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Employment and Community First CHOICES Tier 2 Reportable Event — Provider Investigation Report form

As specified in section 2.15.7.7.4.1 of the *Contractor Risk Agreement*, the provider will notify the Department of Intellectual and Developmental Disabilities (DIDD) and the managed care organization (MCO) by close of the business day in which the provider witnessed or discovered the reportable event. In addition, per section 2.15.7.7.4.2 of the *Contractor Risk Agreement*, the provider submission of the *Tier 2 Reportable Event* form to the MCO and DIDD shall be the anchor date for purposes of tier 2 review timeliness. CHOICES Employment and Community (ECF) providers shall complete all tier 2 investigations and submit an investigation report within 14 calendar days of the anchor date. The MCO may grant a seven-day extension at its discretion.

Submit the completed *ECF CHOICES Tier 2 Reportable Event — Provider Investigation Report* form to:

- Amerigroup Community Care via email ECF-REF@amerigroup.com or fax if email is unavailable to 1-844-759-5952.
- BlueCare via email ECFREF@bcbst.com or fax if email is unavailable to 1-855-472-0156.

Member information

Last name		**First name**		**Middle initial**		**Date of birth**	
Address		**City, state and ZIP code**				**Social Security number**	
County		**MCO**		**Region**		**Member subscriber number**	

Provider information

Provider name: **Medicaid ID:**
Provider phone number:
Person completing form: **Title or role:**
Contact phone number:

Discovery information

Provider's discovery date:	**Name of home- and community-based services (HCBS)/fiscal employer agent worker:**
Submission date:	**HCBS worker removed?** **Date worker removed:**
Reportable event date:	**Time worker removed?** **Reported to DIDD?**

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

Please select the reportable event type and description below			
☐	Allegations that provider personnel (employees, volunteers) engaged in disrespectful or inappropriate communication about a person within eyesight or audible range of the person supported. This may include humiliation, harassment, threats of punishment or deprivation, intimidation, demeaning or derogatory communication (e.g., vocal, written, gestures or any other similar acts that do not meet the definition of emotional or psychological abuse).		**Location of the reportable event**: **If other, please specify:** **Address where the reportable event occurred:**
☐	Person's whereabouts are unknown and could be in a dangerous situation for self or others. This event is reportable if the whereabouts of the member are unknown for 60 minutes or more if the absence is unusual. This absence can be reportable for a shorter time if specified in the person's patient-centered specialty practice (PCSP) or behavior support plan (BSP) or is a known risk as specified in the person's PCSP or the BSP. Reporting that a member's whereabouts are unknown is in addition to, and not a substitute for or priority over, actively looking for the member and contacting law enforcement if necessary.		
☐	Minor vehicle accident not resulting in injury that requires face-to-face medical treatment by someone other than a lay person		
☐	The person is a victim of fire.		

☐	Medication variance resulting in the need for observation, which may include the need to seek practitioner care or advice, but does not require face-to-face medical treatment (including treatment by provider's trained medical staff, physician services, emergency assistance or transfer to an acute inpatient facility for stabilization) because there is no injury or probable risk of serious harm. Variance involving: ☐ Medication omission ☐ Wrong drug ☐ Wrong dose ☐ Wrong person ☐ Wrong time ☐ Wrong rate ☐ Wrong preparation ☐ Wrong route of administration		
☐	There is an unsafe environment (cleanliness/hazardous conditions not otherwise expected in the environment).		
☐	The deliberate misplacement, exploitation or wrongful, temporary or permanent use of belongings or money valued at less than $500 (e.g., less than the threshold for misappropriation).		
☐	Use of manual restraint, mechanical restraint and/or protective equipment that has been approved for use in the person's PCSP or BSP, but used incorrectly or other than as intended.	N/A	

	Note: Events determined to be completely outside of an approved PCSP or BSP or intentionally inappropriate or intentionally in violation of guidelines specified in the person's PCSP or BSP shall be considered tier 1 and therefore, tier 1 reporting requirements must be followed.		

Brief description of event

Please include details of the event, such as events leading up to, during and after the event. Please provide as much detail as possible. You may use an additional page if necessary.

Medical records information **Please select the following as applicable to the reportable event.**	
Documentation of worker interview	
Written worker statement	
Copy of provider investigation	
Copy of worker disciplinary actions (counseling, education, disciplinary action or termination if applicable)	
Drug screen	
Documentation of provider follow-up	
Police report	
Adult Protective Services (APS) report	
Child Protective Services (CPS) report	
Details of provider's investigation:	

Details of provider's follow-up actions

☐ Counseling
☐ Education
☐ Disciplinary action
☐ Termination
☐ Drug screen

Provider requesting extension? ☐ Yes ☐ No
According to section 2.15.7.7.4.2 of the *Contractor Risk Agreement*, the MCO may grant one seven-day extension to the provider based on extenuating circumstances out of the provider's control.

If you are requesting an extension, please provide the reason for the extension below. Please include details of all completed actions, as well as the status of the completed actions up to the point of the request for extension. The extension request is due no later than two business days prior to the original due date.

☐ Autopsy pending
☐ APS investigation pending
☐ CPS investigation pending
☐ Police report pending
☐ Other pending

If other, please provide description.

Details of reason of extension

Provider extension approved or denied by MCO: **Date of MCO decision:**

If approved, due date for final investigation report will be due to the MCO in seven days from the original due date.

MCO comments:

MCO review

According to section 2.15.7.7.4.3 of the *Contractor Risk Agreement*, the MCO shall have 30 calendar days from the anchor date to review the provider's investigation. The MCO may request one seven-day extension from TennCare to complete the review process based on extenuating circumstances out of the control of the MCO. The MCO will be required to make one of the following determinations:

- Accept the report
- Submit findings to the provider (sanctions or corrective actions)
- Request additional information from the provider to make a determination: Per section 2.15.7.7.4.3 of the *Contractor Risk Agreement*, the MCO will notify the provider in writing and will have 14 calendar days from the date of such notification to complete a review of the provider's investigation and determine whether to accept or make findings on the report and notify the provider.

For MCO use only
Date review complete:
Name of reviewer:
Contact number:
Review decision: ☐ Report accepted ☐ Corrective action needed — details: ☐ Network manager engaged: ☐ Additional information needed — details:
MCO extension requested:
If yes, date extension request submitted to TennCare:
Reason for MCO extension: ☐ Autopsy report pending ☐ CPS investigation pending ☐ Police report pending ☐ Further MCO review required ☐ APS investigation pending ☐ Other If other, please provide description:
Date form sent to provider: **Date form sent to DIDD (Once review is completed, the MCO must provide a copy to DIDD within seven business days.):** **Signature of reviewer:** _____ **Title:** _____