STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-04789

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 07 Brevard
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on September 25, 2007, at 9:45 a.m., in Cocoa, Florida. The petitioner was not present. His mother, represented him. stepfather, was also present on behalf of the petitioner. Lisa Sanchez, human services program specialist, Area 7 Medicaid, was present representing the Agency for Health Care Administration (AHCA). Mary Wheeler, review operations manager and Dr. Robert Buzzeo, medical director, both from KePRO, appeared by telephone as witnesses for the agency.

ISSUE

At issue is the respondent's decision of July 27, 2007 to deny private duty nursing services paid by Medicaid for the period of July 6, 2007 to September 3, 2007. Prior to the action under appeal, the petitioner was receiving 208 hours. The agency holds the burden.

FINDINGS OF FACT

1. The petitioner is four years old. He weighs 34 pounds. He lives with his mother, stepfather, and seven-month-old brother. His mother presented Exhibits 1 through 3, which are her accounts of his doctor visits, hospitalizations, medical conditions, and medicines, including the dosage and time of each; these are not medical records. She reports that the petitioner is a medically complex child whose conditions include cerebral palsy, severe developmental delay and dystonia. He has no head control, or the ability to speak or communicate. He has been diagnosed with hypophosphetmic rickets with severe osteopenia and continual fractures. At the time of the hearing, he was in a spica cast because of broken bones. He has Lennox Gestaut Syndrome, which results in sleeplessness and hyperactivity at night. His mother attests that he is awake 21 hours per day. He is fed by gastronomy tube (g tube) and receives his medications by g tube. He is fed six times per day, and receives medications ten times a day. Between July 1, 2007 and September 25, 2007, he was hospitalized six times for fractures, fever, seizures, dehydration, vomiting, diarrhea, or EEG study and video monitoring. He had nine doctors' appointments during the same period.

2. The petitioner has been receiving private duty nursing (PDN) services under Medicaid. A request for 208 hours of PDN services was submitted by the provider,

Pediatric Services of America (PSA), for the period of July 6, 2007 through September 3, 2007.

3. Prior to the action under appeal, the petitioner was receiving PDN services. His mother was on leave from her job at the time of the hearing, but normally works three days a week, eight hours per day. She has been fired from two jobs because of complications from her son's health. His stepfather works three nights a week on Wednesday, Friday, and Saturday, from 2 p.m. to 4:00 a.m., or 2 p.m. to 4:30 a.m., or 4 p.m. to 4 a.m., in addition to a daily job. The requested hours of PDN are for the times when the petitioner's stepfather is at work in the evening.

4. Requests for PDN are reviewed with a contract provider who completes a prior authorization review for the requested service. The contract provider is KePRO. The request for services is submitted by the home health agency. All communication is sent between the provider and KePRO. KePRO reviews the written request for services to determine if the number of hours requested are medically necessary. If additional information is needed, KePRO contacts the provider. In this case, additional information was requested and received.

5. The Respondent's Composite Exhibit 3 contains all of the information KePRO used in making a determination of medical necessity. On July 3, 2007, KePRO received a request for 208 hours of PDN. The original request was for 400 hours, but later clarified as 208 hours based on the request for eight hours per day on Wednesdays, Fridays, and Saturdays. The initial information received by KePRO from the provider listed the petitioner's diagnosis as "abnormal central nervous system function study and failure to thrive". The medications listed are Tylenol, diaper cream,

Lactolose, Keppra, and Triptal. His functional limitations listed are bowel and bladder incontinence, endurance, ambulation, and speech. The report showed no respiratory problems, no pain, no recent hospitalizations, and his mother was able to assist with his care.

6. Additional information was submitted following a request for information that showed the petitioner also had GERD, feeding difficulties, developmental delays, and reactive airway disease. Additional medications were also reported. On July 24, 2007, a physician consultant reviewer recommended denial of the requested hours of PDN, citing "A HHA [Home Health Aide] could assist Mom when Dad not in home".

7. A Reconsideration request was submitted by PSA and reviewed by a KePRO Physician Consultant Board-Certified in Pediatrics. The provider noted that the petitioner's medical doctor ordered nursing while his stepfather is at work because his mother is the only caregiver in the home then to administer g tube feedings and medications while caring for her other son. The original denial was upheld.

