

Medi-Cal Provider-Preventable Conditions (PPC) Reporting Form

By law, providers must identify provider-preventable conditions that are associated with claims for Medi-Cal payment or with courses of treatment furnished to Medi-Cal patients for which Medi-Cal 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:	
<input type="checkbox"/> Wrong surgery/invasive procedure			
<input type="checkbox"/> Surgery/invasive procedure on the wrong body part			
<input type="checkbox"/> Surgery/invasive procedure on the wrong patient			
6. PPC – Health Care-Acquired Condition (HCAC) in an acute inpatient setting:			
Date HCAC occurred:		Admission date:	
<input type="checkbox"/> Air embolism		<input type="checkbox"/> Blood incompatibility	
<input type="checkbox"/> Catheter-associated urinary tract infection		<input type="checkbox"/> Deep vein thrombosis/pulmonary embolism	
<input type="checkbox"/> Falls/trauma		<input type="checkbox"/> Foreign object retained after surgery	
<input type="checkbox"/> Iatrogenic pneumothorax with venous catheterization			
<input type="checkbox"/> Manifestations of poor glycemic control		<input type="checkbox"/> Stage III or IV pressure ulcers	
<input type="checkbox"/> Surgical site infection		<input type="checkbox"/> Vascular catheter-associated infection	
7. Patient's name:			
8. Client Index Number (CIN):			
9. Patient's birthdate:			
10. Patient's address:			
City:		State:	Zip Code:
			Apt. No.:
11a. Is the patient enrolled in a Medi-Cal Managed Care Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (Fee-for Service)			
11b. If "yes" to question No. 11a, what is the plan's three-digit Health Care Plan Code ?			
11c. Name of Health Care Plan:			HCP County:
12a. Do you intend to submit a claim? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
12b. If "yes," what is the claim control number?			
13. Name of person completing report:			
14. Title of person completing report:			
15. Submitted by: <input type="checkbox"/> Medi-Cal Managed Care Plan <input type="checkbox"/> Provider			
16. Phone (including ext.):		Email:	
17. Signature of person completing form:			

Please note: When applicable, both Medi-Cal Managed Care Plans (MCP) and Medicare-Medicaid Plans (MMP) are required to report PPCs using this form.

INSTRUCTIONS

Providers must complete and send one form (front page only) for each provider-preventable condition (PPC). **Please note that reporting PPCs to the Department of Health Care Services for a Medi-Cal beneficiary does not preclude the reporting of adverse events and [healthcare associated infections](#) (HAIs), pursuant to the Health and Safety Code sections 1279.1 and 1288.55, to the California Department of Public Health for the same beneficiary.** Providers must report any PPC to DHCS that **did not exist prior to the provider initiating treatment** for a Medi-Cal beneficiary, even if the provider does not intend to bill Medi-Cal.

Mark “PROTECTED HEALTH INFORMATION: CONFIDENTIAL” and send completed first page only of the report related to a Medi-Cal beneficiary to:

Via Secure Fax
Department of Health Care Services
Audits and Investigations Division
Occurrence of Provider-Preventable Conditions
(916) 440-5060

Via U.S. Post Office
Department of Health Care Services
Occurrence of Provider-Preventable Condition
Audits and Investigations Division, MS 2100
P.O. Box 997413
Sacramento, CA 95899-7413

Via UPS, FedEx, or Golden State Overnight
Department of Health Care Services
Occurrence of Provider-Preventable Condition
Audits and Investigations Division, MS 2100
1500 Capitol Ave., Suite 72.624
Sacramento, CA 95814-5006

Providers must send this form to the Department of Health Care Services (DHCS), Audits and Investigations Division, via fax, U.S. Post Office, UPS, or FedEx. Providers must submit the form after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary. The preferred methods of sending the reports for confidentiality are No. 1, overnight courier with appropriate marking; No. 2, secure fax machine with appropriate marking; and No. 3, U.S. mail with appropriate marking. Providers must comply with HIPAA and any other relevant privacy laws to ensure the confidentiality of patient information. Providers may email questions about PPCs to PPCHCAC@dhcs.ca.gov.

Facility information (boxes 1-4)

1. Enter name of the 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 it 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 a patient.
- Provider performed a surgical or other invasive procedure on the wrong body part.
- Provider performed a surgical or other invasive procedure on the wrong patient.

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 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, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, or secondary diabetes with hyperosmolarity
- A stage III or stage 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, gastroenterostomy, or laparoscopic 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 7-11c)

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.
- 11a. Check "yes" if the beneficiary is enrolled in a Medi-Cal Managed Care Plan or "no" if the beneficiary has Fee-For-Service (FFS) Medi-Cal.
- 11b. If the beneficiary has Medi-Cal Managed Care, the beneficiary's Managed Care Plan should enter the [Health Care Plan's \(HCP\) three-digit plan code](#).
- 11c. If the beneficiary has Medi-Cal Managed Care, enter the name of the Managed Care HCP and the county of the HCP where the PPC occurred.

Claim information (boxes 12a-12b)

- 12a. Click "yes" if you intend to submit a claim to Medi-Cal for the course of treatment associated with the PPC, "no" if you do not, or "unknown" if you do not know at this time.
- 12b. Enter the Claim Control Number (CCN) if you have already submitted a claim for the course of treatment.

Provider Contact information (boxes 13-17)

13. Enter the name of the person completing this report.
14. Enter the title of the person completing this report.
15. Check the appropriate box to indicate whether the person completing this report is a representative for a Medi-Cal Managed Care Plan or a provider.
16. Enter a work phone number, including extension if necessary, and email address where DHCS can contact the person who completed this report.
17. Sign and date the form. Adobe “digital signatures” are 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.