	DEPARTMENT OF PUBLIC SAFETY	EFFECTIVE DATE: DEC 10 2014	POLICY NO.: COR.10.1G.10
	CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	SUPERSEDES (Policy No. & Date): COR.10.1G.10 (12/29/08)	
	SUBJECT: ASSISTIVE DEVICES/AIDS TO IMPAIRMENT		Page 1 of 5

1.0 PURPOSE

To purpose of this policy is to establish guidelines for the purchase of medically indicated prostheses, orthosis and mechanical devices.

2.0 REFERENCES AND DEFINITIONS

.1 References

a. Hawaii Revised Statutes, Section 26-14.6, Department of Public Safety; and Section 353-2, Director of Public Safety, Powers and Duties.

b. National Commission on Correction Health Care, Standards for Health Services in Prisons and Jails (2008).

c. American Correctional Association, Standards for Adult Correctional Institutions.

.2 Definitions

a. Prosthesis: Artificial devices to replace missing body parts or augment the function of a natural function such as a limb, eye, hearing aid, full plate dentures, etc.

b. Orthotic Devices: appliances for the immobilization or stabilization of a body part to prevent deformity, protect against injury, or assist with function can include slings, splints, braces, etc.

c. Mechanical Device: wheelchairs, patient lifts, motorized assistive devices, CPAP.

d. Assistive Device: Any single or combination of prosthetic, orthosis or mechanical devices that assist a person in performing their daily activities of living.

e. Dental Appliance – Partials, bridges, crowns, orthodontic braces, retainers, braces, spacers, implants, bite planes.

f. Basic Level Prosthetics – The level of prosthetic devices such as limbs, hearing aides, eyes that would be covered under the State of Hawaii Medicaid Program.

3.0 POLICY

.1 Physicians and dentists may prescribe medically necessary clinically indicated prosthetics when required to assist the retention or improvement of physical function or when the health of the patient would otherwise be adversely affected.

.2 Prosthetic devices must be authorized as medically necessary through the Special Utilization Review Panel (SURP) before being approved for purchase through the Department. The Department will cover basic level replacement limbs, hearing aides, eyes and the necessary supporting medical supplies such as stockings, batteries, etc. for a patient, who is expected to demonstrate according to their physician's assessment, a retention or improvement in physical function as a result of the device. This device will be provided at no cost to the patient.

.3 Mechanical Devices that are deemed medically necessary to support or sustain the life of a patient such as continuous positive airway pressure (CPAP) and biphasic positive airway pressure (BIPAP) machines for sleep apnea, alternating pressure mattresses, oxygen, feeding pumps, etc., and all medical supplies necessary to operate these devices will be covered at no cost to the patient.

.4 Medical devices other than those listed above such as, but not limited to, appliances for the immobilization or stabilization of a body part to prevent deformity, protect against injury, or to assist with function, including slings, splints, braces, wheelchairs, motorized assistive devices and dental appliances shall be the financial responsibility of the patient. The patient shall pay for all fees, costs including the care of the prosthetic, orthosis or mechanical device.

.5 The Department will cover the cost of medical equipment listed under .4 above, for those patients who have been determined to be indigent under the Health Care Payment plan. The patient must sign a Purchase Agreement allowing any funds deposited above a ten dollar ($10.00) minimum balance in their patient account, be withdrawn from the account until the equipment cost is paid in full. The following conditions apply:

- The patient has a mandatory minimum sentence or parole date with sufficient remaining incarceration time to allow for the potential repayment of the cost of the equipment.
- The equipment is determined to be medically necessary by a State physician.

- The patient is determined to be indigent; and therefore, unable to pay for the cost of the equipment in advance.
- All more cost effective alternatives to the equipment have been considered.
- The patient signs a purchase agreement document.

.6 Prior authorization through the Special Utilization Review Panel (SURP) is required for medically recommended prosthetics, orthoses and mechanical devices that cost in excess of two hundred dollars ($200).

.7 All outstanding medical cost obligations owed by the patient shall be deducted from the patient's account prior to the release of any account balance to the patient.

.8 Prosthetics purchased for the patient shall not be replaced within a frequency period of less than five (5) years, unless the patient's physical condition has changed necessitating a new prosthetic.

.9 Prosthetic devices deliberately damaged by the patient will not be replaced.

4.0 PROCEDURES

.1 Prostheses, orthoses or mechanical devices shall be searched during intake, including the removal of the device, if necessary. The Health Care Section (HCS) shall be notified immediately when a device is to be confiscated. A physician shall determine the medical necessity of the device. If deemed not medically necessary, it will be removed, recorded and managed as an item of the patient's property.

.2 Provisions shall be made for a patient to purchase and maintain an assistive device including corrective eyeglasses, hearing aids, dentures, artificial limbs, wheelchairs and orthopedic appliances, when ordered by a treating State physician or dentist.

.3 Any patient with a physical disability or impairment may request an assistive device through the sick call process. The patient shall be referred to the facility physician or dentist, who shall determine whether or not the requested device is medically necessary. Only devices deemed medically necessary shall be considered for use in the facility.

.4 Approval from the SURP is required prior to the purchase, when the applicable provider fee and the cost of the prosthetic exceed two hundred dollars ($200) and the patient is using the health care payment plan to pay for the cost of the device. The facility health authority or designee is responsible for reviewing and approving purchases totaling less than two hundred dollars ($200).

.5 The patient's mandatory minimum sentence and/or parole date, ability to pay and the availability of cost effective alternatives shall be considered during the approval process.

.6 When a payment plan is utilized for authorized purchases by patients with insufficient funds; funds shall be withdrawn from the patient's account whenever there is more than ten dollars ($10) in the account. A joint voucher will be used to transfer funds from the patient's account to the facility's HCS operating fund if the transfer is made during the fiscal year that the prosthesis is purchased. Patients refusing to sign the purchase authorization shall not be provided with the equipment.