8. Dr. Buzzeo, the medical director at KPRO, believed that the request for PDN that the petitioner could benefit from a HHA, not PDN. He referred to the information submitted by the provider as the basis for the denial. Dr. Buzzeo believed that the petitioner was in a spica cast because of surgery to the hips, that the petitioner's mother was not able to move him because of the cast, and that a HHA would suffice in moving him. The original submission by the provider did not contain information about his severe seizure disorder or recent hospitalizations. Dr. Buzzeo urged the petitioner's mother to contact the provider to submit another request for PDN and he would take a different approach after hearing her testimony.

9. The petitioner's mother does not agree with the decision by KePRO. She believes she did all that she could do through her provider, and believed that her son's medical records were faxed to PSA while he was in the hospital, and that KePRO should have had all of the information when considering the request for PDN.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Families and Children, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 F.S. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

Florida Statute 409.905 addresses Mandatory Medicaid services with section (4) informing that Home Health Care Services can be covered. Under subsection (b) the following information is relevant:

> The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services...The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep and care for other family dependents...

It is concluded that the agency needed to review need for nursing service.

Florida Statute 409.913 addresses **Oversight of the integrity of the Medicaid program,** with (1)(d) describing "medical necessity or medically necessary" standards and says in relevant part: "...For purposes of determining Medicaid reimbursement, the

agency is the final arbiter of medical necessity..." Consistent with statute, Fla. Admin. Code 59.G-1.010, **Definitions**, states for medical necessity:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

The Home Health Services Coverage and Limitations Handbook defines private duty nursing (at page 2-15):

> Private duty nursing services are medically necessary skilled nursing services that may be provided in a child's home or other authorized settings to support the care required by the child's complex medical condition.

The Home Health Services Coverage and Limitations Handbook provide that for private duty nursing, prior authorization must be received (at page 2-17):

> **Service Authorization:** All private duty nursing services must be prior authorized by a Medicaid service authorization nurse prior to the delivery of services.

In accordance with the provider manual (CMS 1500) prior authorization requests must be submitted by the provider (at 2-2):

> **Who Submits the Request** The request for prior authorization must be submitted by the provider who plans to furnish a service, except for out-of-state prior authorization.

Florida Admin. Code 65-2.056 Basis of Hearings.

> The Hearing shall include consideration of:
> (1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance...
>
> (3) The Hearing Officer must determine whether the department's decision on eligibility or procedural compliance was correct at the time the decision was made. **The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the department in making its decision**.

The agency denied or terminated PDN services based on information submitted by the provider in a prior authorization request for services. At the hearing, the petitoner's mother introduced medical conditions, hospitalization information, and other pertinent information not known to the contracted agency when determining medical necessity. Based on the above cited rule concerning de novo hearings, relevant new evidence can be considered. In the absence of medical documentation from the petitioner's treating physician, the undersigned is not able to make a determination of medical necessity. As such, the agency's denial action is reversed and remanded to the agency to consider the additional evidence in determining medical necessity for

PDN for the petitioner for the time period under appeal. A new notice is to be issued once the determination is made, to include appeal rights.

DECISION

The appeal is granted for the reasons stated above.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 9 day of November, 2007,

in Tallahassee, Florida.

Margaret Poplin
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: Petitioner
Judy Jacobs, Area 7 Medicaid Adm.

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-05251

PETITIONER,

Vs.

CASE NO. 1263193005

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 15 Indian River
UNIT: 88500

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on October 11, 2007, at 1:10 p.m., in Vero Beach, Florida. The petitioner was not present. His sister, [illegible] represented him. [illegible] LPN, unit manager, and [illegible]a, business office manager, both of Health and Rehab, were present on behalf of the petitioner. Erika Delgado, economic specialist supervisor, represented the Department.

The record was left open until close of business on October 22, 2007, in order to receive additional evidence. It was received timely and entered into evidence as the Petitioner's Exhibit 4. The record was then closed.

ISSUE

The petitioner is appealing the Department's action to deny Medicaid benefits through the Department's Institutional Care Program (ICP) on the basis that he did not meet the disability criteria. The petitioner holds the burden.

FINDINGS OF FACT

1. The petitioner is 43 years old. His date of birth is An application for ICP Medicaid was submitted to the Department on his behalf on July 19, 2007. As part of the eligibility determination process, the petitioner, among other factors, must be determined to be disabled.

