease was progressing.

So now, you know, we call this state cachexia, you know, where the tumor kind of begins to take over your bodily functions and unfortunately you, you know, deteriorate and you go downhill. So cachexia could be another reason where he just didn't feel like eating.

Q So in addition to the initial metastasis to the arm that was broken during golf to the later identify spreading to the hips and the adrenal glands, was there any other indication of it spreading throughout his body?

A Yeah. You know, in the January PET scan he also had metastatic disease to his right rib cage as well.

Q And what about to his shoulder socket?

A Yes, that also. So you know, unfortunately the disease is progressing to many other parts of his body.

Q The symptoms that the family reported; nausea, vomiting and the beginning of new weight loss, are those also known side effects of other conditions he had at this point other than assuming it was

esophagitis?

A Oh absolutely. I mean, Keytruda the immunotherapy that he was getting is well known to cause nausea and vomiting.

Q What was the immunotherapy he was getting?

A It's Keytruda, K-E-Y-T-R-U-D-A, I believe that's how it's spelt.

Q And what does that do?

A It's an immunotherapy agent that you use in this kind of a situation where the patient has progressed through multiple chemotherapy regimens and he's not responding.

Q What does an immunotherapy agent do?

A The immunotherapy agent is designed to essentially help your immune system attack the cancer cells.

Q Was it working?

A Unfortunately not.

MR. ROBERTS: You can go to the next slide, Audra.

BY MR. ROBERTS:

Q So the last opinion, opinion four that proton beam therapy was not indicated for Mr. Eskew. Is that based on all the things you've discussed with the jury so far this morning?

A Yes, it is.

Q And could you explain just quickly summarize why you don't believe that proton beam therapy was indicated for Mr. Eskew in February 2016?

A Yeah. So I think it's very important to understand, you know, Mr. Eskew's disease and the situation that he was in when he was

diagnosed. You know, he was diagnosed with a right upper lobe lung cancer that had metastasized to his bone. And he was given six cycles of chemotherapy from August to December of 2015, and he progressed during that chemotherapy. By the time he saw Dr. Liao he was progressing on chemotherapy.

So it didn't really matter how, you know, you addressed the right upper lobe lesion. He had -- his disease was progressing to other parts of his body and unfortunately despite chemotherapy his prognosis was actually very bad. And he -- I mean, most stage four disease is incurable, we know that 95 percent is incurable. He was even in a worse situation because he was progressing on chemotherapy.

So it didn't really matter what you did locally to his right upper lobe tumor because even if you remove that, if you got rid of it with radiation he was going to still progress. He had already progressed to other sites. And so -- and I'm sorry, go ahead.

Q I was going to just ask you to address Dr. Chang's viewpoint that he told the jury is that if you had to have it because the tumors in the chest were so close to the esophagus they were in danger of spreading into the esophagus and rupturing it.

A Yeah. Well, actually I disagree with that because they had metastasized to his lymph nodes, but the lymph nodes were moderately -- they were moderate in size, they were not huge. And remember the lymph nodes are still being treated with the chemotherapy. And so I think the goal here is to make Mr. Eskew as comfortable as possible to make sure that he has a high quality of life with whatever treatment you

chose to do so. Remember the first rule of being a physician is do no harm.

So -- I mean, I probably would have taken a very different approach in managing Mr. Eskew. I would have given him a very short course of radiation therapy to his lung cancer to limit the side effects. I certainly wouldn't have treated him with concurrent chemotherapy and radiation because that only exacerbates the side effects and that's why he developed the esophagitis.

And certainly we know that even in locally advanced disease that's not metastatic, that's not stage four, there's no role for proton beam based on the science literature. Because if there was a role for proton beam radiation in non-small cell lung cancer then Dr. Liao wouldn't be heading up a clinical trial comparing proton beams to IMRT in locally advanced non-small cell lung cancer if it was already proven that is was better than IMRT.

So I think certainly proton beam radiation therapy was not indicated for Mr. Eskew because it certainly didn't have any scientific evidence that it was better than IMRT. And what we've seen from the evidence today just because you're delivering lower doses to the surrounding critical organs that doesn't necessarily mean that you're going to have lower side effects. In fact, with proton beams because the point doses can be higher you can actually have a higher rate of acute side effects including esophagitis.

Q Did the use of the IMRT by MD Anderson in conjunction with his chemotherapy instead of proton beam in conjunction with

chemotherapy cause any of the side effects Mr. Eskew suffered including the grade two esophagitis that he was reported to have at MD Anderson?

A I don't think it really would have mattered whether you used IMRT or proton beam. You still -- Mr. Eskew -- because they were using concurrent chemotherapy with the radiation he still would have experienced the grade two side effects, number one.

Number two, they were going -- they were treating him with very high doses of radiation, 6,000 centigray. You know, I probably wouldn't have done that. I would have used much lower doses of radiation to limit the side effects. Remember Mr. Eskew got up to about 3,200 centigray more than half of his radiation dose without having any esophagitis. So theoretically you could counter -- if you would have stopped there he would have never had any esophagitis with IMRT.

Q What about the November hospitalization, was that caused by the use of IMRT instead of proton beam therapy?

A It had nothing to do with radiation period.

Q Thank you, Doctor. I appreciate your time.

A Sure.

MR. ROBERTS: I'll pass the witness.

THE COURT: Thank you, Mr. Roberts. Mr. Terry?

MR. TERRY: Your Honor, may I proceed?

THE COURT: Yes, Mr. Terry.

MR. TERRY: Thank you.

CROSS-EXAMINATION

BY MR. TERRY:

Q Hello, Dr. Kumar.
A Good morning.
Q You and I have never met before today, right?
A That is correct.
Q And as Mr. Roberts pointed out, you've been hired by UnitedHealthcare or Sierra Health and Life in this case to serve as an expert witness on their behalf, right?
A Well, I've been hired by their firm.
Q Well, you know you're working for Sierra though at the end of the day, right?
A You know, I was hired -- I was contacted by Mr. Ryan Gormley.
Q Yeah.
A And to serve as an expert witness on this case.
Q Is Ryan Gormley writing the checks for 60 some thousand bucks that you've made so far or is UnitedHealthcare?
A You'll need to ask Mr. Gormley where he's getting the money.
Q Did they come from the lawyers, or did they come from UnitedHealthcare?
A It came from the attorneys.
Q Okay. Where do you think it comes from?
A I don't know; I'm not going to speculate.
Q Okay. You just -- you don't know, okay. All right. So you're charging 800 bucks an hour for your testimony, right?

A That's correct.
Q And up until the last few days you had worked something like 80 hours on this case?
A Something like that.
Q Within the last few days I assume you've been gearing up to come give your presentation here today, right?
A That's correct.
Q And did you meet with the lawyers for that purpose?
A Yes.
Q How long did you spend preparing for trial?
A Well, we met for about three hours on Sunday, and we met for about two to three hours yesterday evening.
Q Okay. Any phone calls on top of that?
A No.
Q Zoom calls?
A We had a Zoom call last night.
Q Okay. How long did that last?
A About three hours.
Q Three hours, okay. So yesterday evening after court you had a three hour Zoom call?
A That's correct.
Q All right. So all together what'd you say -- what does that work out to be all together preparing for your testimony here?
A Well, between Sunday and Monday evening about six hours.
Q Okay. So a total of 86 hours or so, so you're looking at

something near 70 grand?

A I don't know. I mean, you know.

Q You're a mathematician guy.

A Yeah. So repeat the numbers.

Q So 86 hours -- well, let's do it this way, 80 hours times 800 bucks an hour is $64,000 plus another 8 hours at $800 is another $6400. So you're a little over 70 grand I think.

A Something like that.

Q Okay. So you said -- you told Mr. Roberts in direct that you had never consulted with UnitedHealthcare before?

A That's correct.

Q Or how about Sierra Health and Life?

A Never.

Q How about this law firm?

A Never.

Q Okay. So the first time you had ever met any of these folks was in this case?

A That's correct.

Q Okay. All right. And you said to Mr. Roberts that you accepted this case because it had a lot of validity to it, right?

A Yes.

Q In other words the position of UnitedHealthcare had a lot of validity to it?

A You'll have to ask them what their position is. I looked at the merits of this case based on the medical records.

Q Okay.
A And --
Q So what was valid about it?
A Valid was I don't think that proton beam radiation therapy is indicated for a patient with stage 4 non-small cell lung cancer with progressive disease.
Q And so you feel comfortable coming in here to this courtroom and giving that testimony in light of the medical evidence, and the people involved in generating the medical evidence in this case?
A Well, the medical evidence we've actually shown in our presentation.
Q Well, "we" or "you"?
A Me --
Q Did you make that presentation, or did these guys make that presentation?
A We worked on the presentation together.
Q Did you make it, or did they make it?
A They made it, and I modified it.
Q Okay. So you said, "we've shown the medical evidence." What I asked you, was, you're comfortable coming in here to give this testimony that you've given us here today, in light of the fact of who was the treating physician?
A Dr. Liao.
Q Yeah. You're comfortable, given your testimony, in light of the fact that Dr. Zhongxing Liao was the treating physician in this case?

A Yes.
Q And that she works at MD Anderson?
A Yes.
Q All right. We'll come back to that in a minute. You're also comfortable giving your opinion in this case about a patient that you never laid eyes on, right?
A That's true for Dr. Chang, as well, he never laid eyes on this patient and he gave an expert witness, and so I'm in the same situation as Dr. Chang. Yes.
Q Dr. Kumar, we're going to be a long time if you don't just answer my questions. I asked you a simple question. You are comfortable coming into this courtroom and giving the testimony that you've given today with your light show over here, even though you never laid eyes on Bill Eskew, right?
A That's correct, and the same is true --
Q Okay. Thank you.
A -- for Chang.
Q Thank you, Dr. Kumar.
MR. TERRY: Your Honor, can I get the witness to answer the question, and just answer the question, please?
THE COURT: Your attorney will have an opportunity to clarify the issues, Doctor.
THE WITNESS: Okay. Thank you.
BY MR. TERRY:
Q Okay. So it sounds to me like -- well, let me just ask you a

specific thing. Mr. Roberts asked you something about this, but you wrote a written report in this case, remember?

A Yes.

Q A couple of them, actually.

A A rebuttal report.

Q Right. So two reports?

A Yes.

Q In either of those reports did you ever write down, "I have never treated a single person with proton therapy"?

A No.

Q The first time you've told us that in this case is right here today, right?

A That's correct.

Q Okay. So the truth is, that you have, in all your years of treatment of patients and work in radiation oncology, never prescribed proton therapy for one single patient?

A That's correct, and neither have 99 percent of the other radiation oncologists in this country.

Q Okay. But you're here to tell us -- I mean, 99 percent of the other radiation oncologists in the country aren't sitting on that witness stand as an expert witness in a case involving proton therapy, are they?

A No, they're not.

Q But you are, given the fact that you have never treated one patient with proton therapy, right?

A That's correct.

Q All right. And you're comfortable with that?

A Yes. And the reason I haven't treated patients with proton radiation is because --

MR. TERRY: Your Honor --

THE COURT: Hold on.

THE WITNESS: -- I don't think it's safe to --

THE COURT: Don't. No, Mr. Terry. Do not interrupt the witness.

Counsel, will you approach.

MR. TERRY: Yes, Your Honor.

[Sidebar at 11:33:46 p.m., ending at 11:34:26, not recorded]

THE COURT: Go ahead, Doctor.

THE WITNESS: And the reason I haven't treated patients with protons, just like the other 99 percent of the radiation oncologists haven't treated patients with protons, it's not scientifically proven.

BY MR. TERRY:

Q Okay. So you understand that MD Anderson, as an institution, disagrees with Parvesh Kumar, who's never treated a patient with protons, on that point, right?

A I don't know what their position is --

Q Huh.

A -- I also know -- can I finish? That --

Q Sure. Yes, please.

A -- they also have IMRT, and they treat patients with IMRT, and not every single patient that goes to MD Anderson is treated with

protons. The majority of their patients are not treated with protons, the majority of their patients are actually treated with IMRT and protons.

MR. TERRY: Move to strike as non-responsive, Your Honor.

THE COURT: Overruled.

BY MR. TERRY:

Q Now, Dr. Kumar, does MD Anderson have a proton center?

A Yes, they do.

Q Okay. Does Mayo Clinic have two proton centers?

A I believe they do.

Q Does your beloved University of Kansas have a proton center?

A Not yet.

Q They're building one, aren't they?

