2013 IL App (1st) 122238-U

No. 1-12-2238

SIXTH DIVISION
September 27, 2013

IN THE
APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

HOWARD MARTIN, M.D., PH.D.,	)	Appeal from the
	)	Circuit Court of
Plaintiff-Appellant,	)	Cook County
	)	
v.	)	No. 11 CH 41838
	)	
ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES, and JULIE HAMOS, Director of the Illinois Department of Healthcare and Family Services,	)	Honorable
	)	LeRoy K. Martin, Jr.,
Defendants-Appellees.	)	Judge Presiding.

JUSTICE LAMPKIN delivered the judgment of the court.
Presiding Justice Rochford and Justice Reyes concurred in the judgment.

O R D E R

¶ 1 *Held*: (1) The administrative law judge did not abuse her discretion concerning the admission of expert testimony where the plaintiff did not challenge

the witness's qualifications as an expert; (2) the administrative agency did not exceed its statutory authority to terminate plaintiff from the Medicaid program; (3) the administrative law judge's admission of the expert's testimony concerning the standards for treating hepatitis was not an abuse of discretion; (4) the administrative law judge's factual findings were not against the manifest weight of the evidence; (5) the administrative law judge did not improperly limit plaintiff's crossexamination of the expert witness; and (6) the hearing process was completed in a timely manner.

¶ 2 Plaintiff Howard Martin, M.D., Ph.D., filed a complaint for administrative review against the defendants, the Illinois Department of Healthcare and Family Services (Department) and its director, Julie Hamos, who had terminated plaintiff's eligibility to participate as a Medicaid provider. The Department determined that plaintiff had provided medical care to several patients that was of grossly inferior quality, was in excess of their needs, or placed them at risk of harm.

¶ 3 The circuit court confirmed the Department's decision, and plaintiff appealed. For the reasons that follow, we affirm the judgment of the circuit court, which confirmed the Department's decision.

¶ 4 I. BACKGROUND

¶ 5 At the time of the administrative proceedings, plaintiff, a physician practicing in Chicago, was enrolled as a provider of services to participants needing medical care in the Illinois Medical Assistance Program (Medicaid). In June 2005, a medical quality review committee examined medical records documenting plaintiff's care and treatment of 15 patients. Thereafter, the

Department issued a notice of intent to terminate plaintiff's eligibility to provide services under Medicaid and charged him with violations of the Illinois Public Aid Code (Code) (305 ILCS 5/5-1 *et seq.* (West 2008)), and the Department's corresponding regulations regarding 7 of the 15 patients whose records were reviewed by the committee.

¶ 6 Specifically, the Department alleged that plaintiff failed to appropriately assess, evaluate, and manage the diabetes of patient 1, the hepatitis C of patient 3, and the urinary tract infection (UTI) of patient 5 (count I); ordered unnecessary Helicobacter Pylori (H.pylori) tests for patients 6, 7 and 12 but then, upon receiving positive tests results for those patients, failed to address the results (count II); failed to address the abnormally low hemoglobin level of patient 9, for whom plaintiff was prescribing Dilantin (count III); and failed to recommend or order a mammogram, breast exam, PAP smear, or colonoscopy for patient 3 (count IV).

¶ 7 The administrative hearing began in May 2009, and the Department presented the expert testimony of Dr. Jerome Donnelly, a licensed physician in Illinois. Dr. Donnelly was board certified in family practice and internal medicine since 1989 and later added a subspecialty in geriatrics. He is a certified medical director for nursing homes, assisted living facilities, and long-term care facilities, and, thus, is required to ensure that the facilities comply with the regulations of the Illinois Department of Central Management Services. He is also an attending physician at three hospitals and, until 2007, served in a mixed family practice that included geriatrics.

¶ 8 Dr. Donnelly was a member of the committee that reviewed the records of 15 patients of plaintiff. Dr. Donnelly testified that the standard of care governing the physician-patient

encounter requires that all aspects of care be documented and that any test or prescribed medication that is not warranted by the patient's symptoms is in excess of the patient's needs. He also testified that the failure to do follow-up testing or address a patient's symptoms or positive test results places the patient at risk of harm. Moreover, the failure to fully discuss the risks and benefits of treatment prior to prescribing medication places the patient at risk of unwarranted side effects. In addition, when a patient's test results show potentially life-threatening abnormalities, it is imperative that the patient be contacted immediately for follow-up care. The fact that a positive outcome ultimately occurred does not render the treatment appropriate. Dr. Donnelly testified that patients 1, 3, 5, 6, 7, 9 and 12 received either grossly inferior quality of care, or were placed at risk of harm, or both.

