HB 2027 & HB2028

Good Afternoon Mr. Chairman and Committee Members,

My name is Yolanda Bell, and I am a constituent of Delegate Roem.

I have been here before you every year since my sister, Anastasia Adams, was killed; speaking in favor of Bills that will stop institutions and guardians from doing what was done to her again. I don't know what else I can say to you or show you to impress upon you the importance and urgent need for these bills and meaningful guardianship reform with teeth. So I leave you with the facts and plead with you once again to pass these bills unanimously.

Fact No. 1. Anastasia was placed into a hospital guardianship solely because I, as her power of attorney, refused to consent to her discharge because I believed she was still too ill. A fact that the Office of Medicare Hearing and Appeals (OMHA) confirmed in their ALJ's written decision. Per 42 CFR § 478.38[1], the fact that Anastasia's discharge had been appealed to Medicare in Washington, D.C. nullified Kepro's decision siding with the hospital. But by that time Fairfax had already given her over to Inova and their guardians and they had already taken and removed her and refused to give her back. Bottom line Inova should not have been able to file for and receive guardianship until Medicare rendered their decision.

Her guardian's that have contacted you have lied to you. I leave you with the official court transcript for the guardianship hearing and the Medicare decision. I know you don't have the time to read them now because of other bills you must hear, but I respectfully request you do read them to have a full understanding of the true account of what was done.

Fact No. 2. It was impossible to get back in front of Judge Shannon to have him look at what was happening to Anastasia. Judges must have better oversight of their guardianship cases. Better oversight would have prevented my sisters' suffering and her death.

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[1] *42 CFR § 478.38 Effect of a reconsidered determination - A QIO reconsidered determination is binding upon all parties to the reconsideration* ***unless*** *- (a) A hearing is requested in accordance with § 478.40 and a final decision rendered.*

Fact No. 3. Anastasia was neglected and abused. The guardians did not regularly visit and check on her. When notified of injuries they essentially ignored them. Anastasia weighed over 120lbs when the guardians took her. She weighed a mere 87lbs when she died nine months later.

Fact No. 4. The guardians, in their own words, stopped feeding and hydrating Anastasia solely “so she [would] die faster.”

Fact No. 5. Anastasia had broken bones and too many bruises to count when she died and her body showed signs of abuse, a struggle, and it is believed sexual assault.

Fact No. 6. Anastasia’s right hip/femur and ankle were broken and never fixed causing her excruciating pain and leaving her deformed. The guardians canceled her private medical coverage which was paid for by me.

Fact No. 7. All visitors were banned from seeing Anastasia until I took the guardians to federal court.

Fact No. 8. Visitation was severely restricted by the guardians. This combined with no regular in person visits by the guardians left her vulnerable to abuse and neglect. The eyes of family and friends could have prevented it from happening.

Fact No. 9. Clergy were turned away.

Fact No. 10. Anastasia suffered horribly because there are no laws to prevent any of these things from happening.

Fact No. 11. I told Inova in the January 26, 2017, meeting I would remove Anastasia from the hospital and they took her anyway.

Fact No. 12. Because of the severe visitation restrictions, Anastasia died alone without family, friends, or clergy there to hold her hand.

Thank you for your time and attention.

Respectfully,
YolandaBell
Anastasia’s Voice

In The Matter Of:

INOVA, d/b/a INOVA FAIRFAX HOSPITAL v. ANASTASIA V. ADAMS

HEARING

February 15, 2017

ICR
INABNET COURT REPORTING

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V I R G I N I A

IN THE CIRCUIT COURT OF FAIRFAX COUNTY

----------X

INOVA, d/b/a INOVA FAIRFAX HOSPITAL, : Petitioner, : Case No. 2017-000368

- versus - :

ANASTASIA V. ADAMS, : Respondent. :

----------X

Fairfax, Virginia

Wednesday, February 15, 2017

The above-entitled action came on to be heard before the Honorable Stephen C. Shannon, a judge in and for the Circuit Court of Fairfax County, in Courtroom 4D, Fairfax County Judicial Center, 4110 Main Street, Fairfax, Virginia, 22030, before JoAnne B. Dellosso, a registered verbatim reporter, beginning at approximately 10:00 a.m., when there were present on behalf of the respective parties.

APPEARANCES:

On behalf of the Petitioner:

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Guardian Ad Litem on behalf of Anastasia Adams:

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E X H I B I T S

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Petitioners Exhibit D -- INOVA Records of Ms. Adams	Page 81	--
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T H E P R O C E E D I N G S:

(The court reporter was first duly sworn by the clerk of the Court.)

THE COURT: Good morning.

MS. KIRKLAND: Good morning.

MS. MORISI: Good morning.

THE COURT: Would the attorneys please introduce themselves and their respective parties.

MS. KIRKLAND: Good morning, Your Honor. Laurie Kirkland on behalf of the petitioner, INOVA, doing business as INOVA Fairfax Hospital.

THE COURT: All right.

MS. MORISI: Good morning, Your Honor. My name is Andrea Morisi, and I represent Yolanda Bell. She is the sister of the respondent, Anastasia Adams.

THE COURT: Okay. Is there a third party?

MS. JOHNSTON: Good morning, Saben Johnston, guardian ad litem.

THE COURT: Okay, good morning.

Do we have another party involved in this?

MS. KIRKLAND: That's all, Your Honor.

THE COURT: Okay.

MS. KIRKLAND: The respondent, Ms. Adams, has a guardian ad litem, but she's at the hospital. She won't be present.

THE COURT: Okay, so ma'am, you're the guardian ad litem for --

MS. JOHNSTON: For Ms. Adams, yes.

THE COURT: Okay.

MS. JOHNSTON: Where would you like me to sit?

THE COURT: You can sit wherever you are comfortable. This isn't my usual courtroom, so it's -- wherever you are comfortable, but you have a right to examine folks as well, so if you want to move up, that's fine.

MS. JOHNSTON: Okay.

THE COURT: All right. I've let the parties talk for a while. What's the status of this case right now?

MS. KIRKLAND: Your Honor, on behalf of INOVA, we're prepared to go forward. This comes on our petition to appoint guardians and conservators for Ms. Adams.

We have tried to work something out with her sister, Ms. Bell, but right now we have not reached a

settlement.

THE COURT: All right. Is there anything we need to take up preliminarily before we start with opening statements?

MS. KIRKLAND: I don't have anything.

MS. MORISI: No, Your Honor.

THE COURT: All right, then let's proceed. Opening for INOVA.

MS. JOHNSTON: Thank you, Your Honor.

Again my name is Laurie Kirkland. I represent INOVA Fairfax Hospital, and this comes on our petition to appoint guardians and conservators for a patient at INOVA. Her name is Anastasia Adams, the respondent.

As a professional matter, I don't expect evidence to be undisputed that Ms. Adams lacks capacity. She suffered anoxic brain injury due to a Tylenol overdose in 2005. And currently she is not communicative and in bedridden state.

So the issue before the Court really will be who is the suitable decision maker for her, given that she lacks capacity. INOVA is petitioning for mutual professional guardians and conservers to be appointed,

and we have proposed Ken Labowitz and Anne Heishman, who are two attorneys practicing before the Bar of this Court. Ms. Yolanda Bell is the sister and she has got a cross-petition to be the guardian.

By way of background, as I mentioned, Ms. Adams -- she's a 59-year-old woman. She suffered a brain injury due to the lack of oxygen in 2005. Since 2005 INOVA does understand that Ms. Bell has been her primary caregiver. She also claims to have a power of attorney that's dated 2010, so five years after the brain injury had occurred.

But nonetheless whether she's next of kin making decisions, or making them -- to a power of attorney, INOVA feels it's no longer in Ms. Adams' best interest.

In December of last year Ms. Adams was receiving treatment for pneumonia at INOVA Loudoun Hospital. On December 2, 2016, the evidence will show that Ms. Bell had her sister transferred to INOVA Fairfax Hospital against medical advice. She was advised that due to on-going pneumonia, the fever, respiratory failure, there was no medical reason to transfer her

after there was a risk. Nonetheless, she was transferred against medical advice.

Upon arrival at Fairfax, she was treated for pneumonia by anti-biotics, it was clear. She did develop some fluid around her heart, but within a few weeks that also had been conservatively managed. It was not a problem.

As of December 28, 2016, Ms. Adams was cleared by every division at Fairfax Hospital for discharge. The evidence will show that since that time, for 50 days, Ms. Bell, next of kin or power of attorney, has refused to remove the status from the hospital.

Ms. Adams no longer requires acute care and because she doesn't require acute care, Medicare has denied her coverage, and her only other cover is Kaiser Insurance, and this is out of plan. Ms. Bell signs forms as Ms. Adams power of attorney authorizing those expenses for which Ms. Adams becomes liable.

The Court will hear from Dr. Betzlos. He is the chief medical officer at Fairfax Hospital. He will testify that for the past 50 days Ms. Adams has been stable and ready for discharge.

He will testify he's communicated with Ms. Bell on multiple occasions, including many in-person meetings, and spoke to her to address each and every medical concern she has raised about her sister, Ms. Adams. The issues which -- these are issues Ms. Bell raises that she alone believes prevent discharge.

After 50 days of trying to address Ms. Bell's medical concerns which are ever changing, and are left with no other option but to proceed the petition to appoint a more suitable guardian and conservator for Ms. Adams who cannot make these decisions for herself.

Based on the evidence, INOVA requests the Court appoint Ken Labowitz and Anne Heishman, who currently serve as guardians and conservators for many persons under the direction and under this Court, and in this Court as well that a jurisdiction is in order to reach a -- (unintelligible).

THE COURT: Okay.

MS. KIRKLAND: Finally, I would note that the GAL, Ms. Saben Johnston, has also filed with the Court and reaches the same conclusion. As you will see from her report from her today, she concludes that Ms. Bell

clearly loves and cares for her sister very much, but right now has been unable to make the decision necessary to discharge her from the hospital and find a suitable place for her to receive the appropriate level of care.

For these reasons we will ask that the Court grant the petition to appoint neutral guardians and conservators for Ms. Adams.

THE COURT: Okay, counsel, what is the legal standard?

MS. KIRKLAND: Your Honor, the petition is filed under Virginia Code 64-2000, there's a Code chapter; 2007 will give you the seven factors that you would consider today.

THE COURT: Is that 64.2 or 64 --

MS. KIRKLAND: 64.2-2007.

THE COURT: Okay.

MS. KIRKLAND: And there's seven factors the Court can consider. The one notation for the respondent, the development of the respondent, the availability of less restrictive alternatives, the extent is necessary to protect the respondent from neglect and abuse. The actions needed to be taken by a guardian and a

conservator, the suitability of the proposed guardians and conservators and the best interests of the respondent.

THE COURT: I see, okay. Thank you very much.

MS. KIRKLAND: Thank you, Your Honor.

THE COURT: All right, counsel, opening statement.

MS. MORISI: Thank you, Your Honor.

There's no disagreement that Ms. Anastasia Adams is a person with profound disabilities. And due to those disabilities it's easy for an imbalance in any one of her systems, via cardiac, pulmonary, vascular, digestive; anything that goes out of balance can cause a critical medical issue with this woman. And when a specialist works on addressing one area, they often put another area into an imbalance. And there's a likelihood that this becomes a repeating cycle.

Ms. Yolanda Bell disagreed with INOVA Fairfax Hospital that her sister has been stable for discharge back in late December or early January of this year because it was a hasty discharge from Reston INOVA Hospital to a Potomac Falls nursing home that was

unprepared and unsafe that resulted in the need for her to be readmitted to INOVA Fairfax.

At the time that INOVA Fairfax has been talking about discharge, there's been on-going medical issues with her heart, her lungs, a looming blood clot, and these have given Ms. Bell concern that again she's going to have this revolving door of medical needs as one thing gets addressed or doesn't get addressed, and other things arise due to the imbalances in her systems.

Ms. Bell's response to her sister's medical issues is identical to those of a parent or a child. She desires and reaches out for information. What is going on with my sister? What is the course of treatment? What's recommended, not recommended? Is this my sister's new normal? Please help me to understand that. What does this mean?

So ironically INOVA Fairfax Hospital so interested in having Ms. Adams discharged, actually ordered all information, except access to medical records be denied Ms. Bell. So for nearly a month she was not allowed to talk to doctors to get the information that they wanted her to have to make a decision on discharge.

Ms. Bell has been her sister's caregiver, power of attorney, the reminder of her medical history, her staunchest advocate for nearly 12 years, and she should be her guardian if a Court determines one is required. Ms. Bell feels Ms. Adams' medical condition has improved, and that discharge to a safe and appropriate facility or to her home is appropriate provided the care and other concerns needed to get her there are addressed.

THE COURT: All right.

MS. MORISI: She needs continuing medical care in whatever facility she goes to or home, and we're concerned about those being put in place.

THE COURT: But your client, as I understand it, does not want her to go back to her home right now, she wants her to stay in the hospital, correct?

MS. MORISI: If discharge can be arranged to a safe and appropriate place with the assistance she needs, she's ready to do that.

THE COURT: Okay, thank you.

Would the GAL like an opening statement?

MS. JOHNSTON: No, Your Honor, I filed a report yesterday, and they told me you received it?

THE COURT: Yes.

MS. JOHNSTON: Okay, then I'll reserve my statement for argument?

THE COURT: All right, thank you.

All right, INOVA's first witness.

MS. KIRKLAND: We call Dr. Scott Betzlos.

(The witness was first duly sworn by the clerk of the Court.)

Whereupon,

SCOTT BETZELOS, M.D.,

a witness, called for examination by counsel for the petitioner, and having been first duly sworn by the clerk of the Court, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. KIRKLAND:

Q. Good morning. Would you state your name for the record?

A. Dr. Scott Betzelos.

Q. And what is your current occupation and job title?

A. Chief Medical Officer of INOVA Fairfax Hospital.

Q. And can you briefly describe your educational background?

A. Sure. I went to Loyola University for college, and then onto Chicago Medical School to receive my medical degree, and then to Orlando Regional Medical Center where I did my residency in emergency medicine. I also have a master's degree from Touro College in New York in forensic examination, and an MBA recipients.

Q. And do you hold any Board Certifications?

A. I am Board Certified in emergency medicine.

Q. And do you hold a medical license in the Commonwealth of Virginia?

A. Yes.

Q. And how many years of experience do you have as a physician?

A. From 1989.

Q. Do you have any honors or --

A. Just Board Certified of the American College of Emergency Physicians.

MS. KIRKLAND: If I could show this exhibit. They're not marked, but Exhibit A.

THE COURT: Why don't we have the document

marked just so we could keep track of everything.

MS. KIRKLAND: That's great.

(The document referred to above was marked Petitioner's Exhibit A for identification.)