A Yes, they are.

Q Did they ask you about that?

A They -- I had long left, so I don't know.

Q If they would have, you would have said, no, right?

A It depends on the evidence that exists for protons, and I still don't think that scientifically you can justify a proton beam; it depends on a number of factors.

Q Does Emory University disagree with you; do they have a proton center?

A I don't know; you'll need to ask Emory.

Q Well, you haven't looked to see who has proton centers?

A I know that -- no. I mean, there are, I don't know, 25, 30

proton centers in the United States, but do I know where every single proton center happens to be? No.

Q The University of Pennsylvania has one, don't they?

A Yes, they do.

Q Okay. So 25 or 30 cancer treatment centers have proton beam therapy machines at their facilities in this country --

A Yeah.

Q -- and if it was up to Parvesh Kumar, the number of proton therapy centers in the United States would be zero, right?

A No. It's not up to Parvesh Kumar, and --

Q If it was, sir?

A No, no. No. It's not -- this is not about me, okay. This is about the science behind proton. UFC Med School doesn't have a proton; UCLA doesn't have a proton. You know, UCSF doesn't have a proton. There are plenty of reputable institutions that do not have proton centers, so it's not Parvesh Kumar, it's about the science, and that's what we need to stick to.

Q Well, today it's about Parvesh Kumar, sir, because you're here offering this testimony --

A No --

Q -- and we --

THE COURT: No. Doctor --

MR. ROBERTS: We're running out of time, guys.

THE COURT: Doctor, don't interrupt, please.

BY MR. TERRY:

Q And I'm entitled, as the lawyer for that lady, to challenge your opinions, your opinions in court, and that's what I'm intending to do by asking you this. Do you believe, Dr. Kumar, that there should be zero proton centers in this country?

A I don't believe that there is science to support protons at many institutions. I believe that for certain cancers like pediatric tumors, there's a rationale in science to have proton beam radiation therapy. So certainly St. Jude's Children's Research Hospital appropriately has a proton beam center, and I think that's absolutely needed and necessary. So, no, I don't agree with your statement.

Q Okay. So there should be some proton centers in the country?

A Yes.

Q Okay. Just not as many?

A I don't know.

Q So do you understand that MD Anderson is in the process of expanding its proton therapy center in Houston?

A I wasn't aware of that.

Q You're aware that there have been more, and more proton centers being built in this country, right?

A Yes.

Q Do you think that's a bad development?

A No. I think the cost effectiveness of protons has become more efficient over the years. When I look at the proton center at Loma Linda, we were looking at a cost in an excess of 100 million, and we

didn't have the appropriate patient population that would have been benefited from proton radiation. The cost of proton centers has come down, number one. Number two, if you have the appropriate patient population, then you can certainly justify a proton unit, as is the case at St. Jude's Children's Hospital.

Q All right. Have you ever heard of a proton center called the New York Proton Center?

A I've vaguely heard about it.

Q What have you heard about it, vaguely?

A I think it's going to be used by multiple institutions, if I remember correctly.

Q Where did you hear about it?

A I don't remember.

Q Did these lawyers tell you about it; it's part of this case?

A I don't remember.

Q Do you know who owns a significant piece of it and operates it?

A I honestly don't remember.

Q Would it surprise you to learn that it's United Healthcare?

A You know that's United Healthcare; it's got nothing to do with me.

Q Well, okay. Let's talk about that. Did you know that United Healthcare owns a significant interest in and operates the New York Proton Center in New York City, at the time you wrote your reports in this case?

MR. ROBERTS: Objection. Misstates the evidence with regard to who owns it.

THE COURT: Sustained.

BY MR. TERRY:

Q Did you know that UnitedHealthcare and a UnitedHealthcare affiliate operates a New York Proton Center, a proton center in New York, call the New York Proton Center, at the time you wrote your report?

A I wasn't aware of that.

Q So at the time that you gave this opinion that Mr. Roberts had up on the screen, to the effect that proton beam therapy was not indicated for Bill Eskew, because there's not enough science to support it, you didn't know that UnitedHealthcare was operating at a proton center itself, in New York City?

MR. ROBERTS: Same objection.

THE COURT: Hold on. Hold on.

MR. ROBERTS: Mischaracterizes the ownership.

THE COURT: Sustained.

MR. TERRY: I didn't mention the ownership.

BY MR. TERRY:

Q At the time that you gave this testimony, that there's not enough science to support proton therapy, you didn't know that United Healthcare is operating a proton center in New York City?

MR. ROBERTS: Objection, Your Honor. It misstates he's operating a proton beam center in New York City.

THE COURT: Sustained.

MR. TERRY: Can we approach, Your Honor?

THE COURT: Yes.

[Sidebar at 11:41 a.m., ending at 11:43, not recorded]

BY MR. TERRY:

Q Okay, Dr. Kumar, let me try this again. At the time you gave your testimony here in court today, that there's not enough science to support the indication of proton therapy for Bill Eskew's treatment of his lung cancer, you are not aware that right now an affiliate of Sierra Health and Life is currently operating a proton center in New York City, right?

A That's correct.

Q Okay.

MR. TERRY: Jason, let's pull up Exhibit 71, please, page 17.

BY MR. TERRY:

Q Dr. Kumar, this is an exhibit that's been admitted in this trial as a portion of the website, from the New York Proton Center that's operated by an affiliated of United Healthcare, follow?

A Okay.

MR. TERRY: Jason, blow that one there up.

BY MR. TERRY:

Q "Proton therapy for lung and thoracic tumors." This is again from their website.

MR. TERRY: Go to the next page, please Jason. Blow up just that -- just the first paragraph there.

BY MR. TERRY:

Q Again from the website of the New York Proton Center, it

says, "When lung cancer is treated with conventional radiation," that would be protons or IMRT, right?

A It would be protons, I don't know if that's IMRT, or not.

Q Okay, protons. "It is difficult to deliver a high enough radiation dose to control the cancer without also damaging the normal lungs, the esophagus, heart and spinal cord;" did I read that right?

A Yes.

Q Do you agree with that?

A I would need a clarification on what they mean by "conventional radiation." So I don't know what conventional radiation means, so I can't really comment on it.

Q Okay. All right. Let's go to the next paragraph. This is, again, from the website, New York Proton Center, affiliate of UnitedHealthcare operates. "Proton therapy can more effectively treat these tumors, speaking of lung and thoracic, a particularly larger ones, while better protecting critical structures from radiation." Do you see that so far?

A Yeah.

Q Do you agree with that, or disagree with that?

A I don't know what the reference is when it says, "radiation is conventional radiation," is it IMRT, I don't know?

Q As a result protons can minimize side effects, such as lung inflammation, pneumonitis, or scaring, in parentheses fibrosus, difficulty swallowing, heart complications, hospitalizations and other side effects that are commonly seen with conventional lung cancer treatment." Did I

read that right?

A Yes, you did. Your reading is very good.

Q Thank you. And, so --

MR. TERRY: Jason let's go down to the last part. If you could bring up this whole paragraph there.

BY MR. TERRY:

Q "Lung and thoracic cancers, we treat" -- presumably New York Proton Center since it's their website -- "we treat with proton radiation therapy, include" -- what's the first on the list?

MR. TERRY: Jason, the first one on the list?

BY MR. TERRY:

Q "Non-small lung cancer." Did I read that right?

A Yes, you did. Your reading is perfect.

Q So here's my question for you Dr. Kumar, here you are on the stand in this case, and you've take the stand to say, loudly and strongly, that proton beam therapy is not supported in the science to treat lung cancer, right?

A That's correct.

Q So you're speaking out of one side of the mouth of this insurance company, while on the other side of the mouth they're saying these things, on this website.

MR. ROBERTS: Objection, Your Honor. That affiliate is not an insurance company.

THE COURT: Sustained.

BY MR. TERRY:

Q The affiliate of this insurance company is saying these things out of the other side of its mouth; do you see where I'm coming from, Dr. Kumar?

A No, I don't.

Q You don't see the right hypocrisy of that?

A Please don't put me in the same mouth as the insurance company. I'm not a mouth speak -- I'm not a speaker here for the insurance company. Let's get that straight right now. And don't put me in the same mouth as the insurance company.

Q Why not?

A Because I'm not here to represent the insurance company. I'm here to represent my scientific opinions that are based on evidence. That's the point that you're missing.

Q Oh. Well, I'm here to represent that lady over there --

A Well, good for you --

Q -- aren't you --

A -- that's your job as an attorney.

MR. ROBERTS: Gentlemen, move on.

THE COURT: We're going to take an early lunch.

Ladies and gentlemen, you are instructed not to talk to with each other, or with anyone else, about any subject or issue connected with this trial. You're not to read, watch, and listen to any report of or commentary on the trial by any person connected with the case, or by any media of information, without limitation to newspapers, television and/or radio.

Do not conduct any research on your own or anybody in this case, such as consulting dictionaries, using the internet or using reference the materials. You must not make 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, or conduct any other kind of book, or computer research with regard to any issue, party, or to search anybody involved in this case. You're not to inform or express any opinion on any subject connected with this trial until the case is finally submitted to you.

We'll return at 1:00 p.m.

THE MARSHAL: All rise for the jury, please.

[Jury out at 11:50 a.m.]

[Outside the presence of the jury]

THE COURT: Mr. Terry, your behavior is inappropriate, you need to stop this. Do you understand?

MR. TERRY: I understand.

THE COURT: All right. Come back at one o'clock.

[Recess taken from 11:501 a.m. to 1:01p.m.]

[Outside the presence of the jury]

THE COURT: All right. Please be seated, counsel. Are the parties ready for the jury?

MR. ROBERTS: Yes. But I did have something to bring to the Court's attention. I'm constantly surprised in the practice of law, Your Honor, but Mr. Terry has no more questions, which means I'll have no

more questions. And I had expected based on our prior medical doctor that we might be going much, much longer.

So we have a video to play, Mr. Palmer, which should only take 10 to 15 minutes. And then we've got a reading of a witness from California. Ms. Bonney is going to play the witness, Mr. Smith will ask the questions, and we've agreed to admit some of the exhibits that are referenced to the deposition testimony, at the Plaintiff's request. But then our next and last witness, Ms. Sweet, is not available again until tomorrow morning.

And so I was hoping to ask the Court if we could break early and complete our case in the morning. We've discussed our two other potential witnesses, Mr. Guerrero, who was here waiting three hours in the hallway the other day, we've decided we don't really need him. And we're going to not call, Ms. Bhatnagara, because we don't believe the creation of the policies has become an issue, that it's just their content and application.

So Ms. Sweet will be our last witness, and we anticipate resting our case before noon tomorrow.

THE COURT: So tomorrow will only be Ms. Sweet?

MR. ROBERTS: So tomorrow will only be Ms. Sweet.

THE COURT: So the parties just want do Ms. Sweet tomorrow, and then do jury instructions and closings on Monday?

MR. ROBERTS: That would be our preference. Mr. Terry and I would both appreciate the time. So --

MR. SHARP: So is there a way we can argue jury instructions

tomorrow afternoon?

THE COURT: Argue them? You haven't agreed on them?

MR. SHARP: No. There aren't many that we're arguing about, but I think it'd be easier if we settle jury instructions tomorrow, because then we don't have to worry about the jury having to wait while we finalize everything, and we've got a full day to do the closings and deliberations.

THE COURT: That's fine, we'll do that. Has the verdict form been agreed upon?

MR. SHARP: I've got to, I think -- no. I know the verdict form has not been agreed upon.

THE COURT: So how long do you think it's going take tomorrow with Ms. Sweet?

MR. ROBERTS: I originally planned on two to two hours and 15 minutes. I am -- it's my goal to cut that down to about an hour; she's already been on the stand for two hours on cross. So I would think that I would be done by the 10:30 break. I'm not sure how much time they've got on recross.

THE COURT: So we'll just tell the jury we'll do a half day tomorrow --

MR. ROBERTS: Thank you, Your Honor.

THE COURT: And if we're done earlier then they'll be happy.

[Pause]

THE COURT: Juror Number 5 did have a question for the doctor, so if you can approach and then there might be some follow-up

after that question.

[Sidebar at 1:05 p.m., ending at 1:05 p.m., not transcribed]

THE COURT: Okay. So bring the jury in and ask the doctor his question, and then if there's any follow up,

MR. ROBERTS: Thank you, Your Honor.

MR. SMITH: Your Honor, if the jury's coming in we have a stipulation to admit Exhibit 72 and 105.

