



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042

IN REPLY REFER TO
BUMEDINST 6300.17A
BUMED-M3
23 Sep 2016

BUMED INSTRUCTION 6300.17A

From: Chief, Bureau of Medicine and Surgery

Subj: NAVY MEDICINE CLINICAL CASE MANAGEMENT

Ref: (a) Case Management Society of America, Standards of Practice, 2016
(b) DoD Instruction 6025.20 of 9 April 2013
(c) TRICARE Management Activity, Medical Management Guide Version 3.0, October 2009
(d) National Defense Authorization Act (NDAA), 2008
(e) National Defense Authorization Act (NDAA), 2013
(f) DoD Instruction 1300.24 of 1 December 2009
(g) DoD Instruction 6010.24 of 14 May 2015
(h) Memorandum of Understanding between Veteran Affairs (VA) and Department of Defense (DoD) for Interagency Complex Care Coordination Requirements for Service Members and Veterans of 29 July 2015
(i) OPNAVINST 1740.6
(j) BUMEDINST 6320.85A
(k) BUMEDINST 6300.19
(l) BUMEDINST 6000.15
(m) Joint Commission Standards
(n) BUMED memo of 31 Jan 2007 (NAV MED Policy 07/004)
(o) H.R. 1538, Dignified Treatment of Wounded Warriors Act of 2007
(p) Deputy Secretary of Defense Memo, OSD 14743-07 of 18 September 2007
(q) Military Health System Professional Services and Medical Coding Guidelines, Appendix E

Encl: (1) Acronyms
(2) Definitions
(3) Case Management Process
(4) Documentation and Coding Guidelines for Clinical Case Management
(5) Case Management Qualifications, Training and Competency Requirements
(6) Case Management Reporting Requirements
(7) Reference Links

1. Purpose. To establish policy and assign responsibilities for the delivery of clinical case management (CM) and complex care coordination within Navy Medicine. This instruction is a complete revision and must be read in its entirety.

2. Cancellation. BUMEDINST 6300.17.

3. Scope. Provisions of this instruction are applicable to all personnel that provide clinical CM services, including clinical case managers (CCM), CM assistants, and any associated health care staff that provide complex care coordination within Navy Medicine.
4. Background. CM is a multifaceted, coordinative process that enhances resource efficiency, optimizes service delivery, and promotes better care and better health for chronically ill, injured, and at-risk patients. Key philosophical components of CM are holistic, patient-centered, and synchronized to ensure effective care coordination, seamless transitions, and continuity of care. CM is a tenant of medical management and supports population health, health promotion, disease management (DM), utilization management (UM), and patient-centered medical home (PCMH) activities. These synergies lead to improved health and performance outcomes within the population, thereby improving the safety and quality of the health care delivery system. References (a) through (q), establish policy, assign responsibilities, and prescribe guidelines, procedures and standards for the delivery of clinical and non-clinical CM services provided to wounded, ill, or injured (WII) Service members, veterans, families, and caregivers. Navy case managers and complex care coordination personnel are expected to support these programs and processes. Enclosures (1) through (6) provide additional guidance. Enclosure (7) is a list of links for the references used in this directive.
5. CM Goals and Objectives. The goals and objectives of CM must be in alignment with the Department of Defense (DoD), Department of Navy (DON), Interagency Care Coordination Committee (IC3), appropriate directive authorities, Bureau of Medicine and Surgery (BUMED), and medical treatment facility (MTF) strategic plans. The goals of CM are to:
 - a. Provide the appropriate level of care (e.g., care coordination, discharge planning, and other CM services) for those individuals requiring special assistance (e.g., WII Service members, children, and/or elderly population).
 - b. Manage the health care of enrolled TRICARE beneficiaries with multiple, complex, chronic, and catastrophic illnesses or known conditions.
 - c. Coordinate transfer of information with the managed care support contractor (MCSC) case managers when patients require care outside the Direct Care System.
 - d. Communicate with other medical management personnel (DM, UM, and referral management).
 - e. Ensure a seamless transition from one duty station to the next for selected family members enrolled in the Exceptional Family Member Program (EFMP).
 - f. Coordinate a warm hand-off between the MTF, the case manager, and the Department of Veterans Affairs (VA) case manager for all Service members transferring to the VA system.
 - g. Enhance continuity of care and decrease fragmentation by providing education, developing strategies, and intervening when required to restore or maintain optimal health.

- h. Ensure Service member and veterans with multiple, complex, severe conditions with complex care coordination needs are assigned to a lead coordinator (LC) per reference (h).
- i. Support interagency complex care coordination processes using a common operational model.
- j. Facilitate timely access to care, treatment, and services and when required transitional support for Service members with complex care needs going through the Disability Evaluation System.
- k. Ensure care, benefits, and services are provided consistently and effectively across the DoD and VA Departments for Service member/veteran, minimizing fragmentation in service delivery in order to ensure consistent high quality care.
- l. Support coordination of CM services for Service members hospitalized in non-naval health care facilities when medical cognizance has been established for the MTF per reference (j).

6. Responsibility

a. BUMED Care Management Program Manager must:

- (1) Provide program direction, oversight, resource acquisition, and coordination.
- (2) Coordinate and develop overarching policy for the delivery of CM within Navy Medicine by:
 - (a) Establishing guidelines for standards of practice.
 - (b) Outlining required training, education, and competency requirements.
 - (c) Establishing standards for documentation and workload management.
 - (d) Ensuring alignment and supporting implementation of IC3 policies, communication strategies and requirements, including joint monitoring of clinical and administrative outcome performance measures per reference (g).
 - (e) Developing process and outcome metrics to accurately report CM activities across the Navy enterprise.
- (3) Coordinate policy development and provide program implementation and oversight for the Navy Medicine aspect of the Recovery Coordination Program.
- (4) Direct and coordinate system-wide standardization, improvements, and quality control for the CM Program.

(5) Serve as subject matter expert for clinical CM.

(6) Serve as the primary liaison to DON and United States Marine Corps Wounded Warrior Programs (Safe Harbor and Wounded Warrior Regiment).

(7) Coordinate with Force Surgeon, Commander, Navy Reserve Forces Command regarding the development and maintenance of a centralized CM program for the Reserve Component WII Service members on Title 10 orders.

(8) Liaise and collaborate with the sister Services, Defense Health Agency (DHA), VA, and TRICARE in the establishment of standardized Tri-Service and interagency programs.

(9) Liaise and collaborate with DHA, civilian organizations, VA, and other DoD activities to establish best practices for CM.

b. Navy Medicine Regional Commanders must:

(1) Ensure the provisions of this instruction are followed.

(2) Provide regional program direction, oversight, resource acquisition, coordination, and subject matter expertise.

(3) Support implementation of MTF CM efforts and interventions in support of Navy Medicine's strategy.

(4) Identify barriers to implementing CM initiatives and report findings to BUMED program manager.

(5) Facilitate collaboration between regional MTFs, TRICARE Regional Office and their respective networks, VA, civilian organizations, DoD warrior care, interagency complex care coordination, and recovery care programs and activities.

(6) Collect, consolidate, and forward regional MTF monthly and quarterly program activity data and CM outcome reports to the BUMED program manager, as outlined in enclosure (6).

c. MTF Commanding Officers and Officers in Charge must:

(1) Monitor and ensure compliance with this instruction within the MTF.

(2) Provide logistical support, staffing, and funding to meet CM Program requirements.

(3) Prioritize the populations to be served by their CM Program based upon BUMED and regional policy, MTF business and strategic plans, and patient population requirements.

(4) Demonstrate an appropriate balance of health care services in the Direct Care System for achieving goals related to access, cost, quality, and readiness through CM program outcomes.

(5) Ensure CM services are delivered in a multi-disciplinary, collaborative manner.

(a) Per reference (k), ensure integration of CM programs into the PCMH team approach.

(b) Ensure EFMP and Disability Evaluation System functions are coordinated with CM functions, when possible.

(c) Ensure training and role-based access to Navy Medicine approved systems (e.g., CarePoint, Composite Health Care System (CHCS), Armed Forces Health Longitudinal Technology Application (AHLTA), Military Health System (MHS) GENESIS, Essentris, Secure Messaging, Clinical Decision Support Technology) to support health care operations. (Note: MHS GENESIS is the new electronic health record (EHR) that will eventually replace CHCS, AHLTA, and Essentris legacy systems. Throughout the rest of this instruction, it will be generically referred to as the EHR with the legacy system in parentheses.)

(d) Promote coordinated CM practice within the MTF and MCSCs per regional policy to ensure uniform and integrated procedures and programs.

(6) Designate a director by appointment letter to establish and oversee CM program activities promoting a targeted, coordinated plan for improving access, cost, quality, and readiness. Per reference (f), CCMs providing services to WII Service members/veterans must be supervised by a military medical staff officer in the grade of O-5 or O-6 or a civilian employee of equivalent grade or higher within his or her medical chain of command.

(7) Collect and forward monthly and quarterly CM data and annual CM outcomes reports to their respective Navy Medicine Region.

(8) Per reference (o), ensure appropriately trained personnel to support the delivery of CM services throughout the continuum of care.

(9) Sustain required CM workload levels.

(10) Ensure proper coordination and reporting between clinical and non-clinical CMs to ensure seamless coordination and execution of the recovering Service member's Interagency Comprehensive Plan (ICP) and LC Checklist.

