



Department of Defense INSTRUCTION

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USD(P&R)

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

- References:
- (a) DoD Directive 1010.10, "Health Promotion and Disease/Injury Prevention," August 22, 2003
 - (b) DoD Directive 6025.13, "Medical Quality Assurance (MQA) in the Military Health System (MHS)," May 4, 2004
 - (c) DoD Directive 6000.14, "Patient Bill of Rights and Responsibilities in the Military Health System (MHS)," July 30, 1998
 - (d) Standards from the Joint Commission on Accreditation of Healthcare Organizations, current edition
 - (e) through (h), see Enclosure 1

1. PURPOSE

This Instruction:

1.1. Implements policy for establishing Medical Management (MM) programs within the Direct Care System (DCS) according to References (a) through (c). Military Treatment Facilities (MTFs) are responsible for Utilization Management (UM), Case Management (CM), and Disease Management (DM) programs. Appropriate MM is critical since it impacts the MTF's ability to meet business plan goals.

1.2. Defines terms for MM, implements policies, assigns responsibilities, and specifies content for component activities within the MTFs.

1.3. Codifies support for an interdependent MM system between the direct and purchased care systems to improve the delivery and the quality of healthcare.

2. APPLICABILITY

This Instruction applies to the Office of the Secretary of Defense, the Military Departments, the Chairman of the Joint Chiefs of 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 Department of Defense (hereafter referred to collectively as the “DoD Components”).

3. DEFINITIONS

3.1. 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:

3.1.1. Assist individuals in gaining access to medical, social, educational, and other services from different organizations and providers.

3.1.2. Coordinate the continuum of care for those beneficiaries whose needs exceed routine discharge planning but who do not meet requirements for long-term CM.

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

3.3. Clinical Practice Guidelines (CPG). Systematically developed, evidence-based, and nationally recognized statements to assist practitioners and patients in making decisions about appropriate healthcare services for specific clinical circumstances.

3.4. DM. An organized effort to achieve desired health outcomes in populations with prevalent, often chronic diseases, for which care practices may be subject to considerable variation. DM programs use interventions that are evidence-based to direct the patient's plan of care. DM programs also equip the patient with information and a self-care plan to manage one’s own wellness and prevent complications that may result from poor control of the disease process. The term condition management is also used to include non-disease states, such as pregnancy or childhood developmental disorders, or other temporary changes to health status.

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

3.6. UM. An organization-wide, interdisciplinary approach to balancing cost, quality, and risk concerns in the provision of patient care. UM is an expansion of traditional utilization review (UR) activities to encompass the management of all available healthcare resources, including referral management.

4. POLICY

In accordance with References (a) and (b), it is DoD policy that:

4.1. MM strategies should be aligned with population health, health promotion, and clinical quality improvement initiatives.

4.2. MM strategies will use generally accepted standards.

4.3. The MTF shall incorporate MM principles into an organization-wide, interdisciplinary MM plan.

4.3.1. The MM plan will incorporate UM, CM, and DM into an integrated program.

4.3.2. 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.

4.4. The MM program will support decision making, planning, and education and training to achieve and sustain data analysis, cost containment, cultural and behavioral changes, and continuous quality improvement.

5. RESPONSIBILITIES

5.1. The Assistant Secretary of Defense for Health Affairs (ASD(HA)), under the Under Secretary of Defense for Personnel and Readiness, shall:

5.1.1. Set priorities for focusing on MM programs and outcomes measurements.

5.1.2. Ensure that an MM policy is established and monitored according to References (a) and (b) and the Standards from the Joint Commission on Accreditation of Healthcare Organizations (Reference (d)) and MM activities meet all applicable confidentiality, privacy, security, and disclosure requirements according to title 32, Code of Federal Regulations, Sections 199.15 and 199.17, and Public Law 104-191 (References (e), (f), and (g)).

5.1.3. Advocate 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.

5.1.4. Establish a standardized methodology for implementing a DCS Appeals Process, which addresses denial of care based on medical necessity determinations according to References (c), (e), and (f).

5.1.5. Issue a Medical Management Guide (Reference (h)) providing interpretative guidance for the MTFs.

5.2. The Secretaries of the Military Departments shall:

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

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

5.2.3. Evaluate MM resources rendered or applied for within the MHS according to the standards in Reference (d), and implement strategies where indicated.

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

5.2.5. Ensure provision of appropriately qualified staff to successfully execute local MM programs. Employment should be based on locally developed job descriptions.

5.2.6. Ensure that Commanders of MTFs, in the respective Military Departments of their Services, shall:

5.2.6.1. 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.

5.2.6.2. Follow the established DCS Review and Appeal Process for denial of care determinations based on medical necessity according to Reference (e) and the Medical Management Guide (Reference (h)).

5.2.6.3. Incorporate beneficiary complaints regarding non-medical necessity (benefit) determinations within the MTF's existing grievance process according to References (c) and (h) and local policies regarding patient rights and responsibilities.