¶ 9 Plaintiff testified on his own behalf. He stated that he runs an outpatient primary care family practice that treats patients from infancy through old age. His practice is located in a predominantly Asian neighborhood, and 90% of his patients are Asian, with the majority being Vietnamese. They have a high incidence of H.pylori infection from eating contaminated food, and of hepatitis B and C, as well as diabetes due to heavy rice consumption.

¶ 10 After hearing the detailed testimony of Dr. Donnelly and plaintiff concerning the treatment rendered to patients 1, 3, 5, 6, 7, 9 and 12, the administrative law judge (ALJ) issued a 59-page recommended decision that summarized the testimony and made specific findings of fact regarding each patient and count. The ALJ recommended that plaintiff's eligibility to participate in the Medicaid program be terminated.

¶ 11 Concerning count 1, the ALJ concluded that patients 1, 3 and 5 received a grossly inferior quality of care that placed them at risk of harm. Specifically, plaintiff failed to address patient 1's noncompliance with glycemic control through diet and failed to test for possible damage with a monofilament examination, a microalbumin test, a dilated eye exam, or a liver or kidney check. Further, patient 3 could not and did not consent to the risks involved with her hepatitis C treatment where she was 76 years old and already suffered from anemia, hypertension and degenerative joint disease but there was no discussion about the risks and benefits of placing her on interferon and ribavirin, there was no documentation in her chart of any explanation of the risks, and plaintiff was aware that the medication might have been exacerbating her depression. In addition, plaintiff failed to order a urine culture for patient 5 to properly assess and manage her recurrent UTI despite her complaints of pain during seven separate visits over a period of several months.

¶ 12 Concerning count II, the ALJ concluded that patients 6, 7 and 12 received a grossly inferior quality of care that put them at risk of harm. Specifically, after plaintiff ordered H.pylori blood tests for those patients without clear indication, he then failed to properly address the positive H.pylori results by treating the H.pylori, ordering further testing, or documenting any monitoring or discussion of gastric symptoms.

¶ 13 Concerning count III, the ALJ concluded that patient 9 received a grossly inferior quality of care that placed her at risk of harm where plaintiff treated her with Dilantin, failed to appropriately address her two abnormal hemoglobin test results, and failed to document in the patient's chart any action he rendered to educate the patient or her mother about the severity of

the patient's anemia.

¶ 14 Concerning count IV, the ALJ concluded that patient 3 received a grossly inferior quality of care where plaintiff examined her 12 times over a period of about 19 months but failed to recommend or order a mammogram, breast exam, PAP smear, or colonoscopy. However, the ALJ could not conclude that patient 3 was at risk of harm because the evidence did not establish when she last had any of the screening tests, which might have been recommended in cycles longer than the 19 months plaintiff saw patient 3.

¶ 15 The ALJ found Dr. Donnelly's testimony credible and persuasive. Moreover, plaintiff's insistence that he met the standard of care in each instance despite his lack of monitoring, follow-up, and documentation in the patient charts established that he failed to recognize the existence of a problem. The ALJ concluded that plaintiff's failure to recognize the problem supported his termination rather than mere suspension from the Medicaid program. The director of the Department adopted the ALJ's findings and recommendation, and thus terminated plaintiff from the Medicaid program. Plaintiff sought administrative review, and the circuit court confirmed the director's decision. Plaintiff timely appealed.

¶ 16 II. ANALYSIS

¶ 17 The appropriate standard of review of a final administrative decision turns upon whether the question being reviewed is considered one of fact, one of law, or a mixed question of fact and law. *Carpetland U.S.A., Inc. v. Illinois Department of Employment Security*, 201 Ill. 2d 351, 369 (2002). A decision involving a pure question of law is reviewed *de novo*. *Id*. Purely factual findings are reviewed under a manifest weight of the evidence standard because the agency's

findings and conclusions are deemed to be *prima facie* true and correct. *Id*. Mixed questions of fact and law, *i.e.*, an issue that involves an examination of the legal effect of a given set of facts, are reviewed for clear error, an intermediate standard of review. *Id*. In mixed question situations, the historical facts are admitted or established, the rule of law is undisputed, and the issue is whether the facts satisfy the statutory standard. *AFM Messenger Service, Inc. v. Department of Employment Security*, 198 Ill. 2d 380, 391 (2001). Under the clearly erroneous standard, this court will reverse the agency decision only if, after review of the entire record, this court is left with the definite and firm conviction that a mistake has been committed. *Carpetland U.S.A., Inc.*, 201 Ill. 2d at 369.

¶ 18 In addition, an agency's evidentiary rulings during an administrative hearing are reviewed for an abuse of discretion. *Matos v. Cook County Sheriff's Merit Board*, 401 Ill. App. 3d 536, 541 (2010). Furthermore, a litigant who alleges bias on the part of an agency's hearing officer must overcome the presumption that government officials are fair and unbiased. *Abrahamson v. Department of Professional Regulation*, 153 Ill. 2d 76, 95 (1992). Finally, although *de novo* review applies to an agency's decision on questions of law, some degree of deference should be given to an interpretation of a statute by the agency charged with administering it. *AFM Messenger Service, Inc.*, 198 Ill. 2d 380, 395 (2001).