(11) Provide facilities and appropriate infrastructure to support non-clinical case managers (NCCM) and recovery care coordinators (RCC) servicing recovering Service members at MTFs.

d. MTF CM Department Head/CM Division Officer/CM Lead must:

(1) Ensure CM program activities and standard operating procedures comply with requirements outlined in enclosure (3).

(2) Function as local CM subject matter expert:

(a) Serve as resource/educator and consultant to command about the CM Program.

(b) Educate members of the health care team on CM program benefits and outcomes.

(3) Evaluate local program effectiveness from a clinical, quality, and economic perspective.

(4) Prepare and provide monthly and quarterly program metrics and data activity reports to the region in a timely manner.

(5) Keep MTF commanding officers and officers in charge and higher authorities informed of activities, trends, and issues to include data to be reported to the Navy Medicine Regions.

(6) Supervise CCMs to ensure standards of practice are being met per policy.

(7) Ensure correct CM Health Information Portability and Accountability Act (HIPAA) Taxonomy codes are established in the EHR (CHCS). The EHR should be mapped to the provider specialty codes (Nurse Case Manager – 613; Social Worker Case Manager – 714). See reference (q) and enclosure (4).

(8) Monitor CCM patient assignments, intake and assessment processes, documentation, and transitions of care to ensure safe, efficient, and timely hand-offs.

(9) Identify and appropriately monitor WII Service members receiving CM services per reference (h).

(a) Ensure that an existing member of the Care Management Team (CMT) is assigned as the LC for each Service member/veteran who requires complex care coordination, when applicable. When the Service member is in an inpatient setting, the LC must be assigned to a CCM.

(b) Ensure that Service members/veterans requiring complex care coordination have an ICP and LC Checklist.

(c) Ensure completion and appropriate transfer of the LC Checklist and ICP for complex active duty Service members to another LC or to the VA when the patient is ready for transition.

(10) Provide documentation/peer review oversight of all CCMs to ensure compliance with Navy Medicine CM documentation standards.

(a) New case managers require a monthly documentation/peer review during the first 6 months of hire or assignment to a CM role. The review will consist of a minimum of 10 percent or at least 5 active and/or closed records.

(b) Case managers assigned or hired to a CM role greater than 6 months require a quarterly documentation/peer review. The review will consist of a minimum of 10 percent or at least 5 active and/or closed records.

(c) Documentation/peer review reports must be maintained by the department head or program supervisor for a period of 4 years. The NAVMED 6300/18 Case Management Documentation Review form may be utilized.

(11) Promote development and utilization of population based performance measures to ensure appropriate and effective implementation of clinical CM.

(12) Monitor the effectiveness of program interoperability with all Service personnel systems. Service-specific CM programs must be interoperable with apparent seamlessness for the WII Service member.

(13) Ensure all training and competencies are completed, as required.

e. Case Managers must:

(1) Screen and provide CM services to beneficiaries who meet eligibility criteria. Referrals/CM requests will be reviewed within 24 hours or 1 business day of receipt and documentation acknowledging receipt and review will be completed in the EHR consult order per local guidance.

(2) Obtain and document consent on NAVMED 6317/2 Clinical Case Management & Care Coordination Program Patient Consent Form to provide CM services from the patient or legal caregiver or guardian prior to acting on the patient's behalf and place in the EHR.

(3) Ensure WII Service members receive appropriate CM services.

(a) After receiving written consent, consult with WII Service member's chain of command and CMT to validate his or her needs.

(b) Participate in base housing inspections, as required per reference (p). CCMs will not conduct the inspection, but will ensure scheduling to accommodate the member's needs, appointments, and physical limitations and provide insight and recommendations to the housing inspector on pertinent medical and special physical requirements so that the housing being provided is safe, accessible, and facilitates the care and recovery of the Service member.

(c) Refer category (CAT) 2 and CAT 3 patients to Service warrior care programs for RCC assignment consideration per reference (f) and (i).

(d) Assume LC responsibilities for each Service member/veteran who requires complex care coordination per reference (h), when applicable.

1. Serve as the primary point of contact for Service members/veterans and their families or caregivers for coordination of care, benefits, and services. Apply criteria for complex care coordination and perform the responsibilities and procedures as delineated in reference (h).

2. Ensure that Service members/veterans requiring complex care coordination have an ICP and LC Checklist.

3. Collaborate with CMT members to ensure Service members/veterans and any designated family member(s) or caregiver(s) participate in the ICP.

4. Facilitate warm hand offs (person-to-person, verbal communication providing continuity of care and a seamless transfer of information) and transitions to other CCM, non-CCM, health care provider, MCSC CM, LC, RCC, and/or Joint Recovery Coordinator (JRC) or Federal Recovery Coordinator (FRC), when there is a transfer of care to other levels or places of care (another medical facility, agency, or a VA facility) for additional treatment and follow-up.

5. Ensure completion and appropriate transfer of the LC Checklist and ICP for complex active duty Service members to another LC, when the Service member/veteran is ready for transition.

(4) Provide CM services for enrolled beneficiaries requiring special assistance (e.g., WII children, elderly, EFMP) including discharge planning as needed, throughout the continuum of care.

(5) Coordinate with primary care manager (PCM) teams to provide care coordination services according to CM caseload and acuity. When CM caseloads dictate, PCM teams are required to retain responsibility for low acuity care coordination per reference (k).

(6) Utilize Secure Messaging and teleconferencing, when feasible to communicate with CM enrolled patients and other health care professionals.

(7) Document care provided in the patient's electronic medical record as required in enclosure (4).

(8) Actively participate in CM meetings, such as discharge planning meetings, multi-disciplinary rounds, PCMH huddles, and administrative meetings with BUMED, respective region and MTF.

(9) Register in Joint Knowledge Online, SWANK Learning Management System, and the McKesson Clinical Decision Support Tool and complete all training and competency requirements outlined in enclosure (5) within 3 months of hire or assignment to CM or complex care coordination. Complete updated training and new requirements within 30 days of release.

(10) Conduct CCM peer reviews, when assigned.

7. CM Workload Management. Determining standard caseloads is a challenge due to a complexity of factors across diverse CM settings. In addition, rapid changes in the medical management field (e.g., the integration of UM and DM into CM functions) and the increase in complex, condition management strategies have added to those complexities. Per reference (c), the caseload for CM is determined by the intensity of involvement by the case manager, frequency of interventions, and case acuity. In order to prevent case manager burnout, maintain quality of CM services, and ensure MTFs are adequately staffed with case managers, the following guidance will be followed:

a. The recommended standard number of cases to be managed by each case manager is 50 or less, of which no more than 17 can be classified as seriously ill or injured (SII) or very seriously ill or injured (VSI) Service members (i.e., CAT 2 and CAT 3). Evaluation of the number of cases to be managed by each case manager can be modified, where indicated, by the Case Management Department Head/Leadership or higher authority.

b. Each CM program must be able to identify patients actively engaged in CM services and their caseload per case manager or team.

c. CM reports are required per references (b), (d), and (e) and will be submitted to the BUMED CM program lead as specified in enclosure (6).

8. Records Management. Records created as a result of this instruction, regardless of media and format, must be managed per SECNAV M-5210.1 of January 2012.

9. Review and Effective Date. Per OPNAVINST 5215.17A, this instruction will be reviewed annually on the anniversary of its effective date to ensure applicability, currency, and consistency with Federal, DoD, Secretary of the Navy, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will automatically expire 5 years after effective date unless reissued or canceled prior to the 5-year anniversary date, or an extension has been granted.

10. Information Management Control. The reports required in this instruction paragraphs 6a(2)(e), 6b(6), 6c(7), 6d(4), 6d(5), and 7c are exempt from reports control per SECNAV M-5214.1 of December 2005, part IV, paragraph 7j and 7k.

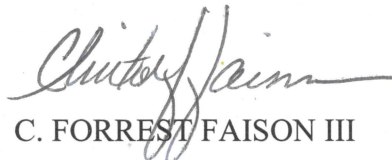
11. Forms

a. The DD Form 2870 Authorization for Disclosure of Medical or Dental Information is available at: <http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm>.

b. OPNAV 5215/40 Review of Instruction is available at:
<https://navalforms.documentservices.dla.mil/web/public/home>

c. The following NAVMED Forms are available at:
<http://www.med.navy.mil/directives/Pages/NAVMEDForms.aspx>.

- (1) NAVMED 5353/16 Substance Abuse Rehabilitation Program.
- (2) NAVMED 6300/13 Inter/Intra-Regional Transfer Documentation Active Duty Service Member (ADSM) Medical Treatment Facility.
- (3) NAVMED 6300/14 Transfer Documentation MHS Eligible/Non-Active Duty Service Member (Non-ADSM) Medical Treatment Facility.
- (4) NAVMED 6300/16 Case Management Discharge Planning Assessment.
- (5) NAVMED 6300/17 Checklist for Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) Patient's Medical Treatment Facility.
- (6) NAVMED 6300/18 Case Management Documentation Review.
- (7) NAVMED 6317/1 Tri- Service Case Management Competencies.
- (8) NAVMED 6317/2 Clinical Case Management & Care Coordination Program Patient Consent Form.