THE COURT: Thank you. Mr. Roberts, is that your understanding?

MR. ROBERTS: Yes, it is, Your honor. I've agreed to that.

THE COURT: Thank you.

MR. ROBERTS: And as long as we're cleaning things up I would ask the Court to take judicial notice of NRS 695G.040.055 and .110, and if Mr. Sharp needs some time to look at those, I can make a request in front of the jury, and he can have some time to look them up.

MR. SHARP: Are you doing that now, or are you doing that tomorrow with -- is that something --

MR. ROBERTS: I'm not going to use them the with a witness. You've just admitted certain regs, and I want some other ones admitted that are related from the same title.

MR. SHARP: NRS 695G.

MR. ROBERTS: 04 --

MR. SHARP: Well, if you're not dealing with it, we can do this after.

MR. ROBERTS: Okay. That's fine. 040055.110.

[Pause]

MR. ROBERTS: So we seem to have one other technical issue, Your Honor, the deposition that's going to be played of Mr. Palmer was videoed from a zoom. There are certain exhibits shown that are not yet admitted, that are on shared screen, and there's no way that we figured out to be able to take those off shared screen.

So we can either just ignore the fact that they're there because they haven't been admitted? We're not going to admit them, or we could just play the audio for the jury, but if you have no objection?

[Pause]

THE MARSHAL: Are you ready for the jurors, Your Honor?

THE COURT: Counsel, are you ready?

MR. ROBERTS: Yes, Your Honor.

MR. TERRY: Yes, Your Honor.

THE MARSHAL: Okay.

[Pause]

THE MARSHAL: All rise for the jury.

[Jury in at 1:10 p.m.]

THE MARSHAL: All the jurors are present.

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

MR. ROBERTS: Yes, Your Honor.

MR. TERRY: Yes, Your Honor.

THE COURT: Thank you. Doctor, there's a question from a juror.

THE WITNESS: Sure.

THE COURT: The question is this. How many adults in the United States have lung cancer, or some other type of thoracic cancer, similar in nature to Mr. Eskew's cancer? For example, greater than a 1,000, greater than 10,000, greater than 50,000, greater than a 100,000, greater than 500,000, greater than a million, or a precise number if known?

THE WITNESS: Okay. A very good question, whoever asked that question. So the incidence of lung cancer in our country varies year by year, there was a time when lung cancer was the most common diagnosis in this country, that's no longer the case. That's the good news, because we've gotten people to stop smoking, and there's about a 20 year lag period from the time that people stopped smoking, to this time, you see the decrease in the incidents of lung cancer.

So now lung cancer is the third most common cancer in the United States. And now the most common is breast cancer and/or prostate cancer, it goes back and forth. Now the number of lung cases diagnosed every year varies, because you know, the population varies and how many people that are -- that started smoking 20, 30 years ago are still smoking, the ones that I haven't quit, but I would estimate, and I haven't seen the latest figures from the American Cancer Society.

The American Cancer Society, every year at the start of every year by 2022, around January, February, they will do an estimate of the number of new cases expected to be diagnosed. I haven't seen the numbers for 2022, but they're probably, from my recollection, probably,

you know, if we had Google and the internet connection, I can actually pull that number for you exactly, right now. But the estimate is probably about, you know, 170, 180,000 cases per year.

Of those, about -- we don't -- and the other issue to remember is, we don't have a good screening tool for lung cancer. It's not like mammograms for breast cancer. It's not like PSA for prostate cancer; we don't have anything like that for lung cancer.

So the only time we are able to diagnose it is when the patient develops symptoms, you know, they can't -- they're coughing, or something is not right, and then we do a chest x-ray and then we diagnose it. So about a third of the cases are usually local and the other cases are maybe regional, so my estimate is probably still, unfortunately, about 30 to 40% of the cases are probably diagnosed at metastases; so patients have metastatic disease when they're diagnosed.

And so you know, if you go by that, you know, again, the estimates vary, and the American cancer society has these exact numbers. If we want to look at those, we can just Google it and get those numbers. So to answer your question, if you go from 20 to 30 percent of Stage 4, you assume 170,000, and so it's probably about, you know, 34 to 50,000 cases per year, as an estimate

THE COURT: Counsel, any follow-up?

MR. TERRY: Not from us, Your Honor.

MR. ROBERTS: No follow-up for us, Your Honor.

MR. TERRY: No further questions from us, Your Honor.

THE COURT: Thank you. Any follow-up from the jury, any

additional questions? No? Thank you, Doctor, you're excused.

THE WITNESS: Thank you so much, Judge.

THE COURT: Thank you.

THE WITNESS: Thanks for everything and good luck with your courtroom.

THE COURT: Thank you, Doctor.

Mr. Roberts, will you call your next witness?

MR. ROBERTS: Yes, Your Honor. The Defense would call Mr. William Palmer by video -- I'm sorry, Mr. Matthew Palmer. William Palmer is a local attorney. Mr. Matthew Palmer, by video deposition.

THE COURT: Thank you. So ladies and gentlemen, what is going to be shown is a video deposition and similar to what was read previously, a deposition is a statement under oath, where the witness testifies to tell the truth under the penalties of perjury, just as if they had given the testimony here in court.

If the witness is unavailable, therefore you'll be actually seeing what took place when the witness gave their statement under oath; otherwise known as a deposition.

[The video deposition of Matthew Palmer was played in open Court at 1:15 p.m. as follows:]

THE COURT REPORTER: Sir. If you raise your right hand, so I can administer the oath.

MATTHEW PALMER, DEFENDANTS' WITNESS, SWORN

Q Okay. And going into your background, what's your current occupation?

A I'm the President and COO of Legion Healthcare Partners.
Q And what does Legion do?
A We provide -- we're owners and operators of a proton therapy center.
THE COURT REPORTER: Of what, I'm sorry?
THE WITNESS: We're the owners and operators of a proton therapy center with other clinical partners around the U.S.
Q And what is your current relation to PTC or UNACO?
A I have no relationship with either of them. I was just a chief operating officer during that time.
Q Okay. And what's your understanding of what PTC or UNACO does?
A It -- the Proton Therapy Center, Houston, LTD and LLP was acquired by MD Anderson. So it's the remain -- remaining company post acquisition.
Q Okay. And does it have any employees, PTC or UNACO?
A I don't know.
Q Are you aware if it has any directors or officers?
A Not that I know of.
Q Okay. And can you just give a quick synopsis of your educational background?
A Yes. I got my bachelor's degree in biology at Baylor University in Waco, Texas, and I have my MBA from University of Houston.
Q Okay. And how long have you been in your role with -- or

how long have you been with Legion?

A Two and a half years.

Q And what was your position before that?

A I was the Chief Operating Officer of the MD Anderson Proton Center.

Q And what years were you in that role?

A From 2016 to 2018, whenever -- the acquisition was completed in November 2013 -- sorry, 2018.

Q And during that time as chief operating officer, who was your employer?

A The Proton Therapy Center Houston and [indiscernible].

Q And it looks like I -- I did a search online, and it looks like before that COO position, you had a variety of roles with MD Anderson; is that correct?

A I was employed by MD Anderson from 2000 to 2017, or 2016, sorry.

Q Okay. And then do you have an understanding of what the lawsuit is about that brings us to this deposition today?

A Yes.

Q And what's your basic understanding?

A Basic understanding is the patient came to MD Anderson. The physician recommended proton therapy and the case was denied.

Q Okay. And, and I can represent to you that the -- that that recommendation occurred in 2016, to help give you a timeframe point of reference. So can you explain, what is PTC or NACO's relationship to the

MD Anderson Proton Therapy Center?

A It's the holdover company post acquisition of Proton Therapy Investors, LLC.

Q Okay. And when you're saying Acquisition" what is that referring to?

A During 2016 MD Anderson owned 51.22 percent of the Proton Center, and the Proton Therapy Center Houston Investors owned 48.78 percent. So --

Q Okay.

A So that in November -- November 30th, 2018, MD Anderson purchased the 48.78 percent that they didn't own, and they currently own a hundred percent of the Proton Center. So PTC or NACO is the follow along post-acquisition.

Q And so is it fair to say that in 2015, 2016, that the MD Anderson Proton Therapy Center was operated as a for profit entity?

A Yes.

Q And approximately how much money was invested in the MD Anderson Proton Therapy Center, prior to 2016?

A I don't know the exact amount.

Q Did it exceed $10 million? Mr. Palmer, do you know if it exceeded $10 million?

A Can I clarify your question? Is that the equity invested in it, or the total project cost?

Q The equity invested?

A Yes. I believe it was more than $10 million.

Q Do you believe that it was more than a $100 million?
A That equity was not [indiscernible].
Q And are you familiar with what the total project cost was?
A Approximately $120 million.
Q Okay. And do you have an estimate of what percentage of that was raised through equity?
A [Indiscernible]
Q And so given PTC or NACO's relation to the Proton Therapy Center, is it fair to say that PTC or NACO is familiar with MD Anderson's contractual relationships with the Proton Therapy Center in 2016 and prior?
A Yes.
Q And under its agreements with the Proton Therapy Center, did MD Anderson agree to promote proton therapy?
A I don't understand the question.
Q Maybe I can try to break it down. Which part was -- did I lose you on?
A Promote. Definition of promote?
Q Okay. What's your understanding of what the word "promote" means?
A Actively recommend.
Q And so if we apply that definition to the word "promote" does that help clarify?
A Yes. MD Anderson had a marketing budget for the Proton Center, they promoted it [indiscernible].

Q And under its agreements with the Proton Therapy Center, did MD Anderson stand to earn a monetary bonus, depending on the financial performance of the center?

A Never.

UNIDENTIFIED SPEAKER: And that if you know you can answer.

THE WITNESS: No, they did not.

Q So it's your testimony that they -- MD Anderson did not stand to earn any monetary bonuses, dependent on the financial performance of the center?

A No.

Q Under its agreements with the Proton Therapy Center, did MD Anderson's rate of financial return increase, depending on the center's financial performance?

A [Indiscernible]

Q And in 2016, did the Proton Therapy Center employ any staff related to appealing denials of prior authorization requests?

A Yes. They had three staff members.

Q And what was that department called?

A Appeals and denials.

Q Okay. So three people comprised the appeal and denials department, and they handled appeals for the whole Proton Therapy Center?

A Yes.

Q And taking a step back, do you know what triggered the

acquisition of the center in 2018 by MD Anderson?

A Yes.

Q And what was that?

A They are expanding the Proton Therapy Center, so there's going to be four new proton rooms. So MD Anderson wanted to build that into their overall strategic plan. So they [indiscernible].

Q And just to clarify, does PTC or NACO have any current financial interest in the Proton Therapy Center?

A No.

Q All right. And so it's true isn't that the physicians at MD Anderson are State employees?

A Yes [indiscernible].

Q They work for the State of Texas, the University of Texas system, more specifically, correct?

A Yes. They -- they're UT -- University of Texas.

Q And they get paid the same, whether they prescribe proton therapy or IMRT or anything else [indiscernible], don't they?

A Yes, you're correct. There's no -- they pick what's best for the patient.

Q So there was -- I'm sorry, there was never any shortage of patients at the Proton Center that you saw; was there?

A I mean, it was adequately -- they had enough patients who treated --

THE COURT REPORTER: It was what, I'm sorry?

THE WITNESS: There was enough patients treated. I don't

-- not a shortage, I guess you can say.

Q In fact, you agree, wouldn't you, that the biggest -- the biggest obstacle getting these people treated with proton therapy, at the Proton Center at MD Anderson was the insurance industry?

A Insurance coverage was a very --

[Video deposition ends at 1:26 p.m.]

MR. ROBERTS: Your honor, I believe that concludes the video deposition of Mr. Palmer.

THE COURT: Thank you.

MR. ROBERTS: At this time we would call Nurse Lou Ann Amogawin, by written deposition, which will be read like we did Dr. Liao's.

THE COURT: Ladies and gentlemen, what you're about to hear again is someone else reading the deposition transcript, which was the statement under oath that was given, prior to trial, because the witness is unavailable.

THE CLERK: Do solemnly swear that you will, well and truly read, the answers of the client, as set forth in the deposition, in response to the questions therein asked by counsel. So help you God?

AUDRA BONNEY, SWORN

MS. BONNEY: Yes.

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

MS. BONNEY: Audra Bonney, A-U-D-R-A B-O-N-N-E-Y.

THE CLERK: Thank you.

[Pause]

MR. SMITH: Sorry, Your Honor, I just wanted to make this to where I can have the page number, so I can read without thumbing through the pages.

