

Idaho Department of Correction Health Services



Guidelines for County Jails

SCOPE OF SERVICES

Table of Contents

CATEGORY 1

Medically Necessary – Acute or Emergent

CATEGORY 2

Medically Necessary – Non-Emergent

CATEGORY 3

Medically Acceptable – Not Always Necessary

CATEGORY 4

Limited Medical Value

OPTOMETRY CARE

DENTAL CARE

MEDICAL AUTHORIZATIONS

IDAHO DEPARTMENT OF CORRECTION HEALTH SERVICES

CATEGORIES OF CARE

CATEGORY 1

Medically Necessary – Acute or Emergent

Medical conditions that are of an immediate, acute or emergent nature, which without care would cause rapid deterioration of the offender's health, significant irreversible loss of function, or may be life threatening.

Examples of conditions considered a Category 1 include, but are not limited to:

- myocardial infarction;
- severe trauma such as head injury;
- hemorrhage;
- stroke;
- status asthmaticus;
- precipitous labor or complications associated with pregnancy; and
- detached retina, sudden loss of vision.

Treatments for conditions in Category 1 are essential to sustain life or function and warrant immediate attention.

A condition that is a Category 1 does not require a Medical Authorization to treat initially, however, a Medical Authorization must be submitted within 72 hours (3 days) for approval of treatment that was provided.

CATEGORY 2

Medically Necessary – Non-Emergent

Medical conditions that are not immediately life threatening but which without care the offender could not be maintained without significant risk of:

- serious deterioration leading to premature death;
- significant reduction in the possibility of repair later without present treatment;
or
- significant pain or discomfort which impairs the offenders participation in activities of daily living.

Examples of conditions considered a Category 2 include, but are not limited to:

- chronic conditions (diabetes, heart disease, bipolar disorder, schizophrenia);
- infectious disorders in which treatment allows for a return to previous state of health or improved quality of life (HIV, tuberculosis); or cancer.

A condition that is a Category 2 will require a Medical Authorization approval prior to treatment.

CATEGORY 3

Medically Acceptable – Not Always Necessary

Medical conditions which are considered elective procedures, when treatment may improve the offender's quality of life. Examples in this category include, but are not limited to:

- dental prosthetics;
- minor surgical procedures;
- diagnostic testing; or
- treatment of non-cancerous skin conditions;

A condition that is a Category 3 will always require a Medical Authorization prior to any treatment.

CATEGORY 4

Limited Medical Value

Medical conditions in which treatment provides little or no medical value, are not likely to provide substantial long-term gain, or are expressly for cosmetic purposes or the offender's convenience.

Examples of items and treatments in Category 4 include, but are not limited to:

Cosmetic / Acne Treatments:

- Face cream, lotion, or wash of any kind
- Acne cream, lotion or wash of any kind
- Antibiotics for acne

Supplements:

- Vitamin or herbal supplements of any kind

Nail Fungus:**Insomnia:****Miscellaneous:**

- shoe inserts
- special footwear
- special shampoo
- chiropractic care

Dental:

- prosthetics
- night or occlusal guards
- teeth cleaning
- root canals

A condition that is a Category 4 will always require a Medical Authorization approval prior to treatment, however, only on rare occasions will these items / treatments receive approval. Any item / treatment in this category which a health care provider recommends may be referred to the IDOC for review. The referral must include documentation from the licensed medical provider stating that the item / treatment is medically necessary.

Optometry Care:

Shall consist of an optical examination at a cost not to exceed \$96.00. Corrective eyewear, **if indicated**, will be approved at a cost not to exceed \$20.00.

Optometry care may also, at the discretion of IDOC Health Services, be deferred to a state facility. The offender may then pursue optical care when transferred.

If a licensed medical provider determines that an optical examination is medically necessary, include that documentation with the Medical Authorization request.

Dental Care:

Examples of dental conditions considered acute or emergent include, but are not limited to:

- face / neck swelling;
- face / neck pitting edema;
- fractured jaw;
- fever;
- purulent drainage;
- fractured tooth at gum line;

A dental condition that is acute or emergent does not require a Medical Authorization approval to treat initially, however, a Medical Authorization must be submitted within 72 hours (3 days) for approval of treatment that was provided.

All other requests for dental care will be approved for **extraction or filling only** and only on the **one** tooth that is causing the problem e.g. pain, cracked, broken, filling fell out, etc. If a licensed dental provider indicates that non-emergent, extensive dental work is needed, please submit this information to the IDOC Health Services for approval to treat at the county or move to a state facility for further treatment.

