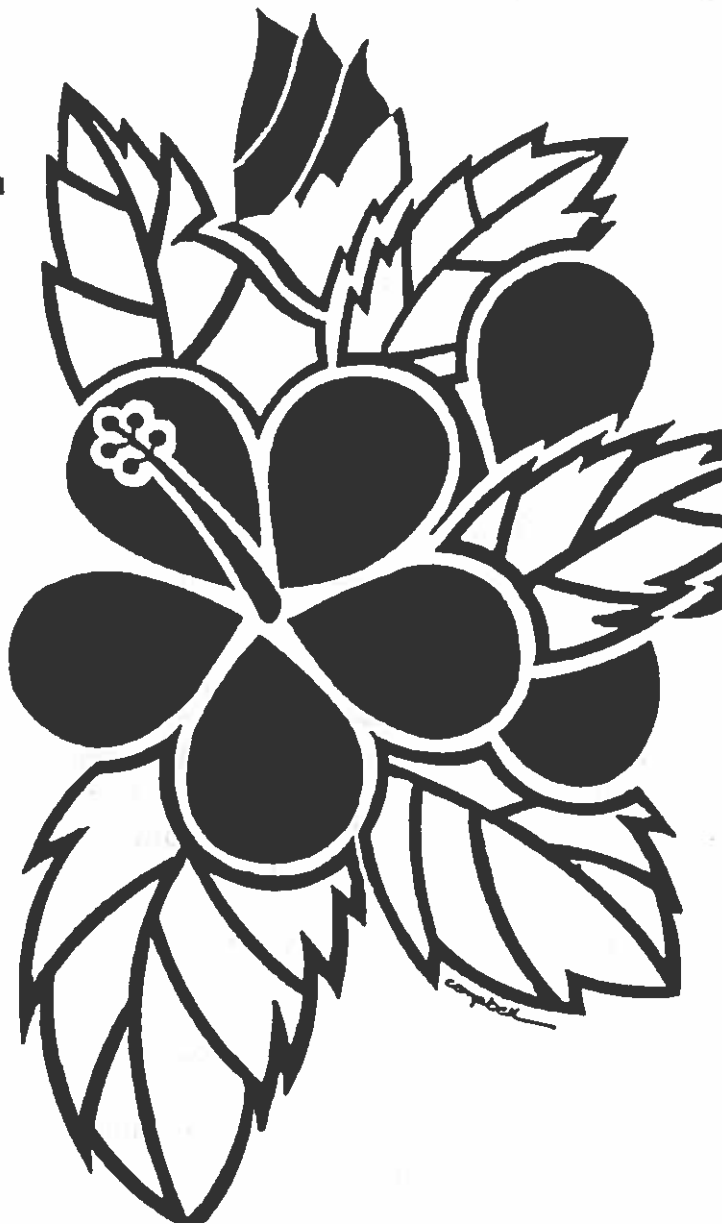


MEDICALLY INDIGENT PROGRAM
RECIPIENTS' MANUAL

Medically Indigent Program

Recipients' Manual

Department
of
Public Health
and
Social Services



INTRODUCTION

This brochure was written to answer basic questions concerning the requirements and benefits to the **MEDICALLY INDIGENT PROGRAM**.

Public Law 18-31 authorizes the Department of Public Health and Social Services, Bureau of Health Care Financing Administration, to administer the Medically Indigent Program (MIP).

MIP, which is 100% locally funded, will provide medical assistance to low income families and those afflicted with tuberculosis, lytico, bodig, and irreversible renal failure. Insulin injections are also free for residents of Guam.

WHO ARE ELIGIBLE FOR MIP?

If you are a U.S. citizen or permanent resident and meet one of the following requirements, inquire at the MIP office:

- You are not eligible for Medicaid coverage; or
- You don't have either medical insurance coverage or the financial ability to pay for medical insurance coverage or for medical services; or
- You have medical insurance coverage but such coverage is inadequate to cover the cost of medically required treatment.

Eligibility is based on income, resources and residency. Aliens with less than three years of residency must provide documentations of their sponsor's income and resources for eligibility (*these resources and income will be treated as unearned income and resources*). MIP also provides hospitalization and medical care for those persons afflicted with tuberculosis, lytico, or bodig, insulin injections for diabetic patients, and irreversible renal failure without regards to income and resources. Residency requirement is waived for persons with tuberculosis.

WHAT ARE THE INCOME AND RESOURCE LIMITATIONS?