C. FORREST FAISON III

Releasability and Distribution:

This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site:

<http://www.med.navy.mil/directives/Pages/BUMEDInstructions.aspx>

ACRONYMS

ADSM	Active Duty Service Member
AHLTA	Armed Forces Health Longitudinal Technology Application
AIDS	Acquired Immune Deficiency Syndrome
AIM	Alternate Input Method
BUMED	Bureau of Medicine and Surgery
CAT	Category
CCM	Clinical Case Manager
CCMC	Commission for Case Management Certification
CHCS	Composite Health Care System
CM	Case Management
CMT	Care Management Team
COOP	Contingency of Operations
CPT	Current Procedural Terminology
DHA	Defense Health Agency
DM	Disease Management
DoD	Department of Defense
DON	Department of Navy
E&M	Evaluation and Management
EFMP	Exceptional Family Member Program
EHR	Electronic Health Record
HAIMS	Health Artifact and Image Management Solution
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Information Portability and Accountability Act
HIV	Human Immunodeficiency Virus
IC3	Interagency Complex Care Coordination
ICD-10	International Classification of Diseases, 10 th Revision
ICP	Interagency Comprehensive Plan
JRC/FRC	Joint Recovery Consultant/Federal Recovery Coordinator
LC	Lead Coordinator
MCSC	Managed Care Support Contractor
MEPRS	Medical Expense and Performance Reporting System
MHS	Military Health System
MHSPHP	Military Health System Population Health Portal
MMSO	Military Medical Support Office
MTF	Medical Treatment Facility
NCCM	Non-Clinical Case Manager
OIF/OEF/OND	Operations Iraqi Freedom/Enduring Freedom/New Dawn
PCM	Primary Care Manager
PCMH	Patient Centered Medical Home
PTSD	Post-Traumatic Stress Disorder
RCC	Recovery Care Coordinator
RN	Registered Nurse

SADR	Standard Ambulatory Data Record
SII	Seriously Ill or Injured
SMART	Specific, Measureable, Achievable, Realistic, and Timely
SW	Social Worker
TBI	Traumatic Brain Injury
TSWF	Tri-Service Work Flow
UM	Utilization Management
U.S.	United States
VA	Department of Veterans Affairs
VSI	Very Seriously Ill or Injured
WBT	Web-Based Training
WII	Wounded, Ill, or Injured

DEFINITIONS

1. AHLTA. Legacy electronic health record used for documentation of outpatient care.
2. 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 discharge planning, but who do not meet requirements for complex care coordination or CM.
3. CM. A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.
4. CMT. The CMT includes individuals who are working together to manage, coordinate, and/or deliver the care, benefits, and services for the Service member/veteran or other eligible beneficiaries and to support the family or caregiver. The professions and individuals who comprise a specific CMT will vary based on the needs of the individual and their family or caregiver (e.g., health care provider(s), attending physician, nurse case manager, therapist, social worker (SW), vocational rehabilitation specialist, command representative, and all others providing care, benefits, and services, including military or community resources). The most appropriate CMT member already providing health care, benefits, or services, will serve as the LC and direct complex care coordination efforts for Service members/veterans with complex care coordination needs.
5. Caregivers. For Service members, a caregiver is an individual who renders to an eligible Service member services to support activities of daily living and specific services essential to the safe management of the beneficiary's condition. For veterans, a caregiver is a person who provides personal care services to a veteran because the veteran is either unable to perform an activity of daily living or needs supervision or protection based on symptoms or residuals of neurological or other impairment or injury. For criteria applicable to VA's Caregiver Programs, see 38 CFR Part 71. For other beneficiaries, caregivers are any individual who provide similar support with activities of daily living.
6. Catastrophic WII. In general, a permanent, severely disabling wound, illness, injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that a Service member/veteran requires personal or mechanical assistance to leave home or bed, or requires constant supervision to avoid physical harm to self or others. For active duty Service members, this wound, injury, or illness would make it highly unlikely that the Service member will return to duty and will most likely be separated from the military. VA has unique definitions of similar terms for specified purposes in statute and regulation.

7. CCM. A CCM uses a collaborative process under the population health continuum to assess, plan, implement, coordinate, monitor, reassess, refer, and evaluate options and services to meet an individual's health and psychosocial needs through communication and available resources to promote quality, cost effective outcomes (CMSA, 2010). The following are examples of CCMs:

a. The MCSC CCM 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 health care in the purchased care system, and accept the offered services.

b. The MTF CCM 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 health care in the Direct Care System, and accept the offered services.

c. The VA Operations Iraqi Freedom/Enduring Freedom/New Dawn (OIF/OEF/OND) case manager (Master's prepared registered nurse (RN) or SW) provides both clinical and non-clinical CM services to eligible OIF/OEF/OND veterans at VA health care facilities. OIF/OEF/OND Service members/veterans with polytrauma, spinal cord injury, blindness, or traumatic brain injury diagnoses may have a specialty care case manager. Non-OIF/OEF/OND Service members/veterans needing CM services can also receive services from SWs or RNs in primary care or specialty areas.

d. Other specialty care case managers have unique expertise in treating and case managing Service members/veterans and other eligible beneficiaries in a specific specialty care area.

8. Complex Care Coordination. Complex care coordination involves assisting the most severely WII Service members/veterans, or those Service members/veterans with complex circumstances. The Service members/veterans that meet the criteria for complex care coordination, are expected to have a prolonged recovery or rehabilitation process, and may require access to clinical, social, educational, financial, and other services across various organizations and providers. The objective of the interdisciplinary complex care coordination team model for Service members/veterans is to establish and optimize the use of an ICP and the resulting application of care, benefits, and services, including military and community resources, to facilitate and promote the Service member's/veteran's recovery or return to as high a level of function as achievable. Complex care coordination can also apply to other eligible beneficiaries who encounter catastrophic injury, illness, or complex circumstance.

9. Essentris. The inpatient electronic documentation system used by the MHS.

10. EFMP. Works with other civilian and military agencies to provide comprehensive and coordinated medical, educational, housing, community support, and personnel services to families with special needs. EFMP ensures sponsors are assigned to those areas where the specialized medical and educational needs of the family member can be met.

11. IC3. A committee for governance established under the Congressionally mandated Joint Executive Committee to implement, maintain, and oversee the provision of IC3 of WII Service members/veterans per with VA-DoD Warrior Care Coordination Task Force recommendations and the IC3 Charter.
12. ICP. The ICP is a Service member/veteran-centered recovery or rehabilitation plan with identified goals for recovery and rehabilitation to ongoing care and community reintegration. The plan is developed from a comprehensive need assessment, which identifies the recovering Service member's/veteran's personal and professional needs and goals with input from their family or caregivers and the services and resources needed to achieve them through specific activities in those key areas, which were reviewed during assessment.
13. JRC/FRC. JRCs or FRCs are assigned to Service members/veterans who require complex care coordination. Their responsibilities include providing clinical and non-clinical assistance and advice about DoD, VA, community, and other resources available to support the ICP. It is unlikely that they will serve as the LC because they provide longitudinal consultation services and assistance to the CMT, the Service member/veteran, and the family or caregiver. JRCs or FRCs may also participate in less severe cases when consulted by the LC. This is not a new position, but rather describes the role of existing personnel who carry out these functions, as appropriate. JRCs or FRCs may or may not be located where the Service member/veteran is receiving care, benefits, or services.
14. LC. The LC is a role for an existing member of the CMT who, while fulfilling their responsibilities of their primary role, assumes responsibility for coordinating the development and overseeing execution of the ICP, but the LC is not responsible for the actual delivery of care beyond their scope of practice. The LC facilitates communication and serves as the primary point of contact to the Service member/veteran and family or caregiver, as well as the rest of the CMT, in order to avoid or reduce confusion. LC can be clinical or non-clinical, and are co-located with the recovering Service member/veteran when feasible.
15. MHS GENESIS. MHS GENESIS is the new EHR being implemented across the MHS Enterprise to document inpatient and outpatient medical and dental care. MHS GENESIS will eventually replace CHCS, AHLTA, and Essentris.
16. NCCM. The NCCM will ensure the recovering Service member/veteran and family or caregiver receive all the non-clinical support they need and/or to which they are entitled. The NCCM role includes: communicating with the Service member/veteran and with the Service member's/veteran's family or other individuals designated by the Service member/veteran regarding non-clinical matters that arise during the care, recovery, and transition of the Service member/veteran; assisting with oversight of the Service member's/veteran's welfare and quality of life; assisting the Service member/veteran in resolving problems involving financial, administrative, personnel, transitional, and other matters that arise during the care, recovery, and/or transition of the Service member/veteran.

17. PCM. A health care provider who oversees and coordinates the general, preventive, diagnostic, and therapeutic care for a particular patient.

18. Secure Messaging. A system for asynchronous communication/coordination between patients and providers, providers and consultants, and between Medical Home Port team members. Secure Messaging allows team members to receive and respond to preventive health care communication; broadcast messaging/announcements, and minor problem management messages from patients.

19. SII. In the case of a member of the Armed Forces, including a member of the National Guard or Reserves, this means a wound, illness, or injury incurred by the member while on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating. It is unlikely that a Service member with this type of wound, illness, or injury will return to duty in a time specified by his or her Military Department and may require medical separation from the military. This includes TBI, psychological trauma, or other mental disorder, incurred or aggravated in the active military, naval or air service that renders the individual in need of personal care services.