BY MS. KIRKLAND:

Q. Dr. Betzelos, is the document we just marked as Exhibit A a copy your CV?

A. Yes, it is.

Q. And does it accurately reflect your relevant education and experience?

A. Yes.

MS. KIRKLAND: Your Honor, I move Dr. Betzelos' CV into evidence.

THE COURT: Any objection?

MS. MORISI: No, Your Honor.

THE COURT: The Court will receive a section of Exhibit. Will that be A or 1, Madam Clerk?

THE CLERK: I marked it as A, Your Honor, that's fine.

THE COURT: All right.

MS. KIRKLAND: Thank you.

(The document referred to above was marked Petitioner's Exhibit A for identification and was received into evidence.)

MS. KIRKLAND: Your Honor, I'd also like to offer Dr. Betzelos as an expert in the field of medicine.

THE COURT: All right, any objection?

MS. MORISI: No, Your Honor.

THE COURT: All right, the Court will recognize the doctor as an expert.

MS. KIRKLAND: Thank you.

BY MS. KIRKLAND:

Q. Dr. Betzelos, are you familiar with a patient, Anastasia Adams?

A. Yes, I am.

Q. Can you describe her overall physical and medical condition?

A. Anastasia suffers from anoxic brain encephalopathy. She's unable to communicate and she's contracted -- her lower extremities are contracted up. She receives her nutrition through a G-Tube, and from a cardiovascular standpoint she is at a stable condition, and from a pulmonary standpoint she is in stable

condition.

Q. And based on her condition, does she have the mental ability to make or communicate important decisions about her health or well-being?

A. Absolutely not.

Q. And does she have the mental ability to make or communicate important decisions regarding her finances or her property?

A. No.

Q. Does she have the sufficient understanding nature of this proceeding regarding guardian or conservatorship?

A. No.

Q. And do you hold those opinions to a reasonable degree of medical certainty?

A. Yes.

Q. When was Ms. Adams most recent admission to INOVA Fairfax Hospital?

A. At around the first week of December. I believe it was the 2nd.

Q. And do you know the reason for her admission?

A. She was a transfer from -- I want to say it was

a transfer from our sister hospital INOVA Fair Oaks -- I'm sorry, INOVA Loudoun where she was admitted for pneumonia, and was transferred to our facility against medical advice at the transferring facility, and was received at our facility.

Q. And why was the transfer against medical advice?

A. The transfer was against medical advice because anytime you transfer a patient that has an acute condition, you put them at a greater risk during that transfer rather than maintain them at the current facility that they're at. So if the benefit doesn't outweigh the risk, we generally do not want to transfer patients.

Q. And was she transferred against medical advice?

A. Yes. According to the records she was transferred against medical advice because she wanted -- she said that she -- the priest at Fairfax Hospital and that's where she wanted to be.

THE COURT: Who is she, sir?

THE WITNESS: I'm sorry, Ms. Bell.

BY MS. KIRKLAND:

Q. Ms. Bell stated the reason for transfer was so that Ms. Adams would be near her priest?

A. Yes.

Q. And in your experience and in your visits and your familiarity with Fairfax, have you seen a priest meet with Ms. Adams?

A. Not to me extent, no.

Q. After admission to INOVA Fairfax, did INOVA successfully treat Ms. Adams' pneumonia?

A. Yes, we did successfully treat the pneumonia.

Q. And how was she treated?

A. She was treated with IV anti-biotics followed by oral anti-biotics. She also had developed a small amount of fluid around the heart, around the pericardial effusion. That's the sack that surrounds the heart, and that fluid was due to the inflammation that you get from pneumonia, and that fluid subsequently has resolved, and so now we treated the pneumonia. We also treated the secondary facts of pneumonia with specific pericardial effusion.

Q. And around what time was the pneumonia and the pericardial effusion treated?

A. Through the timeframe of two weeks of December.
Q. And did there come a time when Ms. Adams was stable and ready for discharge?
A. Yes.
Q. Approximately when was that?
A. That was on or around December 28th. The medical team which included cardiac specialists, pulmonologists, infectious disease, hematology all concluded that Anastasia was stable for discharge to an appropriate level of care; specifically a SNF unit.
THE COURT: To where, sir?
THE WITNESS: To a skilled nursing facility, a nursing home.
BY MS. KIRKLAND:
Q. And why hasn't Ms. Adams not left INOVA Fairfax Hospital to be transferred to one of those homes.
A. Ms. Adams is not approving discharge for Anastasia --
Q. You mean Ms. Bell?
A. I'm sorry, Ms. Bell has not approved discharge of Anastasia to an appropriate level of care claiming that we have not answered her questions regarding the

care that we provided.

Q. And have you met personally with Ms. Bell?

A. Yes, I have.

Q. How many times would you estimate that you had spoken to her?

A. I think Ms. Bell and I spoke at least two times, or maybe three, I can't remember.

Q. And were those in-person meetings?

A. They were in-person meetings, yes.

Q. And in addition, you have other positions than in-communications with her?

A. Every day.

Q. Are you aware of any physician that has been ordered not to speak to Ms. Bell?

A. No, no. What that is about, we asked Ms. Bell to only communicate with our physicians during regular business hours. She has a habit of paging physicians in the late hours of the night, past 11:00 in the evening and disturbing the physicians.

Q. Can you describe generally your experience in dealing with Ms. Bell in order to obtain her authorization for discharge?

A. Say that again?

Q. Sure. Can you describe your experience in dealing with Ms. Bell in trying to address her concerns or obtain her authorization to discharge Ms. Adams?

A. Ms. Bell no doubt loves her sister and cares for her deeply. She has many, many medical questions. Some of it are relevant, some of it are not. We as a medical team have attempted to answer every single one of her questions; however, we never are able to answer her questions to the answer that she wants to hear.

So when we say that the pericardial effusion, the fluid around the heart, will go away, Ms. Bell will ask for another echocardiogram or ask for another consult or ask for a different opinion, and this gets into what we call circular conversation around what is already deemed by the care team as a stable pericardial effusion that will resolve on its own. That's just one example.

And she gets into the medical record and asks questions and says well, there's a millimeter difference here, a millimeter difference there, and we tell her that that doesn't -- that's just a normal thing, you don't have to worry about that kind of thing, and that doesn't

satisfy her; so she says we don't answer her questions when we actually do and say that's not a medical concern.

Q. And in addition to medical concerns, has she raised any issues relating to nutrition or food?

A. Yes. She has brought in G-tube feedings that were backing up into Anastasia's room that the nurses had put in there and they keep putting them in there instead of using them -- they used them, and then bring extras in just to have on the side.

Q. Just for the Court's background, can you explain what the concerns Ms. Bell bought to you was?

A. She was concerned that we were not feeding Anastasia, that we were just putting the bags of food that go into the G-tube in the room, and the nurses were not feeding Anastasia. And the nurses were, they were just bringing in extra in the room to have to be more efficient.

Q. And to your knowledge has Ms. Adams received the proper food package recommended by a nutritionist?

A. Yes.

Q. Was another issue that she raised or a request for percussion therapy for Ms. Adams?

A. Oh, yes, that is true. But can I get back to the G-tube?

Q. Sure, absolutely.

A. Also during our conversation Ms. Bell brought in an expired product of G-Tube feedings, and I was very concerned about that because we actually don't want to give expired food to patients. And I had the lot number reviewed by our spy chain, and that lot number was never purchased by INOVA Fairfax health system.

Q. So to your knowledge based on your personal research, INOVA was not giving expired food to Ms. Adams?

A. Right, that lot number was never purchased by INOVA Fairfax health system.

Q. We were just moving to the issue of percussion therapy. Is that another concern that Ms. Bell had raised?

A. Yes, it is.

Q. And what is percussion therapy?

A. Percussion therapy is bed-ridden patients -- you can many times see physicians take their hand and pump on the patient's chest and back. And what that does is it loosens up mucus phlegm within the chest.

Q. Is percussion therapy a treatment currently ordered by any of Ms. Adams' attending physicians?

A. It's not ordered, but the respiratory therapists are doing that.

Q. And do you know why they are doing that?

A. At the request of Ms. Bell.

Q. Are you aware of any standard of care that requires that therapy?

A. I'm not aware of any standard of care that requires chest percussion therapy.

Q. And to a reasonable degree of medical certainty what is your opinion as to why she requires that therapy at this time?

A. It's added to therapy, not required.

Q. How has Ms. Bell's insistence that her sister receive that therapy hinder INOVA efforts in finding an appropriate facility to which she could be discharged?

A. You know, we have several skilled nursing facilities in the area we can speak with case management, but I think it's greater than 15, and all of them do not do chest percussion therapy.

Q. And so as her insistence on percussion therapy

preventing discharge?

A. It's one of the reasons that it's preventing us from discharging.

MS. KIRKLAND: I think then, Your Honor, I marked this as Exhibit B.

THE COURT: Yes.

(Whereupon, a document was presented to the Court and the witness.)

(The document referred to above was marked Petitioner's Exhibit B for identification.)

BY MS. KIRKLAND:

Q. Dr. Betzelos, having you look at Exhibit B, which are Ms. Adams' medical records from yesterday. Do these records in Exhibit B accurately reflect her current medical condition?

A. Yes, they do.

Q. I would like to direct your attention to the section titled, Plan, on the first page. As of yesterday which division at INOVA Fairfax Hospital cleared Ms. Adams for discharge?

A. It says here that patient is cleared for

discharge by hematology, infectious disease, cardiology, pulmonary, nephrology and internal medicine.

Q. And are you aware of anything that's changed between yesterday and this morning?

A. No, I'm not aware of anything that changes that.

Q. And are you aware of any medical provider who has seen and treated Ms. Adams and does not believe she has been ready for discharge since December?

A. No, I am not.

Q. And how long has she been stable for discharge?

A. About --

THE COURT: About how long?

THE WITNESS: About a month and a half. Since December 28.

BY MS. KIRKLAND:

Q. Okay, so about 50 days?

A. Yes.

Q. Since the --

A. And there was a small episode where she spiked a fever and was given anti-biotics again, but that could have been done in a nursing home as well.

Q. So in the past 50 days nothing has occurred that could not have been treated suitably in a skilled nursing facility?

A. Correct.

Q. Since the date of her discharge in December, 2016, has Medicare been covering her stay?

A. Medicare has not covered her stay since she was cleared for discharge on December 28. Ms. Bell has appealed twice to the QAPI, the Quality Assurance Program for Center Medicare and Medicaid Services, CMS, and they have denied her appeal twice indicating that Anastasia is stable for discharge.

Q. And during this time in the past 50 days, what percent of beds at INOVA Fairfax Hospital have been full?

A. We're in a busy season. We're at 95-plus capacity every single day.

Q. And why is that important?

A. INOVA Fairfax Hospital is a level-one trauma center. The only one in northern Virginia, and we have obligations to serve our community, and we have patients through our emergency department and care for patients as they are admitted. We have patients that are occupying a

bed that are not suppose to occupy a bed and are appropriate for an alternative level of care. It's compromising our ability to treat patients that are presented with acute conditions.

Q. Dr. Betzelos, are you aware that this proceeding is to appoint neutral professional guardians and conservators for Ms. Adams?

A. Yes.

Q. And you support that petition?

A. Yes, I do.

Q. And why do you support it?

A. We believe that -- the care team believes that and INOVA Fairfax Hospital believes that Anastasia Adams is stable for discharge and Ms. Bell is preventing that discharge and compromising the care of Anastasia with that blocking us from being able to transfer Anastasia to an appropriate level of care.

Q. And in your medical opinion, what is the appropriate treatment for Ms. Adams at this time?

A. At this time is transfer to a lower level of care, to a SNF facility.

Q. And in your opinion that a neutral professional

guardian would be able to facilitate that placement?

A. Yes, it is.

Q. And why do you believe that?

A. Because I have had multiple conversations -- I believe Ms. Bell and I met for an hour, along with her attorney, and a number of people to try to resolve this at the hospital. That did not work. I don't believe that Ms. Bell will allow us to discharge Anastasia regardless of the medical condition that she is in.

Q. And at this time do you believe there is any less restrictive alternative that would be in Ms. Adams' interests?

A. No.

MS. KIRKLAND: I have no further questions.

THE COURT: Cross-examination.

MS. MORISI: Thank you, Your Honor.

CROSS-EXAMINATION

BY MS. MORISI:

Q. Doctor, you spoke about the percussion therapy. This is very important, as you know, to Ms. Adams. Is there any risk -- well, what are the risks from percussive therapy?

A. There are no risks to perform percussion therapy.

Q. Okay. Are there benefits?

A. There are benefits, as I indicated earlier, that it can help reduce mucus phlegm.

Q. In a person who's bed ridden or has constrictors such as Ms. Adams?

A. Yes, but it's added to therapy, it's not a standard of care.

Q. All right.

(Whereupon, a document was presented to the Court and counsel.)

THE COURT: Counsel, how would you like this document marked? Since we're going with the alphabet why don't we just say Respondent's A? Does that work good?

MS. MORISI: Intervener A?

THE COURT: Oh, Intervener A, okay. Madam Clerk, what's easier for you?

(Discussion off the record not reported by the court reporter.)

(The document referred to above was marked Intervener's Exhibit A for

identification.)

BY MS. MORISI:

Q. Doctor, do you recognize this as an extra report summary from the record to Anastasia Adams at INOVA Hospital?

A. Yes, I do.

Q. And in the center there where the large circle is, which -- not that it didn't come on the report that way, but those large spikes, could you tell us what that indicates?

A. Well, the top graph is the vital signs, and it looks to be -- I think you got heart rate here and pulse oximetry, and at one point the heart rate spiked to 200, and then dropped to zero, and this is an initial spike, and most likely related to some type of movement in the string of vital signs. It's not uncommon to see something like this.

Q. And does it stream as that from the upper range to the lower range, and that appears to be over a 10-hour period on January 9th?

A. Right. From what I'm guessing, you printed a very condensed piece here, and I think at sometime

between 7-ish, but that's if it was bigger. A lot of things are -- so I could see exactly what it was and it wasn't just an initial spike. It could be that there was an episode of tachycardia, a very fast heart rate which can happen, but I really can't tell you which it is unless you expand this out. But I do know that Anastasia did have an episode of tachycardia at some point in January, so if that's what this is, that's what it is.

Q. I think that might be one example of it; didn't find them all in the strings, those tapes. And I apologize that it appears even though my printer says it has all the ink levels, I know the colors are not right because INOVA is not red, it should be blue.

But below you said the other, the lower graph was on -- is that oxygen saturation?

A. No, I think that the oxygen saturation is built in --

Q. Oh, I'm sorry.

A. -- top graph.

Q. It's in the top graph.

A. And that's an interesting thing that you bring up is because the oxygen saturation was absolutely normal

when the heart rate is supposedly zero, and that can't happen, so that tells me that's an artifact.

