



Department of Defense INSTRUCTION

NUMBER 6025.20

April 9, 2013

Incorporating Change 1, Effective October 2, 2013

USD(P&R)

SUBJECT: Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas

References: See Enclosure 1

1. PURPOSE. This instruction:

- a. Reissues DoD Instruction (DoDI) 6025.20 (Reference (a)), in accordance with the authority in DoD Directive (DoDD) 5124.02 (Reference (b)).
- b. Implements policy for establishing MM programs within the DCS in accordance with DoDD 1010.10 (Reference (c)), DoDI 6025.13 (Reference (d)), and DoDD 6000.14 (Reference (e)).
- c. Establishes policy, assigns responsibilities, and prescribes uniform guidelines, procedures, and standards for the implementation of clinical case management (CM) in the Military Health System (MHS), for TRICARE beneficiaries including care of the wounded, ill, and injured (WII) in accordance with the authority in Reference (b) and DoDI 1300.24 (Reference (f)).
- d. Defines terms for MM, implements policies, assigns responsibilities, and specifies content for activities within the military treatment facilities (MTF).
- e. Establishes an interdependent MM system between the DCS and purchased care system (PCS) to improve the delivery and the quality of healthcare.
- f. Incorporates and cancels Directive-Type Memorandum 08-033 (Reference (g)).

2. APPLICABILITY. This instruction:

- a. Applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this instruction as the "DoD

Components”).

b. Does not apply to the Veterans Affairs (VA) Federal Recovery Coordination Program (FRCP) or the DoD Recovery Coordination Program (RCP). The FRCP is defined in Veterans Administration Directive 0802 and Veterans Administration Handbook 0802 (References (h) and (i)), and the RCP is covered in Reference (f).

3. POLICY. In accordance with References (c) and (d), it is DoD policy that:

a. MM strategies will be aligned with population health, health promotion, Patient Centered Medical Home (PCMH), and clinical quality improvement initiatives.

b. MM strategies will use accepted MM standards.

c. The MM program outcomes should demonstrate an appropriate balance of healthcare services in the DCS for achieving goals related to access, cost, quality, and readiness.

d. Quality healthcare will be delivered consistently and effectively across the Military Departments and joint medical commands for all TRICARE beneficiaries with minimal fragmentation in service delivery in order to ensure consistent, high quality care for all beneficiaries. DoD MM programs will comply with the standards and procedures established in this instruction.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES

a. Procedures for clinical CM. See Enclosure 3.

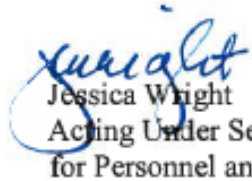
b. Procedures for disease management (DM) and utilization management (UM). See Enclosure 4.

6. RELEASABILITY. **Unlimited**. This instruction is approved for public release and is available on the Internet from the DoD Issuances Website at <http://www.dtic.mil/whs/directives>.

7. SUMMARY OF CHANGE 1. The changes to this issuance are administrative and update organizational titles and references for accuracy.

8. EFFECTIVE DATE. This instruction:

- a. Is effective April 9, 2013.
- b. Must be reissued, cancelled, or certified current within 5 years of its publication to be considered current in accordance with DoDI 5025.01 (Reference (j)).
- c. Will expire effective April 9, 2023 and be removed from the DoD Issuances Website if it hasn't been reissued or cancelled in accordance with Reference (j).



