MEDICALLY INDIGENT PROGRAM (MIP)

TELEPHONE NUMBERS:

CENTRAL	***-***	***735-7245***
NORTHERN	***-***	***635-7432***
SOUTHERN	***-***	***828-7543***

INTRODUCTION

This handbook is prepared to answer basic questions concerning the requirements and benefits of the Medically Indigent Program (MIP).

MIP is a 100% locally funded program established by P.L. 17-83 in October 1983 to provide financial assistance with health care cost to individuals who meet the necessary income, resource and residency requirements.

Public Law 18-31 authorizes the Department of Public Health and Social Services, Division of Public Welfare (DPW), Bureau of Health Care Financing (BHCF) to administer the MIP. This law was revised by P.L. 27-30, which was signed into law September 30, 2003.

WHO MAY BE ELIGIBLE?

Any person who is:

1. A resident of Guam who has resided on Guam for a period of no less than six (6) months and who has been physically living on Guam within the last six (6) months of the year.

2. Not eligible for Medicaid or Medicare coverage and have exhausted all benefits under Title XVIII, XIX of the Social Security Act; or State Children's Health Insurance Program under Title XXI of the Balanced Budget Act of 1997;

3. A child in foster care, age 18 years and below;

4. Eligible to received temporary emergency medical or other special care as provided in Section 2905.3 of the law.

WHAT ARE THE INCOME AND RESOURCE LIMITATIONS?

Income limitation for full MIP coverage follows 100% of the Federal Poverty Guidelines that is updated and effective October 1st of each fiscal year.

WHAT IF MY GROSS MONTHLY INCOME EXCEEDS THE GROSS INCOME LIMITATIONS?

The following applicant may still be eligible for the partial MIP coverage if the applicant's gross income exceeds the gross income limitations:

1. An applicant whose gross income does not exceed three hundred dollars ($300) of the Guam MIP Income Guideline.
2. Individuals who are afflicted with tuberculosis, leprosy, lytico, bodig, end stage renal disease or insulin dependent diabetes mellitus may be eligible if the individual applicant's gross income

exceeds the gross income limitations by an amount not greater than one thousand dollars ($ 1,000.00).

Recipients under partial coverage will be responsible for sharing the cost of medical expense by payment of their liability.

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

The following is a table of the percentage of an applicant's liability for program medical services rendered for each range of available income per month above the income guidelines:

Regular MIP	Afflicted with TB, Leprosy, Lytico, Bodig ESRD or DM (Insulin Dependent)	Percentage Liability
$ 1 – $50	$ 1 – $ 167	7 %
$ 51 – $100	$168 – $ 335	15%
$101 – $150	$336 – $ 502	22%
$151 – $200	$503 – $ 670	30%
$201 – $251	$671 - $ 837	37%
$252 – $300	$838 - $1,000	45%

LIQUID RESOURCES:

The maximum allowable liquid resources of all member of the Medically Indigent Program shall not exceed the two thousand dollars ($ 2,000) household limitation. These resources shall include but is not limited to the following:

1. Cash on Hand
2. Checking or Savings account
3. Stocks and Bonds
4. Shares in Credit Union
5. Lump Sum Payments
6. Time Certificates
7. Other Investment

VEHICLE, REAL PROPERTY AND OTHER RESOURCES:

- The entire value of one (1) licensed vehicle shall be excluded for one (1) parent household and two (2) vehicles shall be excluded for two (2) parent households. All other vehicles shall be individually evaluated at Fair Market Value and that portion of the value which exceeds the current FSP vehicle disregard shall be attributed in full towards the household's resource limit, regardless of any encumbrances on the vehicles.

- Primary house is excluded from real property including any surrounding land in which a client lives and owns or is buying. The Agency shall exclude from " resources" consideration the necessary non-liquid income producing property, but not real property.

MUST AN APPLICATION BE COMPLETED PRIOR TO THE INTERVIEW?

Yes. An application for Public Assistance Program form must be completed and submitted to the Receptionist. The Receptionist will set you up for an interview appointment to an Eligibility Specialist (ES). All required documents should also be submitted during the interview.

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

Yes, but exception will be made. If the head of household is incapacitated or unable to make it to the interview, the spouse or an authorized representative must be present.

WHEN WILL I BE INFORMED OF MY ELIGIBILITY STATUS?

The Eligibility Specialist (ES) has thirty (30) days from the date of interview to determine your eligibility.

WHEN DOES ELIGIBILITY BEGIN?

If eligible, eligibility begins on the first day of the month of application.

IF ELIGIBLE, WHEN DO I GET MY MIP CARD?

Your MIP card will be mailed to the address indicated in your application on the following month after you are determined eligible. You should inform your ES of any change of address. If you do not receive your MIP card by the tenth (10^{th}) of the month, you should inform your ES so a temporary MIP card can be issued to you.