Q. Okay. But it did dip below right after that, didn't it?

A. Yeah, but it wouldn't take that long. If your heart rate went to zero, your oxygenation goes to zero in two minutes. After the fact it goes way low before that, and, you know, I don't see any change in the oxygen saturation, and the high spike before it went up, which means it could have been a stable tachycardia. And the bottom graph --

Q. Do you think this is the monitor alarms?

A. These are the alarms, yeah.

Q. On the equipment that's in her room?

A. Yes, and that's not uncommon either. These alarms go off all the time. They actually cause alarm fatigue to our providers.

Q. This past weekend Ms. Adams suffered from a low oxygen saturation?

A. Yes, that is true.

Q. And what would be the causes from low oxygen saturation?

A. Right. Patients that have hypoxia or low oxygen events that are bid ridden more than likely suffer from either a recurrent infection or a blood clot in the lung called pulmonary embolism.

The physicians immediately identified this and ordered a CT angiogram, that's a CT scan of the heart and lungs where we inject dye and look for blood clots. And that exam revealed that there were no blood clots and no further pneumonia.

Q. And during the times that Ms. Adams suffers from low oxygen saturation, what would it be like for someone who -- is that like us having a chest cold where we are not getting full oxygen in our lungs. What would you say how the symptoms would be?

A. You know, people like us that have normal physiology that suffer from that, we would have the same physiology barrier to prevent us from breathing. But people that are bed ridden, their swallow reflex doesn't work as well as us, and therefore they may swallow saliva instead of going down the swelling tube, the esophagus, it goes down the trachea and cause a temporary plugging of one the alveoli in the lung, and that would cause an

hypoxia event. Does that make sense?

Q. Yes, I understand. Thank you for the physiology discussion. I meant what would she be looking like, would she be in distress, would she be coughing, choking, something like that?

A. It all depends upon the neurological status of the patient; you and I, yes. Anastasia, I'm not quite sure based on her neurological status, but my guess is that she would have some type of display of a very, very -- a neurological display of pain.

Q. And what is the treatment for low oxygen saturation, that's what you call it?

A. Well, the initial treatment is oxygen, and then the diagnostics will detail out to what the further treatment is. And in this case the CT Scan does not reveal any abnormality that requires to do any additional treatment.

Q. Would an incident such as she had this past weekend lead to an order for her to have oxygen on an as-needed basis or on a regular basis?

A. Oxygen therapy is not always the best thing. You want to use it judiciously and when it's appropriate,

so if you're oxygenating well, there is really no need to provide oxygen on an on-going basis, and can actually hurt. So what we want to do is order oxygen during events or preceding events that we believe are going to cause low oxygen.

MS. MORISI: Thank you. I have no further questions.

THE COURT: All right. Cross-examination with GAL.

CROSS-EXAMINATION

BY MS. JOHNSTON:

Q. Ms. Bell had a few other concerns that she had addressed. One of those was related to the weight of her sister. How did INOVA address that, those questions?

A. Well, we've been following her weight, and it's our opinion that she's back to her baseline weight, and we are continuing to feed her through her G-Tube diet with the appropriate hydration.

Q. And also at the meeting there was concerns regarding a blood clot by her sister. How did INOVA address that?

A. We addressed that through ultra-sounds of her

right upper arm extremity, and the ultra-sound shows that the blood clot is resolving and blow flow has returned, and the hematologist has ordered a low dose of Lovenox, which is a blood thinner to help prevent further blood clots.

Q. What was the purpose of the January 28th meeting? What was the goal at that meeting?

A. The goal of the meeting was to -- the care providers had exhausted all possibilities of having a conversation around discharge with Ms. Bell. And the goal of that was to set up this meeting so that we could all gather together, address the concerns, answer the questions that were asked to the best of our ability, and then hopefully bring Ms. Bell to the decision that Anastasia was stable for discharge.

Q. And did you tell Ms. Bell that her sister was stable for discharge?

A. I assured Ms. Bell that the infectious disease, the pulmonologist, the hematologist, internal medicine doctor, cardiologist had all deemed Anastasia stable for discharge.

Q. And so what was the response from Ms. Bell?

A. We had some more conversations around the pericardial effusion. She had some questions that I was able to answer.

Q. And these are subsequent the following day she had further questions?

A. Yeah, there's some multiple emails after that that I answered through the attorneys, I believe.

Q. And with that regarding an echocardiogram, and were there any concerns about fungal infection?

A. The fungal infection was in Anastasia's mouth, and the infectious disease specialist believed that is being treated with Nystatin, that is an anti-fungal liquid, and also they believed, based on medical records, that that is because Anastasia's mouth is chronically open, and you get that film that goes over your tongue, when you keep breathing through your mouth.

Q. And so you responded to Ms. Bell's questions then?

A. I responded through the attorneys.

Q. And then what was Ms. Bell's response after that? Did she have anymore questions that --

A. I did not receive any further questions, via

email, from Ms. Bell.

MS. JOHNSTON: Thank you. I don't have any further questions.

THE COURT: Any redirect?

MS. KIRKLAND: Yes, Your Honor.

REDIRECT EXAMINATION

BY MS. KIRKLAND:

Q. Dr. Betzelos, the incident of tachycardia in January, is that something that would have alerted you that Ms. Adams needed to remain in the hospital?

A. The episode of tachycardia, depending on its ideology, which was investigated, resulted in the fact that Anastasia remains stable for discharge.

Q. And the cardiologist who treated her agreed with that opinion?

A. Yes, we do.

Q. And the oxygen issue that just happened over the weekend we're discussing, is that something that a skilled nursing facility could have addressed just as well?

A. Yes.

MS. KIRKLAND: I have no further questions,

Your Honor.

THE COURT: All right. Is the doctor subject to recall, or is free to go back to work?

MS. KIRKLAND: He's free to go.

MS. MORISI: Yes, Your Honor.

THE COURT: All right. Doctor, you are free to leave. Thank you for coming in today.

THE WITNESS: Sure.

(Witness excused.)

THE COURT: Counsel, your next witness?

MS. KIRKLAND: Your Honor, I call Anita Hall.

THE COURT: Okay.

(Whereupon, the witness was duly sworn by the clerk of the Court.)

Whereupon,

ANITA HALL,

a witness, called for examination by counsel for the petitioner, and having been first duly sworn by the clerk of the Court, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. KIRKLAND:

Q. Good morning. Would you state your full name

for the record?

A. My name is Anita Hall.

Q. And where are you currently employed?

A. INOVA Fairfax Hospital.

Q. And what is your job title?

A. Clinical Case Manager.

Q. And can you briefly describe your job duties.

A. I help in reviewing the charts of discharged patients; identify and address barriers to discharge and help in that discharge planning.

Q. And how many years of experience do you have in positions performing the title of duties?

A. Two years in case management, and prior to that I was a nurse also to help discharge patients.

Q. And are you familiar with INOVA's discharge planning efforts for INOVA's Fairfax's Hospitals patient Anastasia Adams?

A. Yes, I am.

Q. And have you been involved in some of the discharge planning?

A. Yes, I have.

Q. And has INOVA contacted an skilled nursing

facilities to inquire as to whether they would accept Ms. Adams?

A. Yes, over 20.

Q. And when Ms. Adams was discharged back in December to May of 2016, had INOVA lined up an appropriate skilled nursing facility to accept her?

A. Yes.

Q. And which facility was that?

A. Gainesville Health and Rehab.

Q. And was this communicated to Ms. Bell?

A. We attempted to communicate with her, yes, by messages.

THE COURT: Ma'am, what is it called, Gainesville what?

THE WITNESS: Gainesville Health and Rehab.

THE COURT: And that was referred to as a skilled --

MS. KIRKLAND: A skilled nursing facility. You may have to speak up and into the microphone to be heard a little better.

THE COURT: Thank you.

BY MS. KIRKLAND:

Q. I believe your last response was that you attempted to communicate with Ms. Bell. What do you mean attempted?

A. We made numerous phone calls to her and left messages for her to call us back in response to the acceptance of a facility.

Q. And did you hear back from her?

A. No.

Q. Could Gainesville Health and Rehab hold the bed for Ms. Adams indefinitely?

A. No, they cannot, because they have other patients that also need those beds, so if we do not get a clear indication of their acceptance by a family member, they cannot hold a bed.

Q. And since that time how many nursing facilities has INOVA contacted with respect to Ms. Adams?

A. Over 20.

Q. And among these facilities, did INOVA contact any for which Ms. Bell had expressed a -- (inaudible).

A. Yes, we did.

Q. And in the past 50 days, have any of these facilities indicated they can accept Ms. Bell?

A. Yes.
Q. And has Ms. Bell authorized discharge to any of them?
A. No.
Q. Can the facility's ability to accept Ms. Adams' change on a daily basis?
A. Yes, it can.
Q. And why is that?
A. The question again, I'm sorry.
Q. What did it change day to day?
A. Depending on the bed availability.
Q. Did there come a time when you learned that Ms. Bell would not consent to discharge unless the facility would provide percussion therapy?
A. Yes, I did become aware of that.
Q. And is it your understanding that therapy is not ordered as necessary by a physician?
A. Yes, that is my understanding.
Q. Nonetheless, did INOVA search for a facility that provide that treatment at Ms. Bell's request?
A. We did try.
Q. And were any of the 20 facilities contacted

able to provide that therapy?

A. I do not believe so. I think one may have said they would try, but they would need to be trained.

Q. And are -- based on your experience do you believe a neutral professional guardian would be able to facilitate this discharge process?

A. Yes, I do.

Q. And why is that?

A. Because we have been unable to get Ms. Bell to participate in transferring her sister or assist in this transfer.

Q. Are you aware of any other objections the facilities may have in accepting Ms. Adams?

A. No.

Q. So the only impediment to her transfer has been Ms. Bell's inability to authorize the transfer?

A. Yes.

MS. KIRKLAND: I have no further questions.

THE COURT: Cross-examination by the intervener?

CROSS-EXAMINATION

BY MS. MORISI:

Q. Good morning, Ms. Hall.
A. Good morning.
Q. Ms. Bell had indicated that she had a preference for a facility in Manassas called Birmingham Green.
A. That's correct.
Q. Did a bed recently become available at Birmingham Green?
A. Not to my knowledge.
Q. Okay. Were they one of the facilities who said they couldn't do percussion therapy?
A. They had.
Q. Okay. To what was it Gainesville rehab facility that said they could train someone to do?
A. I would have to re-look at my notes to be for sure.
Q. Okay. How often do you talk to Ms. Bell?
A. Well, Ms. Bell has come late in the evenings, and not during the day, so it's been hard to contact her and have a direct conversation with her. But our social worker has also tried to phone -- (unintelligible) and have talked to her a couple of times.

Q. Okay. Would they give her a status as to what facilities were being reached out to and --

A. Yes, they have.

Q. -- you know, we have a bed available?

A. Yes.

Q. Okay. Thank you.

MS. MORISI: I have no further questions.

THE COURT: Cross-examination by the guardian ad litem?

MS. JOHNSTON: I don't have anything further.

THE COURT: Any redirect?

MS. KIRKLAND: No, Your Honor.

THE COURT: All right. Is the witness free to leave?

MS. KIRKLAND: She is, but she is also here for the clients.

THE COURT: Okay. All right, Ms. Hall, you can have a seat next to counsel.

Your next witness, counsel?

MS. KIRKLAND: Your Honor, I have no further witnesses.

THE COURT: All right. So is there anymore

evidence you wish to present?

MS. KIRKLAND: No, the petitioner would rest, Your Honor.

THE COURT: Does the intervener have any evidence in which she would like to present?

MS. MORISI: Yes, I'd like to call Ms. Bell.

THE COURT: All right.

(Whereupon, the witness was duly sworn by the clerk of the Court.)

Whereupon,

YOLANDA BELL,

a witness, called for examination by counsel in her own behalf, and having been first duly sworn by the clerk of the Court, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. MORISI:

Q. Ms. Bell, would you introduce yourself to the Court, and tell the Judge a little bit about yourself.

A. My name is Yolanda Bell. I am Anastasia Adams younger sister, my baby sister, the youngest of four. We had two older brothers but one passed in '92. Our other brother actually resides here, my brother Charles resides

here within the area.

I was the typical little sister always wanted to tag after my sister, begging my mother to make her take me with her. I wanted to be just like her. I have always looked up to my sister.

In June of 2005 -- well, actually prior to that my sister had become disabled. Not in the sense that she is now, but she had a condition called Lycosidae Classic Vasculitis, which is an inflammation of the blood vessels, and can be extremely painful.

It's an autoimmune disorder and can be caused by -- or it's within Lupus family I should say, or it can also be the symptoms caused by an allergic reaction to a medication which the -- eventually found out that that's what was causing it.

There was a medication that she was taking was causing some sort of a reaction within her system, because since she stopped taking those medications in 2005 she hasn't had a flare-up or anything like that.

And so in 2003 she had an episode with the Vasculitis, so she ended up with a blood infection and ended up in the hospital in Arizona.

And at that time she actually made me her power of attorney in 2003 because she -- since we had already lost -- my parents had already lost a child, that that wasn't a decision she wanted to put on my parents, so she asked me being the youngest I would do that, and since I was actually the one who cared for her, and my oldest brother passed away in 1992.

Q. Do you want to tell us about her accident that resulted in this?

A. In June of 2005, she suffered an accidental acetaminophen overdose. The doctors in California weren't communicating with one another and they had her on various different medications. And at least one of the medications, Vicodin, had acetaminophen in it, and when she started spiking a fevers, they told her to take Tylenol on top of that for the fevers.

And what happened is that it built up in her system and her liver went toxic and she went into multiple organ failure and respiratory failure and cardiac arrest.

She was transferred to a hospital in San Francisco, and because they initially thought she was

going to need a liver transplant, but all of that, everything subsequent over her time in the hospital, bounced back.

She had been incubated for 14 days, but bounced back from that. Everything was perfect when she was released from the hospital. She was walking, she was talking, she was cooking her own breakfast.

The baseline that the hospital, that INOVA seems to think is her baseline now, was not her baseline with the brain injury. That became subsequent in 2007 when she actually wound up in a wheelchair again due to a Virginia doctor this time had given her. That gave her long term that was not supposed to be given for that specific length of time.

Q. Okay.

A. And so --

Q. So in 2007 she came to the situation of reduced mobility?

A. She was in a wheelchair, yes.

She was still speaking, although less frequently at that time, because we would have conversations where she described it like a veil coming

over her when this would happen. And so subsequently, eventually she ended up to where she started having he contractions and all. Because even at that time when she was first in the wheelchair, there were times she was walking with her walker, versus the -- in the wheelchair, and she was speaking herself. I mean, she still does that occasionally to this day. She has moments of complete lucidity to where she will talk to you. She will tell you everything that's been going on in the last two weeks, and she was able to feed herself.