¶ 19 A. Admission of Expert Testimony

¶ 20 Plaintiff argues that the ALJ misapplied the standard of care as established by case law because Dr. Donnelly, as a prerequisite to his testimony regarding the standard of care, failed to testify that he was familiar with the degree of knowledge, skill and care that a reasonably well-

qualified physician in the predominantly Asian and Vietnamese community like plaintiff's neighborhood would bring to a similar case under similar circumstances. Plaintiff concludes that this alleged failure concerning Dr. Donnelly's testimony rendered him unable to serve as an expert witness as to the standard of care as a matter of law.

¶ 21 The requirements necessary to demonstrate an expert physician's qualifications and competency to testify as to the standard of care are (1) the physician must be a licensed member of the school of medicine about which he proposes to testify; and (2) the expert witness must show that he is familiar with the methods, procedures, and treatments ordinarily observed by other physicians, in either the defendant physician's community or a similar community. *Purtill v. Hess*, 111 Ill. 2d 229, 242-43 (1986); *Ruiz v. City of Chicago*, 366 Ill. App. 3d 947, 953 (2006). After these two foundational requirements have been satisfied, "the court proceeds to evaluate whether the allegations of negligence concern matters within the expert's knowledge and observation." *Sullivan v. Edward Hospital*, 209 Ill. 2d 100, 115 (2004). It lies within the sound discretion of the trial court or tribunal to determine if the witness is qualified and competent to state his opinion regarding the standard of care. *Purtill*, 111 Ill. 2d at 243 (1986); *Ruiz*, 366 Ill. App. 3d at 953. A "medical expert need not also specialize in the same area of medicine as the defendant doctor in order for the expert to qualify as to the appropriate standard of care." *Gill v. Foster*, 157 Ill. 2d 304, 316 (1993) (lower courts erred in barring expert testimony from a general surgeon who had training and experience in interpreting X rays, instructed medical students on the subject of radiology as it related to surgery, examined tens of thousands of X rays, and was familiar with the standard of care of reasonably well-qualified radiologists; the fact that he was

not a practicing radiologist nor board certified in radiology went only to the weight of his testimony, not the admissibility).

¶ 22 In a negligence medical malpractice case, Illinois courts, in determining the standard of care against which the defendant physician's alleged negligence is judged, have followed the similar locality rule, which requires a physician to possess and to apply that degree of knowledge, skill, and care which a reasonably well-qualified physician in the same or similar community would bring to a similar case under similar circumstances. *Purtill*, 111 Ill. 2d at 242. The similar locality rule developed to "protect the rural doctor when facilities, educational opportunities and an ability to travel caused a distinction between the care received in rural communities and urban centers." *Kobialko v. Lopez*, 216 Ill. App. 3d 340, 346 (1991). Nowadays the standards for educating and licensing physicians are relatively uniform (*Purtill*, 111 Ill. 2d at 246), so the similar locality rule is not broadly applied and had been greatly limited in its effect (*Riordan v. Illinois Department of Regulation and Education*, 205 Ill. App. 3d 344, 347 (1990) (citing *Purtill*, 111 Ill. 2d at 247, for the proposition that an expert is not disqualified by a lack of familiarity with the practice in a particular locality if there are uniform standards applicable to a specific situation throughout the country)).

¶ 23 Generally, a tribunal's decision to admit or exclude evidence, including expert testimony, during a hearing is reviewed for an abuse of discretion. *Ruiz*, 366 Ill. App. 3d at 953. Similarly, administrative agency decisions regarding the conduct of a hearing and the admission of evidence are reviewed for an abuse of discretion, subject to reversal only if there is demonstrable prejudice to the complaining party. *Matos*, 401 Ill. App. 3d at 541.

¶ 24 First, plaintiff forfeited any claim that Dr. Donnelly was not qualified to give expert testimony by failing to timely challenge, at the hearing, Dr. Donnelly's qualifications to testify as an expert or his familiarity with the treatments ordinarily observed in plaintiff's community or a similar community. See *Griffitts Construction Co., Inc. v. Department of Labor*, 76 Ill. 2d 99, 106-107 (1979). Furthermore, concerning the similar locality rule, plaintiff does not contend that, because he practiced in a particular neighborhood in Chicago, he had less of an opportunity for education than other doctors, had limited facilities available to him, or lacked access to specialists for consultation. In addition, our review of the record here reveals no abuse of discretion by the ALJ in allowing Dr. Donnelly's expert medical testimony about the standard of care expected from a primary care family practice physician like plaintiff. Dr. Donnelly's testimony established that he was a licensed physician, was board certified in family practice and internal medicine, had a subspecialty in geriatrics, was an attending physician at three hospitals, and had served in a mixed family practice for several years. Furthermore, Dr. Donnelly's testimony established that the allegations at issue in this case concerning the treatment of diabetes, hepatitis, UTIs, anemia, H.pylori infections and cancer screenings were matters within his knowledge and observation.

