CCHCS Reentry Programs (REPS)
PROGRAM GUIDELINES

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MEDICAL/CLINICAL GUIDELINES

California Department of Corrections and Rehabilitation (CDCR) Reentry Programs (REPS) consist of the Male to Community Reentry Program (MCRP) and Custody to Female Community Reentry Program (FCRP). These populations, while no longer under correctional oversight, remain under the responsibility and oversight of the California Correctional Health Care Services (CCHCS) for their healthcare needs. As such, Community Health Care providers must follow policies and guidelines established by CCHCS when treating CDCR patients.

A. MEDICAL NECESSITY

Medical care provided to CDCR Reentry Programs (REPS) patients shall be aligned with Title 15. According to Title 15, **medical necessity** is defined as health care services determined by the attending physician to be reasonable and necessary to protect life, prevent premature death, prevent significant illness or disability, or alleviate severe pain, and are supported by health outcome data as being effective medical care.

Title 15 Exclusions

(1) Conditions that improve on their own without treatment.
(2) Conditions that are not readily amenable to treatment, including, but not limited to, those which may be made worse by treatment with conventional medication or surgery, and those that are so advanced in the disease process that the outcome would not change with existing conventional or heroic treatment regimens.
(3) Conditions that are cosmetic.
(4) Surgery not medically necessary shall not be provided.
(5) Services that have no established outcome on morbidity or improved mortality for acute health conditions shall not be provided.

(See Appendix A for the full list of Title 15 exclusions.)

B. INITIATING PRIMARY CARE

Upon the patient's initial visit to a primary care provider, the provider shall have the patient complete a CDCR-7385 form for *Authorization for Release of Protected Health Information (ROI)*. This form will allow the patient's medical records to be released from the CCHCS Health Records Center (HRC) and provide to the patient's primary care provider. The completed ROI form can be faxed to (916) 229-0002 or (916) 229-0608 or emailed to releaseofinformation@cdcr.ca.gov. *(See Appendix H for Mailing Instructions for the Health Records Center (HRC).)* Non-urgent ROI requests may take up to 14 days to be received by the requesting provider.

C. ROUTINE HEALTHCARE APPOINTMENTS

Patients shall be seen for an initial appointment upon arrival to the REPS facilities with a Primary Care Provider (PCP), in order to establish care. Patients do not need prior approval for this initial visit, with the exception of appointments for Medication Assisted Treatment (MAT). All follow up visits and/or new occurrences will require an approved REPS Healthcare Appointment Request Form (*See Appendix M*).

D. COORDINATING SPECIALTY CARE WITH CCHCS REPS CLINICAL CARE TEAM

Explain to the patient that health care referrals, non-formulary medications, and Durable Medical Equipment (DME) will be reviewed by the CCHCS REPS Clinical Care Team. These services require special approval and shall not be performed without prior authorization. Refrain from using the following language, "I will order …" (contracting providers may only order after a prior authorization has been approved). Providers should not make any guarantees for services or treatment.

When communicating medical issues and plans of care to patients, providers should emphasize that they will make recommendations to the REPS Physician Advisor (PA) and together decide on the best plan of care. This will help to diminish any incidence of staff-splitting behavior from the patient. When recommending medications, laboratory tests, procedures, diagnostics, or follow-up, be as specific as possible and follow the *Specialty and Non-Formulary Referrals* section of this document.

Urgent medical concerns should be discussed directly via telephone or email with the REPS Clinical Care Team. *(See Administrative Section C for the CCHCS REPS Contacts.)*

E. SPECIALTY AND NON-FORMULARY REFERRALS

Specialty services shall be requested by the Primary Care Provider (PCP) who provided care in the community. The PCP shall inform the patient of the plan for specialty referral, document the plan in the health record, and notify the patient of any revisions to the plan. The requesting provider shall complete a Reentry Service Request (RSR) form for each specialty service desired and indicate the urgency and time frame in which the service is necessary.

Medically necessary specialty referrals for consultation and procedures shall be routed to the REPS Medical Mailbox at CDCRCCHCSREPSMedical@cdcr.ca.gov for review and prior authorization by the REPS Physician Advisor (PA). If a patient requires a specialty consult, specialty procedure, non-formulary or high-cost medication, DME, Medication Assisted Treatment (MAT), or any imaging studies other than basic x-rays, an RSR form and supporting documentation must be sent via encrypted email to CDCRCCHCSREPSMedical@cdcr.ca.gov.

All medical records for the referred patient must be sent overnight to the CCHCS Health Records Center, in order for the REPS Physician Advisor (PA) to review the records and make an informed decision. Please see the *CCHCS Receipt of Health Care Records* for more information.

After submission of the referral request, the PCP must follow the patient as determined necessary by the PCP until the specialist appointment occurs in order to follow the status of the patient's clinical condition and to initiate medically necessary services based on the status of the condition.

F. PRIOR AUTHORIZATION PROCESS*

**Emergent requests are exempt from the prior authorization referral request process. However, a referral request shall be submitted, after the fact, for retrospective tracking of emergent requests.*

1. Specialty and Non-Formulary
   Upon receipt of the specialty or non-formulary referral, the medical documentation will be reviewed by the REPS PA. The review will be based on evidence-based clinical decision support criteria (InterQual). Some services, i.e. Hysterectomies, Hepatitis C treatment, etc., may require a third level review [CCHCS Statewide Medical Authorization Team (SMART) Committee]. All urgent requests will be reviewed and followed up with a response within two (2) business days. All routine requests will be reviewed with a response within seven (7) business days, with the exception of the third-level reviews. Third-level reviews will be responded to within sixty (60) business days.

   Notification of request decision will be through the REPS Medical Mailbox to the original requestor or faxed back to the requesting provider. If the request is approved**, the PCP will then notify the patient of the decision and schedule services with a contracted CCHCS provider. If a contracted provider is not in the network, the PCP may refer to their specialty provider of choice or contact the REPS Admin Team at CDCRCCHCSREPSAdmin@cdcr.ca.gov for assistance. If a request is denied, the PCP shall come up with an alternative treatment plan for the patient and notify the patient.

2. Routine Healthcare
   Upon receipt of the REPS Healthcare Appointment Request Form, it will be reviewed by the REPS PA. Responses to all appointment requests will be sent within two (2) business days. It is the providers' responsibility to verify if the appointment has an approved form. Any appointments without an approved form, with the exception of urgent/emergent needs, will be denied payment.

Any denied requests shall not be performed and will not be paid for by CCHCS.

***Please note, an approved RSR form and/or Healthcare Appointment Request form is only valid during the patient's eligible timeframe. Should the patient leave the REPS program these forms are no longer valid and do not guarantee payment.*

G. CONSENTS AND REFUSALS

Discuss and document the risks and benefits of treatment as well as the risks of refusal if treatment is medically necessary. The surgeon performing the surgery should be the one to obtain consent from the patient. Patients have a right to refuse service. In such situations, complete the Refusal of Examination and/or Treatment Form (*See Appendix K*), have the patient sign and send to the HRC with the patient's medical records.