The following chart indicates the gross monthly income and liquid resources limitations per family size. Liquid resources shall include the following:

- | | |
|-----------------------------------|--------------------------|
| - cash on hand | - shares in credit union |
| - check or savings account amount | - lump sum payments |
| - stock and bonds | - time certificates |

Excess cash resources used for medical treatment-related expenditures are exempted in determining liquid resources.

Other resources such as vehicle, real property, and etc, are derived as follows:

- MIP will allow two vehicles. The blue book value or market value equity less the amount owed should not exceed \$5,000 for each vehicle.
- One additional real property value not to exceed \$25,000 (*appraised by the Department of Revenue and Taxation*) other than the one being lived in will be allowed. This will also include any transfer of property holdings by gift.

<u>Family Size</u>	<u>Gross Monthly Income Limitations</u>	<u>Resources Limitations</u>
1	\$ 410	\$1,200
2	542	1,500
3	648	1,650
4	754	1,800
5	845	1,950
6	935	2,100
7	1,027	2,250
8	1,106	2,500
9	1,184	2,650
10	1,264	2,800
Additional member	+60	+150

MIP recipients whose household falls within the gross income limitations will only pay \$2.50 and \$5.00 co-payment charges for prescribed drugs and use of the GMH emergency room, respectively. If an applicant gross income exceeds the gross income limitation by an amount not greater than \$300, he will still be eligible for partial coverage.

IF I'M ELIGIBLE FOR PARTIAL COVERAGE, WHAT IS MY LIABILITY?

The following chart is the percentage of recipient's liability (*per visit, hospital admission, encounter*) for each range of available income per month above the income guideline.

Recipients who are referred off-island for medical care liability shall not exceed \$2,500 per referral regardless of percentage of their cost share liability rate.

**Available Income Per month
(Above Income Guide)**

\$ 1 - \$ 50
51 - 100
101 - 150
151 - 200
201 - 250
251 - 300

**Percentage Liability Guide
(Recipient's Liability)**

7%
15%
22%
30%
37%
45%

WHAT DO I DO IF I MEET ONE OF THESE ELIGIBILITY REQUIREMENTS?

Come in to the MIP Office and ask for an application form. Application forms may be picked up from 8 a.m. to 3 p.m. Monday thru Friday. When requesting for an application, don't forget to set up an appointment for an interview to determine eligibility.

WHO MAY APPLY?

Anyone who is eighteen years and above and is no longer attending high school may apply for the MIP.

MUST AN APPLICATION BE COMPLETED PRIOR TO THE INTERVIEW?

Yes. Application form should be completed when submitting to the caseworker for the interview. All required documents should also be submitted during the interview.

DOES THE HEAD OF HOUSEHOLD HAVE TO BE PRESENT DURING THE INTERVIEW?

Yes, but exceptions will be made. If the head of household is incapacitated, an authorized representative must be present.

WHEN WILL I BE INFORMED OF MY ELIGIBILITY STATUS?

You will be informed of your eligibility status within 30 days from the date of interview.

WHEN DOES ELIBIGILITY BEGIN?

Eligibility begins on the first day of the month on the date of application.

IF ELIGIBLE, WHEN DO I GET MY MIP CARD?

Your MIP card will be mailed to the address indicated in your application. Your caseworker should be informed of any change of address. If you do not receive your MIP card by the fifth day of the month, come in to the MIP office.

DO I HAVE TO APPLY EVERY MONTH FOR MIP?

No. If you are 55 years old and over with unearned or no income, you are eligible for MIP for one year. All other recipients are eligible for only six months.

WHAT MEDICAL SERVICES DOES MIP PAY?

- Inpatient Services
 1. Maximum of 60 days hospitalization per illness. Prior authorization is required if confinement exceeds 60 days.
 2. Semi-private room and board or private rooms when medically necessary.
 3. Coronary and intensive care.
 4. Nursery intensive and intermediate infant care.
 5. Surgery and anesthesia.
 6. Operating and delivery room.
 7. Laboratory tests.
 8. Diagnostic radiology.
 9. Kidney dialysis treatment.
 10. One doctor's visit per day either by hospital resident or intern in intensive care and coronary care unit.
 11. Emergency room services.
 12. Physical and occupational therapy when prescribed by physician and provided by qualified and registered therapist.
 13. Inhalation therapy.
 14. Care for tuberculosis, lytico/bodig, or end stage renal disease. Care is limited to condition related services.
 15. Insulin injections for diabetes.
 16. Care in an Intermediate Care Facility.
- Outpatient Services
 1. Hospital-based physician services.
 2. Laboratory and diagnostic tests.
 3. Diagnostic radiology.