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Enclosures

1. References
2. Responsibilities
3. Procedures for Clinical CM
4. Procedures for DM and UM

Glossary

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REFERENCES

- (a) DoD Instruction 6025.20, "Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas," January 5, 2006 (hereby cancelled)
- (b) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
- (c) DoD Directive 1010.10, "Health Promotion and Disease/Injury Prevention," August 22, 2003
- (d) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011
- (e) DoD Instruction 6000.14, "DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS)," September, 26, 2011
- (f) DoD Instruction 1300.24, "Recovery Coordination Program (RCP)," December 1, 2009
- (g) Directive-Type Memorandum (DTM) 08-033, "Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Service Member in the Military Health System," August 26, 2009, as amended (hereby cancelled)
- (h) Veterans Administration Directive 0802, "Federal Recovery Coordination Program," March 23, 2011
- (i) Veterans Administration Handbook 0802, "Federal Recovery Coordination Program," March 23, 2011
- (j) DoD Instruction 5025.01, "DoD Directives Program," September 26, 2012, as amended
- (k) Title 32, Code of Federal Regulations
- (l) Public Law 104-191, "Health Insurance Portability and Accountability Act of 1996," August 21, 1996
- (m) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003
- (n) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
- (o) Defense Health Agency, "Medical Management Guide," October 2009
- (p) Office of the Assistant Secretary of Defense for Health Affairs Memorandum, "Policy Memorandum Implementation of the 'Patient-Centered Medical Home' Model of Care in MTFs," September 18, 2009
- (q) Operation Order 11-20, "Army Patient-Centered Medical Home," January 15, 2011
- (r) Air Force Instruction 44-171, "Patient Centered Medical Home and Family Operations," January 18, 2011
- (s) Bureau of Medicine and Surgery Instruction 6300.19, "Primary Care Services in Navy Medicine," May 26, 2010
- (t) Joint Task Force National Capital Region Medical-M 6025.05, "Patient Centered Medical Home (PCMH)," July 2, 2012
- (u) DoD 8910.1-M, "Department of Defense Procedures for Management of Information Requirements," June 30, 1998
- (v) Section 1611 of the National Defense Authorization Act for Fiscal Year 2008, "Comprehensive Policy on Improvement to Care, Management, and Transition of Recovering Service Members," January 28, 2008
- (w) Executive Order 13426, "Task Force on Returning Global War on Terror Heroes Report to

- the President,” March 6, 2007
- (x) Assistant Secretary of Defense for Health Affairs Policy 08-001, “Implementation of New Medical Expense and Performance Reporting System Codes to Track Case Management Associated with Global War on Terror Heroes,” March 2008
 - (y) Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines, current edition Appendix E¹

¹ This publication can be accessed at: http://www.tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm

ENCLOSURE 2

RESPONSIBILITIES

1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R) will be responsible for MM program management and policy oversight.

2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). Under the authority, direction, and control of the USD(P&R), the ASD(HA):

a. Sets priorities for focusing on MM programs and outcomes measurements as appropriate. MM is a key to improve health outcomes of TRICARE beneficiaries.

b. Ensures that a MM policy is established and monitored in accordance with References (c) and (d) and nationally recognized accreditation organizations; and MM activities meet all applicable confidentiality, privacy, security, and disclosure requirements in accordance with sections 199.15 and 199.17 of Title 32, Code of Federal Regulations (Reference (k)) and Public Law 104-191 (Reference (l)), DoD 6025.18-R (Reference (m)), and DoD 5400.11-R (Reference (n)).

c. Advocates development and dissemination of learning platforms for educational products, decision support tools, and centralized technological applications to assist in identifying targeted populations, training staff, and supporting MM activities.

d. Establishes a standardized methodology for implementing a DCS appeals process that addresses denial of care based on medical necessity determinations in accordance with References (e) and (k) and the Defense Health Agency (DHA) Medical Management Guide (Reference (o)).

e. Ensures Reference (o) provides interpretative MM guidance for the MTFs.

f. Develops and oversees implementation of MHS's MM policies and procedures.

g. Ensures MHS's MM policies and processes are uniformly carried out across the Services and the DoD.

3. SECRETARIES OF THE MILITARY DEPARTMENTS AND JOINT MEDICAL COMMANDERS. The Secretaries of the Military Departments and Joint Medical Commanders:

a. Direct establishment of comprehensive MM programs and implement a system for ongoing evaluation within MTFs.

b. Seek opportunities to coordinate activities and resources related to MM among and within all Military Services.

c. Evaluate MM resources rendered or applied for within the MHS in accordance with the standards in Reference (i), and implement strategies where indicated.

d. Establish a standardized process for reviewing beneficiaries' appeal for reconsideration of denied care before beneficiaries' progress from the MTF to an external review organization.

e. Ensure provision of appropriately qualified staff to successfully execute local MM programs.

f. Ensure the Commanders of MTFs, in the respective Military Departments and Joint Medical Commands:

(1) Incorporate MM principles into an organization-wide, interdisciplinary MM plan to include integrating clinical CM, DM, and UM activities.

(2) Integrate MM programs into PCMH team approach to patient care as outlined in the Office of the Assistant Secretary of Defense for Health Affairs Memorandum (Reference (p)) and in Service and joint command guidance. Army guidance is outlined in Army Operation Order 11-20 (Reference (q)); Air Force (AF) in AF Instruction 44-171 (Reference (r)); Navy in Bureau of Medicine and Surgery Instruction 6300.19 (Reference (s)) and Joint Task Force National Capital Region Medical (JTFCapMed) Instruction 6025.05 (Reference (t)).