H. INPATIENT HOSPITAL CASE MANAGEMENT

Hospital case managers and administrators will need to communicate information to CDCR regarding inpatients through the REPS Correctional Counselor III (CC III), as well as, send an email to the REPS Medical Mailbox.

REPS facilities do not provide medical services in-house, therefore any patient that requires more care than can be provided in an independent living home type facility should be referred back to the REPS Medical Mailbox for care coordination and placement at an appropriate level of care.

I. RADIOLOGY SERVICE REQUESTS FOR PLAIN X-RAYS

Primary care providers are not required to submit an RSR form nor obtain prior approval for plain x-rays. All other radiology requests will continue to require an RSR form for approval.

J. PHYSICAL THERAPY SERVICES

MEDICAL NECESSITY

Physical Therapy is not routinely provided service for this patient population. Providers shall review and discern whether patients can do their Activities of Daily Living (ADL) such as feeding, bathing, grooming, and walking to programming.

If the patient cannot do their ADLs and is in need of physical therapy services, the provider must complete an RSR form for review and approval. Should the services not be available in the community, the patient's CC III and REPS PA will arrange for the patient to return to the institution or reassess.

If the patient can perform their ADLs, physical therapy is not a medical necessity.

K. VISION

Basic optometry services, including eye exams and glasses are a covered benefit and do not require an RSR form. Frame and lens purchases must have prior authorization from CCHCS for payment to be approved. Contact lenses are not a covered benefit, unless deemed a medical necessity by the REPS Clinical Care Team.

L. HEPATITIS C VIRUS (HCV) TREATMENT

Hepatitis C Treatment must follow the CCHCS HCV Treatment Care Guide. The CCHCS HCV Treatment Care Guide is available at https://cchcs.ca.gov/clinical-resources/. Providers must review the Care Guide, complete the Treatment Selection Review (TSR) form (Appendix E), and an RSR form (Appendix B). All documents must be sent to the REPS Medical Mailbox for review.

M. DIETARY SERVICES

Dietary services are not a covered benefit. Patients requiring specific dietary needs must inform the program CC III and the REPS Clinical Care Team for further action.

N. LOWER BUNK ACCOMMODATIONS

Lower bunk accommodations are not a covered benefit. Should a patient request or need a lower bunk within their housing facility, provider shall notify the program CC III and the REPS Clinical Care Team for further action.

O. PAYMENT

CCHCS is the obligatory payor for any approved healthcare services for REPS patients. Patients may not pay for any services out-of-pocket, nor can any other form of payment be used (i.e. private insurance, etc.) Additionally, any services performed without authorization may be denied payment.

FORMULARIES

A. MEDICATION FORMULARIES

Providers must adhere to the CDCR/CCHCS formulary as much as possible. The CDCR/CCHCS formulary is available at www.cchcs.ca.gov. Non-formulary medication approval must go through the same *Prior Authorization Process* to obtain approval.

Mental health treatment and medications are to be provided solely by the CDCR Division of Adult Paroles (DAPO) Behavioral Health & Reintegration (BHR) Program. Mental health medications are to be prescribed and approved by authorized BHR physicians only. For mental health medications, providers must adhere to the DAPO Formulary available at https://www.dgs.ca.gov/PD/About/Page-Content/PD-Branch-Intro-Accordion-List/Acquisitions/Statewide-Pharmaceutical-Program. Any mental health non-formulary medication must be reviewed and approved by a CCHCS Clinician.

B. MEDICATION ASSISTED TREATMENT (MAT)

MAT for patients shall follow the *Prior Authorization Process.* Providers must complete an RSR form for these services and specify the treatment plan requested. RSR forms will be reviewed by the REPS Clinical Care Team for approval. Providers can refer to the Substance Use Disorder Guidelines located at https://cchcs.ca.gov/clinical-resources/. (*See Appendix I for the REPS MAT Provider Directory.)*

Should the patient wish to discontinue MAT services, the patient must work with their MAT provider to establish a discontinuation plan.

C. GABAPENTIN
NON-FORMULARY PHARMACY REQUESTS

Gabapentin is considered a Non-Formulary medication. Prescriptions for Gabapentin require an RSR form and prior approval, regardless of dosage or transmission method (pill or solution).

An RSR form must be submitted to the REPS Clinical Care Team for review in accordance with the *Prior Authorization Process.*

D. OVER-THE-COUNTER (OTC) MEDICATIONS AND PRODUCTS
NON-FORMULARY PHARMACY REQUESTS

OTC medications and products are considered non-formulary and require an RSR form and prior authorization, in accordance with the *Prior Authorization Process*.

Only medications and/or products on the OTC Products List are exempt from requiring an RSR form and prior authorization. *(See Appendix L for the OTC Products List.)*

E. DURABLE MEDICAL EQUIPMENT (DME)

Providers are expected to adhere to the CCHCS DME and Medical Supply Formulary. All DME must follow the *Prior Authorization Process* to obtain approval prior to ordering the DME. The CCHCS DME formulary is available at https://cchcs.ca.gov/wp-content/uploads/sites/60/PR/DME-Medical-Supply-Formulary.pdf. CCHCS will order and purchase all approved DME through the Department's Acquisitions Management Section.

MENTAL HEALTH GUIDELINES

A. BEHAVIORAL HEALTH & REINTEGRATION (BHR) PROGRAM

Patients seeking mental health services are to be referred to the Division of Adult Parole Operations (DAPO), Behavioral Health & Reintegration (BHR) Program. The BHR Program locations serve patients in the Northern and Southern Regions of the State and can accommodate all of the REPS patients' mental health needs. BHR is the only program authorized to render mental health services to REPS patients.
(See Appendix J for the BHR Contacts & Locations.)

B. MENTAL HEALTH MEDICATION FORMULARY

BHR providers must adhere to the CDCR formulary and the DAPO formulary as much as possible. The CDCR

formulary is available at www.cchcs.ca.gov. The DAPO Formulary is available at https://www.dgs.ca.gov/PD/About/Page-Content/PD-Branch-Intro-Accordion-List/Acquisitions/Statewide-Pharmaceutical-Program. Any mental health non-formulary medication must be reviewed and approved by a CCHCS Clinician.

DENTAL GUIDELINES

A. PURPOSE

The purpose of the REPS Dental Program is to provide quality clinical dental services in a professional and efficient manner to those eligible for care while housed at a REPS facility. The following will act as a guide to policies and procedures set by CDCR, Adult Correctional Dental Care (ACDC).

B. PROCEDURE

Services will be based on established priorities as listed in the CCHCS Reentry Programs Dental Fee Schedule

C. INITIATING PRIMARY DENTAL CARE

Upon the patient's initial visit to a dental provider, the provider shall have the patient complete a CDCR-7385 form for *Authorization for Release of Protected Health Information (ROI)*. This form will allow the patient's dental records to be released from the CCHCS Health Records Center (HRC) and be provided to the patient's primary dental provider. The completed ROI form can be faxed to (916) 229-0002 or (916) 229-0608 or emailed to releaseofinformation@cdcr.ca.gov. *(See Appendix F for the ROI form and instructions.)* Non-urgent ROI requests may take up to 14 days to be received by the requesting provider.