THE COURT: That's okay, Mr. Smith.

[The deposition of Nurse Lou Ann Amogawin was read into the record as follows:]

Q Ma'am, would you state your name for the record?

A My name is Lou Ann Amogawin.

Q Have you ever had your deposition taken before?

A No.

Q And who are you currently employed by?

A I'm currently working at Kaiser Permanente in Sharp Coronado Hospital.

Q Can you tell me a little bit about your background? What is your professional degree in, I mean, maybe some background about that?

A Sure. My name is Lu Ann and I graduated with a Bachelor of Science in nursing, Manila, Philippines. After which I got hospital job, and I worked as an ICU and ER nurse. After which I worked for an American company for Worker's Compensation. And after which I moved here to the U.S., and my first job was with UnitedHealthcare in Sierra Health and Life.

Q So you worked at ICU in the Philippines?

A Yes.

Q And then you said you worked for, was it a Workers' Compensation company?

A Yes.

Q Was that in the Philippines, as well?

A It was based -- it was based in the Philippines, yes. And what we were doing, American insurance claims.

Q Okay. So it was American insurance claims, but you were doing work in the Philippines?

A Work in the Philippines.

Q Do you remember the name of the company?

A Yes. It's Cognizant and it's -- it was Cognizant, and it was acquired by Cognizant, but it started out as Medical Company.

Q Okay. And how long did you do that?

A Three years.

Q How long did you work in the clinical setting? In --

A Three years.

Q Okay.

A In the hospital, do you mean?

Q Yes.

A Yes. Three years.

Q Did you do any other clinical practice, other than in a hospital?

A I did, as a student nurse, if that's what you're asking, clinical setting.

Q Okay. So once you got out of school in the clinical setting

was the three years you worked in the hospital?

A Yes.

Q Okay. And when did you come to work for United healthcare?

A I worked for UnitedHealthcare in 2014.

Q And do you remember when you left?

A Yes, July 11 of 2017.

Q And where did you work out of, in terms of the physical location?

A In which four? Which?

Q For UnitedHealthcare.

A Oh, I worked physically in the Tenaya office in Las Vegas.

Q It's just geographically. So I understand you came from the Philippines to Las Vegas?

A Uh-huh.

Q Is that a, yes?

A Yes, sorry.

Q That's fine. And then you worked in the Las Vegas office for close to three years?

A Yes.

Q And is there any reason why you left UnitedHealthcare?

A Yes. My husband got a job here in San Diego, and he has his brother here; he grew up here in San Diego.

Q And from UnitedHealthcare, where did you go next?

A I'm sorry?

Q After you left?
A Repeat the question?
Q Yeah. After you left UnitedHealthcare, what was your next job?
A I worked for UCSD, University of California, San Diego. And I also work at Sharp Coronado Hospital, which is my current full-time job right now in Kaiser Permanente.
Q And what do you do for Sharp Hospital?
A I'm a hospital case manager, nurse case manager.
Q And is Sharp Hospital, a Kaiser owned facility?
A No, it's two different hospitals.
Q Okay. So what is it you do for Kaiser?
A I'm a placement nurse case manager in Kaiser Permanente.
Q So what is it that you -- I mean, you gave me the description of what you do, but what is it that you actually do for Kaiser?
A For Kaiser? I place patients from hospital setting -- from an acute care setting to a skilled nursing level setting, for an acute rehab lower level care from hospital site.
Q So you're assisting with level of care issues?
A Yes.
Q When someone says "level of care" in the managed care industry, is that typically inpatient, skilled nurse versus like skilled nursing, or inpatient versus outpatient?
A It depends on which area you are. If you're in the hospital, there's several kinds. There is inpatient, acute level of care, inpatient,

critical level of care, or inpatient telemetry level of care with cardiac monitoring and stuff.

Q How about in the outpatient setting?

A What do you mean by outpatient setting?

Q I mean, is there a series of levels of care in an outpatient setting, like you just listed out for us in an inpatient setting?

A I don't understand the question. Sorry.

Q That's fine. I'm just trying to determine in your -- in your practice in managed care, whether there is a definition or -- well, let me back up, I'll ask the question again. Does the concept of level of care apply in an outpatient setting?

A In my opinion, not necessarily. There is no level of care for outpatient setting.

Q Okay. So when we talk about level of care, that's basically inpatient settings of some sort?

A Yes.

Q And that's been your experience in the managed -- excuse me. And that's been your experience in the managed care industry?

A Yes.

Q So I'm curious, how was it that you ended up coming from the Philippines to UnitedHealthcare? How did you find out about the job and just -- I'm curious about that?

Q Okay. So when I first moved, when I was living in the Philippines, we also have a UnitedHealthcare that is based in the Philippines offshore. And I have several friends, a pharmacist and

nurses who work with UnitedHealthcare in the Philippines, as well.

My company, where I was working at Medical and Cognizant was actually a competitor of UnitedHealthcare when I was in the Philippines, and that's when I first learned about them. And when I first moved here, I submitted multiple applications to different hospitals in different insurance companies, and I luckily got the job at UnitedHealthcare in Las Vegas.

Q Okay. So you came to the United States before you got the job at United healthcare?

A Yes. I got married to my husband.

Q Well, congratulations. I'm sorry, I was confused. I thought you came to the United States --

A I'm sorry, no.

Q Because of UnitedHealthcare. That's fine.

A No, no. I moved because of my marriage. My husband is from here. We were from the same town in the Philippines.

Q Got you. So you moved to Las Vegas with your husband; is that right?

A Uh-huh. Yes.

Q Thank you. And then you applied for a job, and you got a job with UnitedHealthcare in Las Vegas?

A That's right.

Q And you worked out at the physical location, is it Tenaya Way?

A Tenaya Way, yes.

Q And that's at the UnitedHealthcare facility; is that right?

A Yes.

Q And you went to -- I've got in my notes that you went to work in 2014, was there -- what month was that to the best of your recollection?

A It was August, August 14 of 2014, I believe.

Q And when you went to work for UnitedHealthcare, what kind of training did you receive?

A I received vocation management and insurance based training, which means I underwent classroom setting learning about the system, learning about insurance, learning about different insurance there is, like HMO, point of service, PPOs, and that UnitedHealthcare has a nationwide coverage, and even out of the country coverage that are -- well, we have to learn, so they trained us in reviewing different terminologies that insurance companies use.

That, and they also trained us to use the medical criteria policy. And we have several insurance companies that we -- I mean, several insurance products that we are dealing with. Particularly we have Senior Dimensions, which is like Medicare for Las Vegas. We also have Medicaid products, so we are also doing Medicaid. Other CMS guidelines. And we were also -- we also have the health plan State guidelines and also Medical guidelines.

Q Was this training done in Las Vegas?

A Yes, it was done in a classroom setting, and it was done by a utilization management nurse as well, and the systems training was

done by our IT and our trainer.

Q Do you remember if you were given any written materials as part of your training?

A I can't remember, but from what I remember, we -- I jot down notes, and we had online modules as well, that we were required to complete. And we also had like certification tests that we needed to complete in order for us to full -- to be fully passed for the training. And I believe there were several handouts because they quiz us every time.

So like in this case that we're going to talk about, it was a request for proton beam therapy. So part of your job was to take the request for proton beam therapy and match it up with the UnitedHealthcare's guideline?

A Yes.

Q And then, because the guideline said it was not -- said proton beam therapy was not medically necessary, you then referred it off to a medical director?

Q Yes. If there was an unproven medical, not medically necessary, we have to send it for further review to our medical director.

Q Just so I understand the -- whatever the policy, I mean, we're talking about proton beam therapy here, but it could be any procedure where a guideline says a particular procedure or treatment is not medically necessary, the policy that you were taught at UnitedHealthcare, is then the request goes to the medical director for further review?

A Can you simplify the question? I'm sorry. It was kind of

long.

Q I'm just trying -- I'm just trying to figure out the policy, the policy, and we were talking about proton beam therapy.

A Okay.

Q Which is specific to this case, but whenever it doesn't matter, whatever the procedure is, if a procedure is recommended and there's a guideline that says the procedure is not medically necessary, your practice is to send the file to the medical director for further review?

A Yes. Our usual process is if the policy does not -- if the patient indication or clinical diagnosis does not meet the indication for it, or the clinical guidelines for it, we have to send it for further review to our medical director.

Q That's the policy at UnitedHealthcare as you were taught?

A Yes.

Q Okay. And, okay. So we were going through your training, and do you remember how long the training lasted?

A It's about, I believe six to eight weeks of training.

Q And while you're being trained, are you also making utilization management decisions for UnitedHealthcare?

A We would. But then we have UM preceptor who is also a pre-service review nurse who looks through our case to check whether we utilize the correct guidelines, to check whether we are using the proper determination, if we're missing anything in the clinical documentation. So there is -- we do our medical judgment, but we have our preceptor who counterchecks each case that we worked on

Q Does that -- that occurs during the six to eight week training period; is that right?

A Yes.

Q After --

A Yes.

Q After you end your training period, what process exists to check your work?

A So between the six to eight weeks, if the preceptor thinks that you are ready, you will then be asked to take a competency test. It's a series of different cases that would determine your readiness to go solo or do a medical case on your own.

Q Okay. And I take it, you pass the competency test?

A Uh-huh.

Q Is that right?

A Yes. Yes. After passing, yes. I did pass the competency test.

Q And then you started doing the reviews on your own, meaning nobody was overseeing your work to make sure it was correct?

A For the first few weeks we have an auditor. Actually, we always have an auditor, a nurse auditor who filters our cases, who reviews our cases. We -- it's not -- I believe from what I recall, it's done in a, I want to say weekly basis or monthly basis. I think it's a monthly basis.

Q So on a weekly and monthly basis, there's an auditor reviewing the work you've done?

A Uh-huh.

Q Is that a yes?

A If we were utilizing, yes. If you're utilizing the correct criteria, if you're utilizing the correct hierarchy of care or level of policies that we use, if it was a correct one, if we escalated it properly. Yes.

Q So basically they're making sure you're following the guidelines?

A Yes.

Q And that's done on a -- somewhere between a weekly to monthly basis?

A From what I remember, I can't be certain it's been years, but I believe it's one or the other; monthly or weekly basis.

Q That's fine. I should have told you ahead of time. I mean, you're here to give us your best recollection so we understand if things are off, it's no big deal. I'm just trying to make sure I understand your testimony. So with regard to the audits, would you receive a report on those audits?

A Yes. We would have evaluations of it. And if there is something that we missed or wasn't in the document, or we forgot to attach, or we forgot to send, we got audited and we got -- get a coaching session from our nurse auditor.

Q And so what would -- what was your job title, do you remember?

A I believe it's an RN pre-services review -- pre-services review nurse.

Q And who would you report to as the pre-service nurse

reviewer?

A When I first got hired, we had a nurse manager, her name was Susan Graham. But then she left sometime, I'm not sure, in between my years in United, and then I -- we reported directly to Shelean Sweet, our director -- nursing director.

Q What was her name again?

A Shelean .

Q Can you spell that, please?

A Sure. It's S-H-E-L-E-A-N, and then Sweet as in sweet.

Q So there was a period of time where you reported to a nursing manager, at some point the nursing manager left and you reported directly to the nursing director; is that correct?

A Yes.

Q Correct?

A Yes.

Q How many RN pre-services nurses were in the department with you?

A I can't be too sure, but roughly I believe 15 to 20 nurses in our department.

Q Okay. And was there a particular type of review that you did, or is it just whatever came in and got assigned to you, you reviewed?

A It was random, but we have certain assignments. I, for one, was working out of an area and stats in urgent cases.

Q Out of area, in what?

A Stat and urgent cases.

Q What would be an example of an "out of area" -- what do you mean by "out of area"?

A So UnitedHealthcare has a different -- it's a nationwide coverage. So we have families who have PPO, or point of service, meaning they have more benefits to go out of State. So even if they live in Nevada, they can seek treatment anywhere else in the State -- I mean, in the entire U.S. Uh-huh.

Q So when you're staying "out of area" it means out of Nevada?

A Yes.

Q Okay. And so when you were working at UnitedHealthcare, you were, I take it working on Sierra Health and Life preauthorization requests; is that right?

A Yes. We have several other projects, but Sierra Health and Life is one of them.

Q And then Health Plan of Nevada. Were you also doing reviews for that business?

A Yes. Yes.

Q And would that also include, then, UnitedHealthcare? Do they also have a separate line of business?