(3) Appoint an individual (e.g., MM chief or director) to establish and oversee program activities promoting a targeted, coordinated MM plan for improving access, cost, quality, and readiness.

(4) Follow the established DCS review and appeal process for denial of care determinations based on medical necessity in accordance with References (e) and (o).

(5) Incorporate beneficiary complaints regarding non-medical necessity (benefit) determinations within the MTF's existing grievance process in accordance with References (e) and (n) and local policies regarding patient rights and responsibilities.

(6) Ensure the MM plan identifies and selects at least one clinical process each year for improvement through application of clinical practice guidelines (CPGs).

(7) Develop at least two MM measures and monitor outcomes that support goal attainment outlined in the local business plans.

(8) Demonstrate through MM program outcomes an appropriate balance of healthcare services in the DCS for achieving goals related to access, cost, quality, and readiness.

(9) Promote coordinated MM practice within the MTF and Managed Care Support

Contractors (MCSCs) in accordance with regional policy to ensure uniform and integrated procedures and programs.

g. Establish Service and joint command clinical CM policies and processes to comply with this instruction.

h. Provide effective clinical CM processes and appropriately trained personnel to support TRICARE beneficiaries to include WII throughout the continuum of care from recovery through rehabilitation to reintegration in accordance with References (a) and (o), DoD 8910.1-M (Reference (u)) and section 1611 of the National Defense Authorization Act for Fiscal Year 2008 (Reference (v)), and Executive Order 13426 (Reference (w)).

(1) Education. Clinical case managers must, at least, be either licensed registered nurses (RN) or licensed social workers (SW).

(2) Certification. It is highly recommended that clinical case managers obtain certification by a nationally recognized CM organization.

(3) Basic CM Training. At a minimum, clinical case managers must complete required education and training modules as outlined in Enclosure 3 of this instruction. Training focuses on using a patient-centered approach to clinical CM (including the involvement of beneficiaries and their families in developing an interdisciplinary plan of care), common combat-related injuries for WII, and transition care coordination.

i. Document and track formal training for individuals providing clinical CM services.

j. Establish processes to identify TRICARE beneficiaries, including WII for assignment to clinical CM using the recommended criteria outlined in the Reference (o). TRICARE beneficiaries or WII who meet the following criteria should be considered for clinical CM services:

(1) High-risk, multiple, complex conditions or diagnoses.

(2) Catastrophic, extraordinary conditions (e.g., serious head injury, spinal cord injury, traumatic amputation, visual impairment, post-traumatic stress disorder (PTSD), and cancer).

(3) Requirements for extensive coordination of resources and services.

(4) Complex psychosocial or environmental factors (family or military obligations) that impact the ability to achieve health or maintain function.

(5) In addition to the criteria in paragraph j(1)-(4), the categories, listed in the Table, of WII should be considered for clinical CM services as outlined in Reference (f).

Table. Service Member Care Coordination Categories

Category 1 (CAT 1)	<ul style="list-style-type: none"> • Has a mild injury or illness • Is expected to return to duty within a time specified by his or her Military Department • Receives short-term inpatient medical treatment or outpatient medical treatment and or rehabilitation
Category 2 (CAT 2)	<ul style="list-style-type: none"> • Has a serious injury or illness • Is unlikely to return to duty within a time specified by his or her Military Department • May be medically separated from the military
Category 3 (CAT 3)	<ul style="list-style-type: none"> • Has a severe or catastrophic injury or illness • Is highly unlikely to return to duty • Will most likely be medically separated from the military

k. Establish the following clinical CM processes to improve the care provided to TRICARE beneficiaries including WII as they transition along the entire continuum of care in all settings in accordance with References (o), (v), and (w).

(1) Identify and appropriately monitor TRICARE beneficiaries receiving clinical CM services.

(2) Identify and evaluate measurable patient and program outcomes. Refer to examples outlined in Reference (o).

(3) Monitor the timeliness of intake and transfer transitions.

(4) Facilitate continuity of care and a smooth and seamless transition for TRICARE beneficiaries in clinical CM transferring from DCS, PCS, MHS care to VA care among multiple Service and joint command-level settings, inter- or intra-TRICARE regional transfers, between commands, between facilities, from one hospital to another, one level of care to another, and from overseas to stateside.

