

OREGON DEPARTMENT OF CORRECTIONS
Operations Division
Health Services Section Policy and Procedure #P-A-02.1

SUBJECT: LEVEL OF THERAPEUTIC CARE PROVIDED BY OREGON DEPARTMENT OF CORRECTIONS, HEALTH SERVICES SECTION

POLICY: During incarceration, inmate/patients are entitled to responsive, clinically appropriate, and timely diagnosis, treatment and care of health problems. Health Services personnel care for patients with compassion and respect for the patient's privacy and dignity; treatment is provided in an objective and non-judgmental manner; and providers will advocate for the patient's health.

The policy of the Oregon Department of Corrections is to provide those health care services that help preserve and maintain the health status of inmate/patient during incarceration. The health care services provided by the Oregon Department of Corrections will be consistent with the standard for such services in the community. This means that health care procedures will be conducted in a clinically appropriate manner by appropriately credentialed personnel in an appropriate setting.

The following procedure establishes the method and guidelines used to determine whether treatment will or will not be provided by the Oregon Department of Corrections consistent with applicable law and to ensure that sufficient health care resources are available to fulfill the Department's policy of preserving and maintaining inmate's health status during incarceration.

REFERENCE: OAR 291-124-0085

PROCEDURE:

A. Overview

1. Medical care and treatment is prioritized into levels with authorization for each level specified:
 - a. **Medically Mandatory: Level 1**, will be routinely provided to all inmate/patients by Oregon Department of Corrections. Authorization may be given by any licensed health service staff.
 - b. **Presently Medically Necessary: Level 2**, may be provided to Oregon Department of Corrections inmate/patients subject to periodic utilization review by the Chief Medical Officer. Care is authorized by any Oregon Department of Corrections Health Services prescribing practitioner.

- c. **Medically Acceptable but not Medically Necessary: Level 3**, provision of services to inmate/patients will be decided on a case by case basis.
- Acute/On-site - Authorized by Chief Medical Officer.
 - Chronic/Off-site - Authorized by Therapeutic Levels of Care (TLC) committee review.
- d. **Of Limited Medical Value: Level 4**, will not be routinely provided to inmate/patients by Oregon Department of Corrections.

2. If medical or surgical procedures or therapies for an inmate are expected to cost more than \$50,000, the case must be reviewed by the TLC committee. If a delay in treatment would cause irreparable harm, excessive risk or be in clear violation of sound medical principles, the review may be conducted after treatment has been initiated.
3. The levels of care are general categories of diagnosis, therapies and procedures. In some cases, additional factors may need to be considered in deciding whether or not Oregon Department of Corrections will provide a given procedure or therapy.
4. Access of an inmate to adequate diagnosis and review by appropriate medical personnel is essential and is not abridged by this policy (see also policy on Access to Care, P-A-01).
5. The final authority in all TLC reviews will be the Medical Director or designee(s).
6. All TLC generated out of facility referral forms (Attachment 3) shall have the diagnostic information completed by the ordering provider.

B. Definition of Levels of Care and Treatment and Authorization to Proceed.

1. **Medically Mandatory: Level 1**

- a) Definition: Care that is essential to life and health, without which rapid deterioration may be an expected outcome and where medical surgical intervention makes a very significant difference and/or has a very high cost effectiveness. Examples include:
- 1) Acute problems, potentially fatal, where treatment prevents death and allows full recovery, e.g., appendectomy for appendicitis, repair of deep open wound in neck, myocarditis, M.I., etc.
 - 2) Acute problems, potentially fatal, where treatment prevents death but does not necessarily allow for full recovery, e.g., burn treatment, treatment for severe head injuries, M.I., etc.

- 3) Maternity care, e.g., monitoring, delivery, HTN of pregnancy, etc.
- b) Authorization: Any Oregon Department of Corrections Health Services practitioner may authorize care and treatment. In an emergency situation, nursing staff of the Oregon Department of Corrections may authorize care and treatment.
- c) Medically mandatory care is frequently urgent or emergency care and as such is best initiated by Health Services personnel at the time of intervention and is routinely authorized, provided and paid for by Oregon Department of Corrections Health Services.