2. Following a hospital admission on May 23, 2007 for multiple medical issues, the petitioner was discharged to Health and Rehab on June 8, 2007. His diagnoses include a history of alcohol abuse, withdrawal, hypokalemia, hyponatremia, peptic ulcer disease, cellulitis of the left upper extremity, and history of alcohol related seizures. He suffers from diabetes, hypertension, and anemia. He had pseudomembraneous colitis. While he was in the hospital, he developed tachycardia and tachypnea, was intubated and started on mechanical ventilation (Petitioner's Exhibit 4). His sister explains that he had a chemical brain injury due to infection. He responded to medical treatment to resolve many of his abnormal lab test results and infections.

3. When he was admitted to , he could not perform any of his activities of daily living (ADL). While a resident in the nursing facility, he received four weeks of extensive physical, occupational, and speech therapy. He was discharged from the nursing facility on August 3, 2007 to his brother's house. The petitioner's physical

therapy discharge summary shows that he made excellent progress towards independent level of function in all aspects of mobility. The occupational therapy discharge summary shows he achieved independence in all areas but still needed some grip strengthening and restorative nursing. The speech language pathology discharge summary shows that he completed all tasks adequately. Upon his admission, he scored a rating of 75-90 in auditory comprehension, expressive language, orientation, level or arousal/alertness, and articulation/speech production. At discharge, he scored 100 in each category (Petitioner's Exhibit 4). He is walking now and able to communicate, but does not have full use of his left arm as he is not able to totally extend it.

4. As the petitioner was not 65 years old, he required a disability determination. The Department requested that the District Medical Review team (DMRT) evaluate the medical status of the petitioner. On August 20, 2007, the DMRT physician found no disability with an N34 code, which means, "Impairment was not disabling for 12 full months" (Respondent's Exhibit's 1 & 2).

5. The Department explains that the petitioner would have to meet a medical level of care and be determined disabled to be eligible for ICP benefits. The Comprehensive Assessment and Review for Long Term Care Services (CARES) unit determined the petitioner met the level of care required for a stay at the nursing facility for his entire stay (Petitioner's Exhibit 2). Without a determination of disability, the Department could not allow the ICP benefits. Notice was sent on August 24, 2007, informing the petitioner of the denial of his application (Respondent's Exhibit 4).

6. The petitioner applied for Social Security benefits in July 2007. His application was still pending a decision at the time of the hearing.

7. The petitioner is seeking ICP benefits to pay for his stay at _____. His representative inquired about Medicaid to pay for his hospital stay also. The Department explains that his application did not indicate a request for Community Medicaid, but he would still have to meet the disability requirement.

8. The petitioner has an 11th grade education. He has not worked since May 2007. His past relevant work is that of a heavy equipment operator.

CONCLUSIONS OF LAW

The Florida Administrative Code, Section 65A-1.710 et seq., set forth the rules of eligibility for Elderly and Disabled Individuals Who Have Income of Less Than the Federal Poverty Level. For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. §416.905. The regulations state, in part:

> The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy...

Fla. Admin. Code 65A-1.711 **SSI-Related Medicaid Non-Financial Eligibility Criteria** states in part:

> To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F....
>
> (2) For ICP benefits, an individual must be:

(a) Living in a licensed nursing facility, or confined to a hospital swing bed or to a hospital-based skilled nursing facility bed, or in an ICF/DD facility that is certified as a Medicaid provider and provides the level of care that the client needs as determined by the department; or living in a Florida state mental hospital and be age 65 or over; and

(b) Determined to be in medical need of institutional care services according to Rules 59G-4.180 and 59G-4.290, F.A.C., for nursing facility, hospital swing bed placements and placements in a hospital-based skilled nursing facility bed according to Chapter 65B-38, F.A.C., for ICF/DD facilities or according to Rule 59G-4.165, F.A.C., for state mental hospitals.

The Department's Fla. Integrated Pub. Policy Manual states in part:

1440.1204 **Blindness/Disability Determinations (MSSI, SFP)**

If the individual has not received a disability decision from SSA, a blindness/disability application must be submitted to the Division of Disability Determinations (DDD) for individuals under age 65 who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien programs...

The District Medical Review Team (DMRT) handles all other necessary disability determinations (including ICP, OSS, HCBS, and PACE).

20 C.F.R. §416.909, **How long the impairment must last**, states in part:

Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement.

