



Iowa Medicaid Critical Incident Report

Date Received	Incident ID	Staff Reviewer
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Instructions: Submit all pages of this form with as much information as possible within the required reporting timeframes.

Incident Status: <input type="checkbox"/> Initial (pending further investigation) <input type="checkbox"/> Completed (investigation completed) <input type="checkbox"/> Additional information added		Managed Care Organization: <input type="checkbox"/> Amerigroup Iowa <input type="checkbox"/> AmeriHealth Caritas Iowa <input type="checkbox"/> UnitedHealthcare Community Plan <input type="checkbox"/> Non-MCO	
Provider/Facility Information	National Provider Identifier		Phone Number
	Provider or Agency Name		
	Provider Address		
	City	State	Zip Code
Reporting Party	Reporter's First Name		Last Name
	Title		
	Email		Phone Number
	Point of contact to discuss incident if different from reporter:		
	First Name	Last Name	Phone Number
Medicaid Member	Medicaid State Number	First Name	Last Name
	Address		
	City	State	Zip Code
	Date of Birth	Age	Member's gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Service Programs	<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Habilitation <input type="checkbox"/> MFP <input type="checkbox"/> Brain Injury <input type="checkbox"/> Health and Disability <input type="checkbox"/> Other (non-waiver): <input type="checkbox"/> Children's Mental Health <input type="checkbox"/> Intellectual Disability Describe: <input type="checkbox"/> Elderly <input type="checkbox"/> Physical Disability		
	First Name		Last Name
	Address		
	City	State	Zip Code
Case Manager (CM)	Email		Phone Number
	Case manager contacted member within 24 hours of discovering incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Date CM Contacted Member		Time CM Contacted Member

Incident	Date Incident Occurred (<i>required</i>)		Time of Incident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Unknown	
	Was the incident witnessed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Incident Discovered (<i>required</i>)	
	Person to learn of incident:			
	First Name	Last Name	Title	
Location of Incident	Select Location Type (If other, specify.)			
	<input type="checkbox"/> Member's home	<input type="checkbox"/> Community	<input type="checkbox"/> Other location	
	<input type="checkbox"/> Living alone	<input type="checkbox"/> Work	<input type="checkbox"/> State facility	
	<input type="checkbox"/> Living with relatives	<input type="checkbox"/> School	<input type="checkbox"/> Correctional facility or jail	
	<input type="checkbox"/> Living with unrelated person	<input type="checkbox"/> Vehicle	<input type="checkbox"/> Nursing facility	
<input type="checkbox"/> RCF	<input type="checkbox"/> Day program	<input type="checkbox"/> Hospital or clinic		
<input type="checkbox"/> Assisted living	<input type="checkbox"/> Other:	<input type="checkbox"/> PMIC		
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:		
	Name of Location or Facility			
	Location or Facility Address			
	City	State	Zip Code	
Witnesses	People Present During Incident (Provide name of person, initials if a member, and the person's relationship to the member. If other, specify.)			
	1.	<input type="checkbox"/> Another member	<input type="checkbox"/> Staff	<input type="checkbox"/> Family <input type="checkbox"/> Roommate
		<input type="checkbox"/> Other:		
	2.	<input type="checkbox"/> Another member	<input type="checkbox"/> Staff	<input type="checkbox"/> Family <input type="checkbox"/> Roommate
		<input type="checkbox"/> Other:		
	3.	<input type="checkbox"/> Another member	<input type="checkbox"/> Staff	<input type="checkbox"/> Family <input type="checkbox"/> Roommate
	<input type="checkbox"/> Other:			
4.	<input type="checkbox"/> Another member	<input type="checkbox"/> Staff	<input type="checkbox"/> Family <input type="checkbox"/> Roommate	
	<input type="checkbox"/> Other:			
5.	<input type="checkbox"/> Another member	<input type="checkbox"/> Staff	<input type="checkbox"/> Family <input type="checkbox"/> Roommate	
	<input type="checkbox"/> Other:			
Services	Were services being provided? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Service Name			
Reporting	Case manager informed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			Date Informed
	Guardian informed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			Date Informed
	DHS report made? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			Date of Report
	Report Number		DHS report accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Department of Inspections and Appeals (DIA)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			Date of Report
	Law enforcement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			Date Contacted
	Officer Name and Contact Information			
	Other Entity Contacted (Specify)			