¶ 25 B. Termination Based on Risk of Harm

¶ 26 Plaintiff contends the Department had no authority to terminate him from the Medicaid program based on the findings and conclusions that he had placed his patients at risk of harm. According to plaintiff, the Department violated the statutory language of section 12-4.25(A)(e)(2) of the Code (305 ILCS 5/12-4.25(A)(e)(2) (West 2008)), which authorizes the Department to

terminate a Medicaid provider who furnishes services that are *harmful*. Plaintiff contends the Department used an administrative rule to define the statutory term *harmful* in a way that lowered its burden of proof and substantially expanded its authority to terminate a provider who furnishes services that merely *placed an individual at risk of harm*.

¶ 27 Plaintiff argues the statute unambiguously and plainly limits the Department's power to terminate where the care rendered is harmful to the recipient, so the focus must be on the outcome of the treatment or service the patient received. Plaintiff asserts that, given the statutory language, it was error for the ALJ to make findings that the lack of discussion about treatment options and the lack of documentation in the charts concerning those discussions resulted in harm to the patients. Plaintiff argues that the plain meaning of the word *harmful* is injury or loss and the Department was not authorized to twist the meaning of that word to include the potential for injury or loss. Plaintiff asserts that the "statutory language 'harmful to the recipient,' contained in 305 ILCS 5/12-4.25 (A)(e), does not mean 'placing a recipient at risk of harm.' "

¶ 28 An administrative rule "implements, applies, interprets or prescribes law or policy." 5 ILCS 100/1-70 (West 2008). Administrative regulations, like statutes, have the force of law and are presumed to be valid. *Granite City Division of National Steel Co. v. Illinois Pollution Control Board*, 155 Ill. 2d 149, 162 (1993). The construction of statutes and regulations is a question of law, subject to *de novo* review. *Burris v. Department of Children and Family Services*, 2011 IL App (1st) 101364, ¶ 30. Where an agency regulation is not in conflict with the plain language of the statute, a reviewing court must give deference to the agency's interpretation of the statute. *Pollachek v. Department of Professional Regulation*, 367 Ill. App. 3d 331, 341

(2006). If it reasonably can be done, a reviewing court has a duty to affirm the validity of administrative regulations. *Granite City*, 155 Ill. 2d at 164-65.

¶ 29 The statute provides that participants may be terminated from the Medicaid program if they have provided goods or services to a recipient that are in excess of his needs, "harmful" to him, or constitute grossly inferior quality of care. 305 ILCS 5/12-4.23(A)(e) (West 2008). Department regulations interpreting and implementing that statute provided for termination of a provider who has furnished goods and services that, when based upon competent medical judgment and evaluation, were determined to be in excess of a recipient's needs, of grossly inferior quality, or

> "harmful to the recipient (for purposes of this Section *** 'harmful' goods or services caused actual harm to a recipient or placed a recipient at risk of harm, or of adverse side effects, that outweighed the medical benefits sought to be provided)." 89 Ill. Admin. Code § 140.16(a)(7) (2008).

¶ 30 Plaintiff's argument lacks merit. The regulation at issue does not conflict with section 12-4.23(A)(e) of the Code but, rather, interprets and implements the statute. Furthermore, we ascertain and give effect to the intent of the legislature by giving the words used in the statute their plain and ordinary meaning. *People v. Hunter*, 2013 IL 114100, ¶ 13. The plain, ordinary meaning of the word *harmful* is "of a kind likely to be damaging: injurious" (Merriam-Webster's Collegiate Dictionary 530 (10th ed. 1998)), and "damaging, troublesome, injurious" (Webster's Third New International Dictionary 1030 (1981)). Accordingly, we conclude that the plain language of the statute establishes that the Department was not required to prove actual harm; it

was sufficient that the provider placed the patient at risk of harm. Consequently, the Department's decision to terminate plaintiff from the Medicaid program for placing patients at risk of harm was consistent with the Department's authority under the statute.

¶ 31 C. Expert Testimony on Hepatitis C

¶ 32 Plaintiff contends that it was an error of law to find Dr. Donnelly qualified as an expert in the treatment of patients with hepatitis C due to his lack of experience or training in this field of medicine. We find, however, that plaintiff's characterization of Dr. Donnelly's testimony and assertions about his lack of experience and training are not supported by the record.