CASE MANAGEMENT PROCESS

The CM process is carried out within the ethical and legal realm of a case manager's scope of practice, using critical thinking and evidence-based knowledge. The following overarching themes in the CM process include several steps that are iterative, cyclical, and recursive in nature and applied until the patient's needs and goals are met.

The following process outlines steps for carrying out CM within Navy Medicine:

1. Patient Identification

- a. Focuses on identifying beneficiaries who would benefit from CM services.
- b. Sources for the identification of eligible CM patients can include, but are not limited to:
 - (1) Admission and disposition lists (MTF and MCSC)
 - (2) Daily inpatient census (MTF and MCSC)
 - (3) EHR (AHLTA/CHCS) ad hoc reports (e.g., readmissions, long-term patient, pharmacy usage, etc.)
 - (4) Military Health System Population Health Portal (MHSPHP)/Care Point
 - (5) Navy/Marine Corps Wounded Warrior reports
 - (6) Emergency department/urgent care rosters
 - (7) Medical Transition Company (Active Duty) and Medical Hold (Reserve) units
 - (8) Medical claims, (i.e., multiple visits to an emergency department)
 - (9) Communications with multi-disciplinary and care management teams after daily inpatient ward rounds
 - (10) Communication with EFMP coordinators
 - (11) Communication with LC
 - (12) Communication with limited duty coordinators
 - (13) Referrals from the following sources:
 - (a) PCM or specialty care providers (network or non-network).

- (b) Patient (self-referral)
- (c) Family/significant other/caregiver
- (d) UM, DM, and/or discharge planners
- (e) Non-medical/medical case managers such as:
 - 1. RCC
 - 2. FRC
 - 3. JRC
 - 4. NCCM
- (f) Wounded Warrior Program representatives
- (g) CM Service Referrals

1. CM referrals must be provided in writing and screened within 24 hours or 1 business day of receipt. If a written referral is not feasible, one should be requested from the PCM stating where the referral originated. In cases of self-referral, the screening can be completed ahead of time and written into the order acting as the notification to the PCM.

2. Referrals not meeting criteria for receiving CM services will be referred back to the originator of the referral with a written explanation outlining why criteria was not met along with suggested alternatives for addressing the beneficiary's need(s). Documentation will be done within the review comments of the consult order in the EHR (CHCS).

3. Provide non-medical referrals for CAT 2 and CAT 3 Service members/veterans to the appropriate service specific warrior program.

2. Patient Selection Process for CM

a. MTFs must utilize the following high-risk screening criteria to assess enrolled beneficiaries for inclusion in CM.

b. Navy Medicine requires that beneficiaries in any of the following categories, regardless of health status must be screened for CM:

- (1) WII Service members who meet the following criteria:

(a) CAT 1

1. Has a mild injury or illness
2. Is expected to return to duty in less than 180 days
3. Receives primarily local outpatient and short-term inpatient medical treatment and rehabilitation

(b) CAT 2

1. Has a serious injury or illness
2. Is unlikely to return to duty in less than 180 days
3. May be medically separated from the military

(c) CAT 3

1. Has a severe/catastrophic injury or illness
2. Is highly unlikely to return to duty
3. Will most likely be medically separated from the military

- (2) Multiple medical providers
- (3) Catastrophic illnesses or injury
- (4) Chronic or terminal illness
- (5) Multiple, complex medical problems/dual diagnosis (medical and psychiatric)
- (6) Lack of family/social support
- (7) Non-adherence to treatment
- (8) Multiple emergency department visits
- (9) Transplant, high-risk or high-cost
- (10) Special interest
- (11) Functional/physical deterioration

- (12) Frequent utilization of health care resources and services
- (13) Readmissions
- (14) High-risk obstetrics
- (15) Human Immunodeficiency Virus (HIV)/Acquired immune deficiency syndrome (AIDS)
- (16) Severe burns
- (17) History of mental illness or substance abuse, suicide risk, or crises intervention
- (18) Requires extensive coordination of resources and services
- (19) Poor pain control
- (20) Low functional status or cognitive deficits
- (21) Social issues such as a history of abuse, neglect, or no known social support
- (22) Need for admission or transition to a post-acute facility or another treatment facility

3. Consent for CM Services

- a. Patient participation in CM is voluntary.
- b. Case managers will obtain written consent utilizing NAVMED 6317/2 to provide CM services from the patient or their legal representative prior to acting on the patient's behalf.
- c. If written consent cannot be obtained due to a patient's inability to be physically present, the case manager will document verbal consent in the EHR and obtain a written consent at the first opportunity. A witness must be present and sign verifying verbal consent was provided.
- d. A copy of the written consent will be placed in the patient's electronic health record.

4. Authorization for Disclosure of Medical or Dental Information

- a. Patients enrolled in CM must complete and sign a DD Form 2870 Authorization for Disclosure of Medical or Dental Information at the start of CM services or prior to the case manager discussing their case or conducting a warm handoff to a non-covered entity such as an RCC, NCCM, or FRC.

b. An authorization to disclose is valid for 1 year from the date signed, if the beneficiary does not enter a date in Block 10. The maximum limit otherwise is 3 years.

c. This authorization will not apply to alcohol, substance abuse, or mental health. Use NAVMED 5353/16 Substance Abuse Rehabilitation Program in these cases or refer to Legal for additional information.

d. A copy of the form(s) will be placed in the patient's electronic health record.

5. Assessment

a. The assessment is a systematic, ongoing process of collecting comprehensive bio-psychosocial information about a beneficiary's situation (including all relevant sources, military and civilian) to identify needs. This phase of the CM process begins after the completion of the case selection and occurs intermittently, as needed, throughout the case.

b. A complete and full health and psychosocial assessment is documented and completed within 3 business days of accepting the patient into CM.

c. The assessment will include, but is not limited to the following areas for determining CM needs:

- (1) Demographic information
- (2) Physical/functional
- (3) Medical history
- (4) Health status
- (5) Psychosocial status
- (6) Vocational and or educational information
- (7) Spiritual and cultural
- (8) Current/projected resource utilization
- (9) Community/social support systems
- (10) Health risk assessment
- (11) Home/environment assessment

- (12) Patient's health goals
- (13) Caregiver(s) capability and availability
- (14) Self-care-capability
- (15) Health literacy and illiteracy
- (16) Transition, military separation, or discharge plans
- (17) Advance care planning
- (18) Legal, financial, or military concerns
- (19) Readiness to change

6. Problem/Opportunity Identification and Care Planning

a. In this phase, the case manager identifies patient problems that could benefit from CM intervention, prioritizes the needs, establishes goals for the intervention, and determines the type of services and resources that are available in order to address the established goals or desired outcomes.

b. When creating a care plan, the case manager should identify immediate, short-term, long-term, and ongoing needs, as well as develop appropriate and necessary CM strategies and goals to address those needs. The ICP should be leveraged to identify goals and objectives for Service members/veterans requiring complex care coordination.

c. Beneficiaries meeting CM criteria or needing care coordination for greater than 30 days will have the following care plan requirements:

(1) Complete an initial care plan within 7 days and a comprehensive multidisciplinary care plan within 30 days of the initial assessment.

(2) The care plan should be designed to meet the patient's assessed needs for health care and/or services, safety, access to care, quality of care, and identify immediate patient support systems as well as actual and potential resources.

(3) Ensure the comprehensive care plan includes: Specific, Measureable, Achievable, Realistic, and Timely (SMART) goals, actions and specified time frames.

(4) Care plan goals, actions, and timelines should be agreed upon by the case manager, the patient, and the family and/or caregiver, if involved.

(5) A copy of the written care plan must be provided to the patient.

d. Beneficiaries not meeting CM criteria will be referred back to their PCM with suggested alternatives.

7. Implementation and Coordination of Care Activities

a. In this phase, the case manager puts the care plan into action and employs ongoing assessment and documentation to measure the patient's response to the plan of care.

b. Implementation is a process of executing interventions identified in the plan of care that will lead to accomplishing/achieving the stated goals.

(1) Communicate with the patient, family, or caregiver to assure their understanding of the care plan as well as their critical role in the care plan.

(2) Communicate the care plan to the health care team members and when indicated, the RCC, LC, or CMT for inclusion into the ICP.

(3) Document ongoing collaboration, treatment progress and any modifications of the plan in the electronic health record, as appropriate.

c. Coordination of care activities involves organizing, securing, integrating, and modifying resources necessary to accomplish the care plan goals. This step is critical to:

(1) Problem-solving and conflict resolution

(2) Avoiding duplication of services

(3) Ensuring timely and appropriate provision of services

(4) Identifying barriers to care delivery and exploring alternatives

(5) Matching patient needs with available resources

(6) Optimizing health care resources in the MHS, TRICARE, and VA communities to address targeted needs

(7) Organizing and managing the activities outlined in the care plan

(8) Supplying the patient with information and resources necessary to make informed decisions

(9) Coordination with the TRICARE regions, wounded warrior programs, RCC, FRC, LC, JRC, NMCM, VA Medical Facilities, DHA-Great Lakes (formally known as Military Medical Support Office (MMSO)), MCSCs, civilian health care facilities, and any venue where TRICARE beneficiaries receive care.