Medical Authorizations:

All requests for provider visits, medications, tests, optometry needs, dental needs, or any other medical treatment require an approved Medical Authorization form prior to providing such services. The Medical Authorization form should be submitted at the time of service but can be submitted within a 72 hour period. **Medical Authorizations that are submitted after 72 hours are subject to non-payment.**

A new Medical Authorization form is provided with this packet. Please use this form **only** for all medical requests. **All areas on the form must be complete, if an area is not completed, or if an old form is used it will be returned to you.** Prompt, accurate documentation of medical requests enables the IDOC Health Services to efficiently process all bills submitted by the county and in turn ensure prompt payment.

*** Please specify if payments are to be sent to the county or to the vendor.**

Idaho Department of Correction - Health Services:

1299 N. Orchard, Suite 110
Boise, Idaho 83706

Rona Siegert RN, Health Services Director
Phone: 208-658-2047
E-mail: rsiegert@idoc.idaho.gov
Fax: 208-327-7007

Vicky Brady, Technical Records Specialist II
Phone: 208-658-2128
E-mail: vbrady@idoc.idaho.gov
Fax: 208-327-7007

Zarah Martin, RN Virtual Prison Program
Phone: 208-672-3434
E-mail: zmartin@idoc.idaho.gov
Fax: 208-327-7007

If you have any medical questions or concerns, please contact Zarah Martin or Rona Siegert. If you have any questions regarding billing, please contact Vicky Brady.

Instructions for Completing Request for Payment Form

Effective November 1, 2007

The purpose of the new Request form is to streamline the authorization/billing/payment process and hopefully reduce the number of requests that have to be returned for clarification. **The new Request Form will be required starting November 1, 2007. Please do not change the format of this form. You may receive it by e-mail so that you can add your county, phone and fax numbers provided you do not change the general format of the form.**

Please fill out as many of the sections on the form as possible, failure to do so may result in your request being returned to you for clarification and delay authorization. Most of the form is self-explanatory. Please note that Inmate IDOC number and Medical Provider are required fields. Initially we will provide the Inmate IDOC number. We ask that you make note of the number to be used on future medical requests.

Type of Service: If you are only requesting medication authorization please only check the medication box. If you have already requested a medical/dental/mental health visit and it has been authorized, you do not need to check the visit box AND the medication box when requesting medications. Checking only one box will help us clarify what is actually requested and reduce the number of payments being denied because of confusion or lack of information however; you may request more than one service on the same form.

Details of Current Illness/Injury: Please briefly state the reason for the service being requested. If you are only requesting medications you can skip this section.

Treatment Plan: List treatment recommendation i.e. needs glasses, medical visit, x-ray, etc. If you are only requesting medications you can skip this section

List Medications Requested: If you are only requesting medications this is the only section you will need to complete. We are now requiring more information when you are requesting medications. You will only need to request authorization for a medication one time; as long as the offender is still housed in the county jail and has not left and come back. However, there will be exceptions to this; for example, antibiotics will not have an unlimited authorization.

If you have any questions or concerns regarding the new form or the Jail Guidelines please do not hesitate to call Vicky Brady 658-2128, Zarah Martin 672-3434 or the Health Services Director, Rona Siegert, RN 658-2047.

Medical Request for Payment Authorization

Idaho Department of Correction - Central Office

County: _____ Date: _____ Phone #: _____

Requesting Attendant: _____ Fax #: _____
 (Deputy, Nurse, etc.)

Inmate: _____ Inmate IDOC #: _____

Date of Birth: _____ Date Patient Seen: _____

Responsible Licensed Medical Provider: _____

Type of Service Requested Check all that apply <input type="checkbox"/> Medical Visit <input type="checkbox"/> Medication Request <input type="checkbox"/> Dental <input type="checkbox"/> Optical <input type="checkbox"/> Mental Health Visit <input type="checkbox"/> Lab <input type="checkbox"/> X-ray <input type="checkbox"/> ER With Ambulance <input type="checkbox"/> ER No Ambulance
--

Details of Current Illness/Injury <hr/> <hr/> <hr/> <hr/>
Treatment Plan <hr/> <hr/> <hr/> <hr/>

List Medications Requested			
Medication	Strength	Days Prescribed	Diagnosis (Required)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IDOC HEALTH SERVICES RESPONSE

Approved _____ Deferred _____ Denied _____ Need More Information _____

Reason for Deferral/Denial: _____

Comments: _____

 Authorized Signature

 Title

Date of Authorization ____ / ____ / ____