D. REFERRALS

The patient's primary dental provider will also serve as a referral center. Referrals to dental specialty care shall be based on established priorities, approvals, program exclusions, clinical necessity, and available resources. Referrals must be completed on a Reentry Dental Service Request (RDSR) Form *(See Appendix C)* and emailed to CDCRCCHCSREPSDental@cdcr.ca.gov referrals must have prior authorization. Claims received without prior authorization will be denied for payment.

E. PLAN EXCLUSIONS AND LIMITATIONS

Some Services Not Covered Under the Plan Are:

1. Services or supplies that are covered in whole or in part under any other part of the REPS program.
2. Those for replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
3. Those for plastic, reconstructive, or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
4. Those for or in connection with services, procedures, drugs or other supplies that are determined to be experimental or still under clinical investigation by health professionals.
5. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.
6. Services that REPS Dental Program defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended, or approved by the attending physician or dentist.
7. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified "By Report."
8. Those for orthodontic treatment.
9. Those for general anesthesia and intravenous sedation.
10. Those for treatment by other than a dentist, except that scaling or cleaning of teeth may be performed by a licensed dental hygienist as well as topical application of fluoride. In this case, the treatment must be given under the supervision and guidance of a dentist.
11. Services needed solely in connection with non-covered services.
12. Services done where there is no evidence of pathology, dysfunction, or disease other than covered preventative services.

F. OTHER IMPORTANT INFORMATION

This benefits summary of the REPS Dental Program provides information on benefits provided when a contracted provider renders services. In order for a person to be eligible for benefits, a primary care dentist selected from the network of contracted dentists must provide the dental services unless otherwise approved and authorized by the CCHCS REPS Administration.

G. SPECIALTY REFERRALS

Under the REPS dental plan, services performed by specialists are eligible for coverage only when prescribed by the primary care dentist and authorized by the REPS Dental Program. Payment to the specialty dentist is based on a negotiated fee for which the member does not have a copayment for the service(s) under this plan.

Orthodontic services are excluded under this program.

H. EMERGENCY DENTAL CARE

If emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency is needed, coverage must be made available 24 hours a day, 7 days a week.

I. REPS DENTAL PLAN COVERAGE RULES

REPS Dental Plan coverage is subject to the following rules:

1. REPLACEMENT RULE: The replacement of, addition to, or modification of an existing denture, removable partial denture, or other prosthetic appliance is covered only if **one** of the following terms is met:
    a. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture, removable partial denture, or other prosthetic appliance was originally delivered.
    b. The existing denture, removable partial denture, or other prosthetic appliance cannot be made serviceable, and was delivered at least 5 years before its current need for replacement.
2. ALTERNATE TREATMENT RULE: If more than one service can be used to treat an eligible person's dental condition, REPS Dental Program may decide to authorize coverage only for a less costly covered service provided that **all** of the following terms are met:
    a. The service must be listed on the CCHCS REPS Dental Fee Schedule;
    b. The service selected must be deemed by the dental profession to be an appropriate method of treatment; and
    c. The services selected must meet broadly accepted national standards of dental practice.

ADMINISTRATIVE

A. AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (ROI) FORM INSTRUCTIONS

Upon initial visit with a REPS patient, the PCP is to have the patient complete a CDCR-7385 form for *Authorization for Release of Protected Health Information (ROI)* form. The PCP and the patient must complete all parts of the ROI form. All sections must be completed for the authorization to be honored. Use "N/A" if not applicable. Detailed instructions are on pages 3 & 4 of the CDCR-7385 form.

- Indicate type of documents needed (Part V) Medical Services, Dental Services or Other. *Please note if the PCP is requesting all medical records for the patient, delivery could take up to 14 business days.*
- If the request is urgent, the turnaround time is 24 – 48 business hours.
- Authorization must be signed by the patient. If the Authorization is not signed by the patient, the request will be rejected.

The PCP must fax or email the completed ROI form to the contacts below:

- Fax: (916) 229-0002 or (916) 229-0608
- E-Mail: releaseofinformation@cdcr.ca.gov

If you have any questions regarding these instructions please contact the CCHCS REPS Help Desk:

- Phone: (916) 691-0699
- E-Mail: CDCRCCHCSREPSAdmin@cdcr.ca.gov

B. CCHCS RECEIPT OF HEALTH CARE RECORDS

Providers must mail all health care records to the CCHCS Health Record Center (HRC) via General Logistics Systems (GLS) within 48 hours of the patient encounter. This ensures that CCHCS Utilization Management has all of the necessary documentation regarding a patient's medical needs and allows for a thorough review and decision. Providers shall not send the documents by portable medium, e.g., CD, DVD, USB flash drive, etc. All documents must be sent in hard copy via GLS. See *Appendix H, Mailing Instructions for the Health Records Center (HRC)* section for detailed instructions on how to mail health care documentation to CCHCS for REPS patients. A delay in submittal of these records could affect claims payment.

C. CCHCS REPS CONTACTS

Medical Team		
Reentry Service Request (RSR) Forms/Healthcare Appointment Request Forms		CDCRCCHCSREPSMedical@cdcr.ca.gov
Medical Questions		
REPS Physician Advisor	Jelena Nikolic, MD	

Dental Team		
Treatment Authorizations/ Referral Requests		CDCRCCHCSREPSDental@cdcr.ca.gov

Dental Team			
Dental Questions	Philip Abeldt, DDS		

Administrative			
General Questions	Help Desk	(916) 691-0699	CDCRCCHCSREPSAdmin@cdcr.ca.gov
Medical Bills/Claims			CDCRCCHCSREPSAdmin@cdcr.ca.gov
Dental Bills/Claims			CDCRCCHCSREPSDental@cdcr.ca.gov

D. BHR ADMINISTRATIVE CONTACTS

Area:	**Northern Region**
Contact:	Felicia Lewis-Clifton, Mental Health Program Supervisor

Area:	**Southern Region**
Contact:	Farida Hanna, Mental Health Program Supervisor

E. BILLING INFORMATION

1. Medical claims must include the appropriate REPS facility abbreviation, city, state and zip code (*See Appendix N*). Medical Claims may be submitted via CMS-1450 or CMS-1500 to the address listed below:

   Correct Care Integrated Health
   P.O. Box 349026
   Sacramento, CA 95834-9026

2. Dental claims must include the appropriate REPS facility abbreviation, city, state and zip code (*See Appendix N*). Dental Claims may be submitted via J430D ADA Dental Claim Form to the address listed below:

   Correct Care Integrated Health
   P.O. Box 349026
   Sacramento, CA 95834-9026

Appendix A

TITLE 15

ARTICLE 8: MEDICAL AND DENTAL SERVICES
3350. Provision of Medical Care and Definitions.