Q. Okay. In 2010 you sought out legal counsel for your sister to execute a durable medical power of attorney in advance, medical directive.

A. Right.

MS. MORISI: That was included with an intravenous petition, Your Honor.

BY MS. MORISI:

Q. Can you give us the background that you had executed that?

A. Yes, like I said previously, my sister had in 2003, and then again in the beginning of 2005 before the brain injury, had effected two power of attorneys making

me her -- both, the first health power of attorney that she did we were told by someone that -- my parents had actually witnessed that one, and they said because they were family that that wasn't necessarily valid. So the beginning of 2005, I believe January or February, my sister -- we went down and had another set done, both a health power of attorney and a durable power of attorney for property and finances done and notarized along with a living will.

Q. Is that the document that you presented to the hospital?

A. No, that one was -- I believe it was February or actually could have been May of 2005, but it was before her injury. Whatever time it was that year that I actually visited, and I can't remember exactly. I'd have to go back and pull those documents out.

Q. What is the latest one?

A. The latest one is the one in June of 2005. So what we did was, we brought those and along with my sister here in Virginia, because like I said she was still having moments where she could talk to you. She knew what was going on, and we took it to an elder law

attorney in Manassas. And they came out, they spoke with my sister. They had actually seen her more than once, I believe, and explained to her and she let them know that she understood what was going on. They also looked at the previous power of attorneys that she had executed, and my assumption is that they took that into consideration as well, but I can't speak for them.

MS. MORISI: Your Honor, may I have the bailiff present or may I approach?

THE COURT: Yes, you can approach, counsel. Thank you for asking.

(Whereupon, a document was presented to the witness.)

BY MS. MORISI:

Q. This is the one I was referring to. Do you recall that one?

A. Yes, I do. This is the one from 2005 that was done here in Virginia.

Q. Would you check the date on the back of it, please?

A. This was April 2, 2010.

Q. Okay. So is this the document that was

executed where they came down to the car?

A. Yes.

Q. You were just saying they came down and met with her?

A. Yes.

Q. Okay.

A. The reason why they came down to the car is because this particular office doesn't have a ramp or anything to take her inside. It's a series of about 10 or 12 steps, and that's a little bit more than I can carry her up in a wheelchair.

Q. And so that -- could you review that? That was witnessed?

A. Yes, it was witnessed by two individuals that I guess were also worked out of the same building or the same law firm.

Q. Okay.

A. Carla -- excuse me, I can't -- Angie. Carla is the one that was the notary, and Marie Woods, I believe is her last name.

Q. Okay. So it was witnessed and notarized?

A. Yes, witnessed and notarized.

Q. Okay. And so your sister's condition now. How would you say your sister's condition is now?

A. What do you mean?

Q. Today.

A. She is better than what she was when she was initially admitted into INOVA Fairfax. As far as her -- she's not at what her baseline was before she entered the hospital.

Q. What is her baseline? What would you say is her baseline?

A. Her baseline is that my sister is alert. My sister understands everything that you say to her. She may not necessarily be able to communicate back with you at specific times, but she understands everything that is going on, and she does communicate via expressions. She'll blink once for yes, twice for no. She will nod her head, and her weight is drastically less than what it was from what the normal weight is. The normal weight is approximately 120 to 125 pounds, and she appears gaunt, but she does look better than she did when she was admitted.

Q. All right. Why did you disagree with the

discharge in December and January and early February?

A. I initially disagreed with the discharge because I felt that my sister was still at risk. When they initially came with the discharge at the end of December, she had a very large pericardial effusion. It wasn't small; it wasn't minor, and it was hemodynamic involvement, meaning that it's pushing on one of the ventricles of the heart so you're not getting full blood flow. And that is listed in their actual echocardiogram that they did on the 21st.

It mentions that it was larger on the backside. I'm confused with the understanding of the terms interiors; sometimes maybe that's from the back, but whichever side that is pointing to, and that one of the ventricles of her heart was not filling fully because of this. And when that happens you have fainting, you're not getting sufficient oxygenated blood flowing through your body.

And so that was a concern, that and the DBT, the blood clot that she had in her upper right arm was, at that time, 12 inches long, and they didn't want to treat it. I asked why, and they just -- it was Dr.

Balaji first, and he just said we are not going to treat it because invasive procedures carry an inherent risk, and I do understand that.

And I did understand why they would not do the blood clot because they weren't sure if there was blood in the fluid that was around the heart; and by giving her a blood thinner that could increase the bleeding, which makes perfect sense; that's logical. But when I asked they would not even test the fluid to see if there was blood in it.

And I kept getting different answers and conflicting answers back and forth about why they would or they wouldn't, and when I asked regarding it can also be treated via medication, Dr. Balaji said he couldn't do that either.

So the only conclusion that I could come to is that because -- and this is my opinion, my opinion based upon what I read in the medical records and conversations I had with a couple of the doctors, that the reason is they did not think she had any quality of life. In fact there is a statement in her medical records by one of the physicians in the care team that he does not believe that

she would want to live this way.

And lastly, based upon everything that they see with my sister, the brain injury, the contractions, the fact that she's in the wheelchair, all of that's been done by the medical field, so I question everything that doctors tell me now.

Every medication they give her, I question because if not for the doctors in California and not paying attention and talking to each other, they wouldn't have had her taken the Tylenol on top of it. It wouldn't have shut her liver down. She wouldn't have ended up with a brain injury. That's also why she was in the hospital down there. It wasn't necessarily the Tylenol that did it, they gave her the wrong medication when she was in the hospital, which -- and the day after was the difference in her mental capacity to where you could see it, she was child-like the next day where she wasn't the day before.

Q. You want your sister to be in the hospital?

A. No, I want my sister to be home with me. My sister wants to be at home. So I miss my sister. I mean, because we stay together. She knows when I'm

having a hard day. She knows -- excuse me. She knows if I had a hard day or if I'm stressed about something. She has her ways of making me laugh. I mean, she'll put a certain expression on her face where she smiles with her tongue; a specific way sticking her tongue out at me that will automatically make me laugh, because she knows when there is something wrong.

I've developed a habit of whenever we're in the same room together, or in the house together, that I'm talking out loud as to what I'm doing so she knows where I'm at, and I'm including her in every single thing that I'm doing, every conversation that I am having, or any decisions that I am making.

So she knows what's going on. She doesn't know who Ms. Johnston is, but she knows when she came in and read the petition to her. When I got there later that day, my sister was terrified. She -- and this is the first time she has done this since her hospitalization; I walked in and the room nurse came in actually right after me as well and the regular nurses that she's seen pretty much everyday since she's been there, she literally drew up and towards me, and that's the first time I've seen

her do that in the hospitalization. I mean, because she gets poked and prodded, she's somewhat used to it. No one likes it, but she's used to it. So, no, I want her home with me. That's where she was before. That's where she's happiest and frankly, that's where she will get the best care.

Because at least up until her -- shortly before this hospitalization or the one in Reston, she had people coming in. We were on the waiver program, and we had skilled nursing for the skilled respite, we had an RN that came in, we also had an aide that came in during the week.

So a perfect example of the care she gets at home versus the care she gets in the hospital or a skilled nursing facility, my sister has been in that wheelchair since 2007, so we're looking at ten years.

Up until her hospitalization at Reston or transferred the release, messed up transfer to Potomac Falls Nursing Facility, my sister has never had a bed sore; never had skin break down. My sister was in that place ten days and within a two-day period came out with a grave bed sore that was about the size of a quarter, to

where you're down to the white skin and all of that underneath it, and the red and bleeding. And I can say it was within a two-day period because that Monday I had taken my sister out for a doctor's appointment and I'm the one that actually cleaned her up and got her dressed.

And on Tuesday and Wednesday I had appointments for myself that I needed to go to because I had to -- I actually was sleeping at the skilled nursing facility because the paramedics did not want to leave my sister there because that place was that bad. It did not feel safe and almost turned around and took her back to Reston Hospital, but we were able to gerry-rig something with the bed to make her marginally safer until they could get another bed in.

And so on that Tuesday and Wednesday I had appointments. That Thursday is when she wound up in the emergency room and went there and she had this quarter-size bed sore.

Q. Okay. So your plan ultimately is for her to return to the home with you with the care --

A. Yes.

Q. -- that you just mentioned?

A. Yes.
Q. Skilled and the nurses aides --
A. Yes.
Q. -- who can attend to her?
A. Yes.
Q. If there needed to be a stay in a skilled nursing facility --
A. A very brief stay.
Q. Okay, you would agree to the stay in the nursing facility or --
A. Depends on which one, a very brief stay. There are nursing homes. I have been researching and dealing with nursing homes for the last 11 years.

Now, there are good and there are some that are really not very good, and based upon the federal -- the Medicare when they come in and do their inspections, there are a few nursing facilities in the area that have within their inspections verified complaints of patient abuse, patient neglect and my sister not being able to speak for herself at times, or people assuming that she doesn't know what's going on around her, because she cannot push the button or call admin, she gets neglected

or ignored.

There was one particular nursing facility within the area that when I had to travel on business, before I retired, they -- what they had done, my sister was completely sore when I got there, had been obviously for a while, and they had medicated her so much that she slept for 24 hours.

They do that because as Dr. Balaji says that the staff becomes alarm fatigued, or they also can become fatigued from a patient that is making just noises, and that is my sister's way when she is not able to speak because her voice when she speaks is very low, to get their attention to let them know that something is going on. And you have to be around her for a while to know what the difference specific noises mean. Whether or not she wants to be changed, or she's in pain, or she's uncomfortable, or she just doesn't want to do what you are asking her to do.

Q. Okay. The percussion therapy; you have been quite persistent about it?

A. Yes, I have been persistent about the percussion therapy because she came into the hospital

with percussion therapy, chest PT order. She was given chest PT at Reston Hospital, she was given chest PT at the nursing facility that she was in. Dr. Baid, B-A-I-D, is the pulmonologist at INOVA Fairfax that initially was seeing my sister, and he's the one that did the bronchoscopy that actually cleared all of the gunk out of her lungs.

And speaking of that when they did that, my sister -- she looked so comfortable when she came back, it's like I can breathe again. Looked completely at ease and not in any type of distress, and it's the best I've seen her in months. And he is the one in her initial order that stated for her to have the chest PT.

And in every progress note whether it be from pulmonology, infectious disease or even one of the other specialties that came in, all stated continue chest PT. This is the first order that I've seen that hasn't had that in there; the one that was printed yesterday.

Q. Okay. Can you just describe for the Court what this piece of equipment is?

A. It is a hand-held device approximately 10 inches in diameter. There's two different types, there's

an electrical one that plugs into the wall, and then there's one that works on the hospital room there or on the portable compressor. And you hold that, and what that does is it repetitively beats on the area, provides a percussion, and it has variable speeds. But it is more than just a back massager type of thing that you work over the lungs, and it helps to loosen, and helps her move the mucus to get it out, and it keeps her left lower lobe from re-collapsing because of the mucus that's in there. But without this, because of the aspiration that she gets -- it's a small amount over time; this isn't something that happens immediately, that it will build up and it will compress, it will collapse again. And generally percussion therapy is the only way to prevent it and get it to open outside of doing an invasive procedure, like a bronchoscopy, putting her under sedation and going down and actually removing the mucus itself, suctioning that out.

Q. So you would say, despite the medical -- Dr. Balaji saying this wasn't a standard of care, you feel this is a standard of care for your sister for prolonged health?

MS. KIRKLAND: Objection, Your Honor.
THE COURT: Sustained.
MS. MORISI: Okay.
THE COURT: She's not an expert. She can't testify to standard of care unless you establish that she has some medical training.
MS. MORISI: Fifteen years of taking care of her sister since 2005, but --
THE COURT: Counsel, do you have any citation in the country that would support that proposition?
MS. MORISI: No, I respect your decision to --
THE COURT: It's not my decision. Do you have any case in the country that would support what you just said?
MS. MORISI: No, I don't.
THE COURT: Please proceed.
BY MS. MORISI:
Q. The availability events, Ms. Hall talked about availability events. Have you ever been informed?
A. Other than the Gainesville bed early on, no, I have not. There's been numerous conversations going on between the attorneys, Delegate Marshall and myself, and

Maureen and other hospital personnel regarding the situation with my sister. And we were told -- Delegate Marshall was told, as I believe --

MS. KIRKLAND: Objection, hearsay. I believe she is reporting what Delegate Marshall was told.

THE COURT: I sustain the objection.

THE WITNESS: Okay, I'm sorry.

THE COURT: Ma'am, leave out what Delegate Marshall may have spoken with somebody about.

THE WITNESS: Okay, I was told that -- or I was not told -- I was told that a bed at Birmingham Green had come available, but after the fact, it had been given away, and so I had no knowledge that this bed was available because had that bed -- had I known that that bed was available at that time, that is my chosen facility because it's closer to where we live, it is closer to our church, and to where more people could come to visit her throughout the day. She could see people that she's used to seeing on a regular basis, and had I known about that, she would be there now.

But that is not something I was told about and was not able to make that decision. My decision -- my

capability was taken from me even though I am her legally designated power of attorney, and have been for many years.

A meeting was held on the 6th of January with case management, Anita, Dr. Kelly Armstrong, Dr. Duncan, and one other woman from the finance department, I believe. Basically, they -- I was under the impression that when I spoke to Dr. Armstrong that the meeting was going to be to answer my medical questions. And when I got there I was flattened, flat out told that, no, we are not here to answer your medical questions. We are here to get you to agree to discharge your sister by 8 p.m. tonight. We have already arranged an ambulance to come and get her at 8 p.m., so we don't want to hear anything that is outside of that purview.

And I reiterated at least three times during the hour that we were in the room, and they again told me, no, they were not interested. That time had come and gone, that they had answered all the questions they were going to answer, and that if I didn't agree to her discharge, they were going to sue me and take me to court for guardianship. That is also what Dr. Armstrong said

to me during the phone conversation that we had the day before when we scheduled that meeting, because she initially stated that they were taking me to court for guardianship, for abandonment for my sister. I'm at that hospital every single day.

As a matter of fact, with everything I had to do yesterday, I didn't get there until very late, but I went to the hospital at one o'clock this morning. I'm surviving on maybe an hour-and-a-half sleep, because I slept in the chair at the hospital, which is not uncommon for me to do.

And so after not being able to come to an agreement on the 6th, the nursing staff, in my presence, were promptly told they were not to share any health information with me at all about my sister. And in fact, I stood and witnessed them -- there are machines on the wall that's their blood pressure test, the thermometer, and they have a pulse ox that goes on her finger for her oxygen levels. I witnessed the nurse disconnect it and throw it away, so I could not see anything that was on the monitor.

My sister, during this time, came down with an

infection. I had no idea what the infection was. I didn't know if she was being treated because I would ask the nurses and they would tell me we are not allowed to give you the information. And it's stated in her chart, and within her charts there's a note from Dr. Armstrong actually addressed that.