A Yes. We Have several products. As I mentioned, there's HMO, there's point of service, there's PPO, and there's Medicare and Medicaid patients and products.

Q So whatever falls within the Nevada business for UnitedHealthcare, you would be involved in doing pre-authorization

reviews?

A Yes. We were all trained to handle different types of insurance, yes.

Q If an insured in Las Vegas was seeking treatment outside of Nevada, the required pre-authorization, you would be one of the reviewers that would get the claims assignment?

A Yes.

Q Was there any other out of area reviewer?

A Yes. We have several nurses who are cross-trained to do it. If I'm not there, or if my colleague is not there, there are several nurses who were cross-trained to fill in to do the review.

A Who were cross-trained to fill in, to do the review.

Q Okay. Do you remember how many others?

A I believe, I can't remember for certain, but I believe we have like a good possibly two or three nurses that can, including our manager and our director of course, since they know the process forwardly.

Q Okay. And when you said "stat and urgent" that would include Nevada cases as well?

A Yes.

Q How many -- do you know if -- can you tell me how many reviews you would get in a day on average?

A It depends. And I can't remember for certain as to the exact number, but it can range between 20 to 40 cases. It depends on how difficult each case is.

Q Is that 20 to 40 per day or --

A Yes.

Q -- per week?

A Yes. That's 20 to 40 per day.

Q Do you know if you were provided any type of -- I'm a little lost? Were you provided any type of goals that you had to, like, complete a certain number of reviews per day?

A We were given a number, but we -- our management believes in quality versus quantity. So as I mentioned, it depends whichever case it is, because sometimes it will be -- they'll be -- we have everything already. Sometimes we don't have clinicals, no information what they're requesting, so it takes a lot more time in review.

Q Okay. View. Okay. So, and I appreciate that, but what was the number, if you recall, that you were expected to process per day?

A Okay. I can't remember, to be honest with you, but I believe, I want to say estimated is around 40.

Q Okay. Were you given, as part of your auditing, was that part of the auditing to make sure you were processing an appropriate number of cases per day?

A It wasn't, not really. It's not -- the auditing part is for the quality of the reviews. If you use all the guidelines properly, or if you estimated it properly, but not for the number of cases that you did.

Q Now as part of your training were you trained on the duty of good faith and fair dealing?

A Yes, we were.

Q You were? And this would be part of the insurance-based

training that we had talked about. You had given a fairly extensive discussion about, but the duty of good faith training was part of your insurance-based training?

A Yes.

Q What do you recall, or what is your understanding from what UnitedHealthcare taught you about what the duty of good faith and fair dealing is?

A That we have to be equal and fair in our decision making to every member that we give a decision to.

Q Okay. Anything else?

A Just equality and fairness.

Q When you say "equality" is that equal consideration?

A Yes. Considering that the patient's medical clinicals were reviewed and used proper guidelines for it. Yes.

Q Yeah. I'm just asking -- and, I mean, if you don't know that's fine. It's just at UnitedHealthcare, were you taught that UnitedHealthcare has to consider its insured's interest at least equal to its own interest?

A I am. We were taught about the need to be fair in every decision making, if that's what you're asking?

Q So my question -- my question is specific. Did UnitedHealthcare teach you that UnitedHealthcare has to consider its interest, its insured's interest at least equal to its own interest?

A That question is kind of vague to me, but I would, in my opinion, we were trained to treat everyone with fairness, meaning we have to review it from -- from the clinical guidelines and make sure it

meets the criteria, or if it doesn't meet the criteria we escalate to proper authority.

Q So as long as --

A I'm not --

Q From your training, as long as you were following the medical guidelines, you were acting consistent with the duty of good faith and fair dealing?

A I believe so.

Q And whatever the guidelines are, it can be a guideline adopted specifically by UnitedHealthcare, or it could be a Medicare guideline if it's a Medicare insurer, but the policy is to follow the guideline, true?

A Yes. That is our -- we were trained to follow the policies and the guidelines, yes.

Q I understand that part of it. My question is more into concepts. And again, if you weren't taught these concepts by UnitedHealthcare, then that's fine. But were you taught by UnitedHealthcare that when a preauthorization request comes in UnitedHealthcare needs to conduct a prompt, thorough and objective investigation?

A Meaning UnitedHealthcare or the employee who is reviewing it, we should conduct a proper investigation of it?

Q Well, I mean, you're acting on behalf of UnitedHealthcare, right?

A Uh-huh. Yes. When I was working at UnitedHealthcare, I

was trained to follow the procedures and conduct a thorough investigation of whatever the request is, what the treatment request is and follow up if there's like a missing clinical that might be important for the patient to meet a criteria. Where the patient does not meet a criteria, it would tell in the patient's clinicals. Yes. We would conduct a thorough investigation of the patient's case.

Q So the investigation would be tied to make sure you can match it to a particular guideline?

A Yes. That would be the case.

Q Okay. Were you taught by UnitedHealthcare, as part of your investigation, that you should diligently search for and consider evidence that supports the preauthorization request?

A Yes. We were taught by UnitedHealthcare guidelines to countercheck if the clinical's presented and the diagnosis presented by the patient, and whatever the request or the treatment procedure is, that if it meets guidelines, then yes. If it is medically necessary, we can approve it.

Q I mean, I know you do that, but that's -- what I'm talking about is once you get the information, I mean, for example, when the request came in for Bill Eskew for proton beam therapy, do you recall that if you reviewed documents, that you were involved in, processing a preauthorization request for Bill Eskew?

A Yes. So we would normally gather information, review the information, and countercheck with our clinical policy guidelines that the patient does not meet the criteria, or does not meet -- or does not meet

the criteria, then we have to escalate to further level, for further review to our -- to medical director.

Q Okay. So in the case of Bill Eskew, the request was made for proton beam therapy, right?

A Yes.

Q And the medical guidelines said that proton beam therapy is not medically necessary, right?

A Yes.

Q Do you have any discretion to say, well, in evaluating the case, the treating physician makes more sense than the guideline. as an example?

A I can only speak for myself when I'm reviewing the cases, because I'm only reviewing the clinical. I'm not part of the treatment party who requested the treatment procedure. So I'm just looking at it objectively by reading the clinical guidelines that -- and counterchecking, if the patient's condition meets the guidelines.

Q That's what I'm getting at. Do you have the discretion to say, I don't think the guidelines should apply in a particular case?

A I do not create the guidelines. I'm only following it and counterchecking with the patient's condition.

Q And I appreciate you didn't follow it, but my question is specific. Did you have the discretion in your job to say, I am not going to follow the guidelines, I'm going to follow the recommendation by a treating physician, when the two conflicted?

A No. I have to follow the clinical guideline that we have.

Q Okay. And that -- and it doesn't matter how, the type of condition, it doesn't matter how good the treating physician is, the guideline says, no, your requirement is to escalate and send it to the medical director; is that fair?

A Yes, that is right.

Q And you were taught by UnitedHealthcare, that that policy is fair to the insured?

A Yes, it was. It was created by UnitedHealthcare for us to follow.

MR. SMITH: Your Honor, may we approach?

THE COURT: Yes.

Q I mean, you would agree with me, as a practical matter, when a guideline conflicted with the treating physician, the guideline was always followed by you, correct?

A Yes.

Q And that was what -- that's, because you were taught by UnitedHealthcare. that that was the policy and procedure, correct?

A Yes.

Q The policy and procedure, when there was a conflict between what the medical guidelines said and the treating physician, the policy and procedure you followed was you always favored the guideline over the opinion of the treating physician, because that's what you were taught?

A I was taught to follow the clinical guidelines. Yes.

Q Did somebody at UnitedHealthcare, when they were teaching

you about the duty of good faith and fair dealing, say, this is -- this policy of always favoring the guideline over the opinion of the treating physician is fair and consistent with UnitedHealthcare's duty of good faith and fair dealing?

A As I mentioned, we were taught to follow the guidelines in proper escalation process, which entailed --

Q Did anybody at UnitedHealthcare say this policy that we've adopted, of favoring the guideline over the treating physician is consistent with our duty of good faith and fair dealing; did they ever tell you that?

A We were taught to follow the guidelines, and that's what we were sticking to, following the guidelines.

Q So would it be fair to say in the context, like we have here, where the proton beam therapy says it's not medically necessary, and MD Anderson says that proton beam therapy is medically necessary, that your job was to give only consideration to the guideline, true?

A I was reviewing it under the guideline, and when the guideline says that it -- says it's not medically necessary, then I have to escalate it to our medical director for further review.

Q So when the guideline conflicts with the treating physician, the treating physician's opinion is not given any consideration from your -- from just the policy and the practice that you're implementing?

A In our process -- in our process we have to escalate it to our physician, as well. So we have to send it to him, or to our doctor for further review.

Q When you say "our doctor" what do you mean by that?
A We have our medical director. And in this case for oncology cases, he had Dr. Ahmad.
Q When you say "our doctor" you mean the medical director?
A Yes.
Q Do you know if the medical director had discretion not to follow the guidelines?
A I am not the medical director, so I wouldn't know.
Q Were you taught about the provisions within the insurance policy?
A Do you mean the agreement of coverage?
Q Yes. Yeah.
A Yes. We were taught.
Q You were given instruction on the various terms within the insurance policy?
A Yes. We were educated on that.
Q In evaluating the request for Bill Eskew, did you review the insurance policy, or -- I don't remember what you called it, the coverage agreement?
A Agreement of coverage, yes, we do. We -- because we have to determine what kind of agreement of coverage, because as I mentioned, we handle numerous kinds of different insurance products, including commercial, Medicare, and Medicaid projects products, so each --
Q So --

A -- coverage has different -- different coverages.

Q Okay. So aside from -- so with regard to Bill Eskew, what did you review in his coverage agreement as part of the preauthorization request?

A So I did verify that he had a PPO, point of preferred -- preferred organization. So we had benefits with UnitedHealthcare to seek treatment elsewhere other than Nevada. So they can actually go to different states to seek treatment as a UnitedHealthcare benefit.

Q So you verified the type of coverage, the type of coverage agreement he had?

A Yes.

Q Did you physically review the coverage agreement to make that decision?

A Yes. We have a copy of it. A soft copy of all of our different product agreements and certificates of coverage and evidence of coverages.

Q Okay. Anything else that you reviewed within the coverage agreement as part of your evaluation of Bill Eskew's preauthorization request?

A Yes. That would be right.

Q What else did you review? That's what I'm trying to figure out. I know you reviewed -- basically you reviewed the type of coverage he had, correct.

A Uh-huh.

Q And you verified that he could go out of area, correct?

A Yes. So that agreement, our agreement of coverage or the OAC, would definitely say if the patient had benefits to go out of area. If the patient can seek treatment out of area, or if it's only restricted, it depends on if the facility or the requesting physician is also part of the UnitedHealthcare doctors.

If they need to be contracted, or if they're not contracted, we have to inform the patient that this might not be -- they're not part of the UnitedHealthcare list of doctors, and you might have to pay a certain higher copay to a certain out of plan doctor, or facility that we have to -- we have to keep that -- we have to keep that transparent to them, that we have incurred additional costs regarding it.

Q Okay. So was there any particular provision within the coverage agreement that you would have reviewed as part of your pattern, part of your practice in doing pre-authorization reviews?

A Yes. As I mentioned earlier, that we have to determine if the patient has the capacity to go out of State, excuse me, out of State. For example, if the patient is seeking treatment in this particular case, MD Anderson is in Texas. I have to determine if the physician and facility where they're planning to do the treatment is within the UnitedHealthcare's doctor or facilities, because we have to make sure that we document that, and we have to be transparent to our patient. If the doctor is out of network, we have to let them know because they might be charged additionally for it.

Q Okay. Did you review the definition of medical necessity within the coverage agreement?

A Yes.
Q You did?
A Yes.
Q Are you sure about that?
A Yes.
Q Where is that review documented? Where would that review be documented in the filing?
A It would be part of the agreement of coverage. It also can be seen in each guideline where the patient would meet medical necessity, or if it's not medically necessary.
Okay. So before, just so I understand, before Mr. Eskew's preauthorization request was denied, did you review the actual terms of the policy as to how it defined medical necessity?
A Yes.
Q Well, because the radiation therapy is IMRT at that point --
A Uh-huh.
Q -- did you know it had to go to the medical director?
A Yes. Most of our, IMRT and our proton beam therapy goes to our medical director for further review.
Q So this wasn't the first time you'd had a proton beam therapy request that you were evaluating
A No, I would've received some in the past.
Q Okay. Now it looks like here down at the bottom. Hold on, on page 6 --
A Uh-huh.