¶ 33 According to the record, Dr. Donnelly testified regarding plaintiff's treatment of patient 3, a 76-year-old woman whom plaintiff had diagnosed with active hepatitis C in 2003. Plaintiff prescribed two medicines for her: Intron A (a type of interferon) and ribavirin. He also did an ultrasound that showed no abnormalities of the liver or upper abdomen. In the Fall of 2003 and Spring of 2004, he did blood tests.

¶ 34 Dr. Donnelly testified that he has diagnosed patients with hepatitis C but does not treat them himself; he refers them to a hepatologist (liver specialist). He communicates with the hepatologist and receives copies of the results of any tests the specialist may have ordered. Dr. Donnelly testified that the standard of care is not for a primary care physician to treat hepatitis but to refer the patient to a specialist for a liver biopsy and genome analysis. Those tests are important because interferon and ribavirin are toxic medications that can have serious, life-threatening side effects including bone marrow suppression, depression so severe that it can precipitate suicide, and severe anemia, which can cause heart attack, stroke, and other vascular

complications. The biopsy determines whether there is damage to the liver already or whether treatment may be delayed. The genotype analysis shows which of the three types of hepatitis C the patient has, whether it will respond to treatment, and, if so, whether the treatment should last 24 or 48 weeks. If the biopsy shows that the disease had minimal effect, then, given the severity of the side effects and the 5- to 10-year life expectancy of the average 76-year-old woman, the best approach may be to hold off treatment and simply monitor her.

¶ 35 Dr. Donnelly testified that a patient placed on interferon and ribavirin should be seen every week or two for the first few months, but that was not done and, thus, patient 3 was placed at great risk. In addition, her chart indicated that she had depression associated with her chronic illness and degenerative spine disease, and a substance-induced mood disorder from the interferon. Her chart noted that she was "chronically fatigued, depressed and in constant body ache." Dr. Donnelly testified, citing the American Gastroenterology Association's consensus statement, that unless stopping the medications would be life-threatening, patient 3 should have been taken off the interferon because at that point the risk from her depression appeared to be greater than the risk from her hepatitis. He based that opinion on the information in her chart and the lack of evaluation of the severity of her disease.

¶ 36 In addition, Dr. Donnelly doubted patient 3's ability to give informed consent to taking interferon and ribavirin based on a chart notation that read "[the patient's] motivation to acquire new information is not there" and her "short term memory is minimal due to illness." There was no documentation of informed consent in the chart.

¶ 37 After that testimony, plaintiff filed a motion to strike Dr. Donnelly's testimony regarding hepatitis C; plaintiff explicitly stated that he was "not asking that Dr. Donnelly be disqualified as a witness." The ALJ refused to strike Dr. Donnelly's testimony, explaining that plaintiff's concerns about him not being a specialist in liver disease went to the weight of his testimony rather than to its admissibility.

¶ 38 The ALJ found that Dr. Donnelly had testified persuasively that patient 3 was at risk of harm from the severe side-effects of the medication and plaintiff was aware that the medication might be exacerbating her depression. The ALJ noted that no explanation of the risks was documented in the chart and found that informed consent was unlikely due to the patient's age and condition. The ALJ concluded that patient 3 could not and did not consent to the risks involved with the treatment, that she was placed at risk of harm by plaintiff, and that she had received a grossly inferior quality of care.

¶ 39 We find no abuse of discretion in the ALJ's evidentiary ruling on the admissibility of Dr. Donnelly's testimony on the standards for treating hepatitis. Contrary to plaintiff's assertions on appeal, Dr. Donnelly did not testify that he had no experience or training concerning hepatitis C. The record establishes Dr. Donnelly's credentials as a medical expert in primary care and that he has seen and diagnosed patients with hepatitis C as part of his practice. Moreover, he kept apprised of the issues involved in treating hepatitis by pursuing continuing medical education over the years. Because hepatitis C is a complicated disease, Dr. Donnelly testified that patients who have it should be referred to a specialist for further testing and treatment.

¶ 40 D. Factual Findings

¶ 41 Plaintiff argues that Dr. Donnelly's opinions were based on speculation rather than facts. Specifically, plaintiff complains that Dr. Donnelly did not know whether there was an improvement in the condition of various patients and, thus, merely speculated when he testified that those patients failed to demonstrate improvement. Plaintiff also complains that this was not a case involving record-keeping review and Dr. Donnelly's speculations that plaintiff failed to appropriately address patients' abnormal test results were based on the absence of documentation or notations in the patients' charts. Plaintiff argues that Dr. Donnelly had an insufficient factual basis to form a valid opinion about the goods and services furnished by plaintiff.