As far as information, it's not that -- not contacting the doctors after a certain time, that came later. The initial one was that because we are pursuing guardianship that they were not to share any medical information with me.

Later, they made the decision that it was not to be after 5 o'clock, but when I called -- when the doctor was paged, the doctor that has provided the report here, was contacted in regards to a medical question. I was promptly told, and there is also a note here within the records that addresses this, that I was to call Dr. Armstrong and get the medical information from her. But Dr. Armstrong is a PhD, she is not an M.D., so I found it quite strange that an M.D. was telling me that I needed to talk to a PhD to get a medical information on my sister.

Dr. Armstrong is actually chief of the ethics department and clinical observation, I think is her title, or something to that effect.

Q. All right. Ms. Bell, do you think your sister needs a guardian?

A. No, I think we have been doing quite well with the power of attorney, but I do understand in Virginia that they are not one in the same, they are different. In California it's pretty much the same thing, and I definitely don't believe she needs a guardian that's outside of the family if she does need one.

It should be someone who knows her, and someone that loves her, and that is going to do the best for her; that knows what her religious beliefs are, that knows what her personal values are. That knows enough about her that can make these decisions, and during those periods of times where she is not -- because there is about five-percent of the time that she is not really able to communicate with you at all. There is something that seizes in her brain that prevents her from -- I guess --

MS. KIRKLAND: Objection, foundation.

MS. MORISI: Oh, I'm sorry. Your Honor, I'm ready to -- those are my questions.

THE WITNESS: May I say something?

THE COURT: I'll sustain the objection. Next question, ma'am.

THE WITNESS: I spent a year --

THE COURT: No, there's not a question pending. Counsel, your next question.

MS. MORISI: I'm going to -- I've come to my end.

THE COURT: Okay, very good.

Cross-examination.

MS. KIRKLAND: Yes, Your Honor.

CROSS-EXAMINATION

BY MS. KIRKLAND:

Q. Morning, Ms. Bell.

A. Good morning.

Q. Prior to her admission to INOVA Fairfax Hospital, where was Ms. Adams immediately prior?

A. She was at Potomac Falls Health and Rehab Center there in Sterling, Virginia.

Q. And did she go to INOVA Loudoun in between?

A. They took her from Sterling, Potomac Falls to Loudoun because the ambulance did not directly bring her to Fairfax.

Q. And who made the decision then to transfer her from INOVA Loudoun Hospital to INOVA Fairfax Hospital?

A. I did after speaking with the director of the E.R. and her letting me know that INOVA was a higher standard of care, and if it were her family member, she would have done the same thing.

Q. Prior to transferring Ms. Adams to Fairfax Hospital, were you advised that there was no medical reason to transfer her?

A. No, I was advised that Medicare would not pay for it.

Q. And you were advised that there was a risk of transfer due to her state at the time, with a fever and pneumonia?

A. I was advised that there was a risk if I put her in my car and transferred her that way. I paid for the ambulance to take her.

MS. KIRKLAND: Your Honor, I'd like to mark this as Petitioner's Exhibit C.

THE COURT: All right.

(The document referred to above was marked Petitioner's Exhibit C for identification.)

(Whereupon, a document was presented to the Court and the witness.)

MS. KIRKLAND: Thank you.

BY MS. KIRKLAND:

Q. Ms. Bell, do you recognize this form that has been marked as Exhibit C?

A. It appears to be from her records at INOVA Loudoun.

Q. Do you see as patient representative, is that your signature?

A. I believe so. The printing under relationship is definitely my writing.

Q. And you understand that this form -- in this form you are certifying on behalf of Ms. Adams that she was leaving the hospital at Loudoun against the advice of the attending physician and hospital administration?

A. This is an AMA that all hospitals if you leave.

Q. If you leave against medical advice, correct?

A. If they can give you the same standard of care to where you are going to, yes.

Q. Ms. Bell, in this form by signing it, it states that you acknowledge that you have been informed of the risks involved and release the attending physicians, hospitals and its employees from all its responsibility for any ill effects the -- (unintelligible), correct?

A. The form says that, yes.

Q. And so you understood that by signing this you were leaving the hospital with Ms. Adams against the advice of her attending physicians and hospital administration at INOVA Loudoun Hospital?

A. No, I was removing my sister, or transferring my sister based upon the conversation that I had with the emergency room director. I can't remember what her name was; it's on one of the other forms in here, in one of her notes regarding the conversation that she had with me that -- since she was being transferred within an ambulance with all of her IVs and everything intact, there was a risk; but having the ambulance and the paramedics that transferred her, that it mitigated those.

Q. And this was not the attending physician that

you had this conversation with?

A. This was the attending physician supervisor.

MS. KIRKLAND: Your Honor, I'd move Exhibit C into evidence.

THE COURT: Any objection?

MS. MORISI: No objection.

THE COURT: The Court will receive Petitioner's Exhibit C.

(The document referred to above was marked Petitioner's Exhibit C for identification and was received into evidence.)

BY MS. KIRKLAND:

Q. You mentioned that upon transfer, Medicare would not cover it. Is that correct?

A. They would not cover the ambulance ride because she was already at a facility, and which we would have done from the nursing facility directly from there to INOVA Fairfax. However, I was told by the nursing staff at Potomac Falls that it would take them a good 45 minutes to an hour for LifeCare to get there to remove her from -- to Fairfax. At that time her temperature was still rising.

Q. Just answer my question; Medicare wouldn't cover it because the transfer was not medically necessary, correct? Yes or no.

A. They wouldn't cover it because she was already in a facility where she could receive care.

Q. And she receives Medicare A & B as well, it's Kaiser insurance, correct?

A. Correct.

Q. Did you seek treatment for her other than the Kaiser network?

A. No.

Q. And why not?

A. Because of issues that we had with the Kaiser doctors at Reston Hospital when she was hospitalized there.

Q. And so by admitting her into INOVA, she would be out of plan, correct?

A. She would be out of Kaiser's plan, but Medicare would still cover her.

Q. And when electing that --

MS. KIRKLAND: Actually, I'd like to make this Exhibit D.

(The document referred to above was marked Petitioner's Exhibit D for identification.)

BY MS. KIRKLAND:

Q. Do you recognize this form, Ms. Bell?

A. This is the form that was given to me. I believe this is the same form that was given to me by the Kaiser representative or somebody there at the admissions department.

Q. And this is your signature on the form?

A. It is.

Q. And you're signing as power of attorney and her sister?

A. Correct.

Q. On behalf of Ms. Adams, correct?

A. Correct.

Q. And so by signing this you were obligating Ms. Adams to elect to use out-of-network, out-of-trans benefits, and accept any responsibility for any financial penalties, correct?

A. I was -- that's what it says here, but I was accepting -- she has Medicare part A & B, so Medicare -- because she has Medicare, and the way that the Kaiser

program is managed, she does not have to use them. Now, she will be responsible for paying co-pays that would be responsible at the hospital, but Medicare takes care of her hospitalizations.

Q. And so once you signed this form, her only remaining covering at INOVA Fairfax Hospital is Medicare?

A. Correct.

Q. On December 28, 2016, you learned INOVA Fairfax Hospital cleared Ms. Adams for discharge?

A. What date was it?

Q. December 28th.

A. I'm not sure of the date, but it was somewhere around the end of the month.

Q. Well, on December 28th doesn't seem -- do you recall contacting KEPRO which manages her Medicare to appeal the decision to discharge her?

A. I don't remember the exact date, but it was around -- it was the last week in December.

Q. Okay. And you contacted KEPRO to appeal. Why did you do that?

A. Because I did not agree with the discharge, that she -- with the medical that she had with the blood

clot, and with the pericardial effusion.

Q. And based on that appeal, Medicare denied the appeal and denied further coverage at INOVA Fairfax?

A. KEPRO denied it, yes.

Q. KEPRO on behalf of Medicare?

A. KEPRO is the contract -- the state contracted organization that's a quality assurance organization. They are not part of Medicare; they don't work for Medicare.

Q. Is KEPRO the one that handles the appeals though, whether the Medicare benefits continue to apply?

A. They handle the appeals for discharges, yes.

Q. And based on their review after December 30, 2016, Medicare no longer covered Ms. Adams at INOVA Fairfax Hospital, correct?

A. They left me a voicemail saying that they had agreed with the hospital, and that I could file for leave for consideration.

Q. And you filed for reconsideration?

A. I did.

Q. And they denied that as well?

A. I don't know exactly how many days later, but

yes, they did. In which time I appealed it to Medicare itself, and is now with the Administrative Law Judge.

Q. KEPRO as they make their decisions based on independent position review, correct?

A. That's a matter of opinion.

Q. Is that what you understand from their communications to you?

A. I don't recall them telling me that they were independent, but they have two separate doctors that looked at the initial one, and the other one looked at the reconsideration. If that's what you mean?

Q. And both physicians agreed that she no longer required acute medical care at a hospital facility, correct?

A. Yes, and they did the same thing at Reston, and Reston was overturned by the Administrative Law Judge.

Q. Ms. Bell, you mentioned you didn't know about the bed at Birmingham Green. How many times has a social worker or case manager from INOVA contacted you to discuss discharge?

A. I don't know the number off hand. I would have to log on my phone to tell you.

Q. About how often then would you say?
A. Well, initially when they started calling me, and I wish I could -- I believe her name was Cathy. She called me actually every 20 minutes over a four or five-hour or six-hour period to the point where I had to turn my phone off because I was trying to get some work done for the Federal Court in D.C.
Q. In speaking with any social worker, case manager from INOVA, have you consented to discharge to any facility?
A. Not before my medical questions were answered, but that was the initial thing we were going through. This was before the January meetings; January 26th or 28th meeting, whenever that was. Because whenever I would ask a question I was told, well, that's a specialist's question, so you need to answer them, but yet they could box me into a corner that you can only ask questions between the certain hours and -- I mean, there were times that -- it took Dr. Balaji well over a week to get back with me regarding the pericardial effusion. And then the DBT he referred me to the hematologist.
Q. So to date you have not gone to meet with any

social worker or case manager to find an appropriate facility for Ms. Adams?

A. No, that's not true. I have met with Michelle. I don't know if Lindsay is part of their office or not, but she and I had a long conversation. The meeting that we had on the 6th of January with Anita, Dr. Armstrong, Dr. Duncan; all who are part of case management. I've left Michelle phone messages. I've spoken to her maybe twice on the phone, possibly three times.

Q. And so I believe you testified on direct that you had not been hearing from them. You had in fact had multiple phone calls and meetings with various personnel at INOVA about discharge options?

A. Only, actually Michelle and then Anita at that meeting. The others, the calls I received have been messages, and only once or maybe twice have I actually been asked to call somebody back knowing that I was going to be at the hospital. There was a social worker and I don't know her name, but came somewhere around 6:00 or 7:00 and spoke to me, but again this was before the meeting where we sat down with the doctors and the rest of them had gotten information. And at that point I had

already spoken to Dr. Armstrong, and we were waiting for additional information, or were waiting for the order for (unintelligible) or for something. I can't recall exactly what it was but.

Q. Ms. Bell, sitting here today, do you have a discharge plan for Ms. Adams?

A. A discharge plan?

Q. Meaning do you have a facility in mind where she could go? Have you made any arrangements to facilitate a transfer for her to that facility?

A. I can't go into a facility and ask them and say that I want to transfer her here. From a direct hospital to a facility transfer, that comes from you guys and your office. Now, I've gone and looked at different facilities. I've looked at Gainesville. I've gone and looked at the Manassas Health Rehab. There was one other one, I can't remember, aside from Potomac Falls, there was one other one that I went to look at and got a tour of. So I've gone and actually looked at these places, yes.

Q. And following that tour, did you go to social worker, case manager at INOVA and try to facilitate any

specific transfer to any specific facility?

A. That's how I let them know there were certain ones that I would not have her sent to.

MS. KIRKLAND: No further questions, Your Honor.

THE COURT: All right. Are they any cross-examination questions from the GAL?

MS. JOHNSTON: No, Your Honor.

THE COURT: All right. Any redirect?

MS. MORISI: No, Your Honor.

THE COURT: All right, ma'am, you can have a seat next to counsel.

(Witness excused.)

THE COURT: Counsel, your next witness?

MS. MORISI: I have no further witnesses, Your Honor.

THE COURT: All right, do you have any evidence you wish to present?

MS. MORISI: No, Your Honor.

There was a paper left up there if we could have that back. That was not put into evidence.

THE COURT: Okay.

(Whereupon, a document was returned to counsel.)

THE COURT: All right, does the guardian ad litem have any evidence she wishes to provide?

MS. JOHNSTON: Your Honor, I'd to admit my report into evidence.

THE COURT: All right, Madam Clerk, let's have the GAL report admitted into evidence.

(The document referred to above was marked for identification and received into evidence.)

THE COURT: Does the Petitioner have any rebuttal evidence she wishes to present?

MS. KIRKLAND: Your Honor, I may. Would it be possible to take a very brief recess just so I can determine whether we need to rebut anything?

THE COURT: Yes, we could take a -- well, I usually take a 10-15 minute recess in the morning. We got started a little late, so why don't we take a 10-minute recess.

If you have nothing else, then we'll go to closing arguments.

MS. KIRKLAND: Great, thank you, Your Honor.

(Whereupon, at approximately 12:08 p.m. a brief recess was taken, and resumed at approximately 12:22 p.m.)

THE COURT: Counsel, do you have any rebuttal evidence you wish to present?

MS. KIRKLAND: Yes, Your Honor. I'd like to call Kenneth Labowitz for a few brief questions.

THE COURT: Okay.

(Whereupon, the witness was duly sworn by the clerk of the Court.)

THE COURT: Counsel, please proceed when ready.

Whereupon,

KENNETH E. LABOWITZ, ESQ.,

a witness, called for examination by counsel for the petitioner, and having been first duly sworn by the clerk of the Court, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. KIRKLAND:

Q. Mr. Labowitz, would you state your full name for the record?

A. Kenneth Labowitz.

Q. And are you a proposed guardian and conservator

in this case?

A. That's what I understand, yes.

Q. Along with whom?

A. Along with my partner and my law firm, Anne Heishman.

Q. And can you describe very briefly for the Court your experience in performing these exercises?

A. Sure. Since 1993 I have been appointed as guardian and conservator for one or the other in hundreds of cases. Since 2003 this has been my only practice. We litigate matters of estate administration and guardianships. Anne and I are now guardians, I think for something like 120 people. We do keep track of them; we give them numbers, I think that's what the census is.

Q. And how many persons do you think you've served as guardian and conservator for in your career?

A. At one point I counted 900. It's probably over 1,000 now.

Q. And if you're appointed by the Court to serve as a guardian and conservator for Ms. Adams, what would be your plan of discharge?