8. Evaluation of the CM Plan and Follow-up

a. This phase involves monitoring and evaluating the patient's status and goals and the associated outcomes. The case manager should maximize the patient's health, wellness, safety, adaptation, and self-care through quality CM, satisfaction, and cost-efficiency.

b. Evaluation is the process, repeated at appropriate intervals throughout the entire CM process, for determining the plan's effectiveness in reaching the desired outcomes and goals. Evaluation and follow-up validate:

(1) Appropriateness of patient needs and plan of care

(2) Clinical outcomes for efficacy of care

(3) Cost savings and/or cost avoidances for the patient, family, and MTF

(4) Patient and health care team satisfaction

(5) Effectiveness of the CM Program (i.e., Did the patient meet the defined goals? Were the goals realistic? Were the goals measureable? Was the plan cost effective? Was there a return on investment?)

(6) Impact of CM interventions on population health/DM

(7) Stability of the patient/family home environment

(8) Utilization of evidence-based guidelines in appropriate patient populations

9. Termination and/or Transition of CM Services

a. This phase brings closure to the patient/case manager relationship and focuses on discontinuing and/or transitioning CM services. Facilitation, coordination, and collaboration during this phase is critical.

b. Reasons for terminating, discontinuing, or transitioning CM or complex care coordination include:

(1) Achievement of targeted outcomes or maximum benefit reached.

- (2) Change of health setting.
 - (3) Permanent change of station orders, temporary assigned duty orders, and assignment to another MTF.
 - (4) Change of catchment area or PCM, which may result in reassignment of a case manager.
 - (5) Patient request for different case manager and/or LC.
 - (6) Patient request for discontinuation of CM or complex care coordination services.
 - (7) Change in case manager/LC.
 - (8) Loss or change in benefits (i.e., patient no longer meets program or benefit eligibility requirements).
 - (9) Determination by the case manager that he or she is no longer able to perform or provide appropriate CM services (e.g., patient non-adherence to plan of care, inability to reach patient or patient not returning telephone calls).
 - (10) Patient's care needs exceed that of the MTF and is transferred to another level of care to maintain continuity.
 - (11) Patient expires or other conditions make CM or complex care coordination unnecessary
- c. When terminating CM services:

- (1) Document termination of CM services per standards of practice set forth by the Case Management Society of America, per reference (a).
- (2) Documentation should reflect evidence of agreement of termination of CM services by the patient, family or caregiver, case manager, or provider.
- (3) Documentation of both verbal and written notice of termination of management services to the patient, all treating and direct service providers, and members of the care management team will be made in the electronic health record.

d. When transitioning CM services:

- (1) It is the responsibility of the transferring and gaining case managers or LC to ensure a smooth transition when a beneficiary under CM transfers to another facility, region, case manager, or LC.

(2) Prior to transfer, an accepting physician must be identified and agree to accept the patient.

(3) It is highly encouraged to not only identify the accepting physician, but also to obtain an appointment with the identified physician, coordinate the medical record transfer, and communicate the date and time of the appointment to the patient, family, and caregiver before the patient transitions.

(4) If a gaining case manager or LC cannot be identified, the case must be maintained within the originating CM program until one can be identified.

(5) Responsibilities of the case managers or LC during transfer:

(a) Obtain authorization from DHA-Great Lakes for a patient transfer from a civilian hospital to a VA facility.

(b) Obtain authorization from the MCSC for a patient transfer from the MTF to a VA facility.

(c) Obtain the patient's authorization to release protected health information prior to conducting a warm hand-off to a non-covered entity.

(d) Coordinate transfer of information with the MCSC CM staff when patients require care, in whole or in part, outside of the Direct Care System.

(e) Conduct a warm hand-off (person-to person verbal communication providing continuity of care and a seamless transfer of information) to another case manager, LC, NCCM, health care provider, MCSC case manager, RCC, and/or FRC when there is a transfer of care to other levels or places or care (another MTF, medical facility, agency, or a VA facility) for additional treatment and follow up.

(f) Document transitions according to the standards of practice set forth by the Case Management Society of America.

(6) Upon transfer, the transferring case manager or LC communicates with the gaining case manager or LC at the accepting facility and documents the discussion within the CM notes in the patient's electronic health record. The following must be documented:

(a) Diagnosis or medical condition that prompted the need for CM services. Include a summary of the patient's current medical status.

(b) Date of transfer

(c) Reason for transfer

(d) Mode of transfer

(e) Accepting case manager or LC and physician

(f) A brief summary of the care received, medical and nursing care requirements, social and physical needs, services required, follow-up, durable medical equipment, and potential future needs. Include a copy of the discharge summary (if available), explain the patient's administrative requirement (e.g., Physical Evaluation Board) and change in benefits, and forward copies of diagnostic studies as appropriate, explain the patient's administrative requirement (e.g., Physical Evaluation Board), and change in benefits, and forward copies of diagnostic studies, as appropriate.

(7) The transferring case manager or LC responsibilities do not stop until the gaining case manager or LC accepts the responsibility of the patient.

(8) Provide the patient an electronic or hard-copy of CM plan, and any official paperwork pertinent to his or her medical condition or personnel status.

e. The following forms must be used as part of the Contingency of Operations (COOP) Plan if there is no access to the electronic medical record for an extended period of time and entered into the electronic health record once access has been regained. The forms should be used on a routine basis or the contents contained on the forms must be summarized in the CM notes in the electronic health record:

(1) For inter/intra-regional transfers:

(a) NAVMED 6300/13 Inter/Intra-Regional Transfer Documentation Active Duty Service Member (ADSM) Medical Treatment Facility, is to be used for Active Duty Service members.

(b) NAVMED 6300/14 Inter/Intra-Regional Transfer Documentation Active Duty Service Member (NON-ADSM) Medical Treatment Facility is to be used for Non-Active Duty Service.

(2) NAVMED 6300/16 Case Management Discharge Planning Assessment, is to be used for CM discharge planning.

(3) NAVMED 6300/17 Checklist for Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) Patient's MTF, is a precursor to the ICP and is to be used as an interdisciplinary checklist for new complex care coordination cases of WII Service members (i.e., CAT 2 and CAT 3) admitted to an MTF.

DOCUMENTATION AND CODING GUIDELINES
FOR CLINICAL CASE MANAGEMENT

1. Purpose. Provide documentation and administrative coding guidance for Navy Medicine CCM services per reference (q). Appropriate documentation and coding will facilitate data capture required per reference (b), such as:

- a. Number of clinical case managers
- b. Number of beneficiaries receiving clinical CM services
- c. Acuity level of beneficiaries receiving clinical CM services

2. Documentation. Requirements for CM coding are outlined below:

a. Case managers, case manager assistants and complex care coordinators will document all care provided in the outpatient EHR (AHLTA) under the appropriate CM Medical Expense and Performance Reporting System (MEPRS) clinic (ELAN or ELA2) for all face-to-face, telephonic, secure message, or case conference interactions using the most current version of the Tri-Service Work Flow (TSWF) alternate input method (AIM) form for CM. This requirement does not apply to primary care team nurses or other nurses or SWs performing occasional CM as part of their regular assigned duties.

b. Within 72 hours, generate, complete, and sign an EHR (AHLTA) encounter for each patient contact. All entries should be accurate, relevant, timely, and complete.

c. At least once per calendar month, complete an encounter note for all patients continuing CM services.

d. Documentation initiated by a case manager assistant or complex care coordinator will be reviewed by a case manager and co-signed, when required.

e. Each patient note will be coded per guidelines outlined below.

(1) Administrative Coding: Requirements for CM coding are outlined below. HIPAA Taxonomy and Provider Specialty Codes:

(a) Provider Specialty Codes and their mapping to default HIPAA taxonomy codes are utilized to separately identify SW clinical case managers and nurse clinical case managers.

1. HIPAA taxonomy codes are national 10-digit alphanumeric codes that classify health care providers according to the primary services they render.

2. Provider specialty codes are unique codes used to communicate a provider's specialty.

(b) MTF EHR (CHCS) administrators are responsible for ensuring clinical case managers are assigned the appropriate CCM HIPAA Healthcare Taxonomy Code and the EHR CCM Provider Specialty Code based on the description provided in Table 1. Clinical case managers and CCM supervisors should validate that this information is accurately reflected the EHR.

Table 1 – Clinical CCM HIPAA Taxonomy and EHR Provider Specialty Codes

CCM HIPAA Taxonomy	Description	EHR CCM Provider Specialty Code
163WC0400X	Registered Nurse (RN) Clinical Case Manager	613
1041C0700X	Social Worker (SW) Clinical Case Manager	714

(2) System Codes – MEPRS “Clinic”

(a) MEPRS codes are used to identify CCM FTEs and expenses. Note: CCM MEPRS clinics are not physical clinics and do not indicate the CCM is located in a specific office or clinic. According to DoD Coding Guidance, clinical case managers (i.e., RN, and SW case managers) should be documenting CM workload under MEPRS clinic ELAN or ELA2.

(b) MTF EHR administrators are responsible for ensuring clinical case managers are profiled in the appropriate MEPRS clinic. Clinical case managers and CCM supervisors should validate that this information is accurately reflected in the EHR. If an RN or SW provides both CCM and RN/SW services that involve the recording of coded encounters as an embedded member of a PCMH or specialty clinic, the EHR administrator will:

1. Establish a CCM provider profile using the clinical CCM HIPAA Taxonomy and provider specialty code in a CCM MEPRS clinic (ELAN/ELA2) and
2. Establish a RN or SW provider profile using an RN or SW HIPPA Taxonomy and provider specialty code in a PCMH or specialty (BXXX) MEPRS clinic.