(a) The department shall only provide medical services for inmates, which are based on medical necessity and supported by outcome data as effective medical care. In the absence of available outcome data for a specific case, treatment will be based on the judgment of the physician that the treatment is considered effective for the purpose intended and is supported by diagnostic information and consultations with appropriate specialists. Treatments for conditions, which might otherwise be excluded, may be allowed pursuant to section 3350.1(d).

(b) For the purposes of this article, the following definitions apply:

(1) Medically Necessary means health care services that are determined by the attending physician to be reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain, and are supported by health outcome data as being effective medical care.

(2) Outcome Study means the definition, collection and analysis of comparable data, based on variations in treatment, concerning patient health assessment for purposes of improving outcomes and identifying cost-effective alternatives.

(3) Outcome Data mean statistics such as diagnoses, procedures, discharge status, length of hospital stay, morbidity and mortality of patients that are collected and evaluated using science-based methodologies and expert clinical judgment for purposes of outcome studies.

(4) Severe pain means a degree of discomfort that significantly disables the patient from reasonable independent function.

(5) Significant illness and disability means any medical condition that causes or may cause if left untreated a severe limitation of function or ability to perform the daily activities of life or that may cause premature death.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code.

HISTORY:

1. Repealer of Article 8 (Sections 3370–3372) and new Article 8 (Sections 3350–3359) filed 4-18-80; effective thirtieth day thereafter (Register 80, No. 16). For prior history see Register 77, No. 9.

2. Amendment of article heading, section heading and text filed 7-2-93; operative 8-2-93 (Register 93, No. 27).

3. Amendment of section heading, relocation of subsections 3350(a)–(c) to 3350.2(a)–(c), and new Subsections (a)–(b)(3) filed 2-17-95 as an emergency; operative 3-1-95 (Register 95, No. 9). This regulatory action was deemed an emergency pursuant to section 5058(e) of the Penal Code and remains in effect for 160 days. A Certificate of Compliance must be transmitted to OAL by 8-8-95 or emergency language will be repealed by operation of law on the following day.

4. Amendment refiled 8-7-95 as an emergency; operative 8-7-95 (Register 95, No. 32). This regulatory action was deemed an emergency pursuant to section 5058(e) of the Penal Code and remains in effect for 160 days. A Certificate of Compliance must be transmitted to OAL by 1-16-96 or emergency language will be repealed by operation of law on the following day.

5. Reinstatement of section as it existed prior to emergency amendment filed 2-17-95 by operation of Government Code section 11346.1(f) (Register 96, No. 8).

6. Amendment of section heading, renumbering of subsections 3350(a)–(c) to 3350.2(a)–(c), and new subsections (a)–(b)(3) filed 2-21-96 as an emergency; operative 2-21-96 (Register 96, No. 8). A Certificate of Compliance must be transmitted to OAL by 6-20-96 or emergency language will be repealed by operation of law on the following day.

7. Certificate of Compliance as to 2-21-96 order including amendment of subsection (a) and new subsections (b)(4) and (b)(5) transmitted to OAL 6-18-96 and filed 7-9-96 (Register 96, No. 28).

3350.1. Medical and Dental Treatment/Service Exclusions.

(a) Treatment refers to attempted curative treatment and does not preclude palliative therapies to alleviate serious debilitating conditions such as pain management and nutritional support. Treatment shall not be provided for the following conditions:

(1) Conditions that improve on their own without treatment. Examples include, but are not limited to:

(A) Common cold.
(B) Mononucleosis.
(C) Viral hepatitis A.
(D) Viral pharyngitis.
(E) Mild sprains.
(F) Benign oral lesions.
(G) Traumatic oral ulcers.
(H) Recurrent aphthous ulcer.

(2) Conditions that are not readily amenable to treatment, including, but not limited to, those which may be made worse by treatment with conventional medication or surgery, and those that are so advanced in the disease process that the outcome would not change with existing conventional or heroic treatment regimens. Examples include, but are not limited to:

(A) Multiple organ transplants.
(B) Temporomandibular joint dysfunction.
(C) Grossly metastatic cancer.
(D) Shrinkage and atrophy of the bony ridges of the jaws.
(E) Benign root fragments whose removal would cause greater damage or trauma than if retained for observation.

(3) Conditions that are cosmetic. Examples include, but are not limited to:

(A) Removal of tattoos.
(B) Removal of nontoxic goiter.
(C) Breast reduction or enlargement.
(D) Penile implants.
(E) Removal of existing body piercing metal or plastic rings or similar devices within the oral cavity, except for security reasons.
(F) Restoration or replacement of teeth for esthetic reasons.
(G) Restoration of any natural or artificial teeth with unauthorized biomaterials.

(b) Surgery not medically necessary shall not be provided. Examples include, but are not limited to:

(1) Castration.
(2) Vaginoplasty (except for Cystocele or Rectocele).
(3) Vasectomy.
(4) Tubal ligation.

(5) Extractions of asymptomatic teeth or root fragments unless required for a dental prosthesis, or for the general health of the patient's mouth.
(6) Removal of a benign bony enlargement (torus) unless required for a dental prosthesis.
(7) Surgical extraction of asymptomatic un-erupted teeth.

(c) Services that have no established outcome on morbidity or improved mortality for acute health conditions shall not be provided. Examples include, but are not limited to:

(1) Acupuncture.
(2) Orthoptics.
(3) Pleoptics.
(4) Root canals on posterior teeth (bicuspids and molars).
(5) Dental Implants.
(6) Fixed prosthodontics (dental bridges).
(7) Laboratory processed crowns.
(8) Orthodontics.

(d) Treatment for those conditions that are excluded within these regulations may be provided in cases where all of the following criteria are met:

(1) The inmate's attending physician or dentist prescribes the treatment as clinically necessary.

(2) The service is approved by the Dental Authorization Review committee and the Dental Program Health Care Review Committee for dental treatment, or the Institutional Utilization Management committee and the Headquarters Utilization Management committee for medical treatment. The decision of the review committee, as applicable, to approve an otherwise excluded service shall be based on:

(A) Available health and dental care outcome data supporting the effectiveness of the services as medical or dental treatment.

(B) Other factors, such as:

1. Coexisting medical or dental problems.
2. Acuity.
3. Length of the inmate's sentence.
4. Availability of the service.
5. Cost.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code; and *Perez, et al.* v. *Cate, et al.,* USDC no. 3:05-cv-05241-JSW (No. Cal.).

HISTORY:

1. New section, including relocation and amendment of old subsection 3354.1(a) to 3350.1(b), filed 2-17-95 as an emergency; operative 3-1-95 (Register 95, No. 9). This regulatory action was deemed an emergency pursuant to section 5058(e) of the Penal Code and remains in effect for 160 days. A Certificate of Compliance must be transmitted to OAL by 8-8-95 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 8-7-95 as an emergency; operative 8-7-95 (Register 95, No. 32). This regulatory action was deemed an emergency pursuant to section 5058(e) of the Penal Code and remains in effect for 160 days. A Certificate of Compliance must be transmitted to OAL by 1-16-96 or emergency language will be repealed by operation of law on the following day.

