Drug Medi-Cal Organized Delivery System Provider Preventable Conditions (PPC) Reporting Form

Federal Managed Care regulations (42 CFR 438.6(f)(2)(ii)) require the reporting of any identified provider preventable conditions that are associated with claims for Drug Medi-Cal (DMC) Organized Delivery System (ODS) payment or with courses of treatment furnished to DMC ODS beneficiaries for which DMC ODS payments would otherwise be available. See instructions for a more detailed description of PPCs.

1. Name of facility where PPC occurred:		
2. National Provider Identifier (NPI):		
3. Billing NPI if different from No. 2:		
4. Facility Address where PPC occurred:		
City:	State:	Zip code:
5. *PPC – Other Provider Preventable Condition (OPPC) in any health care setting:*		
Date OPPC occurred:	Admission date:	
☐ Wrong surgery/invasive procedure		
☐ Surgery/invasive procedure on the wrong body part		
☐ Surgery/invasive procedure on the wrong beneficiary		
6. *PPC – Health Care-Acquired Condition (HCAC) in an acute inpatient setting:*		
Date HCAC occurred:	Admission date:	
☐ Air Embolism	☐ Blood Incompatibility	
☐ Catheter-associated urinary tract infection	☐ Deep vein thrombosis/pulmonary embolism	
☐ Falls/trauma	☐ Foreign object retained after surgery	
☐ Iatrogenic pneumothorax with venous catheterization		
☐ Manifestations of poor glycemic control	☐ Stage III or IV pressure ulcers	
☐ Surgical site infection	☐ Vascular catheter-associated infection	
7. Beneficiary's name:		
8. Client Index Number (CIN):		
9. Beneficiary's birthdate:		
10. Beneficiary's address:		
City:	State:	Zip code:
11. Which DMC ODS County is the beneficiary enrolled with?:		
12. Do you intend to submit a claim? ☐ Yes ☐ No ☐ Unknown		
13. If "yes", what is the claim control number?		
14. Name of person completing the report:		
15. Title of person completing the report:		
16. Submitted by: ☐ DMC ODS ☐ Provider		
17. Phone (including ext.):	Email:	
18. Signature of person completing form:		

INSTRUCTIONS

*Providers must complete and send one form (front page only) for each provider preventable condition (PPC). Providers must report any PPC to DHCS that **did not exist prior to the provider initiating treatment** for a DMC ODS beneficiary, even if the provider does not intend to bill DMC ODS.*

Mark "PROTECTED HEALTH INFORMATION: CONFIDENTIAL" and send completed first page only of the report related to a DMC ODS beneficiary to:

Department of Health Care Services
Substance Use Disorder – Program, Policy, and Fiscal Division,
Performance Management Branch
PO Box 997413, MS-2621
Sacramento, CA 95899-7413;

Or by secure, encrypted email to: ODSSubmissions@dhcs.ca.gov

Providers must send this form to the Department of Health Care Services (DHCS), Substance Use Disorder – Program, Policy, and Fiscal Division, Performance Management Branch via U.S. Post Office or secure, encrypted email. Providers must submit the form after discovery of the event and confirmation that the effected party is a DMC ODS beneficiary. The preferred methods of sending reports for confidentiality are No. 1, by secure, encrypted email; or 2. U.S. mail with appropriate marking. Providers must comply with HIPAA and any other relevant privacy laws to ensure confidentiality of beneficiary information. Providers may email questions about PPCs to ODSSubmissions@dhcs.ca.gov.

Facility information (boxes 1-4)

1. Enter name of facility where the PPC occurred.
2. Enter the National Provider Identifier (NPI) of the facility where the PPC occurred.
3. Enter the billing NPI if is different from the NPI for the facility where the PPC occurred.
4. Enter the street address, city, state, and zip code of the facility where the beneficiary was being treated when the PPC occurred.

Other Provider-Preventable Condition in any health care setting (box 5)

5. If you are reporting an OPPC, enter the date (mm/dd/yyyy) that the PPC occurred and the admission date if the beneficiary was admitted to an inpatient hospital.

   Select one of the following if:

   - Provider performed the wrong surgical or other invasive procedure on the beneficiary.
   - Provider performed a surgical or other invasive procedure on the wrong body part.
   - Provider performed a surgical or other invasive procedure on the wrong beneficiary.

Health Care-Acquired Condition (HCAC) in an acute inpatient setting (box 6)

(HCACs are the same conditions as hospital-acquired conditions (HACs) that are reportable for Medicare, with the exception of reporting deep vein thrombosis/pulmonary embolism for pregnant women and children under 21 years of age, as noted below)

6. Enter the date (mm/dd/yyyy) that the HCAC occurred and the admission date the beneficiary was admitted to an inpatient hospital.

   Select one of the following if the beneficiary experienced:

   - A clinically significant air embolism
   - An incidence of blood incompatibility
   - A catheter-associated urinary tract infection
   - Deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement in an inpatient setting. Do **not** check the box if the beneficiary was under 21 or pregnant at the time of PPC.
   - A significant fall or trauma that resulted in fracture, dislocation, intracranial injury, crushing injury, burn, or electric shock
   - Any unintended foreign object retained after surgery
   - Iatrogenic pneumothorax with venous catheterization
   - Any of the following manifestations of poor glycemic control: diabetic ketoacidosis, nonketonic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, or secondary diabetes with hyperosmolarity
   - A stage III or state IV pressure ulcer
   - One of the following surgical site infections:
     - Mediastinitis following coronary artery bypass graft (CABG)
     - Following bariatric surgery for obesity: laparoscopic gastric bypass, gastroenterosomy, or laporoscopic gastric restrictive surgery
     - Certain orthopedic procedures: Spine, neck, shoulder, and elbow
     - Following cardiac implantable electronic device (CIED) procedures
   - A vascular catheter-associated infection

Beneficiary information (boxes 7-10)

7. Enter beneficiary's name (first, middle, last) as listed on the Beneficiary Identification Card.
8. Enter beneficiary's Client Index Number (CIN) from the Beneficiary Identification Card.
9. Enter the beneficiary's birthdate (mm/dd/yyyy).
10. Enter the beneficiary's home street address, including city, state, zip code, and apartment number, if applicable.
11. Enter the name of the county where the beneficiary is enrolled for DMC ODS services.

Claim information (boxes 11-12)

12. Click “yes” if you intend to submit a claim to DMC ODS for the course of treatment associated with the PPC, “no” if you do not, or “unknown” if you do not know at this time.
13. Enter the Claim Control Number (PCCN) if you have already submitted a claim for the course of treatment.

Provider Contact information (boxes 13-17)

14. Enter the name of the person completing this report.
15. Enter the title of the person completing this report.
16. Check the appropriate box to indicate whether the person completing this report is a representative for the DMC ODS or a provider.
17. Enter a work phone number, including extension if necessary, and email address where DHCS can contact the person who completed this report.
18. Sign and date the form. Digital signature is accepted.

THE INFORMATION CONTAINED IN THE COMPLETED FORMS IS PROTECTED HEALTH INFORMATION AND PERSONALLY IDENTIFIABLE INFORMATION, UNDER FEDERAL (HIPAA) LAWS AND CA STATE PRIVACY LAWS. THE PROVIDER IS RESPONSIBLE FOR ENSURING THE CONFIDENTIALITY OF THIS INFORMATION.