Q -- which is Bate stamp SHL325, there's an email from you to Dr. Ahmad; is that right?

A Yes.

Q And just procedurally, how do you -- how is it -- what kind of system do you use to send emails? Is that in Outlook or something like that?

A So it's in Outlook. It's a secure Outlook that Dr. Ahmad has a password on his computer to access our secure mail. So UnitedHealthcare has a secure mail that, excuse me, a secure mail, they give me give that we can create your own password, that we send it to secure mail to Dr. Ahmad. So once we review the case, and deem that the patient, if the patient does not meet or not medically necessary, we have to submit it to the medical director via Outlook for -- for review.

Q Okay. So on your desktop, you're using outlook to type this email?

A It's in Outlook, Microsoft Outlook. Yes.

Q And you're typing it from your desktop in Las Vegas, right?

A Yes. We are typing it in our office desktop, in Las Vegas.

Q Is there a policy that you were taught to save emails?

A We are permitted to save emails. It's on our UnitedHealthcare server.

Q Okay. So once you send it out, once you send it out on outlook, you then deleted it off your desktop?

A It goes to our sent items. They normally -- I believe every 90 days, they clear out our sent items, or the emails we got 90 days onward

to maintain.

Q Okay. And then this is a secured message that you sent to Dr. Ahmad?

A Yes, it is.

Q Okay. Do you know -- do you know why sometimes the time looks -- indicates GMT versus Pacific Standard?

A I am not sure of that. I don't know the answer to that.

Q Okay. So let's go to the next page. So it looks like originally you thought the request was only for IMRT?

A Yes.

Q So you, you asked Dr. Ahmad to evaluate whether -- well, tell me what you meant, request authorization for radiation therapy?

A Yes. So I sent a request authorization, a request for radiation therapy, IMRT versus proton beam therapy treatment, and the number of fractions, energy per dose, total energy in radiation site, which is the lung, and what kind of radiation, IMRT versus IM proton therapy.

Q Okay. So were you -- I'm trying to figure out, what was the medical necessity decision that was being made by UnitedHealthcare?

A So we're reviewing it all for proton beam therapy, proton radiation therapy, and if they're IMRT versus IMPT, that was their recommendation. That's why I have to send it under IMRT versus IMPT, that was the --

Q So --

A -- I'm sorry.

Q So in other words, MD Anderson was recommending proton

beam therapy, other than IMRT?

A They were -- there's a different -- there's a differential. More often some of their requesting physicians would do this, if they're not sure if there's -- if they're not sure whether one would be approved or one would be authorized. So they put a differential, IMRT versus IMPT. So just in case a proton beam therapy gets denied, they can ask for an IMRT further on.

Q Okay. So your understanding was MD Anderson was seeking preauthorization to do proton beam therapy?

A Yes.

Q And if UnitedHealthcare denied the proton beam therapy, they were seeking IMRT as an alternative?

A Yes.

Q Okay. So you're not -- you weren't asking Dr. Ahmad to compare which type of therapy was better for Mr. Eskew?

A Yeah, I was. Yes. That was the -- that was the issue. We were sending it for proton beam therapy, but MD Anderson might be requesting IMRT, in case he gets denied for proton therapy.

Q So for example, in the first paragraph next to the last sentence, it reads: "All relevant clinical information has been reviewed. and this patient is meeting eligibility criteria for treatment with proton beam therapy." Did you have any basis to question that statement?

A I am not part of the treatment per se, of MD Anderson, so I would stick with my objective definition when I'm reading the clinical and counterchecking with the criteria. If it meets the -- if it meets the

clinical indication for the requested treatment for proton.

Q I understand that you're comparing the letter of medical necessity to the guideline. What I'm trying to get at is, you're not comparing the weight, like in other words, which is more persuasive, the opinion of MD Anderson or the guideline; you're not making that analysis true?

A I am reviewing it off the guidelines and whatever is presented by MD Anderson to meet -- to meet, or it doesn't meet the clinical indication based on the policy.

Q Tell me why the guideline is more persuasive than MD Anderson's position on medical necessity?

A It's -- it's a guideline that we follow, and we have been following the guideline, and we are basing it off each and every one of the patients that we review.

MR. SMITH: 61. do you want to approach?

MR. SHARP: No, that's fine, I'll just withdraw it.

Q So then the answer to my question would be, you would agree no one at UnitedHealthcare, at least as far as, you know, considered or asked about the criteria that MD Anderson uses to determine whether proton beam therapy is better than IMRT?

A I am not there when Dr. Ahmad did a review for it. So I would not know if he did verify that information, so I would not have the answer to that.

Q Okay. And that's why I asked it based upon your knowledge, based upon your knowledge?

A Based on my knowledge?

Q Yeah. Based on your knowledge, no one in UnitedHealthcare considered MD Anderson's criteria for determining whether proton beam therapy is preferable to IMRT?

A I did not. I would not know the answer to that.

Q Well, you didn't --

A As far as --

Q Right? You didn't make that -- you didn't consider what their criteria was?

A It is my policy, and the workload is sent to the medical director for review, for further review.

Q What do you know about how UnitedHealthcare developed the policy it had upon proton bean therapy?

A It's outside of my area of expertise.

Q Did you ever talk to anybody who developed the policy?

A Not that I can remember.

Q So it's basically, again, your job is to look at the guideline and decide whether the guideline says it's medically necessary, or not, right?

A Yes. Review it. If the clinical indication diagnosis and any other pertinent information submitted by the requesting physician meets the guideline, if it doesn't meet, I have to send it for further review to our medical director. Yes.

Q And you don't know if the medical director has discretion to say, I'm not going to follow the guideline?

A I'm not Dr. Ahmad. So I would not have any knowledge of that information.

Q Now, when you commuted, when you sent the request to Dr. Ahmad for review, what do you send him?

A So I send him the information, the clinicals that they have sent, and I would create a template for him. So it would be, if you go to page, I believe it was page -- page SHL326. So that would be my template to what the patient -- what the request is. It's an out-of-state stat request, and his insurance information is SHL with UHC benefit.

And I would give the tracking number and the pending review number, patient's name, his age, gender, the requesting physician's names, the service facility name, the request, and the treatment.

The request for IMRT versus IMPT, in the additional information regarding what radiation site, what number of fractions, energy, and doses, the diagnosis. And then it says, "Please see attached clinicals," and I have attached clinicals that MD Anderson has provided.

Q And then I noticed in your email, you wrote: "Hi, Dr. Evan," was that just an error on your part?

A It's a type -- yes, it's a typo, and we have -- our different medical directors for out-of-state area is Dr. Evan.

Q Okay. So as a general rule, Dr. Evan evaluates all out of area requests.

A Yes, Dr. Evan was responsible for out of area request and even local request, actually. But since it's an oncology case, Dr. Evan does not review oncology cases, oncology cases go to Dr. Ahmad.

Q Was there any other doctor that did -- that reviewed oncology requests?

A From what I -- railroad -- at that time, it was only Dr. Ahmad.

Q So every oncology request for preauthorization, no matter the type of treatment, if the guideline said it was not medically necessary, the review then went to Dr. Ahmad?

A Yes. That is -- yes, that is correct.

Q Okay. So this is basically the communication back to you that the request is being denied as not medically necessary?

A That is right.

Q Just in the policies and procedures at UHC, would this be consistent that Dr. Ahmad, whoever the medical director is, when they're denying a claim for medical necessity, they would send you back an email referring to the guidelines?

A Yes. That would be the same procedure. They would be replying on why they're denying their request and which criteria they use to deny it.

Q Is there ever provided to you an analysis of why the doctor believes the proposed procedure is not medically necessary?

A I'm sorry, what was the question?

Q Do you ever receive, within these emails, like an analysis that the doctor engages in, to explain why the doctor doing the review believes the procedure is not medically necessary?

A It would -- it would be normally just based off the criteria that was coded on the email.

Q So, in your experience, when the medical director denies a claim based on medical necessity, the reason being communicated to you is the medical guideline?

A Yes. They would attach the guideline, what criteria they have used.

Q There's nothing unusual about the email we're reading right now from Dr. Ahmad to yourself, when it comes to denial of a claim for medical necessity?

A Are you asking for just -- for this specific criteria that he used, or in general?

Q I'm just talking about general policies right now.

A General policy is, but as I mentioned in my earlier statement, they would -- we would always refer back where Dr. Ahmad would send us the criteria of which he is denying it off, and he would attach that specific criteria in the email, so we would know what he is denying it off.

Q Okay. So this, the next line entry, whether it's Dr. Ahmad, Dr. Evan, whomever, the medical director denying the claim would reference the criteria used, correct?

A Yes.

Q And the criteria you used would be the medical policy guideline at UnitedHealthcare, right?

A Yes.

Q And the effective date for that guideline, right?

A Yes.

Q And then he would --

A Yes.

Q You would receive a case summary?

A Uh-huh. Yes.

Q And it will typically say, when the medical policy says that the claim is not medically necessary, that the requested procedure doesn't meet current HPM policy or Sierra policy, whatever policies apply, there's nothing unusual about that, right, the case summary?

A Yes.

Q The decision would then say -- would be in reference to the policy guideline, right?

A Yes.

Q So in terms of the information you're receiving from the medical reviewer, that information is whether or not the guideline says the claim is medically necessary?

A Yes. We would rely on the criteria they used, and whatever they send to us in the further basis of the denial.

Q And you don't speak to Dr. Ahmad about his denial, do you?

A No, we don't. We communicate by email.

Q So the information, the only information you know, about what Dr. Ahmad did in reviewing Mr. Eskew's claim is the information he sends back to you, right?

A Yes. That would be right. The email that he sends back with the decision would be the communication that Dr. Ahmad and I have.

Q And that information is then used to create the denial letter?

A That would be right.

Q Okay. So now the email time on this is February 4th, 2016 of 4:20. Do you see that?

A Yes.

Q If we go over to -- if we go to SHL321, which is page 2 of Exhibit 1.

A Okay.

Q And this is the same email in substance to the one we were going over earlier, right?

A That's right.

Q And the time on that email is 3:12 p.m. Do you see that?

A Yes.

Q Can you explain to me why there would be the same email with two different times?

A As I mentioned, I don't know the time for the email. I don't have an answer to that.

Q Okay. And the note that you input in February, 2016, at 3:21, do you see where you continue notes?

A Uh-huh.

Q How do you input that information?

A I would copy the email.

Q And so explain to me, since I've never seen how the UnitedHealthcare system works, you get the email, you copy the email from Outlook, I take it, right?

A Uh-huh.

Q Is that, yes.

A Oh, yes. Sorry. Yes.

Q So you copy the email from Outlook. What do you do next?

A I input it to the system under this system.

Q And do you need to do something to input that information? That's what I'm trying to picture, is there like a logging you have to do; I'm just trying to picture the process?

A Okay. So all we normally do is we would copy/paste the information from Outlook and then paste it on our system, and that would be the correspondence.

Q So what I'm also confused about, does Dr. Ahmad normally attach the medical policy guideline as part of his email?

A He would normally attach it, but it's already readily available online; everyone has access to the policies.

Q And in this instance he didn't attach the policy, the medical policy?

A Yes, he didn't.

Q I just -- my question was very simple, Dr. Ahmad cites to the wrong guideline, did that provide you with any concern regarding the thoroughness of his review?

No. The guideline will say there is -- there is two guidelines, It's under Sierra, and it's under UnitedHealthcare. It has the same clinical guideline content, that the UHC number has a different criteria number or policy number, and Sierra Health and Life, and HCN has a different policy number, so we have to be accurate as to which specific guideline we're using.

The content is basically the same, but the policy number attached for the UHC guideline and the one HCN and Sierra guideline are two different numbers. That's why we have to make sure we are operating off the right guideline that we're using.

Q So part of your job is to determine whether the guideline cited by Mr. Ahmad is correct?

A Yes.

Q Okay. And you figured out he cited to the wrong protocol?

A Yes.

Q Now you're asking him to update the denial letter or the denial email, right?

A Uh-huh.

Q Is that a, yes?

A Yes. We -- I'm asking him for the correct UHC policy number criteria that he used.

Q And you're attaching it, the protocol for him, so he can update the denial?

A Yes. I am sending him a copy of the -- the UHC one with the correct protocol number, policy number, so if he really wanted to deny it off that, he can use that.