A. I've talked to people, Ms. Hall and the other

people that have been involved in her care to see what it is that they think she needs. Obviously, I have talked to Ms. Bell to see -- I've heard today many of her objections. They need to figure out what places that I won't send anyone so see if she and I agree on where we should avoid.

It is not a simple process in simply saying she should go to Birmingham Green for example. There has to be a bed at the level of care that Ms. Adams needs. So it is something of a moving target as to what facility has what bed available when.

And my goal would be to identify a place that can provide the quality of care that Ms. Adams needs. I get that Ms. Bell wants to be close to Manassas to her home, if that's possible, that works. It may not be possible. It's not something that I can control or anybody can control. It's the market whether there is a supply of beds in place that is acceptable to provide the care that Ms. Adams needs.

Q. And are you willing to serve along with your partner, Ms. Heishman as a guardian and conservator for Ms. Adams?

A. I am, yes.
Q. Thank you.
MS. KIRKLAND: I have no further questions, Your Honor.
THE COURT: Cross-examination by the Intervenor?
MS. MORISI: Yes, thank you, Your Honor.

CROSS-EXAMINATION

BY MS. MORISI:
Q. I guess it's good afternoon.
A. Yes, it is.
Q. If the Court so chose, would you agree to serve with Ms. Bell, another guardian?
A. That's a difficult question. Typically we do not just because it's the idea of taking votes and deciding by -- you know, we have two votes and she has one vote. That's really not going to work.
Certainly, I can hear the commitment that she has to her sister, and I am happy to communicate with Ms. Bell to the extent that if we get to a place that is available and that works, I think that somebody needs to be a decision maker. I think someone -- or Anne and I

need to be the decision makers. I don't think anybody else -- it just doesn't work to have a committee and a consensus.

Q. Do you foresee a limited guardianship?

A. I don't really know what that means. If what we are talking about is moving Ms. Adams into some sort of care facility where there is an available bed, and continuing that until some time in the future, that works.

We regularly initiate and carry through terminations of guardianships. We've been here as recently as a couple of weeks ago where somebody had reached the end of the need for a guardian and the Court ruled that the guardianship should be terminated.

I get that Ms. Bell is very closely connected to her sister's care. I get it that Ms. Bell is probably going to have questions for me and recommendations for me, and for the staff at whatever facility Ms. Adams ends up at. I don't really understand how it would work for three of us to be guardians together, and limited with -- I don't know what the limitation is. It's just a matter of having Ms. Adams admitted to a facility, and until

some future event happens. That's okay, I understand.

Q. Right, by need or change in circumstance?

A. Sure. And the Court is here every Friday morning to hear changes in circumstances, changes in appointments, and I know the way to the courthouse, so.

Q. Thank you.

MS. MORISI: Nothing further, Your Honor.

THE COURT: Cross-examination.

MS. MORISI: Excuse me, may I consult with my client?

THE COURT: Of course. Take your time.

(Discussions off the record not reported by the court reporter.

MS. MORISI: No further questions, Your Honor.

THE COURT: All right. Cross-examination by the guardian ad litem?

MS. JOHNSTON: I don't have any questions.

THE COURT: All right. Any redirect?

MS. KIRKLAND: No redirect, and no further evidence, Your Honor.

THE COURT: All right, counsel, you may have a seat.

THE WITNESS: Thank you.
THE COURT: Thank you.
(Witness excused.)
THE COURT: Bear with me for just a moment, counselors.
(Brief pause.)
THE COURT: All right, let's proceed with closing arguments for the petitioner.
MS. KIRKLAND: Good afternoon, Your Honor.
As I mentioned in opening, the standard of this petition is set forth in Virginia Code Section 64.2-2007, and it sets forth seven factors for this Court must consider in appointing a guardian and conservator.
The first two factors are the limitations of the respondent and the development of the respondent's maximum self-reliance and independence.
I think there's no dispute in this case, there's been no evidence today that Ms. Adams has the capacity to make decisions for herself. Dr. Betzelos testified that to a reasonable degree of medical certainty she has not, and Ms. Bell has been acting as her next of kin or power of attorney because she cannot

make those decisions. So the first two factors at least weigh in favor of appointing a guardian and conservator.

The third factor; the availability of less restrictive alternatives including powers of attorney and advanced medical directives.

Your Honor, this is what's been in place. Ms. Bell has been acting as power of attorney, and for the last 50 days she been unable or unwilling, for whatever reason, to facilitate a transfer of Ms. Adams to an appropriate facility. There's no evidence before this Court that Ms. Adams is not stable and right for discharge.

The only medical testimony Your Honor heard today was from Dr. Betzelos that testified that every department within INOVA Hospital, Cardiology, Pulmonary, all of them have concluded since December 28, 2016, Ms. Adams is ready for discharge.

A less restrictive alternative like a power of attorney or advanced medical directive has simply not been working in this case. And at least at this time, maybe it is for a certain during, but at least at this time I think there are no less restrictive alternatives

than a guardian I think further who can make decisions for Ms. Adams.

The forth factor is the extent to which is necessary to protect respondent from neglect, exploitation and abuse. I think that factor supports a guardian, I'm not sure it dictates who should serve. So that brings us to the last three factors.

THE COURT: I'm sorry, Counsel, I didn't understand that point. There's no allegation of abuse, exploitation or neglect, right?

MS. KIRKLAND: Correct, that was my point. I think the forth factor weighs in favor of appointing someone, but it doesn't dictate who should serve, because there is no evidence that either the sister or anyone else has abused Ms. Adams. I think she is well cared for by everyone. So I'm not really sure if that factor helps much, but it has to be considered.

THE COURT: Okay.

MS. KIRKLAND: The lasting factors weigh heavily, not only in appointing a guardian and conservator, but also in favor of appointing professionals like Mr. Labowitz and Ms. Heishman, who are

willing to serve for Ms. Adams in this capacity.

The fifth factor for instance is the actions needed to be taken by a a guardian or a conservator. And that's the very issue in this case.

The evidence is Ms. Adams has been ready for discharge since December, and she remains in the hospital. She is not required that level of care, and she's in a hospital that Dr. Betzelos testified is at a 95-percent capacity, and it has its own duty to the public to ensure that its beds are available for patients who actually need acute medical care.

There's a case out of the District Court in D.C. (unintelligible) versus Beacom, (PH) where the Court said a hospital has a moral duty to reserve its accommodations for persons who need medical and hospital care, and it would be a deviation from its purposes to act as a nursing home for persons who need nursing care. The action required in this case is that Ms. Adams needs nursing care, not acute-level care.

I think the evidence supports the only professional guardians we proposed would be willing to make that decision and facilitate a plan today.

Ms. Bell, even sitting here today, knowing that this case is here, has no plan and has made no effort to go to the social worker and case manager at INOVA, pick a place that is available today and make that decision. It's something that changes daily, so she can't wait to get a message and call back a few days later. Doing that in that circular process, as Ms. Hall testified, the bed will never be available. She will just remain in the hospital as she has for the last 50 days.

The sixth factor is similar. It's the suitability of the proposed guardians and conservators. Ms. Bell has been the one that's been making the decisions, and it's not working. Mr. Labowitz testified that he and his partner, Ms. Heishman would consider her interests and her preferences, as well as those of Ms. Adams to the extent they're numb.

He has plenty of experience. He said he represented maybe a 1000, or he served as guardian and conservator for maybe 1000 persons in the northern Virginia area. He's familiar with the facilities. He testified that there are some he would not send anyone to. He's not willing to just discharge her anywhere, he

is thoughtful, careful, and he will be held to a fiduciary standard under the Code, which he will owe to Ms. Adams to ensure that any decisions made in her best interests.

And that brings us to the seventh factor, which is the best interests of Ms. Adams as the respondent.

As this Court has heard from Ms. Hall and also Mr. Labowitz, a professional guardian could facilitate locating an appropriate placement for Ms. Adams at this time.

Additionally, the evidence from Ms. Bell, she transferred Ms. Adams to Fairfax Hospital against medical advice, and now with medical advice saying to please transfer her, she doesn't do it. She testified, the quote I wrote down was, "I question everything a doctor tells me now." And while some level of questioning is healthy and probably in Ms. Adams' bests interests, questioning every little thing to the point where it paralyzes her and makes her unable to make a decision, is not in Ms. Adams' best interests.

As stated by the GAL in her report, Ms. Adams does not need to be in the hospital where she is in a

greater risk of infection.

In order to achieve the desired goal of discharging her a home, a next step is placement in a skilled nursing facility. So consistent with the recommendation of the GAL, INOVA would ask this Court to appoint Mr. Labowitz and Ms. Heishman as the guardians and conservators.

At least for the time now, if the Court wanted to set the matter out on the docket a few weeks for review after she's been discharged and placed to see if it still makes sense to proceed, INOVA would have no objection to putting some type of restraint or duration on it, at least for review. But at this time standing here today, I think the only option is to appoint Mr. Labowitz and Ms. Heishman as the guardian and conservator.

THE COURT: Why a conservatorship?

MS. KIRKLAND: Your Honor, the conservatorship -- perhaps I should have had Mr. Labowitz elaborate. In order to place her, they will need to have Medicare in place to pay for it or fund it. And so in order for them to facilitate the placement after discharge, they will

need access to her financial through Medicare, her Medicaid; be able to get the appropriate waivers needed that she's to go home eventually. She will need -- it's called an EDC waiver to get staff in a home. So in order to facilitate these transfers and discharges, they'll need access to her -- whether it's benefits through Medicare, Medicaid, or her finances to the extent she has any means.

THE COURT: Okay. Well, that will be a question for the guardian ad litem in that closing.

MS. KIRKLAND: Thank you, Your Honor.

THE COURT: Okay. Thank you very much.

Let's go with the closing with the intervenor before we go with the GAL.

MS. MORISI: Thank you, Your Honor.

Well, Your Honor, you have a very difficult decision. Before you is a question that could put a stranger in charge of Ms. Adams.

You heard from my client, she's a walking encyclopedia of her sister's needs. This isn't just a familiar duty. This is a complete love and respect for her sister. She understands her sister's needs, her

pains, her joys. She's always acting in her sister's best interest. This condition is not just something that happened in November, December or January. This is been an on-going issue that she has been involved with. And as I say, she's always acting in the best interests of her sister.

Declining the discharge, when presented to her in January, she felt was in her sister's best interests that further care was needed. And then being kept from the medical information that actually was needed for her to continue making decisions, was further detrimental to her sister's care.

They denied Ms. Bell the ability to be her sister's advocate, and now they criticize her for not being an advocate and not making decisions.

Your Honor, if you determine that guardianship is necessary, I ask that you consider Ms. Bell. Alternatively, if you determine that a neutral guardian should be appointed, that you please make them co-guardian of Ms. Bell, and protect her rights to participate in her sister's medical care decisions and living arrangements. And that you limit the duration of

any guardianship to that which is necessary to effectuate a safe discharge from INOVA.

Ms. Bell is not necessarily disagreeable to a skilled nursing facility, but she feels home is the best place for her sister, and in the past her sister has been discharged directly to home.

What she needs from case managers is assistance in getting the home ready for her sister to be received. That EDC waiver that my colleague mentioned, the percussion equipment, possibly oxygen if that's required or considered necessary, the prescriptions, et cetera, and the nursing staff that's needed.

But that's what my client would like. That's her plan for her sister, for her to be home.

Thank you.

THE COURT: Thank you.

Closing argument of the guardian ad litem.

MS. JOHNSTON: Thank you, Your Honor.

Ideally Ms. Bell could continue to serve as her power of attorney for her sister, Ms. Adams. And that has been in the works for the past couple of months, and all the meetings and negotiations. But really all that

requires her to continue to serve and act in her sister's best interests was to agree to a discharge.

I still want Ms. Bell to take care of her sister, but we've come to essentially a loop that we can't seem to get out of.

And so what I'm hoping is that having the professional guardians and conservators step in and get us off this loop. That the ultimate goal will be that Ms. Bell can step back in as her role, and that the power of attorneys step in and then become unsuspended, and that she's been able to make medical decisions and care for her sister.

Because she does clearly love and care for her sister, that she just seems to be unable to make the decisions required for her sister to be discharged, probably for a number of reasons.

You heard a great amount of distrust that had become familiar over the years for the medical community. And when you are caring for someone that you love, and you think people have ulterior motives, and that they've made mistakes, it's probably natural to distrust. But that distrust has risen to the level we can't move

forward for Ms. Adams' care, and can't move forward to get her back home so that they can live together again.

So it would be my recommendation for the guardianship and conservatorship to be entered with the hope that it's temporary, and that Ms. Bell can return to her care-taking role.

THE COURT: Why are you recommending a bond for the conservatorship of $30,000 with Surety?

MS. JOHNSTON: So that if a Surety Bond is deemed to be necessary. I don't think that a Surety Bond is really necessary. It seems like the Commissioner of Accounts prefers a Surety Bond.

THE COURT: It's usually one-third of the assets of the estate.

MS. JOHNSTON: Right, but that premium amount, that's the smallest premium amount before it goes up, so it doesn't matter if it's one dollar or if she has one dollar or $30,000, that would be the new bond amount. So it could be anything under that. We just don't -- she's indigent.

THE COURT: That's what I needed to know.

MS. JOHNSTON: Yes, yes. So she -- to my

understanding, she does not have separate funds other than disability, and from my understanding as well that Ms. Bell has been serving as her representative, payee, so they haven't needed a conservator thus far. But she's been able to serve in that role, but in terms of the need for the attorneys to have, at least to begin the conservatorship, it will make it easier to get the services in place for Medicaid.

A lot of times with these cases when we're not entirely sure how much money or if the person is indigent, that a conservatorship usually gets dropped within a month or so if it's no longer needed.

THE COURT: Is that through Commissioner Russ?

MS. JOHNSTON: Yes, so what will happen would be that Mr. Labowitz or Ms. Heishman would file a motion to either reduce the bond amount or just close the conservatorship if it's not necessary. It probably won't be necessary long after they do what they needed to do, and it would revert back to Ms. Adams' funds being managed again by her sister.

THE COURT: Okay. Thank you, counsel.

MS. JOHNSTON: Thank you.

THE COURT: All right, the petitioner, the moving party gets the final argument since it's your burden.

MS. KIRKLAND: I have nothing further, Your Honor.

THE COURT: Okay.

So with regard to the petition to appoint a guardian and a conservator, the Court's analysis is driven by statute. The General Assembly has made it clear that Judges are to consider certain statutory factors.

So what I need to do is look at the evidence that was presented in this case, assess the witness testimony and exhibits and apply the relevant facts into the legal factors that the Court requires consideration of, so let me work through this analysis. In particular I am referring to Virginia Code Section 64.2-2007, Subsection (c).