Incident Description	Description (Include who, what, when, where, and how in a clear concise manner noting the circumstances of the incident.)		
	Was the incident preventable? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Root Cause (Describe what lead to or contributed to the incident.)		
	Immediate Resolution (Include action taken to secure the member's safety and proposed prevention plan to address.)		
Incident Type	Circumstances (Select one): <input type="checkbox"/> Physical injury to member <input type="checkbox"/> Physical injury by member		
	<input type="checkbox"/> Physical Injury (Injury requiring physician's treatment or admission to a hospital.)		
	<input type="checkbox"/> Burn	<input type="checkbox"/> Laceration	<input type="checkbox"/> Poisoning or toxin ingestion
	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Puncture wound	<input type="checkbox"/> Other:
	<input type="checkbox"/> Concussion	<input type="checkbox"/> Fracture or break	
	<input type="checkbox"/> Human or animal bite	<input type="checkbox"/> Loss of consciousness	
	Injury Is Due To (Check all that apply.)		
	<input type="checkbox"/> Mechanical restraint	<input type="checkbox"/> Aggressive behavior	<input type="checkbox"/> Vehicular accident
	<input type="checkbox"/> Removal of mobility aids	<input type="checkbox"/> Accidental fall	<input type="checkbox"/> Assault
	<input type="checkbox"/> Personal harm	<input type="checkbox"/> Aspiration or choking	<input type="checkbox"/> Other:
<input type="checkbox"/> Medication Error (Medical intervention sought or pattern of medication errors identified. Check all that apply.)			
<input type="checkbox"/> By staff	<input type="checkbox"/> Wrong dosage	<input type="checkbox"/> Unauthorized administration	
<input type="checkbox"/> By member	<input type="checkbox"/> Wrong medication	<input type="checkbox"/> Overdose	
	<input type="checkbox"/> Missed dose	<input type="checkbox"/> Other:	
	<input type="checkbox"/> Wrong time		
Root Cause (Check all that apply.)			
<input type="checkbox"/> Staff distracted	<input type="checkbox"/> Not verifying correct member	<input type="checkbox"/> Unknown	
Medication Error Lead To (Check all that apply.)			
<input type="checkbox"/> Physical injury	<input type="checkbox"/> Emergency mental health	<input type="checkbox"/> Abuse report	
<input type="checkbox"/> Death	<input type="checkbox"/> Law enforcement		
<input type="checkbox"/> Death Apparent cause of death:			
<input type="checkbox"/> Accident	<input type="checkbox"/> Natural causes	<input type="checkbox"/> Suicide	
<input type="checkbox"/> Homicide	<input type="checkbox"/> Unknown		
Preventable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Autopsy performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Autopsy requested?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was there a DNR order?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hospice involved?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Location Death Occurred			
Location Address			
City	State	Zip Code	

Incident Type (Cont.)	<input type="checkbox"/> Emergency Mental Health (Check all that apply.) Suicidal? <input type="checkbox"/> Yes <input type="checkbox"/> No Self-injurious? <input type="checkbox"/> Yes <input type="checkbox"/> No Aggressive to others? <input type="checkbox"/> Yes <input type="checkbox"/> No Member needed to be admitted for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Law Enforcement Reason involved: <input type="checkbox"/> Criminal <input type="checkbox"/> Medical <input type="checkbox"/> Location unknown/elopement <input type="checkbox"/> Mental health <input type="checkbox"/> Welfare check <input type="checkbox"/> Other (describe): <input type="checkbox"/> Behavioral <input type="checkbox"/> Victim Arrested? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Perpetrator Charged? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Abuse Report or Restriction <input type="checkbox"/> Victim <input type="checkbox"/> Physical injury <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Perpetrator <input type="checkbox"/> Exploitation <input type="checkbox"/> Denial of critical care <input type="checkbox"/> Self-denial of critical care <input type="checkbox"/> Mental injury
	<input type="checkbox"/> Location Unknown/Elopement (Location unknown by provider responsible for protective oversight.) Approximate length of time location unknown:
Resolution	Incident-Specific Resolutions This section includes multiple types of resolutions possible for reported incidents. Check all that apply. Describe the agency course of action, proposed plans, self-corrective actions, measures needed to prevent or diminish the probability for future occurrences or other information needed for each checked resolution.
	<input type="checkbox"/> Staff Review and Updates (Complete this section if staff issues will be addressed by the agency or facility. Describe any changes in staffing patterns.) <input type="checkbox"/> Initiated <input type="checkbox"/> Completed Describe:
	<input type="checkbox"/> Member Review (Complete this section if the member's plan, health, or care needs will be reviewed or revised.) <input type="checkbox"/> Initiated <input type="checkbox"/> Completed Member care and treatment plan revised? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
	<input type="checkbox"/> Equipment and Supplies Review and Updates (Complete this section if necessary equipment or supplies need to be purchased, repaired, or assessed.) <input type="checkbox"/> Initiated <input type="checkbox"/> Completed Describe:

Resolution (Cont.)	<input type="checkbox"/> Environment Review and Updates (Complete this section if the member's environment will be evaluated, accommodated, or modified for safety or accessibility needs.) <input type="checkbox"/> Initiated <input type="checkbox"/> Completed Describe:
	<input type="checkbox"/> Policy and Procedure Review and Updates (A review or adjustment of formal written policies, procedures, and guidelines implemented by the agency or facility.) <input type="checkbox"/> Initiated <input type="checkbox"/> Completed Describe:
	<input type="checkbox"/> Agency Wide Planning (Systemic resolution to include, but not limited to, training or retraining, self-CAP, communication and awareness regarding updates, employee screening, etc.) <input type="checkbox"/> Initiated <input type="checkbox"/> Completed Self-corrective action initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:
	<input type="checkbox"/> No Resolution Required (Indicate how incident was isolated.) Describe:
	Additional Follow-up and Notes (Place additional detail regarding incident or resolution as discovered.)

Critical Incident Submission Guidelines per Iowa Administrative Code Chapter 77

Major incidents require notification by the end of the next calendar day following the incident. Minor incidents are reported to the staff's supervisor within 72 hours of the incident. Cases of abuse require notification to the DHS Abuse Hotline (1-800-362-2178) and the member's assigned MCO. **Note:** Mandatory incident reporting requirements to other entities continue to apply including, but not limited to, Iowa Code Chapter 235B and Iowa Administrative Code Chapter 50.

Submission Instructions

Direct entry of critical incidents can be completed electronically within each Managed Care Organization (MCO) and the Iowa Medicaid Portal Access (IMPA) system. Direct electronic entry is the preferred method. Link information for each MCO and IME electronic systems are provided below. Submit as much information as possible within the required reporting timeframes to the member's assigned MCO or to the IME if not assigned an MCO. If additional investigation is required for full resolution, please indicate this within the report. One will have the ability to return to the original entry in IMPA to add supplemental information regarding the incident and/or resolution.

Definitions

Root cause. A method of problem solving used for identifying the root causes of faults or problems then determining solutions to address those causes to avoid occurrences of the same incident.

Welfare check. A police welfare check takes place when law enforcement is sent out to check the wellbeing of a person. This check is done when the police have a reason to believe someone is harmed or in danger.

Natural causes. Death attributed to a pre-existing illness or disease, old age or an internal malfunction of the body not directly influenced by external forces such as violence or an accident.

Laceration. A break, cut, gash, or tear in the skin or flesh. An incision by a surgeon or physician is not a laceration on a patient.

DNR. Do not resuscitate.

Protective oversight. An awareness of the location of an individual where care is being provided; the ability to intervene on behalf of the individual; the supervision of nutrition, medication, or actual provisions of care; and the responsibility for the welfare of the individual.

MCO and IME Contact and Link Information

Amerigroup Iowa, Inc.

- Fax: 844-400-3465
- Provider Call Center: 1-800-454-3730
- Web: <https://providers.amerigroup.com/IA/Pages/welcome.aspx>
- Email: IAincidents@amerigroup.com

AmeriHealth Caritas Iowa, Inc.

- Provider Telephone Services: 1-844-411-0579
- Web: <http://www.amerihealthcaritasia.com/provider/manual-forms/index.aspx>
- Non-Provider Telephone Services: 1-855-332-2440
- TTY: 1-844-214-2471 | 24 hours a day, 7 days a week
- Email: ACIACriticalIncidentReporting@amerihealthcaritas.com

UnitedHealthcare Plan of the River Valley, Inc.

- Submit completed form by fax to 1-855-371-7638 or email to critical_incidents@uhc.com
- Provider Services Call Center: 1-888-650-3462
- Web: <http://www.uhccommunityplan.com/health-professionals/ia.html>

Iowa Medicaid Enterprise

- Submit via the Iowa Medicaid Portal Access (IMPA) system
- Email: hcsir@dhs.state.ia.us