.7 After completion of the fiscal year, the funds shall be made out to the Director of Finance and transferred to the state general fund. The patient shall sign form DOC 0477, Purchase Agreement (Attachment A) to authorize the withdrawal of funds to pay for the device.

.8 Furloughed patients require the collection of at least one-half the cost of applicable fees and the prosthetic, at the time of the initial examination and measurement. Any purchase that will result in a balance in excess of two hundred dollars ($200.00) requires the authorization of the SURP. The balance shall be an agreed upon amount paid at regular intervals. Payment shall be made to the HCS by cashier's check, facility check or money order. The furloughed patient shall sign Form DOC 0477-B Furloughee Purchase Agreement (Attachment B).

.9 A patient may refuse the purchase of a recommended prosthetic. A refusal of a prosthetic by a patient shall be documented on form DOC 0417, Refusal to Consent to Medical/Dental Treatment/Medications (Attachment C).

5.0 SCOPE

This policy and procedure applies to all correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

Ami Kaman MD 11/18/14
Medical Director Date

12/8/14
Health Care Division Administrator Date

Deputy Director for Corrections Date

APPROVED:

Director

12/10/14
Date

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

PURCHASE AGREEMENT

_____ _____ _____
(Print Inmate's Name) (SID) (DOB)

_____
(List Item(s) to be Purchased)

_____ 1. I have been informed that the items I wish to purchase are not covered benefits under my health plan. I understand that by agreeing to purchase the item(s) listed above. I am responsible for the cost of the item(s) and that I am buying the item(s) from a private business and not from the Department of Public Safety.
(Initial)

_____ 2. I understand by agreeing to purchase the item(s), and I must have sufficient funds in my account to pay for the full cost of the requested item(s), and the entire amount will be deducted from my account.
(Initial)

_____ 3. The Health Care Division (HCD) has a reimbursement payment plan available if I do not have sufficient money in my account to pay for the entire cost of the prosthesis. If I agree to the payment plan, the HCD will purchase the items (s) from the private business so I can have it right away. I will then be obligated to the terms of the payment plan until the entire cost of the item has been repaid.
(initial)

_____ 4. I understand I have the right to refuse the recommended item(s) listed above and participation in the payment plan.
(initial)

_____ 5. If I agree to the payment plan, I understand that whenever there are funds in my account in excess of ten dollars ($10.00), the excess amount will be withdrawn until the cost of the requested item(s) is paid in full.
(Initial)

_____ 6. I understand that if I agree to the payment plan and I am released from jail or prison before I have finished paying for the items(s), any funds remaining in my inmate account will be applied to my debt. I understand that if I ever return to jail or prison, I will be obligated to pay any outstanding balance owed the Health Care Division for the purchase of the requested item(s) as soon as funds are deposited into my account, for any reason, from any source.
(Initial)

_____ 7. I understand that the purchase of the item(s) listed above is non-refundable once the order is placed. An item(s) may be substituted for an item of equal value if the vendor's regulations allow for exchanges.
(Initial)

☐ I refuse the payment plan and I do not wish to purchase the item(s) listed above at this time. _____
(Initial)

☐ I consent to the purchase of the item(s) listed at the top of the page and authorize the amount of $ _____ to be deducted in full or by the reimbursement payment plan if I have insufficient funds in my account at this time. _____
(Initial)

_____ _____
(Inmate Signature) (Date)

_____ _____
(Staff Signature/Title) (Date)

Item(s) ordered on _____ from _____.

Item(s) received on _____ Issued to inmate on _____ _____
(Pt Initial)

Original sent to fiscal on _____

Copy to inmate & medical record

CONFIDENTIAL

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

FURLOUGHEE PURCHASE AGREEMENT

If my funds are insufficient to cover the cost of the requested item(s), I understand that a cashier's check or money order amounting to half the cost of the requested item(s) shall be paid to the Department to purchase the following prosthetic:

_____
List Item(s)

A minimum of $_____ shall be paid at regular intervals every _____ until the cost of the item(s) is paid in full.

_____ _____
Furloughee's Signature Date

_____ _____
Nurse Signature Date

Copy: Fiscal Office
Medical Record
Inmate

STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

REFUSAL TO CONSENT TO MEDICAL/SURGICAL/DENTAL TREATMENT/MEDICATION

NAME: _____ SID: _____ DOB: _____

FACILITY: _____ DATE: _____ TIME: _____

I, the undersigned patient, refuse the following treatment and/or medication: _____

_____

(Describe Treatment and/or Medication)

The risk of refusing treatment or medication has been explained to me and I accept the risk involved. I release the State, the Department, the facility administration and personnel, the Health Care Division administration and medical personnel from any responsibility or liability for any unfavorable reaction, outcome, or any untoward results due to this refusal on my part to accept treatment or medication.

_____ _____

(Signature of Patient) (Date)

I, the undersigned, have explained to the above named patient the risk involved in refusing treatment or medication recommended for the patient's continued good health and I witness the patient's refusal of the recommended treatment or medication

_____ _____ _____

(Print Name) (Signature & Title) (Date)

A referral has been made to a provider: YES NO

I have reviewed this case and if necessary have further counseled this patient on the risk of refusing treatment or medication.

_____ _____ _____

(Print Name of Provider) (Signature & Title) (Date)

** If the patient refuses treatment and/or medication and refuses to sign this consent, please have refusal witnessed by another correctional employee.*

I have witnessed the above named patient refuse the recommended treatment or medication and I have also witnessed the patient's refusal to sign this consent form.

_____ _____ _____

(Print Name & Title) (Signature & Title) (Date)