The first thing the Court needs to do is look at the limitations of Ms. Adams. It's very clear that she does not have the capacity to care for herself in large part due to the accidental overdose that occurred

several years ago.

With regard to the second factor; the development of the respondent's maximum self-reliance and independence. I have no evidence before me that Ms. Adams will ever become self-sufficient, and that's through the testimony of the doctors and also Ms. Bell's testimony.

With regard to number three; the availability of less restrictive alternatives, including advanced directives and durable powers of attorney.

Ms. Adams' sister has had such powers today, and whatever power she has does not seem to be resolving the situation; namely, that we have six specialists at INOVA, who for almost two months have said that Ms. Adams is clear for discharge, and just cannot get the person with the power of attorney and advanced medical directives to agree.

The testimony of the medical professionals is that the argument, the conversations are now circular, so there's no end in point as far as the hospital is concerned, and that is simply not viable.

Number four; the extent to which is necessary

to protect the respondent from neglect, exploitation or abuse. There is no indication of neglect, exploitation or abuse.

What the Court sees is that Ms. Adams is blessed to have a sister who loves her and cares for her, and I don't sense that the petitioner has engaged in any neglect, exploitation or abuse either. They're just dealing with a situation where a medical professional believes that somebody is ready for discharge from the Trauma One Treatment Center, and that's not being facilitated by the person with the power of attorney.

Number five; the actions needed to be taken by the guardian or the conservator if one is appointed.

Well, the guardian will have to identify a suitable facility that is referred to as a skilled nursing-care facility, that could meet Ms. Adams' current, and at least for the short term, future needs.

The conservator would be necessary because Medicare becomes involved. So somebody with the ability to make some financial decisions, is going to have to be involved when interacting with Medicare in order to find an appropriate facility.

And then we have the suitability of the proposed guardian or conservator. We have a couple of options here. Mr. Labowitz and Ms. Heishman have extensive experience for serving as GALs and conservators for almost 25 years, almost. They've exclusively been doing this, and they are well respected in the area for caring for the people who they are appointed to care for.

With regard to Ms. Bell, as I indicated she loves her sister very much, but I don't believe the decision she's been making when it comes to the discharge has been in her sister's best interest. So I don't believe she is an appropriate person to serve as a guardian or a conservator.

In terms of the best interests of Ms. Adams, the Court looks at all the evidence presented, and it is clear to the Court that Mr. Labowitz and Ms. Heishman are the suitable people to serve as guardian and conservators for Ms. Adams to get her discharged from INOVA, and find a skilled nursing facility where she can be cared for until she is able to convalesce to the point where she can go be with her family.

So the Court does grant the petition of INOVA

Healthcare Services to appoint Mr. Labowitz and Ms. Heishman the guardian and conservator for Anastasia Adams.

The Court is going to require a $1,000 without Surety for guardianship and $30,000 with Surety for the conservatorship.

Are there any questions of anyone?

MS. KIRKLAND: Your Honor, the only other thing I would note is that the petitioner is required to accept and bear the costs, and INOVA has agreed to pay Ms. Johnston's GAL fees. We will include that in the order. I'd like to show you the invoice, we might need you to --

THE COURT: Final.

MS. KIRKLAND: -- agree also that it's okay with you.

THE COURT: All right. Is there any objection to the amount that the GAL is asking for?

MS. KIRKLAND: Not by INOVA, and we've agreed to pay it.

THE COURT: All right.

MS. KIRKLAND: Your Honor, just for your reference, that amount is just over $5,000 for her

services. So that's fine.

THE COURT: All right.

MS. KIRKLAND: So we'll just put that in the order.

THE COURT: That's fine, and you prepared an order I'm assuming, counsel?

MS. KIRKLAND: I have, Your Honor. Conferring with Ms. Morisi in looking at it this morning, we made full marks on it, but I just wanted to make sure it's --

THE COURT: I'll step out into the hallway, so you all could confirm it.

MS. KIRKLAND: If you could give us a few minutes, there's a lot that the statute requires. I just want to make sure we got it right.

THE COURT: All right. I'll be waiting outside.

MS. KIRKLAND: Thank you.

(Whereupon, at approximately 12:51 p.m., the hearing in this matter was concluded.)

CERTIFICATE OF COURT REPORTER

I, JoAnne B. Dellosso, do hereby certify that the transcript of the foregoing proceedings was taken by me by voice writing and thereafter reduced to typewriting under my supervision; that said transcript is a true record of the proceedings; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

_____

JoAnne B. Dellosso

Court Reporter

Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Cleveland Field Office
Cleveland, Ohio

Appeal of:	**A. Adams**	ALJ Appeal No.:	**1-5782988247**
Beneficiary:	**A. Adams**		**Medicare Part A**
HICN:	*******4472A**	Before:	**Thomas S. Tyler** U.S. Administrative Law Judge

DECISION

After carefully considering the evidence and arguments presented in the record and at hearing, a **FAVORABLE** decision is entered for the Appellant.

PROCEDURAL HISTORY

The Beneficiary was admitted as an inpatient at Inova Fairfax Hospital (the Provider). The Provider stated that it notified the Beneficiary of its decision to terminate inpatient services and the Beneficiary appealed. KEPRO, a Family Centered Care Quality Improvement Organization (BFCC-QIO), stated in its determination letter dated December 30, 2016, that the Beneficiary was notified by telephone on December 30, 2016 at 4:09:23 PM that the decision to terminate services was upheld and Medicare would no longer cover those services beginning on December 31, 2016 at 12 noon. KEPRO also stated that it informed the Beneficiary that she was responsible for services continued at the Provider's facility beginning on December 31, 2016, except for those services covered by Medicare Part B. The Beneficiary requested that KEPRO reconsider its previous decision. A KEPRO physician who was not involved in the initial determination conducted another review of the medical information. On January 2, 2017 KEPRO issued a reconsideration, upholding its original decision that a continued stay in the hospital was not medically necessary and would not be covered. (Ex. 2).

An appeal and request for an Administrative Law Judge (ALJ) Hearing, pursuant to 42 C.F.R. § 405.1002(a), was timely filed by the Appellant on behalf of the Beneficiary and received by the Cleveland, Ohio, Office of Medicare Hearings and Appeals (OMHA). The amount in controversy meets the jurisdictional requirements for a hearing at OMHA.

The undersigned ALJ held a telephone hearing on February 28, 2017 at 3:00 PM. Yolanda Bell, the Beneficiary's sister and power of attorney, appeared and testified on the Beneficiary's behalf.

The Medicare contractors were advised of the date and time of the hearing but the QIC did not respond and KEPRO waived its right to be present. The witness was sworn according to law and waived the right to an attorney.

The case was decided pursuant to the Administrative Procedure Act (5 U.S.C. § 551 et. seq.), Title XVIII of the Social Security Act (Act), and implementing regulations and policy. All exhibits have been admitted into the record, without objection, and have been fully considered in reaching the decision herein.

ISSUES

The decisions below concluded that the Beneficiary's inpatient care was appropriately terminated. The Appellant claims the Beneficiary continued to require an inpatient acute hospital level of care after December 30, 2016. The issue on appeal is whether the Provider properly terminated the Beneficiary's inpatient services.

FINDINGS OF FACT

The Beneficiary in this case is a 59 year-old woman who suffers from an anoxic brain injury, bronchiectasis, gastroesophageal reflux disease, anxiety, dysphagia, contractures and had a PEG tube. She was admitted to the provider's facility from a skilled nursing facility (SNF) due to cough, fevers, chills and extensive bibasilar pneumonia with aspiration. She completed antibiotic treatment on December 11, 2016. (Ex. 2, p. 12, 81).

On December 22, 2016 an echo of the Beneficiary's pericardium revealed a large pericardial effusion circumferential to the heart. This is an abnormal amount of fluid between the heart and the pericardium (the sac surrounding the heart). There was significant variation in the mitral inflow, however no other evidence of hemodynamic compromise was noted. (*Id. at p. 41*).

The Beneficiary had recurrent fevers and worsening infiltrates in her lungs as seen on a chest x-ray. She was started on a second course of antibiotics for pneumonia on December 25, 2016. (*Id. at p. 12*).

The progress noted of December 26, 2016 noted that the Beneficiary was moaning and agitated without being consoled. She was incontinent of bladder and bowel and cleaned and changed. She was coughing up whitish sputum so her mouth was suctioned and oral care was provided. A healing ulcer was noted on her buttock and balsam peru-caster was applied and covered with a foam barrier adhesive. She was fed through her tube. (*Id. at p. 31*). A progress note from that date indicates the Beneficiary had recurrent fevers and worsening infiltrate on a chest x-ray . (*Id. at p. 25*).

On December 27, 2016, the Beneficiary was noted to have a productive cough and moderate amount of thick white sputum that required suctioning. She remained on continuous tube feeding with water flushes every 3 hours. (*Id. at p. 35*). A pulmonary medicine progress report on December 27, 2016 lists 19 "patient active problems" including aspiration pneumonia, sepsis,

normocytic anemia, leukocytosis, pneumonia, abnormal EEG, seizure and dyspnea. (Ex. 2, p. 36).

On December 28, 2016, the Appellant's family noticed that the tube feeding liquid was too thick and it clogged the line. She reported it to the nurse and the tube had to be replaced with a new one. (*Id. at p. 52*). Also on that date, the Appellant was informed by the social worker that the physician had written the discharge order and there were attempts made by the social worker to find a skilled nursing facility to her to be transferred. (*Id. at p. 66*).

On December 29, 2016, the Beneficiary was noted to be more congested in the morning. Her oxygen saturation was 88% on room air but went up to 92-93% after a large amount of white thin secretions were suctioned. (*Id. at p. 68*).

Ms. Bell appeared at hearing and advocated strongly and passionately for her sister. She reiterated the history of her sister's illnesses leading up to her transfer to the Provider's facility. She stated that her sister had multiple bouts of pneumonia and was unable to speak or eat and had to be placed on a feeding tube. Ms. Bell urged that her sister was not medically stable at the time of transfer and required continued inpatient care through February 17, 2017, when she was able to be transferred to a lower level of care. In addition, she stated that at the time of her discharge, her sister was still being treated for pneumonia which included the production of sputum that had to be suctioned in order for the Beneficiary to breath properly. Further, Ms. Bell argued that her sister's other medical conditions required continued inpatient care. She noted that a large circumferential pericardial effusion was discovered; she suffered from a 12 inch deep vein thrombosis with a clot; she had acute anaerobic fungal blood infection, the source of which had not yet been determined and she suffered from acute malnutrition. (Ex. 3, p. 1; *Hearing CD*). Given her sister's multiple acute illnesses, she maintained that she needed to be closely monitored in an inpatient hospital setting. (*Hearing CD*).

LEGAL FRAMEWORK

I. ALJ Review Authority

A. Jurisdiction

An individual who, or an organization that, is dissatisfied with the reconsideration of an initial determination is entitled to a hearing before the Secretary of the Department of Health and Human Services (HHS), provided there is a sufficient amount in controversy and a request for hearing is filed in a timely manner. (§ 1869(b)(1)(A) of the Act).

In implementing this statutory directive, the Secretary has delegated authority to administer the nationwide hearings and appeals system for the Medicare program to OMHA. (*See* 70 Fed. Reg. 36386, 36387 (June 23, 2005), as amended by 76 Fed. Reg. 19995 (August 8, 2011). The ALJs within OMHA issue the final decisions of the Secretary, except for decisions reviewed by the Medicare Appeals Council. (*Id.*)

The request for hearing is timely if filed within sixty (60) days after receipt of a QIC reconsideration decision. (*See* 42 C.F.R. § 405.1014(b)(1)). These appeals are before the ALJ on a timely request for hearing. The amounts in controversy meet the jurisdictional requirements for an ALJ hearing before OMHA. (42 C.F.R. § 405.1006; 76 Fed. Reg. 59138 (July 4, 2011).

B. Scope of Review

All initial determinations for Center for Medicare and Medicaid Services' (CMS) contractors, subsequent to January 1, 2006, and all cases subject to a QIC reconsideration, are governed by the ALJ hearing procedures set forth at 42 C.F.R. §§ 405.900 through 405.1064. (*See* 70 Fed. Reg. 11420, 11424-26 (Mar. 8, 2005), as amended by 70 Fed. Reg. 37700 (June 30, 2005), 70 Fed. Reg. 50214 (August 26, 2005), and 74 Fed. Reg. 65296 (December 9, 2009)) pursuant to the CMS implementation policy for the Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. Law 106-554, app. F, 114 Stat. 2763, 2763A-463, and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. Law 108-173, 117 Stat. 2066.

The issues before the ALJ include all the issues brought out in the initial, reconsidered, or revised determination that were not decided entirely in the Appellant's favor. However, if evidence presented before or during the hearing causes the ALJ to question a fully favorable decision he or she will notify the Appellant and will consider it an issue at the hearing. (42 C.F.R. § 405.1032(b)).

The ALJ may decide a case on the record and not conduct an oral hearing if the Appellant and all the parties indicate in writing that they do not wish to appear before the ALJ at an oral hearing or the evidence in the hearing record supports a finding in favor of the Appellant on every issue. (42 C.F.R. § 405.1038).

C. Standard of Review

"The ALJ conducts a de novo review and issues a decision based on the hearing record." (42 C.F.R. § 405.1000(d)).

II. Principles of Law

A. Statutes and Regulations

The Medicare program, Title XVIII of the Act, is administered through CMS, a component of HHS. Under the authority of §1842(a) of the Act, the Secretary of HHS is authorized to enter into contracts with private entities for the daily operations of the program.

Medicare Part A entitles a beneficiary to reimbursement for a variety of costs associated with hospital, related post-hospital, home health services, and hospice care for individuals eligible for Medicare. (42 U.S.C. § 1395d (a) (1)). Payment by Medicare is limited by § 1862(a) of the Act which states, in pertinent part: "Notwithstanding any other provision of this title, no payment may be made under Part A or Part B for any expenses incurred for items or Services – (1) (A)

which, ...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. . ." (42 U.S.C. § 1395y(a)(1)(A); see also 42 C.F.R. § 411.15(k)(1)).

Section 1833(e) of the Act states that "[n]o payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period." (42 U.S.C. § 13951(e)).

Section 1871(a)(2) of the Act provides that no rule, requirement or statement of policy, other than a National Coverage Determination (NCD), can establish or change a substantive legal standard governing the scope of benefits or payment for services under the Medicare program unless it is promulgated as a regulation by CMS. However, although not subject to the force and effect of the law, CMS and its contractors, have issued policy and guidelines that describe criteria for coverage for selected types of medical services and supplies.