(5) Facilitate continuity of care and a smooth and seamless transitions for TRICARE beneficiaries across the continuum of care with clinical and non-clinical case managers to include but may not be limited to the:

(a) VA liaisons for healthcare.

(b) Federal recovery coordinators (FRCs).

(c) MCSC case managers.

(d) MTF clinical case managers.

(e) Operation ENDURING FREEDOM /Operation IRAQI FREEDOM /Operation NEW DAWN (OEF/OIF/OND) case managers.

(f) VA specialty care case managers.

(g) Recovery care coordinators (RCCs).

(6) Monitor the effectiveness of clinical CM systems and interoperability with all Service and joint command personnel systems. Service and joint command-specific clinical CM services will be interoperable with apparent seamlessness for TRICARE beneficiaries to include WII service and their families.

1. Develop and deploy comprehensive performance measures to monitor appropriate and effective provision of clinical CM services to TRICARE beneficiaries to include provision of care for the WII. Reports will include, but are not limited to:

(1) Total number of clinical case managers.

(2) Number and percentage of clinical case managers who have completed required training.

(3) Number of patients receiving clinical CM services.

(4) Acuity and or case-mix.

m. Monitor procedures for clinical CM data capture, documentation, and monthly administrative summary reporting, in accordance with ASD(HA) Policy 08-001 (Reference (x)), which is outlined in Military Health System Coding Guidance: Professional Service and Specialty Coding Guidelines (Reference (y)).

n. Direct the Service Surgeon Generals and joint commanders to provide to the ASD(HA) their implementing instructions, to include:

(1) Education and Training. Description of competency based orientation program and ongoing education and training opportunities; mechanism for tracking individuals meeting training requirements.

(2) A Process to Identify WII and Other TRICARE Beneficiaries Requiring Clinical CM Services. Brief description of the process used to identify WII and other TRICARE beneficiaries requiring clinical CM services (include description for beneficiary identification or case finding, case screening, and case selection as described in Reference (o) and applicable Military Service and joint command-specific policies).

(3) Military Service and Joint Medical Command-Specific Clinical CM. Provide a brief description of the process for implementing and documenting (e.g., Armed Forces Health Longitudinal Technology Application (AHLTA) and Alternate Input Method Form 6-step CM

process (assess, plan, implement, coordinate, monitor, and evaluate)). Outline the clinical CM coordination of care within and between the Military Services, joint MTFs, MCSC, and the Veterans Health Administration (VHA). Describe how handoffs occur and what mechanism is in place to ensure TRICARE beneficiaries are monitored as they transition across the continuum of care.

4. DIRECTOR, DHA. Under the authority, direction, and control of the USD(P&R), through the ASD(HA), the Director, DHA:

a. Promotes coordination of MM activities and liaison with MM representatives at the Service level, TRICARE regional offices, single and multi-service market offices, MTFs, and MCSCs through support of the following:

(1) Communicates and disseminates policies and other information related to MM (e.g., decision support tools).

(2) Deploys information management tools to support the provision of effective and efficient MM services that are to be utilized at all MTFs in accordance with Reference (g).

(3) Coordinates MM education and training activities within the local and regional areas.

(4) Provides the training platform and programs to facilitate system-wide accomplishment of MHS-specific MM education and training.

b. Provides overall MHS monitoring of the effectiveness of clinical CM.

(1) Facilitates aspects of clinical CM for TRICARE beneficiaries that need to be performed by the MCSC's clinical case managers to include:

(a) Coordination with MHS clinical case managers when beneficiaries require CM outside the DCS.

(b) Coordination with MHS clinical case managers when beneficiaries require transfer of clinical CM services from DCS to PCS or PCS to DCS.

(2) Monitors comprehensive DoD system-wide performance measurements to ensure appropriate and effective provision of clinical CM services in the MHS. Based upon Military Department and National Capital Region (NCR) Medical Directorate input, monitoring data will include, but not be limited to:

(a) Total number of clinical case managers.

(b) Number and percentage of clinical case managers who have completed required training.

- (c) Number of patients receiving clinical CM services.
- (d) Acuity and or case-mix.

(3) In coordination with the Military Departments through the Surgeon General CM Service leads and the Joint Medical Commands through the NCR Medical Directorate, identify opportunities to unify Military Department efforts in the area of clinical CM services for TRICARE beneficiaries to include WII that will result in a comprehensive DoD-wide systems approach to clinical CM.