¶ 42 Plaintiff does not challenge the evidence showing what the charts contained; rather, he challenges the conclusions Dr. Donnelly drew from that evidence. Our review of the record establishes that the ALJ's factual findings were supported by the evidence in the record and were not against the manifest weight of the evidence. Dr. Donnelly testified as to what was and was not included in the charts he reviewed. Any missing information was attributable to plaintiff's failure to provide care, or failure to document that he provided it or discussed it with his patients. For example, plaintiff did not document his reasons for ordering the H.pylori tests for patients 6, 7 and 12 or whether he ever discussed with the elderly patient 3 the risks versus benefits of placing her on two medications known to cause severe side effects. In addition, plaintiff failed to document whether patient 5 experienced any improvement in her UTI symptoms between her visits after the first three courses of antibiotics he prescribed for her. Furthermore, where plaintiff did not convey any urgency in his note to his staff to call patient 9 for a follow-up

appointment due to her extreme anemia, the ALJ properly concluded, based on the lack of documentation and the testimony that patient 9 was not seen again until six weeks later, that plaintiff had failed to immediately address the patient's severe anemia. Thorough documentation of the care provided is required under the administrative rules and is essential to a patient's continuity of care, both to remind the provider himself of what he has done and to guide any future provider who may have to take over the patient's care. Where the patients' charts contained no indication that care or discussion was undertaken, then the ALJ properly concluded that no such care or discussion occurred.

¶ 43 E. Limitation of Crossexamination

¶ 44 Plaintiff contends the administrative hearing was not impartial because the ALJ was biased against him. Plaintiff argues the ALJ's bias was shown by her improper rulings that limited plaintiff's crossexamination of Dr. Donnelly regarding his training and payment by the Department, medical standards, and his conversations with the Department attorney. We find no support in this record to conclude that the ALJ was biased against plaintiff or in favor of the Department, and the ALJ's evidentiary rulings were a proper exercise of her discretion.

¶ 45 Administrative decision-makers are assumed to be people of conscience, capable of setting aside their own personal views, and of judging a particular controversy fairly on the basis of its own merits. *Abrahamson*, 153 Ill. 2d at 95. An individual challenging the impartiality of an administrative tribunal must overcome a presumption that those serving in such tribunals are fair and honest. *Caliendo v. Martin*, 250 Ill. App. 3d 409, 421-22 (1993). To establish bias, a litigant must prove that the decision-maker adjudged the facts as well as the law of the case in

advance of hearing it. *Williams v. Board of Trustees of Morton Grove Firefighter's Pension Fund*, 398 Ill. App. 3d 680, 693 (2010).

¶ 46 First, plaintiff argues the ALJ did not permit him to crossexamine Dr. Donnelly on the training he received when the Department hired him as a consultant for its committee. The record, however, contradicts this argument. Dr. Donnelly answered the consultant training question by responding that, to the best of his recollection, the training involved: approximately two hours of going through the physician handbook, which described various terms like risk of harm, inferior quality of care, excessive needs, and what those terms meant to the Department; a review of several sample physician consultant reports; and sitting in as an observer on a committee meeting. There was no training beyond that. When plaintiff's counsel asked if the term *grossly inferior quality of care* was contained in the handbook, Department counsel objected based on relevancy, contending the question sought to test Dr. Donnelly's recollection of a training session that occurred about eight years ago. The ALJ sustained the objection. Thereafter, Dr. Donnelly testified that *inferior care* is care that is not optimal but possibly acceptable, whereas *grossly inferior quality of care* would be a significant deviation and it would not be acceptable under any circumstances as a quality of care. The record establishes that the ALJ did not improperly limit plaintiff's crossexamination on the relevant topics.

¶ 47 Second, plaintiff contends the ALJ erred by limiting his crossexamination about Dr. Donnelly's remuneration from the Department by limiting plaintiff's questions about Dr. Donnelly's contracts to two years prior to his 2009 testimony. Plaintiff complains that he could not explore the total income Dr. Donnelly received from the Department over the years he served

as a consultant, including his contract for 2005, which was when the medical review committee considered plaintiff's records in this case.

¶ 48 Our review of the record, however, establishes that plaintiff does not accurately characterize his line of questioning or the ALJ's ruling. According to the record, the ALJ sustained, based on a lack of foundation, the Department's objection when plaintiff's counsel asked Dr. Donnelly if his current contract with the Department was the same as the one he initially signed when be began consulting for the Department. The ALJ acknowledged that questions concerning an expert's fee arrangement were legitimate and went to the issue of witness bias; however, inquiries concerning the frequency of the expert's testimony for a party and the annual income earned from expert testimony were generally limited to two years prior to the trial. See *Pruett v. Norfolk & Western Railway Co.*, 261 Ill. App. 3d 29, 32 (1994). The ALJ also found that plaintiff failed to lay a foundation for the time period involved because Dr. Donnelly could not remember when he first contracted with the Department or details concerning his involvement in the medical review committee meetings concerning this case.