3. Reinstatement of section as it existed prior to emergency amendment filed 2-17-95 by operation of Government Code section 11346.1(f) (Register 96, No. 8).

4. New section, including renumbering and amendment of former subsection 3354.1(a) to 3350.1(b), filed 2-21-96 as an emergency; operative 2-21-96 (Register 96, No. 8). A Certificate of Compliance must be transmitted to OAL by 6-20-96 or emergency language will be repealed by operation of law on the following day.

5. Certificate of Compliance as to 2-21-96 order including amendment of subsection (a), repealer of subsection (d)(2) and subsection renumbering, amendment of newly designated subsection (d)(2), repealer of newly designated subsection (d)(2)(A) and subsection relettering, and amendment of newly designated subsection (d)(2)(A) transmitted to OAL 6-18-96 and filed 7-9-96 (Register 96, No. 28).

6. Amendment of subsections (d)(1)–(d)(2)(A) and (d)(2)(B)1. filed 10-3-2006 as an emergency; operative 10-3-2006 (Register 2006, No. 40). Pursuant to Penal Code section 5058.3, a Certificate of Compliance must be transmitted to OAL by 3-12-2007 or emergency language will be repealed by operation of law on the following day.

7. Certificate of Compliance as to 10-3-2006 order transmitted to OAL 3-7-2007 and filed 4-18-2007 (Register 2007, No. 16).

8. New subsections (a)(1)(F)–(H), (a)(2)(D)–(E), (a)(3)(E)–(G), (a)(5)–(7) and (c)(4)–(8) and amendment of subsections (d)(1)–(2) and Note filed 3-28-2012 as an emergency; operative 3-28-2012 (Register 2012, No. 13). Pursuant to Penal Code section 5058.3, a Certificate of Compliance must be transmitted to OAL by 9-4-2012 or emergency language will be repealed by operation of law on the following day.

9. Certificate of Compliance as to 3-28-2012 order, including further amendment of subsection (d)(2), transmitted to OAL 9-4-2012 and filed 10-4-2012 (Register 2012, No. 40).

Appendix B

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

REENTRY (REPS) SERVICE REQUEST FORM

Email: CDCRCCHCSREPSMedical@CDCR.ca.gov

☐ MCRP ☐ FCRP ☐ OTHER:		
Service is: ☐ **NON-URGENT** ☐ **URGENT** ABUSE OF URGENT PA STATUS WILL BE MONITORED. Urgent requests MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. Services for urgent requests must be provided within 14 days of signing request. CCHCS reserves judgment of urgency and must meet definition above, therefore, please explain reason for urgency below.		Date:
Patient Name: (Last, First, Middle Initial)	Date of Birth:	CDCR #:

Referral/Service Type Requested		
☐ Specialist Consult/Tx/FU Care	☐ LOC Change	☐ Surgical Procedure
☐ Inpatient Admission	From_____ To_____	☐ Inpatient ☐ Outpatient
☐ Major Diagnostic Procedure	☐ Mental Health	Facility:
☐ Medication (non-formulary)	☐ Other:	Date of Service:
☐ DME (refer to PA list)	☐ Comments:	

Requesting Provider Information	**Referring To Provider Information**
Requesting Provider Name: (Last, First)	Referring To Provider Name: (Physician, mg.ipa, Facility, Agency)
Address: (No., Street, City, State, Zip)	Address: (No., Street, City, State, Zip)
Specialty:	Specialty:
Phone Number:	Phone Number:
Fax Number:	Fax Number:

Service Request Information	
ICD-10 Code #/Description:	Code or Description:
Clinical Indications for Request: (Include pertinent past medical history, treatment, physical findings, and attach all relevant medical records and test results, etc.)	
Requesting Practitioner Signature:	Date:

CCHCS UM Staff Use Only			
Criteria/Guidelines Met: ☐ Yes ☐ No	Authorization Status: ☐ Approved	☐ Deferred	☐ Denied
Comments:			
UM Representative Signature:		Date:	

UM Review	
☐ APPROVED	COMMENTS:
☐ MODIFIED	
☐ DENIED	
UM Physician's Signature:	Date:

Confidentiality Notice: This fax transmission, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon the fax transmission is prohibited and may be unlawful. If you have received this fax in error, please notify the sender immediately via telephone at the above phone number and destroy the original documents. Thank you.

CLAIMS PAYMENT IS CONTINGENT UPON PRIOR AUTHORIZATION OF SERVICE

Version 4 May 2024

Appendix C

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

REENTRY (REPS) DENTAL SERVICE REQUEST FORM

Email: CDCRCCHCSREPSDental@CDCR.ca.gov

☐ MCRP ☐ FCRP ☐ OTHER:		
Service is: ☐ **NON-URGENT** ☐ **URGENT** ABUSE OF URGENT PA STATUS WILL BE MONITORED. Urgent requests MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. Services for urgent requests must be provided within 14 days of signing request. CCHCS reserves judgment of urgency and must meet definition above, therefore, please explain reason for urgency below.		Date:
Patient Name: (Last, First, Middle Initial)	Date of Birth:	CDCR #:

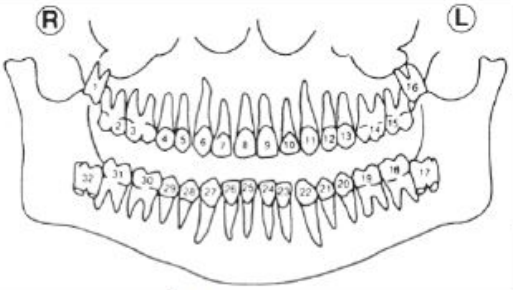
Referral/Service Type Requested

☐ Alveoplasty	☐ Biopsy/Lesion	☐ Cyst/Tumor
☐ Extraction	☐ Incision and Drainage	☐ Infection
☐ Tori Removal	☐ Oral/Facial Trauma	☐ Other:

Requesting Provider Information	**Referring To Provider Information**
Requesting Provider Name: (Last, First)	Referring To Provider Name: (Physician, mg.ipa, Facility, Agency)
Address: (No., Street, City, State, Zip)	Address: (No., Street, City, State, Zip)
Phone Number:	Phone Number:
Fax:	Fax:

Service Request Information

Please Circle Teeth or Area to be Treated



Comments or Concerns:

Requesting Dentist's Signature:	Date:

CDCR/CCHCS Dental Services Review

☐ APPROVED	COMMENTS:	
☐ MODIFIED		
☐ DENIED		
CDCR ACDC Reviewer Signature:		Date:

CLAIMS PAYMENT IS CONTINGENT UPON PRIOR AUTHORIZATION OF SERVICE

May 2024

Appendix D

DO NOT WRITE IN THIS AREA

DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
PO BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST, FIRST, M.I.)	3. SEX M F	4. PATIENT BIRTHDATE MO DAY YR	5. MEDI-CAL BENEFITS ID CARD NUMBER
6. PATIENT ADDRESS			7. PATIENT DENTAL RECORD NUMBER
CITY, STATE		ZIP CODE	8. REFERRING PROVIDER NPI