(4) The NCR Medical Directorate will ensure compliance with this instruction by their assigned Military Treatment Facilities.

ENCLOSURE 3

PROCEDURES FOR CLINICAL CM

1. PROCEDURES FOR CLINICAL CM OVERVIEW

a. MTF MM programs will utilize clinical CM to manage the healthcare of TRICARE beneficiaries to include WII with multiple, complex, chronic, catastrophic illness or known conditions when care is provided exclusively within the DCS.

b. Clinical case managers will provide care coordination for TRICARE beneficiaries requiring special assistance (e.g., children, elderly, WII), including discharge planning for those in need.

c. MTF clinical case managers will coordinate with the MCSC's clinical case managers when TRICARE beneficiaries require clinical CM outside the DCS. The MCSC clinical case manager will perform clinical CM activities for TRICARE beneficiaries whose care is provided, or projected to be provided, in whole or in part, outside the MTF, including coordination of intra- and interregional transfers.

d. Clinical case managers will facilitate care continuity for TRICARE beneficiaries receiving clinical CM by coordinating care with other MTF MM personnel as needed.

e. Clinical case managers proactively coordinate care for families within the Exceptional Family Member Program Medical (EFMP), also referred to as Special Needs Identification and Assignment Coordination, to ensure services are available and in place when an EFMP family arrives at a new duty station.

f. Clinical case managers will coordinate with the PCMH team in communicating and integrating care for patients who require care coordination of services over and above what is normally offered in a PCMH based on patient acuity (to include patients who are high risk and high utilizers of healthcare in both the DCS and PCS) and other needs at the direction of the primary care manager.

2. PROCEDURES FOR CLINICAL CM EDUCATION AND TRAINING

a. Clinical case managers will complete the following required education and training modules. Modules 1-6 and 8-11 can be assessed through the MHS Learn CAC enabled website: https://sso.csd.disa.mil/amserver/UI/Login?org=cac_pki&goto=https%3A%2F%2Fmhslearn.csd.disa.mil%3A443%2Flearn%2Fen%2Flearner%2Fmhs%2Fportal%2Fmhsstaff_login.jsp&shown_banner=true

(1) CM Module 1.

- (2) TRICARE Fundamentals.
- (3) Military Medical Support Office.
- (4) Traumatic Brain Injury Course.
- (5) PTSD: Module 'What is PTSD.'
- (6) Impacts of Deployment.

(7) Clinical decision support tools. Clinical decision support tools are contract specific and have password protected access. Clinical case managers need to contact Service or joint command points of contact to access this training.

- (8) VHA Overview.
- (9) Introduction to the Integrated Disability Evaluation System for Case Managers.
- (10) DoD Recovery Coordination Program.

b. Document and track formal training completed by clinical case managers.

3. PROCEDURES FOR CLINICAL CM DATA CAPTURE AND DOCUMENTATION.

Clinical case managers will use established codes in order to track TRICARE beneficiaries to include WII receiving clinical CM services and to develop and deploy performance measures.

a. Clinical case managers will document and code their services in AHLTA using DoD established provider specialty codes, Health Insurance Portability and Accountability Act (HIPAA) taxonomy codes, Medical Expense and Performance Reporting System (MEPRS) codes, international classification of diseases diagnosis codes, evaluation and management (E&M) procedure codes, and Healthcare Common Procedure Coding System (HCPCS) codes as outlined in Reference (y). This reference is updated yearly and will contain the most up to date clinical CM coding changes.

b. To document in AHLTA, a provider profile must be established in Composite Health Care System (CHCS) for each clinical case manager.

c. The provider specialty codes and HIPAA taxonomy codes will be used in the clinical case manager's provider profile. These provider specialty codes and their mapping to default HIPAA taxonomy codes will be implemented to separately identify SW case managers and RN case managers.

d. MEPRS codes are utilized as the MHS cost accounting method. The MEPRS Management Improvement Group directed the MEPRS codes will be used to identify case manager time and expenses.

e. Current international classification of disease diagnosis and procedure codes will be utilized for clinical CM services.

(1) Primary Diagnosis. There will be a primary diagnosis code for clinical CM encounters and DoD extender codes to indicate if the patient received clinical CM services during the month, if the patient received ongoing clinical CM services, or no longer required clinical CM services. The primary diagnosis and extender codes will be assigned for clinical CM services as appropriate.