Q What do you mean? I mean, the claim has already been denied, right?

A Yes. But we want to make sure that we're denying it off the correct policy number.

Q I understand, but it's not like you're asking Dr. Ahmad to take

a second, look at it and see if you can provide coverage to Bill for proton beam therapy.

A I am not Dr. Ahmad. So I wouldn't know if he looked at the policy again, or if he checked any other policy for that matter. But I -- our practice is, if he put in the wrong policy, we have to make sure, and send the correct policy to him and countercheck with him if he wants to deny it based on the criteria.

Q Okay. You weren't asking Dr. Ahmad to do another review, to see if Bill Eskew was going to get proton beam therapy, right?

A I am sending back the correct policy to you. And I am not Dr. Ahmad. So I wouldn't know if he did a re-review for it.

Q Well then why did you write, "Can you please send me an updated denial with the correct protocol?"

A Because if the physician was to deny, it I'm sending the correct policy. Because if the physician was to deny it, I'm sending the correct policy number, with the correct policy number that needs to be used. And if he still wants to deny it, he may then use it. But if he changes his mind, it's up to him, but I am not Dr. Ahmad, so I would not know if he did agree, for this one.

Q So the email that we were referencing earlier, that had the UAC policy guidelines, you attached it to the email to Dr. Ahmad?

A Yes. That is right.

Q And you highlighted the provisions to the guidelines, correct?

A Yes. That is right.

Q So you pointed out to Dr. Ahmad that proton beam radiation therapy is unproven and medically not -- not medically necessary for treating all other indications of cancer, including, but not limited to, and you went and highlighted lung cancer, right?

A Yes. That is right.

Q Hold on. Let me ask my question. You attached --

A Okay.

Q -- the guideline with the highlighted provision that we're looking at in SHL348?

A Yes, I did 347. Yes. The entire policy, I sent the entire policy to Dr. Ahmad; it's a PDF form.

Q Okay. So your testimony is you sent the entire policy to him.

A Yes.

Q Okay. So you were sending him a highlighted version of this policy to alert him as to the area that said, for lung cancer, proton beam therapy radiation is unproven and not medically --

A No. What I mean is --

Q Hold on.

A Can I correct myself?

Q Let me ask my question. Let me finish my question.

A Okay.

Q Because this is a printed out version. You printed it, right?

A Uh-huh.

Q You've printed it out. You highlighted it, you highlighted the guidelines, right?

A Yes.

Q And the purpose of highlighting the guideline initially, is so that you have a paper trail for the auditor to look at, to make sure you're following the guidelines, right?

A Yes. That is correct.

Q So you took the highlighted portion of the guideline and scanned it into the system, right?

A That's where I'm going to correct myself. When I attach the policy to Dr. Ahmad, I don't scan it. I don't send the highlighted part, because it's readily available online. So what I do is, I save a copy of this entire policy, which is -- it's a lengthy policy, so I don't -- I don't scan it. We're taught to save a PDF form and attach that. So we have a form, so it does not have a highlight on whatever that Dr. Ahmad has received. It's a policy and it is black and white, but it's available in PDF.

Q Why would you attach that if it's already available to him?

A Because this one we do for a paper trail for our ATD team, and first determination team, that process our denial letters, and for our auditors too. So this is attached to the actual medical director review, to the email into the actual clinicals, like the paper clinicals that MD Anderson has submitted, so it goes to one big packet for our first determination team.

Q So once Dr. Ahmad's review comes back to you, once the denial comes back to you on February 4th, do you then communicate --

A Uh-huh.

Q -- with the, with Ms. Pollack [phonetic]?

A Yes. I have to give it to their department for adverse determination team to do their process of notifying their requesting physician and of our position.

Q So, and that's what Ms. Pollack is doing; that's in a telephone call to the physician?

A Yes.

Q And then there's the next entry, it's from a G. Guerrero; do you know who that is?

A Yes, he is Gustavo Guerrero.

Q And is she [sic throughout] with the adverse determination team, as well?

A Yeah, he is part of the adverse determination team.

Q And she -- and then she -- so she then writes the denial letter?

A Yes. He -- he normally does the denial letter. Yes.

Q I'm sorry. He, so --

A Yes.

Q Do you ever write the denial letter?

A No.

Q Do you review the denial letter?

A No.

Q So the denial -- do you know what Mr. Guerrero's qualifications are?

A I'm not sure of how to answer that. He's part of our adverse determination team.

Q I mean, does he -- do you know if he has any medical background?

A He types in, I'm not sure I'm not familiar of their actual process, and how they do their jobs.

Q So is it fair to say that once you communicate with the adverse determination team, you don't know what happens --

A Uh-huh.

Q -- from that point on?

A Yes.

Q Okay. And so when you communicate with the adverse determination team, is that by email? Is it -- how do you do that?

A We forward the correspondence to email. They have their own distribution list in -- in Outlook; it's our ADT team. And we send the physician coming from Dr. Ahmad, through there, and then we also attach the note and the clinicals, the papers that we received from the -- from the requesting physician and the policy that we have used.

Q So that's done by an email from you to the adverse determination team?

A It's -- it's done by both email and actual paper trail.

Q Okay. So do you physically deliver the paper trail to the adverse determination team?

A Yes, we do.

Q And as well as an email with the same information?

A Yes, we do.

Q So in terms of the physical file that you deliver to the adverse

determination team, does that physical file have a name?

A It's called medical notes?

Q Do you maintain a copy of the medical notes you send over to the adverse determination team?

A No. Once I send it it's for theirs to have.

Q Now we've gone over some of the highlighted entries within the medical record, and a policy guideline; do you recall that?

A Yes, I do.

Q And as I understand it, you were -- you were highlighting that information for purposes of the audit?

A Yes. And for the adverse determination team, because we hand over anything that we've used in the review to the ADT.

Q So they take the medical notes, and that file is then delivered to the adverse benefit, adverse determination team, right?

A Yes, that's right.

Q Well, as I understand it, let me just -- so like as an example, we're on page 332 of Exhibit 1 --

A Uh-huh.

Q -- and you had highlighted the information relating to the site, Technique, IMRT versus IMPT.

A Uh-huh.

Q That was something that you took and highlighter and highlighted a piece of paper, right?

A Yes. I physically highlighted it.

Q And the reason was, is the auditors could identify that you

would identify the type of treatment being requested, right?

A That's right.

Q And then we had gone over the policy guideline that you had highlighted, right?

A Yes, that's right.

Q And the reason you had highlighted the policy guideline was to demonstrate to the auditors that you had correctly applied the medical policy guideline.

A Yes. That would be correct.

Q And so what I'm going back to, is you told me that the auditors have access to your system?

A Okay.

Q And would that include these medical notes, at some point they're scanning to the system?

A Yes. They do have a copy of it. They can pull up the records.

Q Do you know at what point your notes are scanned into the system?

A I'm sorry. Do I know what point?

Q At what point are your medical notes scanned into UnitedHealthcare system?

A They do it in every case that they want to make sure that we have the file, and the clinical notes coming from the requesting physician.

Q So I understand that you were trained by UnitedHealthcare and concepts of medically necessary, right? You were trained about

that?

A Yes I was.

Q And you were trained that in order to apply medically necessary, you looked at the treatment being proposed and compare it to the guideline, right?

A Yes. That would be right.

THE COURT: Counsel. We're going to take a 15 minute recess.

Ladies and gentlemen, you are instructed not to talk to 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 limitation to newspapers, television internet, or radio.

Do not conduct any research on your own in this case, such as consulting dictionaries, using the internet or using reference materials. Do not 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 attorned involved in this case. You're not to inform or express any opinion on any subject connected with this trial until the case is finally submitted to you.

So return at 2:45 p.m.

THE MARSHAL: Rise for the jury.

[Jury out at 2:30 p.m.]

[Outside the presence of the jury]

THE COURT: Any issues outside the presence, counsel?

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

THE COURT: Any issues outside the presence of the jury?

MR. SMITH: Your Honor, if you were to permit us, or the Court could inform the jury that questioning is coming from the Plaintiff, wo that it's not confusing. Because some of the questions would seem a bit odd to be asked by the Defense.

THE COURT: So you're asking the Plaintiffs' questions now?

MR. SMITH: This has been entirely -- the questions have been entirely, for the majority of the Plaintiff.

THE COURT: Any objection?

MR. SHARP: I can't think of an objection.

THE COURT: The Court understands. So how much longer do you think you have, Mr. Smith?

MR. SMITH: Your Honor, probably like five or ten minutes, tops.

THE COURT: Oh, okay. Okay. We'll be right back.

MR. ROBERTS: Thank you, Your Honor.

[Recess taken from 2:32 p.m. to 2:47 p.m.]

THE CLERK: Court come to order, we're back on the record.

[Outside the presence of the jury]

THE COURT: Okay.

MR. SHARP: We got two objections to deal with on the -- it's probably better outside the presence so we can just --

THE COURT: What are the objections?

[Pause]

MR. SMITH: May I approach, Your Honor.

THE COURT: Yes.

MR. SHARP: Here's the two questions that are objected to. The objection's by the Defense.

[Court reviews documents]

THE COURT: The first objection is sustained. The second objection is sustained. There's no foundation for these questions.

MR. SMITH: Thanks, Your Honor.

MR. SHARP: Well, can I be heard on that? I know you're [indiscernible].

THE COURT: You can make your -- yes.

MR. SHARP: I mean, she testified she reviewed the entire file. She reviewed the insurance policy, that's what they've been saying, and these two questions deal with provisions in the insurance policy. So that's -- I'm sure you're going to --

THE COURT: The ruling is the same, Mr. Sharp.

MR. SHARP: Thank you.

MR. SMITH: With that, Your Honor -- we can -- would the Court prefer to inform the jury that these are Plaintiffs' questions, after we're done?

THE COURT: No. The Court can do that.

MR. SMITH: Okay. Thank you, Your Honor.

THE COURT: Thank you.

We're ready, Marshal. Thank you.

THE MARSHAL: Okay.

MR. SMITH: 9714 is what I have. Audra, does that sound about right?

MS. BONNEY: Yes. That's the page I noted.

[Pause]

THE MARSHAL: We just need another minute or so, we still have a juror in the restroom.

THE COURT: Thank you.

[Pause]

THE MARSHAL: We're all set. All rise for jury.

[Jury in at 2:52 p.m.]

THE MARSHAL: Everyone in the jury is present.

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

MR. SHARP: Yes, Your Honor.

MR. SMITH: Yes, Your Honor.

THE COURT: Thank you. Please be seated.

Ladies and gentlemen, for some context, the questions that have been asked recently to this witness are actually questions from the Plaintiff, even though the Defense attorney has been reading them. Just so that gives you some clarification and context.

MR. SMITH: Thank you, Your Honor.

THE COURT: Thank you, Mr. Smith. Please proceed.

[Reading of deposition of Lou Ann Amogawin continued as follows:]

Q And you were trained that in order to apply medically necessary, you look at the treatment being proposed and compared to the guideline, right?

A Yes. That would be right.

Q If the guideline says no, then you refer it to the medical director, right?

A Yes. If the patient doesn't meet the criteria, we refer to medical director for further review.

Q But beyond the process you weren't told by UnitedHealthcare, what medically necessary specifically means?

A We were trained to look at -- to look after those words. If an indication -- if the diagnosis of the patient meets a clinical indication for the request, and if it's medically necessary, then we can go ahead and authorize a procedure. But if it falls under it's not medically necessary or unproven area, then we have to send to the medical director. But, yes, we were trained to determine, yeah, if it's medically necessary or not medically necessary, based on the guidelines.

Q So it's fair to say you have no opinion as to whether proton beam therapy was necessary to improve Mr. Eskew's condition, or preserve his existing state of health?

A No. I can only attest for the guideline that I use, based on UnitedHealthcare.

Q And you have no personal knowledge about the basis of, excuse me. And you have no personal knowledge about the basis for those guidelines, correct?

A No, I don't.

Q Do you have any criticism that the level of healthcare being proposed was on an outpatient basis?

A I don't know how proton beam at MD Anderson is being performed. I don't know their policy as to what they -- how they normally do it, if it's an inpatient versus an outpatient setting. I don't know their policies and workflow, as to how they perform each and every of their treatments --

Q So --

A -- they provided.

Q So if I represented it to you, that the treatment is done on an outpatient basis, do you have any criticism on the level of healthcare?

A I would revert to my initial answer that I would have no idea if that would be an inpatient versus an outpatient setting. So I don't know their policy, so I can't answer that.