9. CHECK IF RADIOGRAPHS ATTACHED? YES	11. CHECK IF ACCIDENT/INJURY? YES	13. CHECK IF OTHER DENTAL COVERAGE? YES	16. CHDP CHECK IF CHILD HEALTH AND DISABILITY PREVENTION? YES
HOW MANY? _____	EMPLOYMENT RELATED? YES	14. MEDICARE DENTAL COVERAGE? YES	17. CCS CALIFORNIA CHILDREN SERVICES? YES
10. OTHER ATTACHMENTS? YES	12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK) YES	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK) YES	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? YES

19. BILLING PROVIDER NAME (LAST, FIRST, M.I.)	20. BILLING PROVIDER NPI	BIC Issue Date: _____
21. MAILING ADDRESS	TELEPHONE NUMBER ( )	EVC #: _____
CITY, STATE	ZIP CODE	
22. PLACE OF SERVICE: OFFICE HOME CLINIC SNF ICF HOSPITAL IN-PATIENT HOSPITAL OUT-PATIENT OTHER (PLEASE SPECIFY)		

EXAMINATION AND TREATMENT

26. TOOTH # (JTR, MDH, QUAD)	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

34. COMMENTS	35. TOTAL FEE CHARGED	
	36. PATIENT SHARE-OF-COST AMOUNT	
	37. OTHER COVERAGE AMOUNT	
	38. DATE BILLED	

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

X _____ SIGNATURE _____ DATE

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

IMPORTANT NOTE:
In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, **MUST** be attached to this form. The X-ray envelopes (DC-214A and DC-214B) are available free of charge from the Denti-Cal Forms Supplier.

www.denti-cal.ca.gov

DC-217 (R 9/13)

Appendix E

HCV TREATMENT SELECTION REVIEW: QUESTIONNAIRE FOR MEDICATION SELECTION (Rev. 01/2021)

Patient Last Name:		CDCR #:		Date Form Completed:	
It is imperative that this patient be able to complete the entire HCV treatment course (typically 12 weeks) without any interruptions.					
Release Date: *If <5 months, patient cannot complete tx prior to release and tx should not be started.*					
Does patient have ability to give informed consent and cooperate with treatment?				☐Y ☐N	
Have you documented that patient is not pregnant and is able to practice contraception?				☐Y ☐N	
Does patient have a life expectancy of less than 12 months? *Patient may not be a candidate for HCV treatment.*				☐Y ☐N	
Most recent FIB4 score:					
COMORBIDITIES / COMPLICATIONS - DOES THE PATIENT HAVE:					
History of cirrhosis? ☐Y ☐N		History of organ transplant? ☐Y ☐N		GFR < 30 or Hemodialysis? ☐Y ☐N	
Known HIV co-infection? ☐Y ☐N		Known HBV co-infection? ☐Y ☐N		Any HCV extra-hepatic manifestations? ☐Y ☐N	
FIBROSIS STAGING STUDY *Most patients do not require a staging study. If patient's FIB4 score is 1.45-3.25 please order a Fibroscan ®.*					
Fibroscan® (kPa):		Fibroscan® Date:			
HCV TREATMENT HISTORY					
Has this patient had prior HCV treatment? ☐Y ☐N If yes, provide: Treatment Year, Location, Regimen Used and Duration of Treatment in weeks:					
Response to Prior Treatment: ☐ Null ☐ Partial Responder ☐ Relapse/Reinfection ☐ SVR 12 achieved ☐ Unknown *Critical to ensure appropriate medication selection and whether resistance testing is required prior to medication selection.*					
HCV GENOTYPE *Must be done within the past 12 months if patient has had prior treatment.*					
HCV Genotype Result:		HCV Genotype Date:			
If experienced and Genotype 1a, Order RAS testing Quest Code (92447). No results are required for submittal.					
HCV VIRAL LOAD					
HCV Viral load results:		HCV Viral load results Date:			
HEPATITIS B STATUS: MUST BE WITHIN PAST 12 MONTH *MANY patients require a Hepatitis Viral DNA level prior to treatment. Please carefully review Hepatitis B labs and order HBV DNA if indicated. Medication cannot be started without this information.*					
Hepatitis B surface ANTIGEN (HBsAg) Result:		Hepatitis B surface ANTIGEN (HBsAg) Date:			
Hepatitis B surface ANTIBODY (HBsAb) Result:		Hepatitis B surface ANTIBODY (HBsAb) Date:			
Hepatitis B Core ANTIBODY (HBcAb) Result:		Hepatitis B Core ANTIBODY (HBcAb) Date:			
HBV DNA REQUIRED ONLY IF: HBsAg positive OR HBcAb positive and HBsAb negative					
HBV DNA Result:		HBV DNA Date:			
LABS: MUST BE DONE WITHIN PAST 12 MONTHS					
HIV Result:		HIV Result Date:			
LABS: MUST BE DONE WITHIN THE PAST 3 MONTHS					
CBC Date:		CMP Date:		PT/INR Date:	
CURRENT MEDICATION INFORMATION					
Medication Allergies:					
Is patient on any of the following medications?					
Oxcarbazepine ☐Y ☐N		Carbamazepine ☐Y ☐N		Phenytoin ☐Y ☐N	
Phenobarbital ☐Y ☐N		Rifampin ☐Y ☐N			
Medication Selected/Duration:					
Special Instructions if any:					
CCHCS HQ HCV Oversight Provider (signature):			**Date:**		

Appendix F

STATE OF CALIFORNIA
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
CDCR 7385 (Rev. 10/19)

DEPARTMENT OF CORRECTIONS AND REHABILITATION
Form: Page 1 of 2
Instructions: Pages 3 & 4

All sections must be completed for the authorization to be honored. Use "N/A" if not applicable.

I. Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

CDCR# _____ Date of Birth: _____

Street Address: _____ **City/State/Zip:** _____

II. Individual/Organization Authorized to Release Personal Health Records if Other Than CDCR

Name: _____

Address: _____ City/State/Zip: _____

III. Individual/Organization to Receive the Information

[45 C.F.R. § 164.508(c)(1)(ii), (iii) & Civ. Code § 56.11(e), (f)]

The undersigned hereby authorizes CDCR's Health Information Management to release the health information pursuant to this authorization.

Name: _____

Relationship to **Patient**: _____ Phone: _____ Fax: _____

Address: _____ City/State/Zip: _____

IV. Authorization Expiration Event or Expiration Date for Release of Verbal Information/ Written Correspondence

[45 C.F.R. § 164.508(c)(1)(v) & Civ. Code § 56.11(h)]

Unless otherwise revoked by the **patient**, this authorization for the release of health care information to the above-named **individual/organization** will expire on the date specified below, **event identified,** or 12 months from the date signed **in Section IX**, **whichever occurs first:**

Date of Expiration: _____ **Event:** _____

From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____

V. Health Care Records to be Released - General

[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code § 56.11(d), (g)]

I authorize records for the following period of time **to be released** (must be completed to receive records):

From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____

☐ Medical Services ☐ Dental Services ☐ **Other:** _____

NOTE: Health records released as part of this authorization may contain references related to mental health, substance use disorder, medication assisted treatment, genetic testing, communicable disease, and HIV medical conditions.