(2) Secondary Diagnosis. If an active duty Service member is WII and or receiving clinical CM services due to a deployment related problem, a secondary diagnosis code will be assigned.

(3) E&M Codes. Clinical CM services are “non-count” and will be assigned an E&M code for all encounters.

(4) HCPCS Codes. The HCPCS codes will be used to assign a level of acuity for each beneficiary receiving CM services.

(5) Procedure Codes. A procedure code combined with units of service will be used by all clinical case managers to document time spent on clinical CM activities for the reported encounter.

f. Clinical case managers will:

(1) Report clinical CM services during each documented clinical CM encounter.

(2) Use currently established diagnosis, E&M, acuity, and procedures codes each time they see a patient receiving clinical CM services.

ENCLOSURE 4

PROCEDURES FOR DM AND UM

1. DM. The MTF's MM plan will establish, implement, and integrate the following DM processes in accordance with the information and guidelines described in Reference (o). The plan must:

- a. Assess the population to determine the need for specific DM programs by evaluating health data of the MTF's population through available information systems.
- b. Utilize evidence-based tools, such as VA/DoD CPGs, as specified in Service or joint command policy or after designated local MTF authorities have reviewed and approved them, when implementing the DM program.
- c. Develop and implement DM for the PCMH team and positively impact their enrolled patients' disease and chronic condition outcomes in accordance with applicable CPGs, support staff protocols, and or clinical decision support tools.
- d. Coordinate, communicate, and collaborate with other members of the MTF healthcare team, and MCSC MM staff as necessary, to ensure continuity of care for patients with chronic illness.
- e. Provide information and tools that empower patients and establish self- management techniques that enhance shared decision making skills.
- f. Continuously evaluate program processes and identify areas for modification and improvement.
- g. Develop and deploy comprehensive performance measures to monitor appropriate and effective provision of DM services to TRICARE beneficiaries to include Service-specific Healthcare Effectiveness Data and Information Set (HEDIS) measures.

2. UM. The MTF's MM plan will establish, implement, and integrate the following UM processes in accordance with nationally recognized accreditation organizations information and guidelines. The plan must:

- a. Use systematic, data driven processes to proactively identify and improve clinical and business outcomes, as well as define target populations for focused interventions.
- b. Incorporate applicable utilization review (UR) activities in accordance with nationally recognized accreditation organizations.

- (1) Use the same generally accepted standards, norms, and criteria to review the quality,

completeness, and adequacy of healthcare provided within the MTF, as well as its necessity, appropriateness, and reasonableness.

(2) Establish procedures for conducting reviews, including identification of types of healthcare services for which preauthorization or concurrent review will be required.

(3) Adhere to the established standardized DCS appeal process for resolving beneficiaries' request for reconsideration of MTF denials of care based on medical necessity determinations in accordance with References (e) and (o). After following the directed methodology for appeals, the MTF will also adhere to its respective Service or joint commands' process for intermediate notification, if any, prior to progressing from the internal to external level of appeals.

c. Adhere to the MHS and Military Department's or Joint Medical Commands' referral management policies to manage internal and external referrals.

(1) Incorporate UM strategies as part of the referral management center's routine processes.

(2) Ensure processes monitor, manage, and optimize demand or capacity (access).

d. Ensure coordination and communication among all MM staff, including clinical and business personnel, to assure efficient, effective, quality care and services.

e. Collaborate with the PCMH team to develop performance measures and processes for clinically important conditions, as determined by the PCMH teams and MTF leadership. These clinically important conditions should include but may not be limited to high -cost, high-volume, or problem-prone diagnoses, procedures, services, and beneficiaries that utilize healthcare at higher rates than average and who may benefit from intervention and more intense care coordination.

GLOSSARYPART I. ABBREVIATIONS AND ACRONYMS

AF	Air Force
AHLTA	Armed Forces Health Longitudinal Technology Application
ASD(HA)	Assistant Secretary of Defense for Health Affairs
CAT 1	Category 1
CAT 2	Category 2
CAT 3	Category 3
CHCS	Composite Health Care System
CM	case management
CPG	clinical practice guidelines_
CRP	Comprehensive Recovery Plan
DCS	Direct Care System
DHA	Defense Health Agency
DM	disease management
DoDD	DoD Directive
DoDI	DoD Instruction
E&M	evaluation and management
EFMP	Exceptional Family Member Program
FRC	federal recovery coordinator
FRCP	Federal Recovery Coordination Program
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
JTFCapMed	Joint Task Force National Capital Region Medical
MCSC	Managed Care Support Contractors
MEPRS	Medical Expense and Performance Reporting System