20 C.F.R. §416.920, Evaluation of disability of adults, in general, states in part:

(a) *Steps in evaluating disability.* We consider all evidence in your case record when we make a determination or decision whether you are disabled...Your impairment(s) must be severe and meet the duration requirement before we can find you to be disabled. We follow a set order to determine whether you are disabled...(c) *You must have a severe impairment.* If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled...

The Social Security Administration Program Operations Manual (POMS) DI 25505.010 Duration Not Met - Impairment Prevents(ed) SGA for a Period of Less Than 12 Months states:

> When evidence shows that within 12 months of onset the individual's impairment(s) did not or will no longer prevent SGA, a durational denial is appropriate. It is necessary to consider duration in the context of the sequential process, however, since duration does not become an issue unless at some time an impairment is severe and prevents SGA.
> A. Projecting Severity and Residual Functional Capacity
> In most cases in which the evidence substantiates a finding of disability, it will be readily apparent from the same evidence whether or not the impairment is expected to result in death or has lasted or is expected to last 12 months from the onset of disability. When the application is being adjudicated before the impairment has lasted 12 months, the nature of the impairment, the therapeutic history, and the prescribed treatment will serve as the basis for determining whether the impairment is expected to result in death or will continue to prevent the individual from engaging in any SGA for the additional number of months needed to make up the required 12 months duration.

The Department uses the above federal regulations to determine disability. An individual must have a condition or combination of conditions listed in the Federal Regulations that is expected to last for at least 12 full months.

The hearing officer evaluated the petitioner's claim of disability using the sequential evaluation as set forth in 20 C.F.R. §416.920. The first step is to determine whether the individual is working. The petitioner is not working; therefore, he meets the first step.

The second step is to determine whether an individual has a severe impairment. In order to meet this definition of a severe impairment, an individual must have an impairment that is established by medical evidence consisting of signs, symptoms, and laboratory findings, and not only by the individual's statement of symptoms alone, as

per 20 C.F.R. §404.1508. In addition, such impairment "must have lasted or must be expected to last for a continuous period of at least twelve months," in order to meet the duration requirement, as per 20 C.F.R. §404.1509. Thus, in summary, in order to meet this step, an individual must have a medically diagnosed impairment(s) that meets the duration requirement.

The medical evidence submitted did not contain any evidence of the duration period. The medical evidence presented shows that the petitioner thrived after receiving several weeks of various intensive therapies and medications, and was discharged from a skilled nursing facility after his goals were met. Testimony showed that the petitioner had progressed remarkably. The hearing officer recognizes that the petitioner holds a slight burden at step two, however in the absence of any evidence showing a disabling condition with a duration of 12 months or more, the undersigned concludes that the petitioner does not meet step two of the sequential evaluation set forth above and therefore, is not determined to be disabled.

The petitioner may want to initiate contact with Vocational Rehabilitation in order to learn of any services that may be available to him.

DECISION

The appeal is denied as stated in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay

the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 16 day of November, 2007,

in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: Petitioner
15 DPOES, Judy Sickles

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-04558

PETITIONER,

Vs.

CASE NO. 1238232931

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 04 Clay
UNIT: 88369

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 3, 2007, at 1:08 p.m., in Jacksonville, Florida. The petitioner was not present; she was represented by her son, and future daughter-in-law, Present as witnesses were administrator of facility at and business office manager of

The record was held open through October 15, 2007 to allow the Department to determine eligibility for the retroactive period of March, February and January 2007. The Department completed the determination and informed of its determination on October 15, 2007. The eligibility results were entered as Respondent's Exhibit 7.

ISSUE

The petitioner is appealing the Department's action of June 25, 2007 approving Institutional Care Program (ICP) Medicaid beginning April 2007. The petitioner is seeking ICP Medicaid coverage beginning March 1, 2006. The petitioner held the burden of proof.

PRELIMINARY STATEMENT

The hearing was requested on August 3, 2007. The only action taken by the Department within 90 days of the hearing request date was the approval action taken on June 25, 2007. The hearing officer can review the three month retroactive period related to this application of March, February and January 2007, as there was no evidence that a notice addressing these months was issued.

The prior denial action taken by the Department was April 10, 2007. Therefore, the hearing officer does not have jurisdiction to review the April 10, 2007 denial action as the petitioner was beyond the 90 day time restriction to file an appeal based on Florida Administrative Code 65-2.046.