¶ 49 Accordingly, the ALJ did not prevent plaintiff from crossexamining Dr. Donnelly about whether he had a financial interest in this case or whether he got paid based upon its outcome. Instead, plaintiff was merely stopped from conducting an irrelevant exploration into how Dr. Donnelly's current contract compared with his initial contracts. Plaintiff does not show how the ALJ's ruling harmed him or converted the hearing into a partisan process, and we conclude that the ruling was not an abuse of discretion.

¶ 50 Third, plaintiff argues the ALJ improperly limited his crossexamination of Dr. Donnelly concerning the 76-year-old patient 3. Specifically, plaintiff challenges the ALJ's ruling, on grounds of hearsay and lack of foundation, that plaintiff could not question Dr. Donnelly about a statement contained in a 2003 press release concerning the American College of Obstetricians and Gynecologists (ACOG).

¶ 51 According to the record, the Department had alleged that plaintiff saw patient 3 12 times between March 2003 and October 2004 but failed to give her the option of getting a mammogram, breast exam, PAP smear or colonoscopy. On direct examination, Dr. Donnelly testified that even though mammograms, breast exams, colonoscopies and PAP smears were not mandatory for a 76-year-old woman, the standard of care for wellness in 2003 and 2004 required a primary care physician to discuss with the patient the pros and cons of doing those tests and to offer the tests, taking into consideration the patient's life expectancy and other health problems. There was no documentation in the charts of any discussion concerning any of those tests with patient 3. Dr. Donnelly opined that plaintiff provided patient 3 with a grossly inferior quality of care and placed her at risk of harm.

¶ 52 During crossexamination, Dr. Donnelly testified that a consensus among authoritative bodies had changed the standard for mammogram testing for women over 80 years old: if their life expectancy was less than 10 years, then they might not benefit from having a mammogram. Dr. Donnelly testified that, based on her chart, patient 3 had a life expectancy of 6 to 8 years. Dr. Donnelly further testified that, based on her chart, patient 3 never had a colonoscopy before, and her anemia could have been an indication of colon cancer, so she should have been advised to

have a colonoscopy. Based on the results of that colonoscopy, a physician would then determine when it would be advisable for her to have another colonoscopy. Dr. Donnelly testified that patients should start having colonoscopies at 50-to 55-years of age, but after the age of 80 the risks may outweigh the screening benefits. Concerning PAP smears, if a women aged 70 or older had never had an abnormal PAP smear, the benefit of having that test is questionable.

¶ 53 When plaintiff's counsel attempted to question Dr. Donnelly about a July 2003 press release that was printed from the Internet, the ALJ sustained the Department's hearsay objection based on counsel's inadequate foundation for the document, which was not an authoritative article or treatise on medicine. Then, plaintiff's counsel asked if Dr. Donnelly agreed with a statement in that press release, which said that physicians can determine on an individual basis when an older woman can stop having cervical cancer screenings based on such factors as medical history and physical ability to monitor the patient in the future. The Department objected. Although the Department conceded that plaintiff's counsel could ask a question based on the press release, the Department argued that counsel improperly couched his question by citing the unauthenticated, hearsay press release as authority for the basis of that question. The ALJ sustained the Department's objection, stating that plaintiff's counsel did not ask a valid question but, rather, read a statement word-for-word from the hearsay document.

¶ 54 Thereafter, plaintiff's counsel asked Dr. Donnelly what his understanding in 2003 was of the ACOG's recommendation regarding when PAP smears could be discontinued. Dr. Donnelly testified that in March 2003, the data was that all women should be screened; however, upon reading the hearsay press release, Dr. Donnelly learned that the ACOG's recommendation

changed in July 2003 so that after the age of 70, PAP smears could be stopped. The Department moved to strike Dr. Donnelly's testimony regarding his knowledge of the ACOG's recommendation because it was based on his reading during the hearing of the press release, which was not authenticated and, thus, was a hearsay document. The ALJ denied the motion, finding that the Department failed to timely object before Dr. Donnelly had read the press release. The ALJ also admonished plaintiff's counsel not to refer to the press release and to stop asking questions about it.

¶ 55 "An expert may be cross-examined with articles and treatises he does not recognize, provided some other expert has testified that the publications are authoritative." *Iaccino v. Anderson*, 406 Ill. App 3d 397, 408 (2010). The record supports the ALJ's limitation of the crossexamination here because plaintiff failed to establish that the press release, which was printed off the Internet and was not an authoritative medical article, was an authoritative publication. Furthermore, the record establishes that plaintiff succeeded in questioning Dr. Donnelly about the press release despite the ALJ's hearsay and foundation ruling because the ALJ determined that the Department failed to timely object to that line of questioning. Finally, the ALJ ruled in plaintiff's favor by finding that he did not place patient 3 at risk of harm by failing to recommend cancer screening tests, so any alleged error in limiting the crossexamination on that issue did not prejudicially affect plaintiff. See *Material Service Corp. v. Department of Revenue*, 98 Ill. 2d 382, 386 (1983).