MHS	Military Health System
MM	medical management
MTF	military treatment facilities
NCR	National Capital Region
OEF/OIF/OND	Operation ENDURING FREEDOM/Operation IRAQI FREEDOM/Operation NEW DAWN
PCMH	Patient Centered Medical Home
PCS	purchased care system
PTSD	post-traumatic stress disorder
RCC	recovery care coordinator
RCP	Recovery Coordination Program
RN	registered nurses
RSM	recovering Service members
RT	recovery team
SW	social workers
TMA	TRICARE Management Activity
UM	utilization management
UR	utilization review
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
VA	Veterans Affairs
VHA	Veterans Health Administration
WII	wounded, ill, and injured

PART II. DEFINITIONS

These terms and their definitions are for the purpose of this instruction.

care coordination. Care coordination uses a broader social service model that considers a patient's psychosocial context (e.g., housing needs, income, and social supports). It is a process

used to assist individuals in gaining access to medical, social, educational, and other services from different organizations and providers and coordinate the continuum of care for those beneficiaries whose needs exceed routine disposition planning but who do not meet requirements for long-term clinical CM.

clinical CM A collaborative process under the population health continuum that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's healthcare needs through communication and available resources to promote quality, cost effective outcomes.

clinical case manager. A clinical case manager uses a collaborative process under the population health continuum to assess, plan, implement, coordinate, monitor, and evaluate options and services to meet an individual's health needs through communication and available resources to promote quality, cost effective outcomes. The MCSC clinical case manager delivers CM to TRICARE beneficiaries in the region where they reside who meet the CM criteria outlined by the regional MCSC, receive the majority of their healthcare in the PCS system, and accept the offered services. The MTF clinical case manager delivers CM to TRICARE Prime enrolled beneficiaries who meet the criteria outlined in this document and by the Services or Joint Medical Commands, receive the majority of their healthcare in the DCS, and accept the offered services. The VA OEF/OIF/OND case manager (Master's prepared RN or SW) provides CM services to eligible OEF/OIF/OND veterans at VA healthcare facilities. WII OEF/OIF/OND Service members and veterans with polytrauma, spinal cord injury, blindness or traumatic brain injury diagnoses may have a specialty care case manager. Specialty care case managers have unique expertise in treating and case managing patients in a specific specialty care area. The VA developed the concept of a VA lead case manager who assumes responsibility for coordinating care, communicating with the healthcare team, and serves as a central communication point for the veteran and his or her family. Non-OEF/OIF/OND Service member or veterans needing CM services are provided by SW or RNs in primary care or specialty areas.

CPGs. Systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances. CPGs define the role of specific diagnostic and treatment modalities in the diagnosis and management of patients. The statements contain recommendations based on evidence from a rigorous systematic review and synthesis of the published medical literature.

DCS. Hospitals and clinics that are operated by military medical personnel.

disease manager or DM specialist. A healthcare professional that uses a collaborative approach in identifying patient and disease specific education and care needs, to provide comprehensive, patient-centered, proactive strategies promoting prevention, health, and wellness concepts that support the provider's Plan of Care. In the DCS, the disease manager delivers DM services to Prime enrolled TRICARE beneficiaries at the MTF. The DM specialist in PCS provides individualized, one-on-one telephonic education and resource health information services designed to empower the beneficiary to better self-manage their disease and communicate with their provider.

DM. An organized effort aimed at achieving desired health outcomes in populations with prevalent, often chronic, diseases from which healthcare delivery is subject to considerable variation. DM programs use evidenced-based guidelines, to provide information and tools in promoting self-management activities with MHS Quadruple Aim goals of increasing patient and provider satisfaction and improving clinical and financial outcomes, while advocating the appropriate utilization of resources.

FRCP. A joint program of DoD and VA designed to assist severely WII post 9/11 Service members, veterans, and their families with access to care, services, and benefits provided through the various programs in DoD, VA, other federal agencies, States, and the private sector. Eligibility for FRCP is not dependent upon the geographic location where the injury or medical diagnosis occurred or was made.

FRC. Master's prepared RN or licensed clinical SW who is assigned to a severely WII Service member and veteran. The FRC is stationed at either at a MTF, VA Medical Center or Wounded Warrior Program and serves as the constant point of contact for severely WII Service members, veterans, and their families ensuring that the Service members and veteran's clinical and non-clinical needs are met. The FRC initiates and maintains the Federal Recovery Individual Recovery Plan. The FRC ensures that:

The appropriate clinical and non-clinical case managers are engaged at the right time to achieve a Service member's or veteran's goals.