FINDINGS OF FACT

1. A prearranged funeral agreement was purchased for the petitioner on December 9, 2005 in the amount of $6,955. The petitioner's son provided the money to purchase the prearranged funeral agreement to his sister (petitioner's daughter), who had power of attorney at that time. The contract was signed by the petitioner's daughter for her mother. The contract indicates both the purchaser and the beneficiary as Hazel Vining. The contract shows itemized services and merchandise that totals $6,955. Of these, the contract reflects $995 for the casket, $895 for the vault and $995

for the opening and closing of the grave. Page 3 of the contract under the "Terms and Conditions," number 10 states, "Refund upon cancellation is 100% of the funds paid, within the first 30 days of the Agreement date, 90% thereafter through the third year and 100% of the fourth year and after" (Petitioner's Exhibit 2 and Composite Exhibit 3).

2. The petitioner was placed in the nursing home in March 2006 under Medicare. Her daughter had been handling some of her financial affairs and required institutionalization herself. Once this happened, and after some delay, the facility began working with the Department seeking ICP eligibility. An ICP application was denied February 2007 due to the level of care denied, as the form signed by the physician was outdated. A subsequent ICP application was denied on April 10, 2007 due to assets exceeding the limit, due to the value of the Prearranged Funeral Agreement. At this time, the agreement had not been made irrevocable.

3. A reapplication was made on April 16, 2007. Because the Prearranged Funeral Agreement was made irrevocable on April 17, 2007, the assets were under the $2,000 asset limit and the ICP application was approved beginning April 2007.

4. The Department determined the appropriate ICP asset limit was $2,000 based on the petitioner's income. Her monthly income consisted of $453 Social Security and $314.25 pension from the City of Jacksonville, for a total of $767.25 (Respondent's Exhibit 4).

5. The Department requested guidance from its Program Office staff on how to apply the $2,500 burial fund exclusion policy to the Prearranged Funeral Agreement for the three retroactive months prior to the April 2007 application, for the time before the agreement was made irrevocable. The Program Office responded that itemized

expenses such as casket, headstone, opening/closing at the site could be deducted, as well as the $2,500 exclusion (Respondent's Exhibit 3). This exhibit also shows that the April 2007 application is the third one made.

6. The Department evaluated eligibility for the retroactive months of January 2007, February 2007 and March 2007, while the hearing record was held open. According to Respondent's Composite Exhibit 7, the Department began with a revocable Prearranged Funeral Agreement amount of $6,976 and subtracted $995 (casket), $1,195 (opening and closing), $990 (headstone) and the $2,500 burial fund exclusion for a countable asset balance left in the Prearranged Funeral Agreement of $1,296. The petitioner's resident trust fund amount of $1,491.59 was added, to total $2,787.59 in assets for the month of March 2007. The $1,296 left of the Prearranged Funeral Agreement was added to the petitioner's resident trust fund amount of $945.39, to total $2,241.39 for the month of February 2007. The $1,296 left of the Prearranged Funeral Agreement was added to the petitioner's resident trust fund amount of $1,245.16, for a total of $2,541.16 for the month of January 2007. Because the assets exceeded the $2,000 asset limit, the Department determined that there was no ICP eligibility for the three retroactive months prior to the April 2007 application. There was no evidence that a notice was issued.

7. Also included in Respondent's Composite Exhibit 7 is a screen print from the Florida Medicaid system showing the petitioner's coverage. From February 1, 2006 through March 31, 2007 the petitioner was covered under the Qualified Medicare Beneficiary (QMB) Program. Beginning April 1, 2007, the petitioner was covered under the ICP Medicaid coverage group reflected as "MI I."

8. The petitioner's Social Security income and her pension income are both direct deposited into her resident trust fund account. The Social Security direct deposit monthly amount is $453 and the pension direct deposit amount is $109.10 twice per month, for a total income deposit amount of $671.20. The January 2007 lowest patient trust fund balance was $1,056.74. The February 2007 lowest patient trust fund balance was $603.10. The March 2007 lowest patient trust fund balance was $925.30. The only interest shown on the three months' of patient trust fund accounts was on January 31, 2007 in the amount of .16 (Petitioner's Exhibits 6 and 4 and Respondent's Exhibit 6).