VI. Health Records to be Released - Specify

[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code § 56.11(d), (g)]

☐ **Communicable Disease Records**	**from** _____ to _____	Signature: _____	Date: _____
☐ **Genetic Testing Records**	**from** _____ to _____	Signature: _____	Date: _____
☐ **HIV Test Results**	**from** _____ to _____	Signature: _____	Date: _____
☐ **Medication Assisted Treatment Records**	**from** _____ to _____	Signature: _____	Date: _____
☐ **Mental Health Treatment Records**	**from** _____ to _____	Signature: _____	Date: _____
☐ **Substance Use Disorder Records**	**from** _____ to _____	Signature: _____	Date: _____

NOTE: Health records released as part of this authorization may contain references related to dental, medical, mental health, substance use disorder, medication assisted treatment, genetic testing, communicable disease, and HIV conditions.

Requests for psychotherapy notes require a separate CDCR 7385 and may not be combined with any other request for health records.

☐ Psychotherapy Notes

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state laws.

STATE OF CALIFORNIA
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
CDCR 7385 (Rev. 10/19)

DEPARTMENT OF CORRECTIONS AND REHABILITATION
Form: Page 2 of 2
Instructions: Pages 3 & **4**

All sections must be completed for the authorization to be honored. Use "N/A" if not applicable.

VII. Purpose for the Release or Use of the Information
[45 C.F.R. § 164.508(c)(1)(iv)]

☐ Health Care ☐ Personal Use ☐ Legal ☐ Other (please specify): _____

VIII. Authorization Information

I understand the following:

1. I authorize the use or disclosure of my individually identifiable protected health information as described above for the purpose listed. I understand this authorization is voluntary.

2. I have the right to revoke this authorization. To do so I understand I can submit my request in writing to my current institution's Health Information Management (health records). The authorization will stop further release of my protected health information on the date my valid revocation request is received by Health Information Management. [45 C.F.R. § 164.508(c)(2)(i)]

3. I am signing this authorization voluntarily and understand that my health care treatment will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii)]

4. Under California law, the recipient of the protected health information under the authorization is prohibited from re-disclosing the protected health information, except with a written authorization or as specifically required or permitted by law. [Civ. Code § 56.13]

5. If the organization or person I have authorized to receive the protected health information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.[45 C.F.R. § 164.524(a)(2)(v)]

6. I have the right to receive a copy of this authorization. [45 C.F.R. § 164.508(c)(4) & Civ. Code § 56.11(i)]

7. Reasonable fees may be charged to cover the cost of copying and postage related to releasing this protected health information. [45 C.F.R. § 164.524(c)(4) et seq. & California Health and Safety Code § 123110, et seq.]

8. I understand that my substance use disorder records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be redisclosed without my written consent unless otherwise provided for by the regulations.

IX. Patient Signature
[45 C.F.R. § 164.508(c)(1)(vi) & Civ. Code § 56.11(c)(1)]

Name: (Print): _____

Signature: _____ Date: _____
If no expiration date is specified in section IV, this authorization will expire 12 months from this date.

Name of person signing form, if not patient (Print): _____

Signature: _____ Date: _____

Describe authority to sign form on behalf of patient: _____

Name of translator/interpreter assisting patient, if applicable (Print): _____

Signature of translator/interpreter: _____ Date: _____

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state laws.

STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
CDCR 7385 (Rev. 10/19)

Instructions

Note: Part IV is the request for release of verbal health care information or health care information as part of written correspondence, and Part V is the request for release of health care records.

Part I - "Patient Information": Records the patient's full name (last, first, and middle), CDCR number, date of birth, and address if he/she is paroled or released (incarcerated patients do not need to provide an address).

Part II - "Individual/Organization Authorized to Release Personal Health Records if Other Than CDCR": Records the name and address of the individual or organization authorized to release personal health records if other than CDCR.

Part III - "Individual/Organization to Receive the Information": Records who is to receive the information.

Part IV - "Authorization Expiration Event or Expiration Date for Release of Verbal Information/Written Correspondence": Used by the patient to limit the time period during which information may be shared.

- The patient may enter the date he/she wants the authorization to expire.
- The patient may enter an expiration event.
- The patient may enter a date range of information to be shared.
- If no expiration date is specified, this authorization is good for 12 months from the date signed in Section IX.

Part V - "Health Care Records to be Released - General": Contains a designated line for the date range of health care records to be released.

- **"Medical Services"** is checked when the patient wishes to have information released related to medical care.
- **"Dental Services"** is checked when the patient wishes to have information released related to dental treatment.
- **"Other"** is checked when the patient wishes to further restrict or further authorize the release of his/her medical information, and he/she is to write those wishes on the line provided.

Part VI - "Health Records to be Released - Specify": Health care information in this section requires a date range, additional signature, and signature date.

- **"Communicable Disease"** is checked when the patient wishes to have information released related to communicable disease testing and treatment. Communicable disease includes sexually transmitted infections.
- **"Genetic Testing"** is checked when the patient wishes to have information released related to genetic testing.
- **"HIV Test Results"** is checked when the patient wishes to have HIV test results released.
- **"Medication Assisted Treatment Records"** is checked when the patient wishes to have information related to medication assisted treatment released.
- **"Mental Health Treatment Records"** is checked when the patient wishes to have information released related to mental health treatment.
- **"Substance Use Disorder Records"** is checked when the patient wishes to have information related to substance use disorder treatment released.
- **"Psychotherapy Notes"** is checked when the patient wishes to have psychotherapy notes released. Requests for psychotherapy notes require a separate CDCR 7385 and **may not be combined with any other request for health care records.**

Under HIPAA, there is a difference between regular personal health information and psychotherapy notes. The following is HIPAA's definition of psychotherapy notes (§164.501):

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state laws.

STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
CDCR 7385 (Rev. 10/19)

Instructions (continued)

Part VII - "Purpose for the Release or Use of the Information": Should have at least one box checked. The patient may utilize this section to check the provided boxes or select "Other" and describe the reason(s) he/she wants to have the information released. If the patient does not want to designate a purpose, he/she may check the "Other" and state "At the request of the individual authorizing the release."

Part VIII - "Authorization Information": Below this section are eight points which detail patient rights in regards to authorizing release of information.

1. Tells the patient that he/she is giving authorization voluntarily.
2. Explains how to stop this authorization. The patient may revoke the authorization by **submitting his/her request in writing to his/her** institution's Health Information Management. The authorization will be removed from the patient's medical record when the revocation is received by Health Information Management.
3. Explains that signing this authorization is voluntary and will not affect treatment.
4. Explains that the recipient of the protected health care information under the authorization is prohibited from re- disclosing the information, except with a written authorization from the patient or as specifically required under law.
5. Explains that the released information may no longer be protected by federal privacy regulations depending on the intended recipient of the released information.
6. Explains that the patient has the right to receive a copy of this authorization. This will be sent to the patient by Health Information Management.
7. Explains that reasonable fees may be charged to cover copying and postage costs related to releasing the patient's health information.
8. Explains that substance use disorder records are protected and cannot be disclosed without the patient's written consent unless otherwise provided for by the regulations.