The Service member, veteran, or family is never alone in meeting access challenges or managing system barriers.

Systemic barriers to care and services are resolved at both the individual and system level.

The FRC engagement with the client is related to the clients' needs and goals. Clients remain enrolled in the program as long as there is a perceived need and benefit to the client.

HEDIS. A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 75 measures across 8 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis.

joint medical command. Connotes activities, operations, organizations, etc. in which elements of two or more Military Departments participate.

medical manager. Individual assigned by the MTF or joint commander to establish and oversee MM program activities (CM, DM, and UM) promoting a targeted, coordinated MM plan for improving access, cost, quality, and readiness. In smaller MTFs, this individual may also perform any of the MM program activities.

MHS Quadruple Aim. The ultimate goal for the MHS, the MHS Quadruple Aim, represents the

MHS leadership's commitment to delivering value to all they serve and is aligned with the MHS strategic goals and value proposition to include:

Readiness: Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.

Population Health: Improving the health of a population by encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience.

Experience of Care: Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.

Per Capita Cost: Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

MM. An integrated managed care model that promotes UM, clinical CM, and DM programs as a hybrid approach to managing patient care. It includes a shift to evidenced-based outcome-oriented UM, and a greater emphasis on integrating CPGs into the MM process, thereby holding the system accountable for patient outcomes.

multi-service market office. Links area Tri-Service facilities in a given TRICARE area to form an integrated network under one health plan to optimize healthcare delivery.

PCS. Civilian hospitals or clinics or physician or provider offices where healthcare is provided to TRICARE beneficiaries.

RCC. The DoD Service Specific Wounded Warrior Program RCC serves as the recovering Service members' (RSM) non-medical point of contact on the multidisciplinary recovery team (RT) to help the RSM define and meet their individual goals for recovery, rehabilitation, and reintegration. Have primary responsibility for development of the Comprehensive Recovery Plan (CRP), in conjunction with the RT, and assist the commander in overseeing and coordinating the services and resources identified in the CRP. Ensure, in coordination with the Secretary of the Military Department concerned, that the RSM and family and or designated caregiver have access to all medical and non-medical services throughout the continuum of care. An RCC is assigned to CAT 2 and CAT 3 RSMs as described in the Table of this instruction and others as defined by the Service Wounded Warrior Programs. The RCC is the expert on identifying services and resources needed to help RSMs achieve their identified goals. The RCC ensures that the RSM and family get all the non-medical support they need to include: communicating with the RSM and the RSM's family or other individuals designated by the RSM regarding non-medical matters that arise during the recovery, rehabilitation, and reintegration of the RSM; assisting with the oversight of the RSM's welfare and quality of life: assisting the RSM in resolving problems involving financial, administrative, personnel, transitional, and other matters that arise during the recovery, rehabilitation, and reintegration of the RSM. The RCC

minimizes delays and gaps in treatment and services for the RSM.

UM. A methodology that addresses the issue of managing the use of resources while also measuring the quality of the care delivered. UM is an organization-wide, interdisciplinary approach to balancing cost, quality, and risk concerns in the provision of patient care. UM is an expansion of traditional UR activities to encompass the management of all available healthcare resources, including referral management.

utilization manager. Provides UM activities and functions by using MTF-specific quality improvement processes to identify areas for review from data, suspected problem areas, and input from departments or services within the facility. The utilization manager prioritizes accordingly based on high dollar, high volume or problem prone diagnoses. The utilization manager:

Identifies gaps between desired and actual program outcomes and develops an action plan to fix gaps.

Determines effectiveness of the plan and continually evaluates the impact of implementation.

Incorporates applicable utilization review tasks to ensure patients receive the right care, at the right time, in the right place, with the right provider, at the right cost.

Collaborates with staff, facility departments, and outside agencies to determine the best, most cost-efficient care.

VA liaison for healthcare. The VA liaison for healthcare (RN or SW) facilitates the transfer of ill or injured active duty, National Guard or Reserve Service members from the MTF to a VA healthcare facility closest to their home or most appropriate for the specialized services their medical condition requires. VA liaisons collaborate with military case managers to identify treatment needs and obtain referral information in order to coordinate this care at the VA.