Table 2 - Navy CCM MEPRS “Clinic” Codes

Service	Warrior in Transition or Wounded, Ill, or Injured (Other Contingency Funded)	All Other Beneficiaries (MTF Funded)
Navy	ELA2	ELAN

(3) Documentation requirements for patients ‘OPENED IN’ CCM.

(a) A non-count administrative encounters record called a standard ambulatory data record (SADR) is generated with each encounter for each unique patient and CCM. Only RN and SW case managers identified in the EHR with the appropriate CCM HIPPA taxonomy and Provider codes (613/714) should utilize CCM International Classification of Diseases (ICD) Diagnosis codes and document under the CCM ELA2 or ELAN MEPRS “Clinic” codes.

(b) Clinical case managers should ensure that an appropriate CCM ICD-10 diagnosis code for patients ‘Opened in CCM’ is documented first. Table 3 provides CCM ICD diagnosis codes for patients ‘Opened in CCM’.

Table 3 – First Listed ICD Diagnosis Codes for Patients OPENED IN CCM

ICD-10-CCM Code	MHS Description	MHS Use of Code
DOD0301	Clinical CM Start	Relates to the INITIAL CCM encounter
DOD0302	Clinical CM Continue	Relates to all SUBSEQUENT CCM encounters other than Termination encounter
DOD0303	Clinical CM End	Relates to the CCM TERMINATION encounter

(c) Clinical case managers are not required to document secondary diagnoses; however, utilization of the codes identified in Table 4 assists with identification of patients receiving CM services with deployment related conditions. Case managers should NOT utilize ICD-10 codes beginning with A-T to code secondary diagnosis for medical conditions.

Table 4 – Secondary ICD Diagnosis Codes for deployment related conditions

ICD-10-CCM Code	MHS Description	Examples
Z91.82	For Active Duty or retired Service members with deployment related conditions	Relates to Chronic Pain, PTSD, TBI, Feared Medical Conditions, etc.
Z63.31	Spouse/child with concern related to Active Duty Service Member (ADSM) upcoming or current deployment	Relates to bedwetting, depression, insomnia, cutting, etc.
Z63.71	Spouse/child with concerns upon return of Service member from deployment	Relates to headache, stomach pain, anxiety due to adjusting to Service member being back home

(d) The Evaluation and Management (E&M) field for CCM Services for patients ‘OPENED in’ CCM should be left blank when reporting the acuity level of patients.

(e) The clinical case manager assigns one Episode-of-Management current procedural terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Code (G code/acuity level) per encounter for each patient receiving CCM services, in the ‘Procedure 1’ field utilizing the guidance provided in Table 5.

1. Documentation must support the G-code/acuity level selected and reflect the patient’s case--including activities performed under the six steps in the CM process: assessing, planning, implementing, coordinating, monitoring, and evaluating. This includes CM services that might not actually be face-to-face or direct interaction with the patient.

2. A minimum of one Episode-of-Management (G9XXX) Acuity Code must be documented in a calendar month for each patient open in CCM.

Table 5 - CCM Episode-of-Management Acuity Administrative Coding

Acuity Code <i>(Enter in ‘Procedure 1’ field)</i>	Acuity Level	Number of Interventions	Examples
<i>G9002</i>	1	1-2	CM follow-up less than 1 time/week
<i>G9005</i>	2	3-4	CM coordination and follow-up; >2 interventions; 3-4 times/month
<i>G9009</i>	3	5-6	CM coordination and follow-up; up to 4 or more interventions; 1-2 times per week; less than 30 minutes each session
<i>G9010</i>	4	7-8	CM coordination and follow-up; > 6 interventions; 3 times/week; less than 30 minutes each session
<i>G9011</i>	5	>8	Complex CM interventions and follow-up; a minimum of 3 times/week; > 30 minutes each session; significant coordination; may involve daily contact

(4) Documentation for patients receiving CCM Services but NOT opened in CCM – Care Coordination.

(a) Clinical case managers providing care coordination services for patients who are ‘NOT Opened’ in CCM (e.g., one time or episodic care) will document those services utilizing the first listed (Primary) ICD-10 CCM code Z02.89. Table 6 provides additional guidance on the use of the care coordination ICD-10 CCM code.

Table 6 - First Listed ICD Diagnosis Code for Patients NOT opened in CCM

ICD-10-CCM Code	MHS Description	MHS Use of Code
Z02.89	CM, Other and Unspecified <i>[Encounter for other administrative examinations]</i>	Relates to encounters for non-case managed patients (i.e., one time or episodic services from a clinical case manager)

(b) Clinical case managers providing care coordination services only will enter E&M code 99499 under the appropriate ELAN or ELA2 MEPRS clinic so that the coded encounter will transfer to the central MHS data repository.

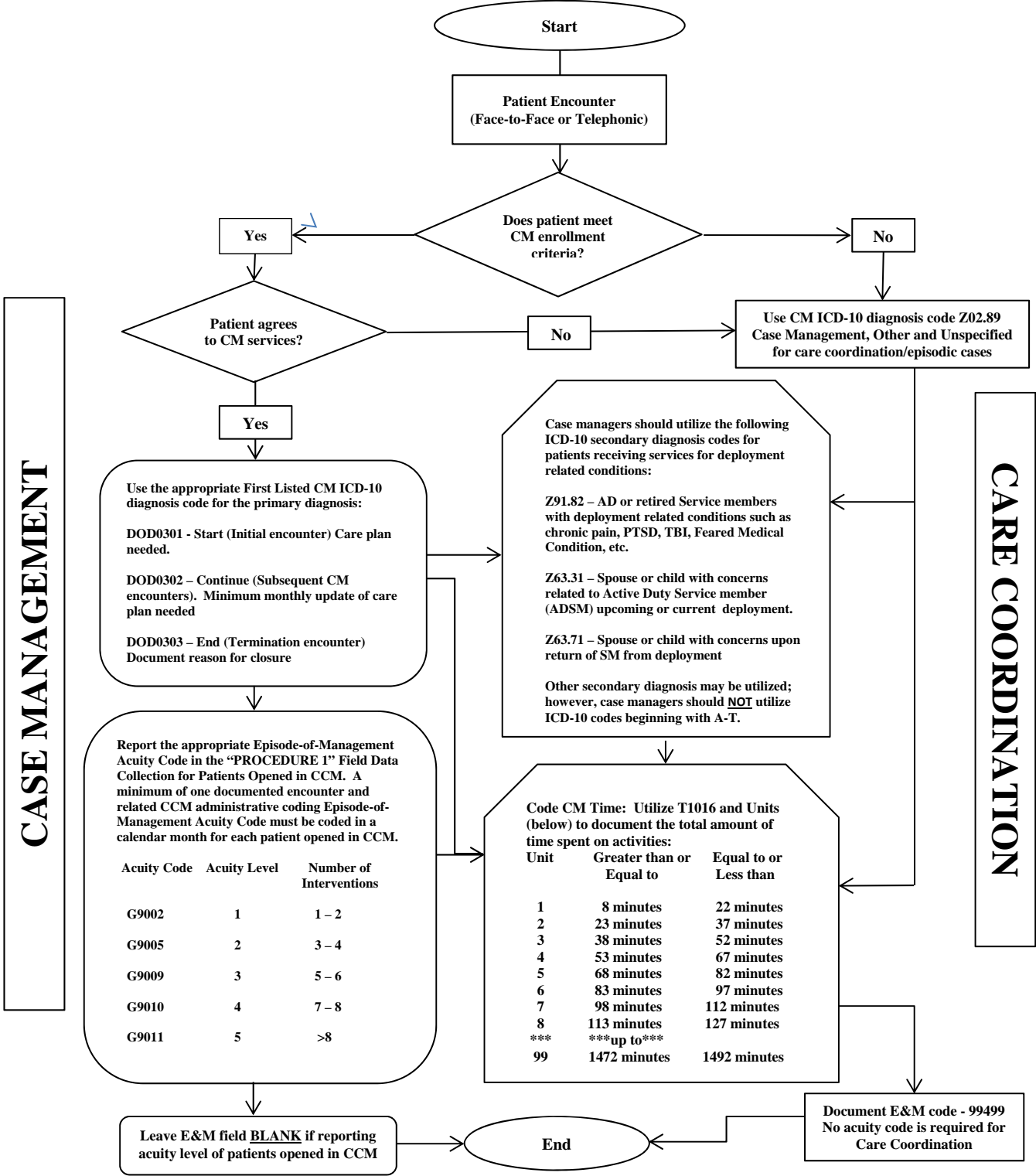
(c) CPT/HCPCS Episode-of-Management Acuity Codes (i.e., G9002, G9005, G9009, G9010, and G9011) are not utilized for patients receiving care coordination services. Episode-of-Management Acuity Codes is only for patients opened in CCM.

(5) HCPCS - Use of Procedure “T1016.” Navy clinical case managers must document time spent on CCM patients, patient representative interaction activities, or care coordination for the reported encounter in 15-minute intervals. Table 7 provides a baseline framework for time-coded data collection and consistent application to collect clinical case manager patient/patient representative interaction time.

