UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 7 2013

The Honorable Carl Levin
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This report is in response to Senate Report 111-35, pages 149–150, accompanying S.R. 1390, the National Defense Authorization Act for Fiscal Year (FY) 2010, which requests the Secretary of Defense assess the efficacy and cost of case management services for TRICARE behavioral health clients with serious mental health problems.

In order to comprehensively address the congressional request, the Department of Defense developed a two-phased retrospective review. Phase I of the two-phased retrospective review was provided to the congressional defense committees on May 25, 2012, and provided demographics, prevalence estimates, and a description of utilization of the defined population from FY 2009 administrative data.

The enclosed report covers Phase II of the review and includes a descriptive evaluation of available data that targets Military Health System beneficiaries with mental health diagnoses. This report was promised to the congressional defense committees in November 2012, but was delayed due to extensive review of the final outcomes. We apologize for the delay. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 7 2013

The Honorable Kirsten E. Gillibrand
Chairwoman
Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Madam Chairwoman:

This report is in response to Senate Report 111-35, pages 149–150, accompanying S.R. 1390, the National Defense Authorization Act for Fiscal Year (FY) 2010, which requests the Secretary of Defense assess the efficacy and cost of case management services for TRICARE behavioral health clients with serious mental health problems.

In order to comprehensively address the congressional request, the Department of Defense developed a two-phased retrospective review. Phase I of the two-phased retrospective review was provided to the congressional defense committees on May 25, 2012, and provided demographics, prevalence estimates, and a description of utilization of the defined population from FY 2009 administrative data.

The enclosed report covers Phase II of the review and includes a descriptive evaluation of available data that targets Military Health System beneficiaries with mental health diagnoses. This report was promised to the congressional defense committees in November 2012, but was delayed due to extensive review of the final outcomes. We apologize for the delay. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Lindsey Graham
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 7 2013

The Honorable Howard P. "Buck" McKeon
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This report is in response to Senate Report 111-35, pages 149–150, accompanying S.R. 1390, the National Defense Authorization Act for Fiscal Year (FY) 2010, which requests the Secretary of Defense assess the efficacy and cost of case management services for TRICARE behavioral health clients with serious mental health problems.

In order to comprehensively address the congressional request, the Department of Defense developed a two-phased retrospective review. Phase I of the two-phased retrospective review was provided to the congressional defense committees on May 25, 2012, and provided demographics, prevalence estimates, and a description of utilization of the defined population from FY 2009 administrative data.

The enclosed report covers Phase II of the review and includes a descriptive evaluation of available data that targets Military Health System beneficiaries with mental health diagnoses. This report was promised to the congressional defense committees in November 2012, but was delayed due to extensive review of the final outcomes. We apologize for the delay. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 7 2013

The Honorable Joe Wilson
Chairman
Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This report is in response to Senate Report 111-35, pages 149–150, accompanying S.R. 1390, the National Defense Authorization Act for Fiscal Year (FY) 2010, which requests the Secretary of Defense assess the efficacy and cost of case management services for TRICARE behavioral health clients with serious mental health problems.

In order to comprehensively address the congressional request, the Department of Defense developed a two-phased retrospective review. Phase I of the two-phased retrospective review was provided to the congressional defense committees on May 25, 2012, and provided demographics, prevalence estimates, and a description of utilization of the defined population from FY 2009 administrative data.

The enclosed report covers Phase II of the review and includes a descriptive evaluation of available data that targets Military Health System beneficiaries with mental health diagnoses. This report was promised to the congressional defense committees in November 2012, but was delayed due to extensive review of the final outcomes. We apologize for the delay. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Susan A. Davis
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 7 2013

The Honorable Richard J. Durbin
Chairman
Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This report is in response to Senate Report 111-35, pages 149–150, accompanying S.R. 1390, the National Defense Authorization Act for Fiscal Year (FY) 2010, which requests the Secretary of Defense assess the efficacy and cost of case management services for TRICARE behavioral health clients with serious mental health problems.

In order to comprehensively address the congressional request, the Department of Defense developed a two-phased retrospective review. Phase I of the two-phased retrospective review was provided to the congressional defense committees on May 25, 2012, and provided demographics, prevalence estimates, and a description of utilization of the defined population from FY 2009 administrative data.

The enclosed report covers Phase II of the review and includes a descriptive evaluation of available data that targets Military Health System beneficiaries with mental health diagnoses. This report was promised to the congressional defense committees in November 2012, but was delayed due to extensive review of the final outcomes. We apologize for the delay. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Thad Cochran
Vice Chairman

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 7 2013

The Honorable Barbara A. Mikulski
Chairwoman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Madam Chairwoman:

This report is in response to Senate Report 111-35, pages 149–150, accompanying S.R. 1390, the National Defense Authorization Act for Fiscal Year (FY) 2010, which requests the Secretary of Defense assess the efficacy and cost of case management services for TRICARE behavioral health clients with serious mental health problems.