Q So would it be fair to say as part of your review, you never evaluated what the clinically appropriate level of healthcare was that needed to be provided to Mr. Eskew?

Q I did my job to review the clinical that was presented. It wasn't part of the treatment. I'm sorry. I wasn't part of the treatment. I wasn't physically at MD Anderson. I wasn't in an office. I was given clinicals, and I reviewed the clinicals and counterchecked it with the

criteria. The patient did not meet the criteria, so I have to send for further review to our medical director.

Q We talked about it at the beginning of this deposition about level of healthcare. Do you remember that discussion?

A Uh-huh.

Q Is that, yes?

A Yes, I do.

Q And do you make those decisions?

A Yes, I do.

Q And you've had experience making decisions about level of healthcare, right?

A When I was working, yes. When I was working at UnitedHealthcare, we would determine if a brain service, a request, let's say, let's say radiation, or not really radiation, can I just revert to an x-ray, of course, that's an outpatient setting. Because if it's not an urgent matter if the patient needs -- the patient doesn't need to be admitted in a hospital to get x-rays, they can do it in a freestanding outpatient radiology clinic or radiology facility.

Q So when we say -- so when we say the level of healthcare, that's generally inpatient versus outpatient?

A I'm sorry. What was the question?

Q When somebody -- when you're asked to evaluate the level of healthcare that is generally on an inpatient versus outpatient, or the type of inpatient, whether it's acute ICU, that sort of stuff, right?

A It would be dependent on the actual treatment request, but

for this matter, they did not provide us whether it's going to be inpatient or outpatient setting, basing on this case

Q So you never made a decision. You've never made an analysis whether the matter in which MD Anderson proposed to do the proton beam therapy was the most clinically appropriate level of healthcare?

A I cannot -- I cannot answer the question relating to MD Anderson, because as I mentioned, I'm not really part of MD Anderson, so I wouldn't know how they conduct the treatment. I can only attest for what they're asking, which in this case is a proton beam radiation treatment, but they didn't indicate whether they want to do an inpatient setting versus outpatient. If they did, it would be included in the clinical request.

Q So a follow-up, you therefore never evaluated the level of healthcare that was going -- that was being proposed by MD Anderson?

A No. We didn't, because it wasn't requested.

Q Okay. Do you have any evidence that it was clinically inappropriate for Dr. Liao to recommend proton being therapy treatment?

A No, I don't.

Q Now in terms of like -- I'm still a little confused on like how the audits were communicated to you. I know that you're audited to make sure you're complying, following the guidelines --

A Uh-huh.

Q How is that --

A Uh-huh.

Q How are the results communicated to you?

A So they will get the case number or tracking number off a certain case that we reviewed. Let's say for this specific case, if the person needs therapy that got denied, they would check if I need to write the proper policy, which is the UnitedHealthcare 2015P, 5T, T0132T policy, and whether I proper -- followed the escalation process, then I submit it to our medical director for review.

Did I quote the right policy for the review? Did I have enough protocol to review it? Do I have the correct diagnosis, the requesting physician's name, the correct CPT codes or the treatment codes to be provided to the patient? Do I have every of those information in the response? Did I document correctly? Did I mistype something?

And even the typos are circled for change, because if you've been doing a lot of typos, they would tell you to take your time, or maybe try to review it before, try to proofread it before saving it to the system to avoid any erroneous typo.

Q Okay. And who would be -- I'm just trying to -- I understand what they did, but I'm just trying to figure out who communicates the results to you?

A How they -- the auditor will be. So the auditor will have our like random cases that we've done over, like the month or week, and then she would notice if we have committed like mistakes and say here, Lou Ann, you have several typos, you are sending it to Dr. Ahmad, but then you put in Dr. Evan.

And then let's say, I put the IMPT versus IMRT, IMRT versus an IMPT. And then if you did an additional note and then the correction, and you can justify that. And then there is, if you're citing the policy differently, then they would put it -- so they reach out to us, they would allot, like, let's say 15 or 20 to 20 minutes of coaching sessions for the things you might have missed during that case, or any other cases that you have approved, but were citing to a different criteria instead of the actual criteria to be used, so our nurse auditor communicates that to us.

Q Okay. Do you -- did you receive any kind of job evaluation while you were at UnitedHealthcare?

A We do have like an annual performance review. Is that what you're asking?

Q Yeah, what's -- what's the annual performance review called?

A So I believe -- I can't remember honestly, the name of how you call it, but it's technically just an annual performance review of what your goals. Are you planning to take a master? Do you want to be certified in this area? Like future plans? What is your goal plans for your career? Do you want to be in a different position? Are you still enjoying what you're doing in this position, and then evaluate your attendance and all the good things?

Q So what type of things are you evaluated upon as a part of your performance review?

A Honestly, there are a lot of components, but I can't remember each and every one, there's like tons, you know. When your manager does your performance review, it's numerous pages of

different aspects; and I can't remember what the sections would be. But just your attendance, your -- what is your future goal for yourself? How can you -- what are your area for what they call it room for improvement, stuff like that. What do you want to be in this career? How are you enjoying it? Are you being a team player, stuff like that? I can't remember the exact.

Q Does the performance review include your accuracy in terms of following the medical policy guidelines?

A Yes. That would also be weighed in if you're utilizing the proper guidelines and policies, because that's where the nurse auditor weighs in for your performance.

Q So the auditors -- what the auditor is doing is part of your performance review?

A Yes.

Q Okay. Are you -- does any part of your performance review include the number of claims or preauthorization requests you're processing?

A To be honest with you, I can't remember. It's been years. I'm sorry.

Q That's okay. Were you given any sort of incentive pay, bonus, anything like that?

A No. No.

Q Did you believe, when you evaluated the request for proton beam therapy, did you believe that MD Anderson was proposing the therapy solely for the convenience of the insured, Bill Eskew or

MD Anderson?

From what I did for this request, when I got the request coming from MD Anderson, I objectively reviewed the clinicals. So it's not a matter of if I believed in MD Anderson's capabilities of doing proton, or if that's the correct treatment for him, because I'm not part of their treatment procedure, but I am part of the review process. When I receive a clinical, I review it and then match it to our clinical guideline. So --

Q I understand that --

A -- the review process -- uh-huh.

Q But if you just focus on my question, my question is not -- I understand the policy. Did you believe that, and it's -- did you have a belief one way or the other, maybe, no, I did not have a belief? Did you have a belief that MD Anderson was proposing proton beam therapy solely for the convenience of Mr. Eskew or MD Anderson?

A Yeah, I would say -- I would -- I would say, no.

Q Do you have any evidence that MB Anderson was recommending treatment that was inconsistent with Mr. Eskew's diagnosis of cancer?

A Do I have like an evidence? No.

Q Do you have any evidence that the treatment being recommended by MD Anderson was inconsistent with the treatment of Mr. Eskew's cancer?

A No, I don't have evidence.

Q Okay. Ma'am we're back on the record.

Just so I've got a picture in my mind, your role in utilization management as the request for authorization is assigned to you as the nurse, right?

A Yes.

Q And then you take the medical records, determine what the request for preauthorization is, right?

A Yes. We determine the requested treatment for the patient. Yes.

Q So in this case you were assigned Mr. Eskew's claim, right?

A Yes.

Q And you determined that MD Anderson was proposing proton beam therapy for Mr. Eskew, right?

A Yes.

Q And you determined that Mr. Eskew had lung cancer, right?

A Yes.

Q And then you went to the medical policy for UnitedHealthcare that says, proton beam therapy is not medically necessary for lung cancer, right?

A Yes.

Q And then pursuant to the policies and procedures, you then sent the claim to Dr. Ahmad, right?

A Yes. And Dr. Ahmad --

Q When Dr. Ahmad responded back, denied, you observed that he was using an incorrect guideline number, right?

A Yes.

Q And you asked him to clarify by providing the correct guideline, right?

A Yes.

Q Then when he came back to you and again said the claim was denied, you then shifted over to the adverse benefit determination team, right?

A Yes.

Q So you're not being asked to provide any of your independent clinical judgment throughout any of this process?

A My judgment went into sending it to Dr. Ahmad. When I saw that the indication and the diagnosis to the patient does not meet the criteria of the guideline,

Q But it isn't really your judgment, that was what the system required you to do, right?

A Yes.

Q So what I mean is, you're not being asked in your role as a nurse to make an independent analysis as to whether or not the medical care being proposed is appropriate?

A If the patient has met the criteria, then I didn't even have to send it to Dr. Ahmad. But if the patient does not meet the criteria for the medical necessity, and that's why I have to send it to Dr. Ahmad,

Q I understand all that, but that's just you following the medical policies, right?

A Yes.

Q That's not -- that's what I'm getting at. You understand in the

medical world, there's a -- there's things called clinical judgment, where you make a call, there could be two or three different treatments appropriate, and the doctor says treatment A instead of B or C; do you understand that concept in medicine?

A Yes.

Q And that's not what UnitedHealthcare is asking you to do, they're just asking you to take the preauthorization request and apply it to the medical policies. True?

A Yes. We follow the guidelines. Yes.

Q Then once the claim is denied, it's not up to you or your role to go back to Dr. Ahmad and say, did you really look at this closely? Your role is only to ship the file over to the adverse benefit determination team, right?

A Yes.

Q And that's what you did in this case?

A That is right.

Q You follow, you took the information, you determined that proton being therapy isn't covered under the guidelines. You sent it to Dr. Ahmad. When he denied the claim you sent it off to the adverse benefit, determination team, right?

A Yes.

Q You strictly followed the policies and procedures that were in place at UnitedHealthcare, right?

A Yes.

Q This particular preauthorization request for Mr. Eskew, was

handled just like all the other preauthorization requests you had received, right?

A Yes.

Q And this particular denial that you were a part of, you handled it in the same way that you've handled every other denial of a preauthorization request while at UnitedHealthcare, correct?

A Yes. I would follow the same rule of following the policy, yes.

Q And you were never criticized at UnitedHealthcare for following the medical policies?

A Yes. I wasn't.

Q In fact, you were expected to follow those policies, right?

A Yes, that's right.

Q In fact, you could be reprimanded if you didn't follow the policies?

A Yes. That would be right.

MR. SMITH: Your Honor, that concludes the reading.

[End of reading of deposition of Lou Ann Amogawin]

THE COURT: Thank you.

Do you have any additional witnesses, Mr. Smith?

MR. ROBERTS: Your Honor, for our next witness, we would recall Ms. Shelean Sweet. Unfortunately she's not available this afternoon, and we would ask to adjourn and allow her to testify starting first thing in the morning.

THE COURT: Thank you. And she'll be your last witness?

MR. ROBERTS: She will be our last witness, Your honor.

THE COURT: Ladies and gentlemen, we will adjourn early today. We will start tomorrow at 9:00 a.m. It'll be the last witness of the Defense. We'll be done before lunch tomorrow. So we'll be not having trial Thursday and Friday. So the witnesses will end tomorrow, and then we will, on Monday, do jury instructions, and counsel will submit their closing arguments to you.

During the interim, you are instructed not to talk to 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 to the case, or by any medium of information, including without limitation, newspapers, television, internet, radio

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

So ladies and gentlemen, you did hear one witness say, well, you could just Google some of these issues. You are not permitted to

Google any of the issues despite what the witness may have indicated. Do you understand that?

Great. All right. We'll see you tomorrow at 9:00 a.m.

THE COURT: All rise for the jury.

[Jury out at 3:10 p.m.]

[Outside the presence of the jury]

THE COURT: Any issues outside the presence of the jury?

MR. TERRY: No, Your Honor

MR. ROBERTS: None, Your Honor.

THE COURT: Okay. All right. We'll see you tomorrow at 9:00 a.m., and then tomorrow afternoon or after Ms. Sweet, we will settle jury instructions and the verdict form.

MR. TERRY: Thank you, Your Honor.

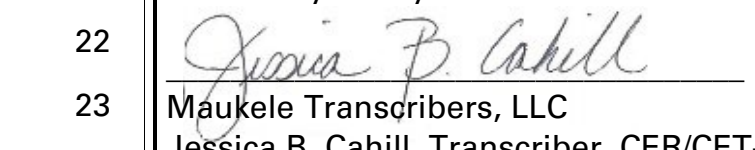
MR. ROBERTS: Thank you, Your Honor.

MR. SMITH: Thank you, Your Honor.

THE COURT: Thank you. Have a great evening.

[Proceedings adjourned at 3:11 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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