CONCLUSIONS OF LAW

Florida Administrative Code 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, states in relevant part:

> (1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C...(2) Exclusions. The department follows SSI policy prescribed in 20 C.F.R. Part 416 in determining what is counted as a resource with the following exceptions, as mandated by federal Medicaid policies, or additional exclusions, as adopted by the department under section 42 U.S.C. § 1396a(r)(2)...(d) The individual, and their spouse, may designate up to $2,500 each of their resources for burial funds for any month, including the three months prior to the month of application. The designated funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The $2,500 is not reduced by the value of excluded life insurance policies or irrevocable burial contracts. The funds may be commingled in the retroactive period.

Florida Administrative Code 65A-1.716, Income and Resource Criteria, states in relevant part:

(5) SSI-Related Program Standards. (a) SSI (42 U.S.C. §§1382 – 1383c) Resource Limits: 1. $2,000 per individual...

The Department's Integrated Manual, 165-22, Appendix A-9 sets forth the income and resource standards and shows the ICP resource limit for an individual at $2,000 and the ICP-MEDS resource limit for an individual at $5,000. This same chart shows the MEDS income limit at $749 for an individual.

The Department's Integrated Policy Manual, 165-22 gives further guidance to the Department on counting burial related resources and is quoted below beginning at section 1640.0509 and ending with section 1640.0516:

1640.0509 Prepaid Burial Contracts (MSSI, SFP)

A prepaid burial contract (or special mortuary fund) is an agreement in which an individual prepays his burial expenses and the seller agrees to furnish the burial. Prepaid burial contracts should not be confused with burial insurance or burial trusts. The prepaid burial contract funds are not included as an asset if:

1. the contract cannot be liquidated without significant hardship to the individual; or
2. the contract seller refuses to revoke or liquidate the contract; or
3. the contract is irrevocable.

If the contract does not meet the above criteria, the amount the individual would receive by revoking or liquidating the contract, minus any penalties, is the amount included as an asset for the individual.

1640.0510 State Law Regarding Prepaid Burial Contracts (MSSI, SFP)

State laws may impose varying types of conditions on burial contracts. Depending on the state in which the contract was made, there may be unique provisions for:

1. the process for revoking or liquidating prepaid burial contracts;
2. the conditions required before a burial contract can be revoked or liquidated; and
3. the conditions necessary for a contract to be defined as irrevocable. Any Medicaid applicant may make an irrevocable contract and exclude this asset. District Legal Counsel may be consulted when it is necessary to determine if a contract is revocable. If the burial contract was purchased

in another state, contact the central office to determine whether the contract is irrevocable.

1640.0511.01 Revocable Prepaid Burial Contract (MSSI, SFP)

Contract provisions for a revocable prepaid burial contract may prohibit liquidation of the asset. The ESS must examine the contract and determine if it includes this type of provision.
The contract is not included as an asset if the individual would have to move out of state to liquidate the contract or if another person's consent is required and the person will not agree to liquidate the contract.

1640.0511.02 Value of the Prepaid Burial Contract (MSSI, SFP)

Unless the contract meets a condition for exclusion, ***the amount the individual would receive upon revoking or liquidating the contract is included as an asset.*** (emphasis added) This amount is often different from the face value of the contract. Guidelines for determining the amount to be received are usually set by state law and differ from contract to contract.
The contract must be examined to determine the amount to be received from liquidating or revoking the contract. If the contract is unclear, the individual or ESS must contact the funeral director to determine the amount.
The value of prepaid burial contracts liquidated by means other than revocation such as sale or transfer is the amount the individual would receive if the contract was sold on the open market.
The individual can rebut the amount with appropriate verification and documents. For example, the State Funeral Directors Association or a local funeral director may provide information showing that sellers of prepaid burial contracts can only expect to receive a percentage of the face value, or the individual may provide proof that only a certain amount was offered or that the contract was advertised for sale and no offers were received.

1640.0512 Irrevocable Burial Trusts (MSSI, SFP)

If the irrevocable burial trust is created in connection with a funeral home or funeral director, it is treated like an irrevocable prepaid burial contract. As long as it is irrevocable, the trust is not considered an asset to the individual.
If the irrevocable burial trust is not created in connection with a funeral home or funeral director, it is considered a transfer of assets. Regular burial exclusion policy is applicable to the uncompensated value of the burial trust fund. Up to $2,500 of the trust can be excluded as a burial asset. The remaining uncompensated value would count as an asset to the individual according to policies in Section 1640.0600.