2. **Presently Medically Necessary: Level 2**

- a) Definition: Care without which the inmate could not be maintained without significant risk of either further serious deterioration of the condition or significant reduction of the chance of possible repair after release or without significant pain or discomfort. Examples include:
 - 1) Chronic, usually fatal conditions where treatment improves life span and quality of life, e.g., medical management of insulin dependent Diabetes Mellitus, surgical treatment for treatable cancer of the uterus, medical management of Asthma, HTN, etc.
 - 2) Immunizations
 - 3) Comfort care such as pain management and hospice type care for the end stages of diseases such as Cancer and AIDS.
 - 4) Proven effective preventive care for adults, e.g., preventive dental care, mammograms, pap smears, BP screenings.
 - 5) Acute but non-fatal conditions where treatment causes a return to previous state of health, e.g., fillings for dental cavities, medical treatment of various infectious disorders.
 - 6) Acute non-fatal conditions where treatment allows the best approximation of return to previous health, e.g., reduction of dislocated elbow, repair of corneal laceration.
- b) Authorization: Any Oregon Department of Corrections Health Services practitioner may authorize care and treatment. The decisions of practitioners are subject to periodic review and limitation by the institution Chief Medical Officer.

- c) Level 2, Presently Medically Necessary care, when not of an emergency nature, should undergo periodic review by the Medical Director (designee) for utilization review and appropriateness. These services will be routinely provided and paid for by Oregon Department of Corrections Health Services.

3. Medically Acceptable but not Medically Necessary: Level 3

Care will be authorized on an individual-by-individual basis or a problem-by-problem basis as outlined below.

- a) Definition: Care for non-fatal conditions where treatment may improve the quality of life for the patient, e.g., routine hernia repair, treatment of non-cancerous skin lesions, corneal transplant for cataract, hip replacement, etc.

- b) Authorization:

- 1) Medical and surgical procedures and therapies from Level 3 which can be appropriately done on premises in a routine clinic and are within the skills of the attending practitioner may be offered at the discretion of the attending practitioner and/or Chief Medical Officer. Any case may be referred by a practitioner to the Medical Director for review.
- 2) Off-site procedures and therapies for chronic diseases from Level 3, if deemed appropriate for treatment by the institution Chief Medical Officer, will be referred to the Medical Director for clinical review.

- c) Clinical Review:

The form "Therapeutic Level of Care" form (attached) shall be completed by the Chief Medical Officer or designee and submitted to the Medical Director. The Medical Director may form a review committee comprised of one or more Oregon Department of Corrections practitioner(s) and Medical Services Manager to review requests on a case-by-case basis. Factors that will be considered either singularly or in combination when deciding if a clinical service should be provided include:

- 1) The urgency of the procedure and the length of the inmate's remaining sentenced stay. Whether the surgery/procedure could be or could not be reasonably delayed without causing a significant progression, complication, or deterioration of the condition and would not otherwise be in clear violation of sound medical principles.
- 2) The necessity of the procedure/therapy:
 - i. Any relevant functional disability and the degree of

functional improvement to be gained.

ii. Medical necessity - the overall morbidity and mortality of the condition if left untreated.

- 3) Pre-existing conditions, whether the condition existed prior to the inmate's incarceration and where treatment was not obtained prior, the reasons for not obtaining treatment.
- 4) The probability the procedure/therapy will have a successful outcome along with relevant risks.
- 5) Alternative therapy/procedures, which may be appropriate.
- 6) Patient's desire for the procedure and the likelihood of the patient's cooperation in the treatment efforts.
- 7) Risk/Benefits if known.
- 8) Cost/Benefits if known.
- 9) Pain Complaints/Pain Behaviors.

4. **Limited Medical Value: Level 4**

- a) Definition: Care that is valuable to certain individuals but significantly less likely to be cost effective or to produce substantial long-term gain. This includes treatment of minor conditions where treatment merely speeds recovery, where treatment gives little improvement in quality of life, offers minimal palliation of symptoms, or is exclusively for the convenience of the individual. Examples include:
 - Tattoo removal, minor nasal reconstruction, oral aphthous ulcers, elective circumcision, common cold, infectious mononucleosis, surgery for gynecomastia.
- b) Care and treatment will not be routinely authorized by the Oregon Department of Corrections.
- c) Inmate/patients may obtain services for this level of care from an outside provider at their own expense according to the Health Services Administrative Rule "Purchase of Care". Oregon Department of Corrections treating practitioners are not obligated to carry out any recommendations or treatment plans formulated by these outside practitioners if ongoing care is required.