4. Emergency room for warranted emergencies. Five dollars co-payment will be required from recipient.
 5. Drugs which are prescribed by physicians and cannot be bought without a prescription. \$2.50 co-payment per prescription will be required from the recipient. Those recipients with liabilities must pay \$2.50 plus their liability share.
 6. Medical and surgical supplies.
 7. Operating room.
 8. Dialysis treatment.
 9. Physical and inhalation therapy. Prior authorization is required from MIP.
 10. Insulin injections for diabetes.
 11. Lytico-bodig related services.
- Physician, Laboratory and X-Ray
 1. Medical and surgical services.
 2. Injections and drugs dispensed by the physicians.
 3. Services and supplies incidental to physician services.
 4. Kidney dialysis.
 5. One hospital visit per day except consultation in ICU or CCU which requires justification.
 6. Laboratory and diagnostic x-ray procedures ordered by physicians.
 7. Insulin injections for diabetes.
 8. Lytico/bodig related services.
 - Skilled Nursing Care for 180 days per year for recipients.
 - Eye examination not to exceed one exam every two years. Prior authorization is required.
 - Eyeglasses as are medically necessary provided that all resources for such glasses are exhausted and with limitations. A minimum co-payment of \$25 per eyeglasses is required from the recipient. Prior authorization is required.
 - Audiological evaluation required by an ENT specialist.
 - Emergency dental services such as restoration, extraction, and root canal treatment necessary to alleviate severe pain for recipients age 17 and above.
 - Hearing aids to correct significant disability as are medically necessary provided that all available community resources for such hearing aids have been exhausted. Co-payment of \$100 per hearing aid is required from the recipient. Prior authorization is required. Replacement will be limited to one hearing aid every five years.
 - Prosthetic/orthotic devices except orthopedic shoes for children nineteen years and below. Prior authorization is required.

- Voluntary sterilization for females and males who are mentally competent and are 21 years old and above. Prior authorization is required.
- Family planning services to include birth control pills and contraceptive devices. However, MIP recipients still have the option of availing themselves of services at Public Health Clinics.
- Abortion when medically necessary in which the life of the mother would be endangered if the fetus were carried to term. A justification from the attending physician is required before the prior authorization will be issued.
- Circumcision when medically necessary. A justification from the attending physician is required before the prior authorization will be issued.
- Emergency Dental Services (*Restoration, extraction and root canal treatment*) which are necessary to alleviate severe pain are covered for recipients age 17 and above.

- Home Health Services

1. Medical Supplies

A list of medical supplies prescribed by the attending physician including the diagnosis must be submitted to MIP before prior authorization can be issued. The following supplies are covered:

- a. Dressing supplies.
- b. Colostomy and ileostomy supplies.
- c. Urinary appliances.
- d. Supports and abdominal binders, not to include braces.
- e. Syringes and needles.

2. Medical Equipment

A prescription from the attending physician including the diagnosis and the anticipated period of use along with a referral from the Home Care Program must be submitted before prior authorization can be issued. The following equipment is covered:

- a. Wheelchairs.
- b. Walkers.
- c. Crutches.
- d. Hospital beds.
- e. Bedside rails.
- f. Bedpans.
- g. Oxygen related equipment.

- Drugs

1. Outpatient prescribed drugs in accordance with drug formulary.
2. Recipients will pay \$2.50 co-payment charge per prescription. Those recipients with liabilities must pay \$2.50 plus their liability share.
3. Prior authorization is required for drugs not listed in the Drug Formulary.

- Physical, occupational and inhalation therapy. Prior authorization is required. Any extension beyond six weeks will require prior approval from medical consultant.
- Cat scan (*head or body*) provided on an outpatient basis. Prior authorization is required with justification from the attending physician to be submitted to MIP.
- Off-island referral if the treatment is medically necessary and care is not available on Guam. Services must be pre-authorized by the MIP. Round trip air transportation will be provided to MIP recipients, Medicaid recipients, Services for Handicapped Children Program recipients and other clients who meet the program criteria. One parent or guardian will be covered if the recipient is a minor (*17 years or below*). Recipients with cost-sharing rate requirements will be responsible for their share of costs and must make payments directly to service providers. The recipient's liability off-island care per referral shall not exceed \$2,500 regardless of cost-share percentage.
- Mortuary expenses. If a client expires during course of off-island treatment, mortuary expenses will be covered for those MIP and Medicaid recipients who receive both medical and air transportation assistance under MIP. Coverage is limited to mortuary fees, container for shipping remains, and shipping costs. Funeral caskets are not covered.

WHAT SERVICES ARE NOT COVERED MY MIP?