Section 1879(a) of the Act provides that if the services provided are deemed to be not reasonable and necessary for the diagnosis and treatment of an illness or injury or to improve the functioning of a malformed body member or are deemed to be custodial, payment may still be made if both the Beneficiary and the Provider of the services did not know, nor reasonably should have been expected to know, that the services would not be reimbursable by Medicare. If no payment may be made under this section, the Beneficiary's liability for the charges incurred may be waived if the Beneficiary did not know, nor reasonably should have been expected to know, that the services would not be reimbursable by Medicare. (§ 1879(b)). Medicare reimbursement under § 1879 cannot be made when Medicare coverage is denied for any basis other than under the provision of § 1862(a)(1). (§ 1879(a)(1)).

CMS regulations consider a provider or supplier to have known that items or services would not be covered by Medicare if they are given direct notice of this by CMS or any of its agents, including intermediaries and carriers, by utilization review committees, or by the beneficiary's attending physician. (*See* 42 C.F.R. § 411.406(b) and (c)). A provider or supplier is also considered to have notice that services are not covered if it is clear that they should have known of Medicare's coverage criteria based on the receipt of notices from CMS or its agents, publication in the Federal Register, or based on their "knowledge of what are considered acceptable standards of practice by the local medical community." (42 C.F.R. § 411.406(e)). According to the Medicare Program Integrity Manual (MPIM), the supplier is liable for the amount where the patient's medical record does not support medical necessity for the item, unless a properly executed Advance Beneficiary Notice has been obtained. (*MPIM,* Pub. 100-08, Ch. 5, § 5.2.1).

B. Policy and Guidance

Administrative Law Judges may also give consideration to the manuals and rulings issued by the CMS in determining benefit coverage and eligibility. Although not binding on the

Administrative Law Judge, the respective manuals provide guidance in the administration of the Medicare program. (*Shalala v. Guernsey Memorial Hospital*, 514 U.S. 87 (1995)).

The Medicare Benefit Policy Manual (MBPM) gives guidance regarding coverage requirements in a skilled nursing facility setting. The Medicare Benefit Policy Manual ("MBPM"), CMS Publication 100-2, Chapter 8, CMS further incorporates the coverage requirements, as follows:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel *See* §§ 30.2 - 30.4; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services.

- The patient requires these skilled services on a daily basis *See* § 30.6; and as a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. *See* § 30.7.

- The services must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity." *Id.* at § 30.

CMS further instructs that if any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. *Id.* When reviewing SNF services to determine whether the level of care requirements is met, CMS suggests that contractors first determine whether a patient needs skilled care. *Id.* "The intermediary considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service." *Id.* at § 30.2.2.

Sections 1154, 1866(a)(1)(F) and 1886(f)(2) of the Act require that a Quality Improvement Organization (QIO) review services furnished by physicians, other health care professionals, providers and suppliers as specified in its contract with the Secretary of HHS to determine compliance with Medicare law and policy. CMS instructs that under Part A of Medicare, the QIO for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and the judgments are binding for purposes of Medicare coverage. *Id.* Medicare regulations set forth at 42 C.F.R. § 476.100 require that, in assessing the need for and appropriateness of an inpatient health care facility stay, a QIO must apply criteria to determine the appropriateness of providing services at a particular health care facility or at a particular level of care.

CMS provides guidance for the QIO to apply when it conducts a review of admissions and discharges as specified in 42 C.F.R. § 476.71(a)(6). This guidance is contained in the Medicare Quality Improvement Organizations Manual (MQIOM) (Internet-Only Manual Publ'n 100-10), ch 4, § 4110 (Rev. 2, 07-11-03), in relevant part as follows:

QIOs must conduct review of admissions and discharges as specified in 42 C.F.R. 476.71(a)(6). Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient at any time during the stay. The patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

A. Determining Medical Necessity and Appropriateness of Admission/Discharge -- Review the medical record and use appropriate criteria to determine if an admission to a PPS or non-PPS hospital should be referred for physician review. Similarly, use criteria to identify, for physician review, cases of potential premature discharge (i.e., the patient was not medically stable and/or discharge was not consistent with the patient's need for continued acute inpatient hospital care) (See §4510 on screening criteria).

The case is referred to a physician reviewer when the non-physician reviewer cannot approve the hospitalization as necessary and/or another level of care would have been appropriate without posing a threat to the safety or health of the patient.

The physician reviewer must consider, in his/her review of the medical record, any preexisting medical problems or extenuating circumstances that make admission of the patient medically necessary. Factors that may result in an inconvenience to a patient or family do not, by themselves, justify inpatient admission. When such factors affect the patient's health, consider them in determining whether inpatient hospitalization was appropriate.

Inpatient care rather than outpatient care is required only if the patient's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical conditions, factors that may cause the patient inconvenience in terms of time and money needed to care for the patient at home or for travel to a physician's office, or that may cause the patient to worry, do not justify a continued hospital stay or justify your approval of a higher-than- necessary level of care.

Certain services are considered regulatory examples of skilled services and those include; 1.) overall management and evaluation of a care plan; 2.) observation and assessment of an unstable patient's changing condition; 3.) Levin tube and gastrostomy feedings; 4.) ongoing assessment of rehabilitation needs and potential; 4.) therapeutic exercises and activities provided by a skilled therapist; 5.) gait evaluation and training; and 6.) intravenous or intramuscular injections and intravenous feedings. 42 C.F.R. §409.33.

Medicare laws state that if a hospital concludes that inpatient services will no longer be covered by Medicare, the hospital is required to issue the Beneficiary an Advanced Beneficiary Notice (ABN). The purpose of an ABN is to inform a Medicare beneficiary, before he or she receives

specified items of services, that Medicare certainly or probably will not pay for the items or series in that particular instance. The ABN allows the beneficiary to make an informed decision whether to receive the items or services for which he or she may ultimately be financially liable. (Medicare Claims Processing Manual, Pub. 100-4, Ch. 30, §§ 10, 50.1)

To be acceptable, the ABN must give the beneficiary a reasonable idea of why the service provider is predicting the likelihood of Medicare denial so that the beneficiary can make an informed consumer decision whether to receive the service and pay for it personally. (*Id.* at §§ 40.3, 40.3.8)

An ABN must meet certain standards to be acceptable as evidence of the beneficiary's knowledge for the purposes of liability. To be acceptable, the ABN must be in writing, in the CMS-approved format, use approved notice language, ensure readability to facilitate the beneficiary's understanding, cite the particular service or services for which payment is likely to be denied and cite the service provider's reasons for believing Medicare payment will be denied. (42 C.F.R. § 411.408(f)(1)).

ANALYSIS

The QIO concluded that the Appellant's discharge from an acute hospital setting was appropriate because it determined that she was medically stable and there was no plan for evaluation or treatment that required a continued hospital stay. The Appellant claims that the Beneficiary's needs required continued inpatient hospital services beyond December 30, 2016 and up to February 17, 2017.

Medicare sets forth the conditions for placing or maintaining a patient in an inpatient setting. "Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the patient at any time during the stay. The patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis." The Medicare rules go further to state that "[i]npatient care rather than outpatient care is required only if the patient's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting." The beneficiary must have qualifying medical conditions. "Without accompanying medical conditions, factors that may cause the patient inconvenience in terms of time and money needed to care for the patient at home or for travel to a physician's office, or that may cause the patient to worry, do not justify a continued hospital stay or...a higher-than-necessary level of care." Medicare Quality Improvement Organizations Manual (MQIOM) (Internet-Only Manual Publ'n 100-10), ch 4, § 4110.

In addition, Medicare rules state that if a hospital determines that inpatient services will no longer be covered by Medicare, the hospital is to issue the Beneficiary an Advanced Beneficiary Notice (ABN). The purpose of an ABN is to inform a Medicare beneficiary, before he or she receives specified items of services, that Medicare certainly or probably will not pay for the items or services in that particular instance. The ABN allows the beneficiary to make an

informed decision whether to receive or decline the items or services for which he or she may be financially liable. (Medicare Claims Processing Manual, Pub. 100-4, Ch. 30, §§ 10, 50.1)

To be acceptable, the ABN must give the beneficiary a reasonable idea of why the service provider is predicting the likelihood of Medicare denial so that the beneficiary can make an informed consumer decision about whether he or she may agree to receive the service and potentially pay for it out of their own pocket. (*Id.* at §§ 40.3, 40.3.8) The ABN must be in writing, in the CMS-approved format and use approved notice language, ensure readability to facilitate the beneficiary's understanding, cite the particular service or services for which payment is likely to be denied and cite the notifier's reasons for believing Medicare payment will be denied. (42 C.F.R. §411.404; 411.408(f)(1)).

In this case, the evidence shows that the Beneficiary was transferred to the provider's facility from a skilled nursing facility and admitted as an inpatient on December 2, 2016 after being diagnosed with pneumonia. The Beneficiary's sister stated that the Beneficiary had already had pneumonia in November 2016 and was discharged from a previous hospital and became reinfected. (*Hearing CD*). The Beneficiary suffered from an anoxic brain injury caused by a Tylenol overdose as well as bronchiectasis, gastroesophageal reflux disease, anxiety, dysphagia, contractures and she was fed through a PEG tube. The Beneficiary was rarely verbal but could communicate at times. At the time of her hospitalization in December 2016, the Beneficiary was noted to be non-verbal and incontinent of bowel and bladder. There is no question that the Beneficiary required inpatient care at her admission. She was a very debilitated individual on a PEG tube with pneumonia.

The Beneficiary completed one course of antibiotics and seemed to be doing better. Discharge planning was initiated sometime in early to mid-December. However, on December 17, 2016, the discharge order was cancelled because the Beneficiary became medically unstable. (Ex. 2, p. 84). The medical notes indicate new recurrent fevers as of December 13, 2016 and worsening infiltrate seen on a chest x-ray. (*e.g., Id. at p. 20*).

The Beneficiary was started on a second course of antibiotics for pneumonia on December 25, 2016. The record documents frequent episodes in which the Beneficiary was coughing up whitish thick sputum that had to be suctioned out by the nurse. In fact, on one occasion she had so much sputum that it was affecting her oxygen saturation level. On December 29, 2016, the Beneficiary's oxygen saturation was 88% on room air. The oxygen saturation was raised to an acceptable 93% after the Beneficiary had the sputum suctioned. The record indicates the Beneficiary had atelectasis, or partial collapse, of the left lower lobe of her lungs as of December 27, 2016. (Ex. 2, p. 43). Furthermore, as noted by the Appellant the documents prior to discharge indicate the Beneficiary had a fungal infection of the blood of unknown origin, a recently diagnosed pericardial effusion and a 12 inch deep vein thrombosis.

The Beneficiary's sister was a passionate and effective advocate on her sister's behalf. She maintained that the Beneficiary required continued inpatient hospital care due to her pneumonia, inability to speak or eat, requirement for PEG feeding for all of her nutrition and other acute illnesses. We acknowledge that factors such as inconvenience or increased cost to a beneficiary or his or her family does not justify a continued inpatient hospital stay. The medical condition of

the Beneficiary must be such that the Beneficiary's health or life would be jeopardized in a less intensive setting.

After our review of the medical records, we agree with the claims of the Appellant. The record shows that the Beneficiary had multiple bouts of pneumonia and was unable to speak or eat. Additionally, she continued to require tube feedings in order to obtain all of her nutrition. The Beneficiary had a right ischial tuberosity (right sitting area) wound 1.2 x 2 cm that was treated with venelex and foam dressing. (Ex. 2, p. 24). The Beneficiary had not been able to sit in a wheelchair since her admission on December 2, 2016. The Beneficiary's sister noted that in the previous 12 years since her brain injury, the Beneficiary had never had a pressure sore. The Beneficiary also had a new diagnosis of a large pericardial effusion and a deep vein thrombosis. A pulmonary medicine progress report as of December 27, 2016 lists 19 "patient active problems" including aspiration pneumonia, sepsis, normocytic anemia, leukocytosis, pneumonia, abnormal EEG, seizure and dyspnea. (Ex. 2, p. 36). The Appellant's representative urged that her sister was not medically stable at the time of the discharge and required continued inpatient care. We cannot disagree. The Beneficiary was in a medically tenuous condition at the time the hospital intended to transfer the Beneficiary to a lower level of care. The Beneficiary had a new acute thrombosis in her upper extremity. She still had several significant acute illnesses, the most significant of which involved her pulmonary status. The Beneficiary had been treated with antibiotics beginning December 2, 2016 and continued to show an increase of infiltrates through December 17, 2016 despite aggressive efforts to stop it. Moreover, the Beneficiary had a propensity for recurrent infections and still had decreased breath sounds as of December 25, 2016. The Beneficiary's sister noted that the Beneficiary had two more instances of pneumonia since December 31, 2016. (*Hearing CD*). More germane to the present issue, though, two days before the proposed discharge, the Beneficiary had a decreased oxygen saturation level of 88% and the hospital needed to remove mucus from her lungs to increase her respiratory capacity. The Beneficiary also had ancillary issues, including a recently diagnosed pericardial effusion and fungal infection of her blood. Given the Beneficiary's dangerous respiratory status and unstable condition, as well as the other discovered issues, she had a significant risk of adverse consequences without the close monitoring and treatment that could only be provided in an inpatient hospital setting. The Beneficiary was not ready for discharge to a skilled nursing facility as of December 31, 2016.

Furthermore, we also note that the notice to the Beneficiary was not shown to be effective. The QIO maintained that the Beneficiary was advised via telephone of the hospital intent to terminate inpatient services, despite the fact that the Beneficiary is unable to speak. There is no documentation that such a telephone notice occurred. There is no summary of the telephone conversation in the record. Additionally, the hospital never furnished the Beneficiary or her representatives with written notice of its intent to cease the inpatient services. (*Hearing CD*). Pursuant to Medicare regulations, if a hospital determines that services will no longer be covered by Medicare, the hospital is to issue an advanced beneficiary notice (ABN) which must be in writing. There is no evidence in this record that the hospital issued an ABN in writing to the Appellant. The only written notice that is in the record from the hospital is a document titled "An Important Message From Medicare About Your Rights" and states "Patient sister is not at bedside 12/29" and "Patient nonverbal." The initials "MA" are next to this statement. (Ex. 2, p. 46). Otherwise, there are only the KEPRO documents in the file which find in favor of the

hospital's decision. (Ex. 1). Consequently, on this basis too, the Appellant received defective notice and was entitled to continued care as an inpatient.

Accordingly, the inpatient services after December 30, 2016 were medically reasonable and necessary and Medicare should have continued to cover any inpatient acute hospital level of care after that date until the Beneficiary stabilized and was able to be transferred to a lower level of care.

CONCLUSION OF LAW

The Beneficiary was entitled to continue to receive Medicare covered inpatient acute hospital level of care after December 30, 2016.

ORDER

The Medicare Contractor is **DIRECTED** to process this claim in accordance with this order.

SO ORDERED.

Date: MAR 03 2017

Thomas S. Tyler
U. S. Administrative Law Judge