5. **Exceptions**

- a) There will be occasions when the level of care of a certain disorder will be unclear or when it is not appropriate to apply the levels of

care to an individual patient, e.g., an individual where it may not seem appropriate to provide care for a Level 2 diagnosis, or when it may seem appropriate to provide care for a Level 4 case.

- b) Any individual case or proposed therapy can be reviewed for appropriateness, second opinion, approval or denial of coverage, etc. by submitting a Therapeutic Level of Care form to the Medical Director for clinical review.

Effective Date: _____
Review date: Review date: August 2014
Supersedes P&P dated: April 2014

Attachment 1
P-A-02.1

Oregon Department of Corrections
THERAPEUTIC LEVEL OF CARE

TO: Clinical Medical Director/Dental Director Date: _____

FROM: _____

INSTITUTION NAME: _____

SUBJECT: Prior Authorization for Medical/Dental/Surgical Procedure or Treatment

Release Date: _____

Diagnosis: _____

Level: _____

How long has the patient had this diagnosis? _____

Treatment Proposed: _____

Factors for consideration, discuss as appropriate.

1. Urgency of need vs. time of sentence left.
2. Overall necessity, re: morbidity, mortality and functional disability.
3. Pre-existing condition prior to incarceration.
4. Risk/Benefit
5. Cost/Benefit
6. Alternatives
7. Pain complaints/pain behavior

Committee comments and recommendation: _____

Patient Purchase – Debt Patient Purchase – Pay in Advance

Date reviewed: _____

Committee Signature

Committee Signature

Committee Signature

Name: _____
SID#: _____
DOB: _____

Oregon Department of Corrections
Hep C – THERAPEUTIC LEVELS OF CARE

TO: Clinical Medical Director Date: _____

FROM: _____

INSTITUTION NAME: _____

SUBJECT: Prior Authorization for Medical/Surgical Procedure or Treatment

Release Date: _____

Diagnosis: _____

How long has the patient had this diagnosis? _____

Attach HCV evaluation work sheet.

Treatment proposed: _____

Possible Medical Contraindications or Barriers to Treatment with Ribavirin and Interferon (Check if Pertinent)

Committee comments and discussion as appropriate:

Major Medical

Minor Mental Health

Risk Behavior for Hepatitis

No Live Enzyme Elevation

Time to Serve

Decompensated Cirrhosis

Aggressive Behavior

Non-Compliance

Liver Biopsy Results

Other

Date reviewed: _____ and recommendations: _____

Committee Signatures:

Effective: October 2006

Name:
SID#:
DOB:

HEALTH REFERRAL OUTSIDE AGENCY

P-A-02.1

TO:

Appt. Date: _____ Time _____

Contact Provider _____

Institution Approval: N/A TLC

Phone: INSTITUTION SPECIFIC DATA HERE

FAX: INSTITUTION SPECIFIC DATA HERE

Diagnosis or Reason for Referral: Routine (1-4 Weeks) Priority (1-3 Days) Stat (Today)

Pertinent History: _____

Chronic Conditions: _____

Special Equipment: Wheelchair _____ O2 _____ Other _____

Allergies: _____

Data to be sent with patient:

Lab X-Ray Chart Note Dr. Orders MAR Other _____

Specific Service Requested: _____

MEDICAL

DENTAL

OPTICAL

Consultation Only

Treatment Only

Lab, X-Ray, Special Procedure

Consultation and Surgical Treatment

Emergency Care

☛ If not marked, any additional x-ray, lab, surgical, or other special procedure requires additional authorization from referring institution health care services. ☛

Please send the invoice for today's services to:

Correctional Health Partners
Oregon Department of Corrections
PO Box 13589
Denver, CO 80201-1738

Please write today's diagnosis and recommendations on the reverse side.

Thank you for your interest in our patient. If you have any concerns with this patient, please contact us.

Name: _____
SID#: _____
DOB: _____

Date Form Prepared: _____

Form Prepared By: _____

Attachment 3
P-A-02.1

Provider's Returning Information

Diagnosis and Findings:

Provider's Recommendations and Orders (Do not mention any follow up dates of times to the inmate/patients for security reasons):

Provider's Signature: _____ Date: _____

Please remember to send or FAX a copy of your written report to the referring Physician

Post Consult DOC Comment Section (Institution Use Only)

Order Approved

Order Denied

To TLC

Comments:

ODOC Provider: _____ Date: _____