

**SMMC Managed Care Report Guide**  
**Effective 9/01/2019**

**Chapter 15: Critical Incident Report - Individual**

**BENEFIT TYPE(S)**

The following Managed Care Plans must submit this report:

- LTC
- MMA & MMA Specialty
- Dental

**REPORT PURPOSE:**

The purpose of this report is to monitor Long-term Care Plans' critical incident reporting and management system for critical incidents that negatively impact the health, safety or welfare of Long-term Care enrollees. This includes critical incidents in all home and community-based service delivery settings applicable to enrollees.

**FREQUENCY & DUE DATES:**

Report Year Type	Report Year Period
C = Calendar	01/01 – 12/31

Report Frequency	Reporting Data Period
V = Variable	Two-digit day of submission date (01-31)

This report is due immediately upon occurrence and **no later than twenty-four (24) hours** after detection or notification [to the health plan](#).

**REPORT CODE & SUBMISSION:**

**Automated Incident Reporting System (AIRS)**

The Managed Care Plan must submit the following via the AIRS to the Agency:

- Critical Incident Report using the format provided within AIRS.
- A report attestation as described in Chapter 2.

**Manual Reporting**

When AIRS is not available, the Managed Care Plan shall proceed with the manual submission requirements.

<b>Report Code</b>	0118
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Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following via secure, encrypted email to the Agency's Managed Care Plan Contract manager:

- Critical Incident Report using the template provided.
- A report attestation as described in Chapter 2.

**INSTRUCTIONS:**

**AIRS**

The Long-term Care Plan must report the following to the Agency in accordance with the format set forth in the Critical Incident Report template [AIRS System](#):

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- Plan Name auto-populates following sign-in on the “Create New Report” screen
- Person Reporting Information
  - Reporter’s Name, Email address and Phone number auto-populate based on user
  - Title—select from drop-down list
  - License Number---only required for licensed staff, i.e. registered nurses
- Enrollee Information
  - Enrollee’s first ~~and last~~ name
  - Enrollee’s last name
  - Enrollee’s Medicaid ID#
  - AHCA Area/Region (from drop down list)
  - Enrollee’s County of Residence (from drop down list)
- Incident Information
  - Incident Date
  - Date Incident Reported to Plan
  - Incident Location (choose from drop down: Facility, Home, Transport, Other Location in the Community)
  - Depending on which incident location is selected, additional fields will open for reporting home address details, provider names and/or other provider information
  - Facility Type (choose from drop down: Adult Daycare, Adult Family Care Home, Doctor’s Office, Home Health)
- Critical Incident Type (check most appropriate incident type from the list provided)
- Individual(s) Involved---may list more than one individual/witness
  - Name
  - Role
  - Involvement
  - License number required, if licensed health professionals were involved
  - Social Security Number is an optional field
- Investigation
  - Details of the Incident—to include enrollee’s age, sex current medication if applicable, source of information, all reported details about the event, the home and community- based services being provided, action taken by plan or provider, and any other pertinent information, including current status of enrollee.
  - Follow-Up Planned or Required-- Based on the apparent cause(s) of the incident presented in the analysis, describe the corrective or proactive action(s) to be implemented to prevent this type or a similar type of incident from reoccurring to this or other patients/residents.
  - Incident Resolution (yes or no)
  - Resolution Date (if applicable)

**Manual Reporting**

**The Long-term Care Plan must report the following to the Agency in accordance with the format set forth in the Critical Incident Report template:**

- Plan Name
- Plan Medicaid ID (nine digits)
- Today’s Date (Date the plan is reporting to the Agency) (MM/DD/YYYY)
- AHCA Area/Region (from drop down list)

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- Enrollee's County of Residence
- Enrollee's Medicaid ID (ten digits)
- Enrollee's full name (first, last)
- Date of incident (MM/DD/YYYY)
- Facility (Yes/No)
- Name of facility or Unit (if applicable)
- Facility Type (choose from drop down: Adult Daycare, Adult Family Care Home, Doctor's Office, Home Health or Other type of provider)
- Address of incident
- ICD-10 Code for Diagnosis
- Incident Type (select from drop down list)
- Details of Incident
- Follow-up Planned
- Assigned Provider
- Staff Involved
- Witnesses
- Date Reported to Plan
- Report Submitted By
- Risk Manager Name
- Date Resolved (MM/DD/YYYY)

**VARIATIONS BY MANAGED CARE PLAN TYPE:**

No variations.

**REPORT TEMPLATE**

**AIRS**

[Registration and access to the AIRS system can be obtained via the following web address:-  
https://apps.ahca.myflorida.com/SingleSignOnPortal/login.aspx. Users of AIRS must be approved by the Agency in advance of report submissions.](https://apps.ahca.myflorida.com/SingleSignOnPortal/login.aspx)

**Manual Reporting**

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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