¶ 56 Finally, plaintiff argues the ALJ erred when she sustained the Department's objection to the following question posed by counsel during Dr. Donnelly's crossexamination:

> "Did you discuss your opinions regarding that issue [count I, which related to plaintiff's alleged failure to appropriately assess, evaluate and manage the diabetes, hepatitis and UTI of three patients] with [the Department's attorney] between the first hearing and today?"

Plaintiff argues this line of questioning could have shown that Dr. Donnelly was influenced by the Department's attorney.

¶ 57 Although the preparation of a witness for testimony may be a proper subject of crossexamination, the latitude a party is given to pursue it is not unlimited. *West Chicago St. R.R. Co. v. Byrne*, 85 Ill. App. 488, 493 (1899). In cases that allowed the inquiry, the proponent had a basis for it. *E.g.*, *Harmon v. Town of Cicero Municipal Officers Electoral Board*, 371 Ill. App. 3d 1111, 1113, 1116 (2007) (an officer of the court testified that she heard the witness being coached prior to the hearing on what to say during his testimony); *White v. Garlock Sealing Technologies, LLC*, 373 Ill. App. 3d 309, 313-14 (2007) (in a case involving an egregious discovery violation, the expert witness gave testimony that was inconsistent with his disclosed opinion concerning a central issue in the case and counsel failed to amend the Rule 213 disclosure to include the expert's revised opinion). Here, plaintiff has not shown any basis for his proposed inquiry. The ALJ found that plaintiff's line of inquiry was nothing more than a "fishing expedition," and plaintiff identified no specific topic upon which he wished to adduce testimony, nor any harm that resulted from the ALJ's ruling. Accordingly, we find no abuse of discretion. Even assuming, *arguendo*, that it would have been proper to allow plaintiff's counsel to inquire about any discussion between Dr. Donnelly and the Department's attorney during the course of

the hearing, the record establishes that any such error would not reasonably have affected the result of the hearing. See *People v. Davis*, 126 Ill. App. 2d 114, 118-19 (1970).

¶ 58 F. Timely Proceedings

¶ 59 Plaintiff argues that the hearing process was not completed in a timely manner, in violation of due process and section 12-4.25(F) of the Code (305 ILCS 5/12-4.25(F) (West 2008)). We disagree.

¶ 60 The hearing took place on 10 dates between May 19, 2009, and March 11, 2011. Section 12-4.25(F) of the Code does not contain any time limits or guidelines on completing the hearing; it provides only that the "Department must complete a proceeding under this Section in a timely manner." 305 ILCS 5/12-4.25(F) (West 2008). Even where a statute, unlike this one, provides time frames within which to conclude a hearing and issue a decision, delays are generally excused where a litigant has acquiesced in scheduling and sought his own continuances. See *Lyon v. Department of Children and Family Services*, 209 Ill. 2d 264, 274-76 (2004).

¶ 61 Plaintiff forfeited review of this issue by failing to object at any time to the scheduling of the various hearing dates during the proceedings before the Department. See *Griffitts Construction Co.*, 76 Ill. 2d at 106-07. Such forfeiture notwithstanding, the record shows that the parties agreed to the continuance dates and there were instances when plaintiff's attorney sought to end the proceedings earlier in the day than the ALJ had anticipated. In addition, proceedings in this matter were scheduled to accommodate plaintiff, who was generally not available except on Fridays. The ALJ and the Department tried to accommodate plaintiff's schedule, consistent with their own prior commitments in other cases. The nearly two-year time span it took to

complete this hearing is attributable mainly to plaintiff's own unavailability. On this record, we reject plaintiff's claim of untimeliness.

¶ 62 III. CONCLUSION

¶ 63 We have determined that the Department's decision to terminate plaintiff's eligibility to participate as a Medicaid provider was not against the manifest weight of the evidence, or contrary to law, or in excess of the Department's statutory authority. Moreover, the ALJ did not abuse her discretion in determining that Dr. Donnelly was qualified and competent to testify. The ALJ also allowed substantial crossexamination of Dr. Donnelly and did not abuse her discretion in limiting that crossexamination. Finally, under the circumstances of this case, plaintiff's due process rights were not violated by the length of the administrative hearing. Accordingly, we affirm the judgment of the circuit court that confirmed the administrative decision.

¶ 64 Affirmed.