Table 7 – T1016 Code

Unit of Service	Greater than or equal to	Equal to or Less than
1	8 minutes	22 minutes
2	23 minutes	37 minutes
3	38 minutes	52 minutes
4	53 minutes	67 minutes
5	68 minutes	82 minutes
6	83 minutes	97 minutes
7	98 minutes	112 minutes
8	113 minutes	127 minutes
...	up to ...	
99	1478 minutes	1492 minutes

NAVY MEDICINE CODING PROCESS FOR CLINICAL CASE MANAGEMENT



CASE MANAGEMENT QUALIFICATIONS, TRAINING
AND COMPETENCY REQUIREMENTS

1. Qualifications. CM personnel must maintain competence in their area(s) of practice.

a. Education

(1) Clinical Case Manager: Must be either a licensed RN or a licensed clinical SW, graduated from a program accredited by a nationally recognized accreditation agency recognized by the U.S. Department of Education and must hold an active, valid, current, and unrestricted license to practice nursing as a RN or to practice social work as a licensed clinical SW in any U.S. State or jurisdiction.

(2) Clinical Case Manager Assistant: May be either a licensed RN, a licensed clinical SW, or licensed practical nurse, graduated from a program accredited by a nationally recognized accreditation agency recognized by the U.S. Department of Education and must hold an active, valid, current, and unrestricted license to practice nursing as a RN or licensed practical nurse or to practice social work as a licensed clinical SW in any U.S. State or jurisdiction.

(3) Complex Care Coordinator: May be either a licensed RN, a licensed clinical SW, or licensed practical nurse, graduated from a program accredited by a nationally recognized accreditation agency recognized by the U.S. Department of Education and must hold an active, valid, current, and unrestricted license to practice nursing as a RN or licensed practical nurse or to practice social work as a licensed clinical SW in any U.S. State or jurisdiction.

b. Training

(1) MTFs must provide appropriately trained case managers, case manager assistants, and complex care coordinators to support all TRICARE Prime beneficiaries, including WII Service members. MTF training programs must offer:

(a) Initial orientation and/or training for all CM staff before assuming assigned roles and responsibilities.

(b) Ongoing training, as needed to maintain professional competency age/population specific and cultural competence.

(c) Training in accreditation requirements, confidentiality, protected health information/personally identifiable information, and records management, as related to job functions.

(d) Organizational structure

(e) Documentation of all training provided

(2) All CM personnel must register in Joint Knowledge Online, the SWANK Learning Management System, and the McKesson Clinical Decision Support Portal and complete all required education and training modules. All case managers must complete required education and training modules that utilize a patient-centered approach to clinical CM (including the involvement of WII Service members and their families in developing an interdisciplinary plan of care), common combat-related injuries, and transition care coordination. A complete list of training requirements is outlined in Table 1 of this enclosure.

(3) Newly hired or assigned case managers must complete all required training within 3 months of hire or assignment.

(4) All case managers must complete refresher training and new training requirements within 30 days of update or course availability.

c. Certification. It is strongly encouraged that clinical case managers become certified in CM within 3 years of hire. The case manager (nurse or SW) has the option to obtain certification by the following organizations:

(1) Commission for CM Certification: The Certified Case Manager.

(2) American Nursing Credentialing Center: The Registered Nurse-Board Certified.

(3) National Academy of Certified Care Managers: Certified Care Manager.

(4) National Association of Social Workers: Certified Social Work Case Manager.

d. Competency

(1) Initial CM competency must be assessed within 3 months of hire or assignment to a care management role. It is recommended that the newly oriented case manager conduct a self-assessment at the beginning of orientation.

(2) Competency reassessment must be conducted at least once every 2 years or more frequently, if required by hospital policy. Re-assessment must demonstrate professional competencies reflecting a sustained ability to assess, plan, document, manage, coordinate, and transition the health care of beneficiaries with multiple, complex, chronic, and catastrophic illnesses or known conditions.

(3) Both the initial competency and competency reassessment must be documented using the approved NAVMED 6317/1 Tri-Service Case Management Competencies and maintained in the case manager's training record.

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(4) Per the Recovery Coordination Program (DoD Instruction 1300.24), clinical case managers will be supervised by a military medical staff officer in the grade of O-5 or O-6 or a civilian employee of equivalent grade or higher within his or her medical chain of command. MTFs are expected to assign staff with the appropriate qualifications, knowledge, skills, and experience to serve as mentors and assess competency for new CM staff.

Table 1. NAVY MEDICINE CASE MANAGER AND CARE COORDINATOR TRAINING AND COMPETENCY REQUIREMENTS

COURSE TITLE	COURSE NUMBER	TRAINING TYPE	COMPLETION REQUIREMENTS					COURSE OVERVIEW	WEB SITE
			Frequency	Requirement	MIL	CIV	CON		
TRAINING									
CM Module 1	US010	Web-Based Training (WBT)	One time	All new CMs and CCs within 3 months of hire or assignment	X	X	X	This course provides an overview of CM, roles and responsibilities.	http://jko.jten.mil
DoD Recovery Coordinator Program	US011	WBT	One time	All new CMs and CCs within 3 months of hire or assignment	X	X	X	This course will provide an overview of the Recovery Coordination Program and provide the ability to identify and list the roles and responsibilities of the Recovery Team members. The course will also provide an overview of the roles and responsibilities of the RCC, medical care case manager (clinical case manager), non-medical care manager and of the Federal recovery coordinator.	http://jko.jten.mil
DHA-Great Lakes (formally known as MMSO)	US012	WBT	One time	Updated course will be required by all CMs and CCs and within 3 months of new hire or assignment	X	X	X	This course will provide an overview of the DHA-Great Lakes and how this office works to support and assist the provision of health care for Tri-service and Coast Guard Service members enrolled in the TRICARE Prime Remote Program; remotely locate Reserve Component members and other eligible Service members.	http://jko.jten.mil
Introduction to DoD Disability Evaluation System for Case Managers	US018	WBT	One time	All new CMs and CCs within 3 months of hire or assignment	X	X	X	This course explains the role of medical care case managers and their collaboration with medical and non-medical personnel who are involved in the Integrated Disability Evaluation System. Scenarios address common CM issues that, when resolved, will result in a more expeditious process for the Service member.	http://jko.jten.mil
Tri-Service Work Flow (TSWF) CM AIM Form Recorded Training	US020	WBT	One time	All new CMs and CCs within 3 months of hire or assignment	X	X	X	This course provides training of the most up-to-date TSWF CM AIM form. The purpose of this form is to capture standardized documentation of CM services across the MHS.	http://jko.jten.mil

**Table 1. NAVY MEDICINE CASE MANAGER AND CARE COORDINATOR TRAINING AND COMPETENCY REQUIREMENTS
(CONTINUED)**

COURSE TITLE	COURSE NUMBER	TRAINING TYPE	COMPLETION REQUIREMENTS					COURSE OVERVIEW	WEB SITE
			Frequency	Requirement	MIL	CIV	CON		
TRAINING									
Psychological Impacts of Deployment: Working with the WII	US025	WBT	One time	All new CMs and CCs within 3 months of hire or assignment	X	X	X	This course increases the learner's awareness of the potential for returning WII Service members and veterans suffering from PTSD, suicidal or homicidal thoughts or behaviors, and other behavioral health concerns. This course will also provide practice assessing the warning signs of problematic post-traumatic disorders.	http://jko.iten.mil
Understanding PTSD	US027	WBT	One time Replaced "What is PTSD?"	New Requirement for all existing CMs and CCs and new CMs and CCs within 3 months of hire or assignment	X	X	X	This course will provide basic information about PTSD and how it is diagnosed. Some explanation as to why some people continue to suffer from PTSD symptoms after a traumatic experience, while others recover without psychological intervention are also addressed. Lastly, this course will also review some comorbid conditions of PTSD.	http://jko.iten.mil
Health Artifact and Image Management Solution (HAIMS)	US049	WBT	One time	All new CMs and CCs within 3 months of hire or assignment	X	X	X	The purpose of this course is to provide users with a brief overview of the HAIMS application, ways through which they can log into the HAIMS application, what to expect when they log in such as Dashboard features and where to view their assigned role(s), and finally an overview of basic HAIMS functionality such as searching for patients and searching for assets. When they have completed this course, they may contact their System administrator or HAIMS account administrator about creating their user account.	http://jko.iten.mil

**Table 1. NAVY MEDICINE CASE MANAGER AND CARE COORDINATOR TRAINING AND COMPETENCY REQUIREMENTS
(CONTINUED)**

COURSE TITLE	COURSE NUMBER	TRAINING TYPE	COMPLETION REQUIREMENTS					COURSE OVERVIEW	WEB SITE
			Frequency	Requirement	MIL	CIV	CON		
TRAINING									
TRICARE Fundamentals Course	US051	WBT or Classroom	One time	All new CMs and CCs within 3 months of hire or assignment	X	X	X	The TRICARE Fundamentals Certification Course is an intense, in-depth review of the TRICARE benefit for MHS staff. The 11 modules in this course cover key concepts, TRICARE programs and options, Guard and Reserve, dental, pharmacy, claims, appeals, and more. There's a pre-test, a 50-question final exam, and a course evaluation	http://jko.iten.mil
Veterans Health Administration Overview	US058	WBT	One time within 3 months of hire or assignment	All new CMs and CCs within 3 months of hire or assignment	X	X	X	This course provides a broad overview of VA initiatives, roles, and responsibilities.	http://jko.iten.mil
TBI for Clinical Case Manager	US059	WBT	One time within 3 months of hire or assignment	All new CMs and CCs within 3 months of hire or assignment	X	X	X	This course presents an overview of TBI issues that primary care practitioners may encounter when providing care to veterans and active duty military personnel.	http://jko.iten.mil
Clinical Decision Support Tool Recorded Webinar: Introduction to InterQual Criteria and Anonymous Review	N/A	WBT	One time	New Requirement for all existing CMs and CCs and new CMs and CCs within 3 months of hire or assignment	X	X	X	This recorded Webinar provides an introduction to the core features of using InterQual Criteria to conduct reviews. This course must be completed before access to the tool will be granted and other Web-based Training can be launched.	http://mckesson.learnflex.net