Part IX - "Patient Signature": The bottom of page two is for the patient's, his/her representative's, **or the translator/interpreter's signature. The patient's printed name, signature, and date are to be entered in the boxes provided. If this authorization is completed by a patient representative (e.g., power of attorney, estate representative, next of kin), his/her printed name, relationship to patient, signature, and date are to be entered in the boxes provided. Also attached must be a copy of either the Power of Attorney, letters issued in estate proceeding, or declaration of next of kin. If an interpreter/translator assisted the patient in filling out this form, his/her printed name, signature, and date are to be entered in the boxes provided.**

Appendix G

REQUEST FOR GSO SHIPPING LABELS

DATE: _____ BILLING CODE: 16071-REPS

DELIVER TO: _____
ADDRESS: _____
ATTENTION: _____
PHONE #: _____

FROM: _____
ADDRESS: _____
UNIT: _____
NAME: _____
PHONE #: _____

SEND EMAIL CONFIRMATION TO: CDCRCCHCSREPSAdmin@cdcr.ca.gov
COMMENTS/SPECIAL INSTRUCTIONS: _____
Please include an area on the label for the provider to include "Amount Per Package"

REQUEST FOR GSO SHIPPING LABELS

DATE: _____ BILLING CODE: 16071-REPS

DELIVER TO: _____
ADDRESS: _____
ATTENTION: _____
PHONE #: _____

FROM: _____
ADDRESS: _____
UNIT: _____
NAME: _____
PHONE #: _____

SEND EMAIL CONFIRMATION TO: CDCRCCHCSREPSAdmin@cdcr.ca.gov
COMMENTS/SPECIAL INSTRUCTIONS: _____
Please include an area on the label for the provider to include "Amount Per Package"

Appendix H

MAILING INSTRUCTIONS FOR THE HEALTH RECORDS CENTER (HRC)

1. Contracted health care providers who see any patient that is a part of the CCHCS Reentry Programs (REPS) are required to send all patient health care records from each encounter to the HRC within 48 hours.

2. California Correctional Health Care Services (CCHCS), Healthcare Invoicing Section (HIS) will provide pre-printed General Logistics Systems (GLS) shipping label(s) and packaging materials to the contracted health care provider on an as-needed basis.

3. If a provider runs out of GLS shipping labels or packaging, they must email the REPS Administrative Mailbox at CDCRCCHCSREPSAdmin@cdcr.ca.gov to request more.

4. When preparing the package for shipment please note the following:

    - Health care records may not be sent by portable medium (CD, DVD, USB flash drive, etc.)
    - Only health care documentation of REPS patients shall be sent to HRC.
    - GLS is to be the only shipping company to be used.
    - Ensure all documents sent to HRC have the correct Patient Identifiers such as: California Department of Corrections and Rehabilitation (CDCR) #, last name, first name and date of birth.
    - Note the tracking number for each package that is sent to HRC.
    - Handwrite the size of the records package in inches of thickness on the label.

Appendix I

CCHCS Reentry Programs (REPS)
REFUSAL OF EXAMINATION AND / OR TREATMENT

REFUSAL OF EXAMINATION AND / OR TREATMENT		
PATIENT NAME (TYPE OR PRINT CLEARLY)	CDCR NUMBER	INSTITUTION

Having been fully informed of the risks and possible consequences involved in refusal of the examination and/or treatment in the manner and time prescribed for me, I nevertheless refuse to accept such examination and/or treatment. I agree to hold the Department of Corrections and Rehabilitation, the staff of the medical department and the institution free of any responsibility for injury or complications that may result from my refusal of this examination and/or treatment, specifically:

Describe the examination and/or treatment refused as well as the risks and benefit of the intervention:

_____

_____

_____

_____

_____

_____

PATIENT SIGNATURE	DATE	☐ PATIENT REFUSES TO SIGN	DATE
WITNESS			
NAME OF WITNESS (PRINT/TYPE)		NAME OF WITNESS (PRINT/TYPE)	
WITNESS SIGNATURE	DATE	WITNESS SIGNATURE	DATE

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state law.

Appendix J

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Over-The-Counter (OTC) Products List
The chart below details the specific OTC products approved for distribution:

OVER-THE-COUNTER PRODUCTS (MEDICATIONS)		
Indication	**Category**	**Product Name**
1. Gastrointestinal Reflux/Heartburn	Antacid	Aluminum Hydroxide/Magnesium Hydroxide/Simethicone
2. Gastrointestinal Reflux/Heartburn	H-2 Blocker	Ranitidine 150 mg
3. Allergy-Seasonal	Antihistamine	Loratadine 10 mg
4. Allergy-Seasonal	Antihistamine	Cetirizine 10 mg
5. Pain/Fever	NSAID	Naproxen 220 mg
6. Pain/Fever	NSAID	Ibuprofen 200 mg
7. Athletes Foot	Topical-Antifungal	Clotrimazole 1%
8. Skin Irritation	Topical-Steroid	Hydrocortisone 1%
***OVER-THE-COUNTER PRODUCTS (NON-MEDICATED COMFORT)**		
Indication	**Category**	**Product Name**
9. Nasal Congestion	Nasal Moisturizer	Saline Nasal Spray
10. Dry Eyes	Eye Lubricant	Artificial Tears
11. Dry Skin	Topical-Lotion	Moisturizing Lotion
12. Sun Exposure	Topical-Sunscreen	Sunscreen Lotion SPF 30

*** Patients admitted to the following inpatient health care facilities; Acute or Intermediate Care, CTC, SNF, PIP, MHCB, etc., shall have access to all non-medicated comfort products only.**

February 2019 OVER-THE-COUNTER PRODUCTS LIST

Appendix K

CCHCS Reentry Programs (REPS)
Healthcare Appointment Request Form

This form is for routine visits and/or procedures and is not required for emergency care.

Date _____ FCRP/MCRP Location _____

Patient Name _____ Patient Signature _____ CDCR# _____ DOB _____

Appointment Request

Service Requested:
- ☐ Medical
- ☐ Dental
- ☐ Mental Health*

Type of Visit:
- ☐ In-person
- ☐ Telehealth

Follow-up/New Symptom:
- ☐ Follow-up
- ☐ New Symptom

Reason for Request:

List of Medications:

Received By

Received By Name & Title (Print) _____ Signature _____ Date _____

Clinician Review

COMMENTS:

CCHCS Clinician's Signature _____ Date _____

- ☐ Approved
- ☐ Denied

REPS Program Staff

Scan and email this form to the Program Director, CCIII, and to the applicable email address listed in the *Healthcare Appointment Request Form Procedure*.

*Mental Health/BHR Program requests do not require approval, only notification.

May 2024