5.2.6.4. Ensure the MM plan identifies and selects at least one clinical process each year for improvement through the application of CPGs.

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

5.2.6.6. Promote coordinated MM practice within the MTF and between the MTF and Managed Care Support Contractors (MCSCs) in accordance with regional policy to ensure uniform and integrated procedures and programs.

5.3. The Director, TRICARE Management Activity (TMA), under the ASD(HA), shall ensure that the TRICARE Area Offices (TAOs) and TRICARE Regional Offices (TROs) ensure availability of personnel to serve as MM liaisons with the TMA, Single and Multi-service Market Managers, MTFs, and MCSCs through support of the following:

5.3.1. Communicate and disseminate policies and other information related to MM (e.g., decision support tools).

5.3.2. Coordinate MM education and training activities within the local/regional areas.

6. PROCEDURES

The MTF's MM plan will establish, implement, and integrate the following processes according to information and guidelines described in the MM Guide (Reference (h)).

6.1. UM

6.1.1. Use systematic, data-driven processes to proactively identify and improve clinical and business outcomes, as well as define target target populations for focused interventions.

6.1.2. Incorporate applicable UR activities according to Reference (d).

6.1.2.1. Use the same generally accepted standards, norms, and criteria to review the quality, completeness, and adequacy of health care provided within the MTF, as well as its necessity, appropriateness, and reasonableness.

6.1.2.2. Establish procedures for conducting reviews, including identification of types of healthcare services for which preauthorization or concurrent review shall be required.

6.1.2.3. 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 (c) and (h). After following the directed methodology for appeals, the MTF will also adhere to its respective Service's process for intermediate notification, if any, prior to progressing from the internal to external level of appeals.

6.1.3. Adhere to the MHS and Military Department's referral management policies to manage internal and external referrals.

6.1.3.1. Incorporate UM strategies as part of the referral management center's routine processes.

6.1.3.2. Ensure processes monitor, manage, and optimize demand/capacity (access).

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

6.2. CM

6.2.1. Utilize CM to manage the health care of beneficiaries with multiple, complex, chronic, catastrophic illnesses or known conditions when care is provided exclusively within the DCS.

6.2.2. Provide care coordination for those individuals requiring special assistance (e.g., children, elderly), including discharge planning for those patients in need.

6.2.3. Coordinate with the MCSC's case managers when beneficiaries require CM outside the DCS. The MCSC case manager will perform CM activities for 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.

6.2.4. Ensure case managers coordinate with other MTF MM personnel as needed to facilitate care continuity for case managed patients.

6.2.5. Proactively coordinate care for families within the exceptional family member program (EFMP) to ensure services are available and in place when an EFMP family arrives at a new duty station.

6.3. DM

6.3.1. Assess the population to determine the need for specific DM programs by evaluating health data of the MTF's population through various information systems.

6.3.2. Use evidence-based tools, such as CPGs, after designated local MTF authorities have reviewed and approved them, when implementing the DM program.

6.3.3. Monitor implementation of CPGs to identify clinical outcomes and practice pattern trends, which can be shared with MTF provider staff.

6.3.4. Coordinate with other MTF and MCSC MM staff as necessary to ensure continuity of care for DM patients.

6.4. Outcomes Management

6.4.1. The Services will assist MTF Commanders in developing and continuously monitoring local MM measures.

6.4.2. Local measures should complement those included in the MHS Standard Metric Set, as those noted in the following subparagraphs.

6.4.2.1. Number of work relative value unit adjusted visits per full-time equivalent provider, per 8-hour days in U.S. MTF primary care clinics.

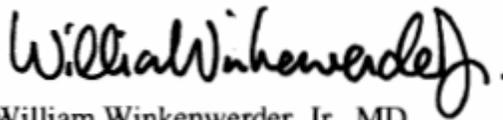
6.4.2.2. Number of bed days per 1,000 enrollees adjusted for demographic mix.

6.4.2.3. Medical cost per member per month adjusted for demographic mix.

6.4.3. Local MM measures are aggregated and incorporated into Service measurement systems, which are included in the HA Balanced Scorecard and monitored by TMA.

7. EFFECTIVE DATE

This Instruction is effective immediately.



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Assistant Secretary of Defense for Health Affairs

Enclosures - 1

E1. References, continued

E1. ENCLOSURE 1

REFERENCES, continued

- (e) Title 32, Code of Federal Regulations, Section 199.15, “Quality and Utilization Review, Peer Review Organization Program”, current edition
- (f) Title 32, Code of Federal Regulations, Section 199.17, “TRICARE Program”, current edition
- (g) Public Law 104-191, “Health Insurance Portability and Accountability Act” (Title II, Sections 261-264)
- (h) Medical Management Guide, January 2006 (available for download on www.dodmedicalmanagement.info)