**Table 1. NAVY MEDICINE CASE MANAGER AND CARE COORDINATOR TRAINING AND COMPETENCY REQUIREMENTS
(CONTINUED)**

COURSE TITLE	COURSE NUMBER	TRAINING TYPE	COMPLETION REQUIREMENTS					COURSE OVERVIEW	WEB SITE
			Frequency	Requirement	MIL	CIV	CON		
TRAINING									
LC Training	N/A	WBT or Classroom	One time	New Requirement for all existing CMs and CCs and new CMs and CCs within 3 months of hire or assignment	X	X	X	This course provides an overview of the LC Concept. At the end of this course students will be able to: 1. State why and how the LC concept was developed. 2. State the definition and purpose of the LC role. 3. Name the tools used by the LC. 4. List the steps in an LC-to-LC transition of care. 5. Describe post-transition of care responsibilities of the LC.	TBD
MHS Population Health Portal Reducing Avoidable Readmissions Care Point	NMETC-16 MHSPHP CarePoint-1.0	WBT	One time	New Requirement for all existing Medical Managers (Case and Utilization Managers) and new CMs and CCs within 3 months of hire or assignment	X	X	X	This course is a comprised of a 3-part video series, which provides information on utilizing MHSPHP Care Point to reduce readmissions rates. By watching the video series, you will learn how to utilize MHSPHP Care Point to: 1. Identify and manage Prime enrollees at high risk for readmission. 2. Analyze top readmission diagnoses and rate data for high-risk patients. 3. Learn about MHSPHP Care Point resources such as High Risk Readmission Registries and Reports.	www.swankhealth.com
Privacy and Personally Identifiable Information Awareness Training	DOD-PII-2.0	WBT	Annually	Required for all medical and clinical staff	X	X	X	Course assignment based on requirements contained in SECNAVINST 5239.3C, NAVADMIN 213/15, and NAVADMIN 166/16	www.swankhealth.com

**Table 1. NAVY MEDICINE CASE MANAGER AND CARE COORDINATOR TRAINING AND COMPETENCY REQUIREMENTS
(CONTINUED)**

COURSE TITLE	COURSE NUMBER	TRAINING TYPE	COMPLETION REQUIREMENTS					COURSE OVERVIEW	WEB SITE
			Frequency	Requirement	MIL	CIV	CON		
TRAINING									
HIPPA and Privacy Act Training	DHA-US001	WBT	Annual	Required for All medical and clinical staff	X	X	X	This course provides an overview of two critical privacy laws - the HIPAA of 1996 and the Privacy Act of 1974 - and discusses how these laws are applicable to the MHS. This training provides high-level regulatory standards that apply the same to operations staff, clinical staff, and senior management.	http://iko.jten.mil
EHR Training (AHLTA/CHCS)	N/A	Classroom MTF	One time within 3 months of hire or assignment	All new CMs/CCs within 3 months of hire/assignment	X	X	X	The content of this course provides an overview of the documentation tools that are available in the EHR. A demonstration on how to use these tools for office visits and telephone consults will be demonstrated. The current legacy system (AHLTA) AIM forms and templates are built around a diagnosis, symptom, or theme. These documentation tools may be shared enterprise-wide and facilitate the documentation process.	<u>MTF (classroom)</u>
COMPETENCIES									
CM Competencies	N/A	N/A	Competency assessment is required within 3 months of new hire or assignment. Reassess at least once every 2 years or more often if required by MTF policy.	New Requirement The new Tri-service competencies are required for all existing CMs and CCs and new CMs and CCs within 3 months of hire or assignment.	X	X	X	Utilize the Final Standardized Tri-service CM Competencies attached. NAVMED 6317/1.	<u>Available on BUMED Web site</u>

CASE MANAGEMENT REPORTING REQUIREMENTS

1. National Defense Authorization Act for Fiscal Year(s) 2008 and 2013 require the Secretary of Defense to collect and report on uniform performance outcomes used by each Military Department. These performance measures, and associated metrics and milestones, are provided to Congress by the Services, per DoD Instruction 6025.20. To assist with this effort Navy Medicine region and MTF commanders are required to submit CM related performance measures and associated metrics for their respective area.

2. CM Caseload and Training Compliance Reports

a. Navy Medicine region commanders are required to collect, validate, and submit the following data for their respective MTFs to the BUMED program manager.

(1) Monthly Report includes:

(a) Total number of case managers by type

(b) Number of patients receiving facility based CM services

(c) Number of active duty personnel referred to and receiving CM services through Service-specific wounded warrior programs (e.g., Navy Safe Harbor, and Marine Corps Wounded Warrior Program)

(d) Acuity

(e) Case-mix

(f) Number of WII Service members receiving CM services

(2) Quarterly Report includes: Number and percentage of case managers, by course name, who have completed required training.

b. Consolidated region reports must be uploaded into the Navy Medicine tasker system by Navy Medicine region commanders using the data reporting forms available in the system:

(1) Monthly reports are due to BUMED Care Management (BUMED-M33) by the 15th day of each calendar month.

(2) Quarterly reports are due to BUMED-M33 by the 10th day of March, June, September, and December.

3. CM Outcome Reports

a. CM program outcomes should be measured based on CM program goals and the MTF's strategic plan. A few examples are listed below, but it is not an exhaustive list by any means:

- (1) Cost effectiveness of CM interventions in achieving goals documented in the care plan.
- (2) Patient activation measure or the readiness to change behaviors in order to maintain health.
- (3) Reduction in complications and readmissions.
- (4) Percentage of patients that were cleared to return to full duty or work.
- (5) Patient and provider satisfaction with CM.
- (6) Percentage of individuals that refused CM services.
- (7) Pain and symptom management.
- (8) Decrease utilization of MTF resources (i.e., emergency department visits, no-show appointments, increase in homecare and hospice, etc.).
- (9) Client compliance with care plan.
- (10) Compliance with evidence-based guidelines.

b. By the 30th day of September each calendar year, each Navy Medicine region is required to submit outcome reports of their respective MTFs to BUMED-M33, Care Management showing the effectiveness of clinical CM.

REFERENCE LINKS

References:

- (a) Case Management Society of America, Standards of Practice, 2016
<http://solutions.cmsa.org/acton/media/10442/standards-of-practice-for-case-management>
- (b) DoD Instruction 6025.20 of 9 April 2013
<http://www.dtic.mil/whs/directives/corres/ins1.html>
- (c) TRICARE Management Activity, Medical Management Guide Version 3.0, October 2009
https://www.qmo.amedd.army.mil/medical_management/MMG_v3_2009.pdf
- (d) National Defense Authorization Act (NDAA), 2008
http://www.gsa.gov/portal/mediaId/184487/fileName/National_Defense_Authorization_Act_2008.action
- (e) National Defense Authorization Act (NDAA), 2013
http://www.dtic.mil/congressional_budget/pdfs/FY2013_pdfs/AUTH_CRPT-112hrpt705.pdf
- (f) DoD Instruction 1300.24 of 1 December 2009
<http://www.dtic.mil/whs/directives/corres/ins1.html>
- (g) DoD Instruction 6010.24 of 14 May 2015
<http://www.dtic.mil/whs/directives/corres/ins1.html>
- (h) Memorandum of Understanding between Veteran Affairs (VA) and Department of Defense (DoD) For Interagency Complex Care Coordination Requirements for Service Members and Veterans of 29 July 2015
<http://www.health.mil/Policies?&query=Complex%20Care%20Coordination>
- (i) OPNAVINST 1740.6 <https://doni.documentservices.dla.mil/default.aspx>
- (j) BUMEDINST 6320.85A
<http://www.med.navy.mil/directives/Pages/BUMEDInstructions.aspx>
- (k) BUMEDINST 6300.19
<http://www.med.navy.mil/directives/Pages/BUMEDInstructions.aspx>
- (l) BUMEDINST 6000.15
<http://www.med.navy.mil/directives/Pages/BUMEDInstructions.aspx>
- (m) Joint Commission Standards <https://www.jointcommission.org/>
- (n) NAVMED Policy 07/004 of 31 January 2007
<http://www.med.navy.mil/policy-guidance/Pages/PG2007.aspx>
- (o) Dignified Treatment of Wounded Warriors Act of 2007 (H.R. 1538)
<https://www.congress.gov/110/bills/hr1538/BILLS-110hr1538pp.pdf>
- (p) Deputy SECDEF Memo, OSD 14743-07 of 18 Sep 2007
<http://www.acq.osd.mil/housing/docs/DoD%20Hsg%20Insp%20Stds%20-Medical%20Hold%20-Sep%202007.pdf>
- (q) Military Health System Professional Services and Medical Coding Guidelines, Appendix E <http://www.health.mil/Military-Health-Topics/Technology/Support-Areas/MHS-Specific-Coding-Guidelines>