DO I HAVE TO APPLY EVERY MONTH?

No. If you are fifty-five (55) years old and over with unearned or no income, you will be certified for twelve (12) months. All other recipients are given a maximum of six (6) months eligible. You need to renew to continue your MIP coverage.

WHAT MEDICAL/DENTAL SERVICES DOES MIP PAY?

- ✓ In-patient services
  - In-patient hospitalization;
  - Semi-private room and board, or private room when medically necessary;
  - Coronary and intensive care;
  - Neonatal intensive care, intermediate Nursery care and wellborn nursery care;
  - Surgery and anesthesia;
  - Operating room, delivery room and licensed birthing center services;
  - Diagnostic laboratory services;
  - Diagnostic radiology, ultrasound and mammography screening services;
  - Renal dialysis treatment;
  - Physician services;
  - Emergency Room services;

- Acute physical and occupational therapy;
- Respiratory therapy;
- Prescribed drugs;
- Podiatry services;
- Care in an Intermediate Care
- Ambulance services.

✓ Out-Patient Services
- Physician evaluation and management services;
- Laboratory diagnostic services;
- Diagnostic radiology, ultrasound and mammography screening services;
- Emergency room services for urgent and life threatening medical problems;
- Prescription drugs;
- Ambulatory surgical services;
- Renal dialysis treatment;
- Physical and occupational therapy;
- Respiratory therapy;
- Physical examination.

✓ Physician, Laboratory and Radiology Services
- Physician, evaluation and management services (in-patient and out-patient);
- Consultation services;
- Specialty services.

✓ Skilled Nursing Facility Services
✓ Intermediate Care Services
✓ Mental Health Services:
- Inpatient care;
- Out-patient facility/day treatment;
- Maintenance counseling;
- Chemical dependency services;
- Psychological and neuropsychological testing;
- Mental illness coverage for patients diagnosed with mental retardation and mental illness to address mental illness concerns;
- Generic Prescription Drugs

✓ Optometrist Services and Lenses
✓ Audio logical Examination and Hearing Aids
✓ Orthopedic Conditions and Prosthetic Appliances
✓ Voluntary Sterilization Services
✓ Home Health Services
- Home health visits by licensed practitioner or home health aid;
- Prescribed medical supplies not otherwise available over the counter;
- Intermittent equipment and appliances provided on a part-time/intermittent basis.

✓ Durable Medical Equipment:
- Standard Wheelchair;
- Standard Hospital bed;
- Walker;
- Bedside Rails;

- ♦ Bedpans;
- ♦ Oxygen Related Equipment Only

✓ Prescription Drugs
✓ Physical and Occupational Therapy
✓ Acupuncture Care and Chiropractic Care
✓ Off-island Medical Care and Air Transportation

MEDICAL BENEFITS LIMITATION

Acupuncture:
- 10 visits per contract period
- $50.00 per visit

Air Fare:
- Round trip air transportation to an eligible patient one (1) parent if the patient is a minor or one medical escort when medically necessary.

Audio logical examination:
- $ 100.00 maximum per visit

Blood and Blood Products:
- $50,000.00 maximum per year except hemophilia or hemophilia-related conditions

Cardiac Related Services:
- 10% co-insurance

Chemical Dependency:
- $10,000.00 per year

Corrective Lenses:
- $100.00 maximum every 2 years

Eye Examination:
- $50.00 maximum once a year

Hearing Aid:
- $500.00 maximum per hearing aid

Home Health Services:
- Limited to 100 days per year

Hospice Care:
- 180 days maximum

Off Guam Medical Care:
- $175,00.00 per year including airfare and escort fees

Orthopedic services and Appliances:
- $50,000.00 maximum per year; 10% co-insurance on all services

Pharmaceutical Prescriptions:
- Limited to thirty (30) days supply at one time except birth control pills 90 days supply; limited to generic drug only with $2.50 co-payment per prescription filled

Physical Examination (PE):
- $5.00 co-payment for each PE related services

Physical Therapy:
- First 20 visits full coverage, 50% coverage required thereafter

Radiology:
- 10% co-insurance on all services

Radiation Therapy:
- 10% co-insurance on all services

Renal Dialysis:
- Limited coverage to first twelve (12) months. Premium payments and co-insurance thereafter

Skilled Nursing Facility:
- 180 days maximum per year

Well Child Care:
- Six (6) visits per year up to age two (2) excluding visits for immunization

MEDICAL EXCLUSIONS

➢ Voluntary abortions, abortions and interrupted pregnancy that are not medically necessary;