1. Voluntary abortions.
2. Unskilled services.
3. Cosmetic surgery.
4. Acupuncture.
5. Private duty nursing services.
6. Personal comfort or convenience items.
7. Any service or items which are not medically required for the diagnosis or treatment or a disease, injury or condition.
8. Section 2103 drugs on Food and Drug Administration listing.
9. Drugs not listed in the Drug Formulary.
10. Over-the-counter drugs.
11. Non-emergency use of emergency room.
12. Vaccine supplies provided free by Public Health.
13. Fertility procedures.
14. Orthopedic conventional shoes.
15. Rehabilitation services.
16. Podiatrists services.

17. Local transportation services.
18. Services for any inmates or residents or a public institution.
19. Drug and alcohol treatment on outpatient basis.
20. Circumcisions which are not medically indicated.
21. Mental disorders and psychiatric services.
22. Speech and language therapy.
23. Physical examinations.
24. Services performed to patients who are not MIP clients.

IF I NEED MEDICAL SERVICES, WHERE SHALL I GO?

MIP recipients must seek medical care from their primary physician as indicated on their MIP card. If the primary physician is not available, go to another MIP provider or call the MIP office and fill out a request for a change in primary physician. Reason(s) for requesting a change must be given.

WILL MIP PAY FOR MEDICAL BILLS I ALREADY HAVE?

If you've accumulated any medical bills for a period of three months (*90 days*) before you filed your application for MIP benefits and those bills are for: (1) services covered by MIP; (2) services provided by MIP providers; and (3) services not requiring prior authorization, bring those bills to the MIP Office and see your caseworker. Those bills will then be reviewed based on your income and resources for that period.

Should these services be covered by MIP and you are found eligible for retroactive coverage, you should present these bills to the MIP providers. The MIP providers should then claim payments by submitting the proper MIP Claim form to the MIP Office. Only MIP providers will receive retroactive payments.

HOW ARE MIP BILLS PAID?

All payments covered by MIP are made directly to the physicians, hospital, clinics, dentists, and other providers.

MIP recipients **SHOULD NOT MAKE PAYMENTS** to MIP providers for any medical services, equipment, or supplies other than for: (1) co-payment charges, and (2) liability share.

MIP recipients **WILL NOT BE REIMBURSED** for any medical payments. If you are billed by a provider for a service you feel should be covered by MIP, please contact the MIP Office before making any payments.

IF I'M UNDER THE MEDICARE PROGRAM OF THE SOCIAL SECURITY ADMINISTRATION, CAN I APPLY FOR MIP?

Yes. Medicare, a health insurance program, is not entirely free. If you are covered by both MIP and Medicare, MIP will only pay for those costs which Medicare does not pay.

WHAT SERVICES REQUIRE PRIOR AUTHORIZATION?

1. Admission to GMH prior to the date of elective surgery.
2. Confinement at GMH exceeding 60 days per illness.
3. Physical, occupational, inhalation therapy.
4. Eye refractive examination.
5. Eyeglasses.
6. Medical supplies and equipment.
7. Cat scan (*head or body*).
8. Drugs not listed in drug formulary.
9. Hearing aid.
10. Prosthetic devices.
11. Sterilizations.
12. Off-island medical care.
13. Dental.

All services requiring prior authorization from MIP other than eye refractive examination must be prescribed by the attending physician.

MIP will issue to the recipient a pre-numbered prior authorization to be presented with their current MIP card to the attending physician. The prior authorization will indicate the valid date(s) the services should be provided to the recipient. Recipients are required to properly utilize the prior authorization. Any extensions will require justification, diagnosis, and evaluation report from the attending physician.

PENALTIES FOR FRAUD UNDER THE MIP

Under P.L. 18-31, Section 2913.36, the Program will conduct a review of applicants to insure the validity of such applications. Any recipients found ineligible on the basis of false declaration shall be liable for repayment and shall be guilty of a misdemeanor or felony as cited in the Criminal and Correctional Code. Such recipient shall be ineligible for the Program services for one year.

TERMINATION

The following shall constitute grounds for termination from the Program:

- False declarations in seeking program eligibility.
- Failure to report changes in household status as required in P.L. 18-31.

**Department of Public Health
and Social Services**

BUREAU OF HEALTH CARE FINANCING

MEDICALLY INDIGENT PROGRAM
2nd floor, Room 236

Office Hours:
Monday thru Fridays
except Holidays
8:00 a.m. thru 5:00 p.m.

Telephones:
734-2951 thru 2959, Ext. 222,325, and 326
734-4827
734-2944

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