- Elective cosmetic surgery, except as provided for in the Women's Health Act;
- Custodial care, domiciliary care, private duty nursing services or rest cures, unskilled services, except as provided for in hospices;
- Personal comfort or convenience items;
- Any services not medically necessary for the diagnosis or treatment of a disease, injury or condition;
- Non-emergency use of Emergency Room;
- Over the counter drugs not listed in the Drug Formulary;
- Experimental drugs, treatments or procedures;
- Fertility procedures, reversal of sterilization and services related to artificial conception
- Treatment, services and supplies related to sexual dysfunction
- Trans-sexual surgery and related services;
- Mental health services for a person with mental retardation;
- Motorized limbs;
- Services for any incarcerated person;
- Care or services furnished by immediate relatives or members of the patient's household;
- Health care services, which are provided and reimbursed by other local or federal programs, MIP is the last resort payer;
- Speech and language therapy;
- Tissue and organ transplants and other related services during and after transplant;
- Treatment and services for artificial weight reduction, including gastric bypass, stapling or reversal, or liposuction;
- Treatment for injuries sustained in the commission of an illegal or criminal act, including driving under the influence;
- Any work related injury, subject to compensation pursuant to the Workers Compensation Law;
- Care for military service connected disabilities to which the patient is legally entitled to government benefits or care;
- Physical therapy services determined not to result in significant and demonstrable improvements in the patient's ability to function independently;
- Occupational therapy, acupuncture and chiropractic services related solely to specific employment opportunities, work skills or work settings;
- Any diagnostic service requiring prior authorization, which has not been obtained or has been denied;
- Off-island emergency medical services;
- Off-island living expense;
- Benefits and services not specifically listed as covered.

DENTAL BENEFITS AND LIMITATIONS

Emergency dental services (restoration, extraction and root canal treatment) which are necessary to alleviate severe pain and annual routine dental treatment (dental examination and cleaning) are covered for all persons age seventeen (17) and above.

MIP clients are responsible for twenty percent (20%) of the cost of each treatment.

DENTAL EXCLUSIONS:

The following dental services or procedures shall not be covered by MIP:

1. Cosmetic or cosmetic related treatments;
2. Treatments initiated while no on existing plan;
3. Services or treatments not in accordance with accepted dental therapeutics;
4. Any services not listed in American Dental Association's procedure codes;
5. Any treatment or services related to temporomadibular joint dysfunction syndrome (TMJ/TMD) or disease, including but not limited to crowning, wiring or repositioning of teeth;
6. Posterior composites;
7. Broken appointment fees;
8. Dental implants and implant prosthesis;
9. Ordontics or orthodontic-related treatments.

WHAT SERVICES REQUIRE PRIOR AUTHORIZATION?

1. In-patient hospital services if confinement exceeds sixty (60) days.
2. CT Scan or MRI diagnostic services;
3. Elective or specialized surgical procedures;
4. Physical and Occupational therapy;
5. Eye Examination and Corrective lenses;
6. Off-island medical care and Air transportation;
7. Physical Examination;
8. Acupuncture and Chiropractic Services

WHAT SHOULD I DO IF I NEED PRIOR AUTHORIZATION?

Visit the MIP Office on the 2nd Floor, Mangilao Public Health Room 219, for on-island prior authorization. The following documents are needed to facilitate the issuance of prior authorization for services 1 to 5 above:

- Physician's prescription;
- Physician's justification for the prescribed medical services.

For off-island medical care, visit the MIP Office, Mangilao Public Health, 2nd Floor Room 236.

WHAT OFF-ISLAND MEDICAL TREATMENT DOES MIP COVER?

All medical treatments or procedures that are not available in Guam, are covered by MIP provided a prior authorization is obtained before the treatment is rendered.

WHAT AIRFARE ASSISTANCE CAN MIP PROVIDE FOR ITS RECIPIENTS?

Round trip air transportation will be provided to MIP recipients when all criteria for off-island care have been met. One (1) parent or guardian will be covered if the patient is a minor, seventeen (17) years of age or below. Air transportation and per diem will also be provided for medical escort

(registered nurse or physician) when the MIP Advisory Council certifies it as being necessary to accompany and assist the patient while on referral. The referring physician shall provide a written request of the reasons for the medical escort.

HOW ARE MIP BILLS PAID?

Payments of bills are made directly to the physicians, hospitals, clinics, dentists and other health care providers.
MIP recipients SHOULD NOT MAKE PAYMENTS TO MIP PROVIDERS for any medical services, equipment, or supplies other than the co-payment charges and 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 Bureau of Health Care Financing (BHCF) before making any payments.

PENALTY WARNING

The following shall constitute grounds for termination from the program:

- ✓ False declaration in seeking program eligibility
- ✓ Failure to report changes in household status as required by P.L. 27-30

FOR MORE INFORMATION, PLEASE CALL THE FOLLOWING:

BUREAU OF ECONOMIC SECURITY

Certification Section	MANGILAO	-	735-7245
	NORTHERN	-	635-7432
	SOUTHERN	-	828-7543

BUREAU OF HEALTH CARE FINANCING ADMINISTRATION

Prior Authorization Section	735-7243
Claims Section	735-7275/7281/7302