In order to comprehensively address the congressional request, the Department of Defense developed a two-phased retrospective review. Phase I of the two-phased retrospective review was provided to the congressional defense committees on May 25, 2012, and provided demographics, prevalence estimates, and a description of utilization of the defined population from FY 2009 administrative data.

The enclosed report covers Phase II of the review and includes a descriptive evaluation of available data that targets Military Health System beneficiaries with mental health diagnoses. This report was promised to the congressional defense committees in November 2012, but was delayed due to extensive review of the final outcomes. We apologize for the delay. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Richard C. Shelby
Vice Chairman

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 7 2013

The Honorable Harold Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This report is in response to Senate Report 111-35, pages 149–150, accompanying S.R. 1390, the National Defense Authorization Act for Fiscal Year (FY) 2010, which requests the Secretary of Defense assess the efficacy and cost of case management services for TRICARE behavioral health clients with serious mental health problems.

In order to comprehensively address the congressional request, the Department of Defense developed a two-phased retrospective review. Phase I of the two-phased retrospective review was provided to the congressional defense committees on May 25, 2012, and provided demographics, prevalence estimates, and a description of utilization of the defined population from FY 2009 administrative data.

The enclosed report covers Phase II of the review and includes a descriptive evaluation of available data that targets Military Health System beneficiaries with mental health diagnoses. This report was promised to the congressional defense committees in November 2012, but was delayed due to extensive review of the final outcomes. We apologize for the delay. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY 7 2013

The Honorable C.W. Bill Young
Chairman
Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This report is in response to Senate Report 111-35, pages 149–150, accompanying S.R. 1390, the National Defense Authorization Act for Fiscal Year (FY) 2010, which requests the Secretary of Defense assess the efficacy and cost of case management services for TRICARE behavioral health clients with serious mental health problems.

In order to comprehensively address the congressional request, the Department of Defense developed a two-phased retrospective review. Phase I of the two-phased retrospective review was provided to the congressional defense committees on May 25, 2012, and provided demographics, prevalence estimates, and a description of utilization of the defined population from FY 2009 administrative data.

The enclosed report covers Phase II of the review and includes a descriptive evaluation of available data that targets Military Health System beneficiaries with mental health diagnoses. This report was promised to the congressional defense committees in November 2012, but was delayed due to extensive review of the final outcomes. We apologize for the delay. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Peter J. Visclosky
Ranking Member

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2010

Phase II Response to Senate Report No. 111-035 (pages 149-150)

Report on the Efficacy and Cost of Case Management Services for TRICARE Behavioral Health Clients with Serious Mental Health Problems

April 2013

TRICARE Management Activity

Preparation of this report cost the Department of Defense a total of approximately $5,840 in Fiscal Year 2012

Generated on
2012Nov13
RefID: E-9939FA7

EXECUTIVE SUMMARY

Senate Report number 111-35, which accompanied the National Defense Authorization Act for Fiscal Year (FY) 2010, directed the Secretary of Defense to assess the effectiveness and cost of case management (CM) services for TRICARE beneficiaries diagnosed with serious mental health illnesses (SMI). Senate Report No. 111-35 identified these variables that should be included in the analysis of CM services: cost of their care; hospital admissions and length of stay; change in mental health symptoms and day-to-day functioning of beneficiaries with SMI; utilization of community behavioral health services (including associated dropout rates); and beneficiary and family satisfaction with care.

The Department of Defense (DoD) conducted a two-phased retrospective review of administrative data and the electronic health records of TRICARE beneficiaries who were diagnosed with SMI during FY 2010. The Phase I Report, submitted to Congress in May 2012, identified the prevalence and demographics of the TRICARE population diagnosed with SMI. The Phase I Report also identified utilization and cost of behavioral health services for each of these mental health conditions.

This Phase II Report focuses on the effectiveness and cost of CM services for some TRICARE beneficiaries with SMI. Our study was severely limited because of our inability to identify all of our patients with SMI who were receiving formal CM. Similarly to that situation found in the private, civilian health care markets, CM has not been a service whose specific cost has been reimbursed directly to the health care provider. As a result, the provision of formal CM most often could not be identified by an administrative review of claims data or review of the electronic medical record of our beneficiaries. Accordingly, there were very few cases in which it was clear whether or not CM services were being provided to patients with SMI. Further, because these data were severely limited, very few conclusions can be made. However, we were able to make some preliminary observations.

There were 539,024 beneficiaries from a total population of 9,677,511 in the Military Health System (MHS) diagnosed with a mental health condition during FY 2010; this is a prevalence rate of potential *serious* mental illness of 5.6 percent. Of these beneficiaries, 4,430 (0.82 percent) were identified by administrative data as being specifically enrolled in a program providing CM services. Among the sample of 75 CM enrollees whose charts were available for abstraction:

- 11 percent lacked any documentation of care coordination activities
- Those beneficiaries diagnosed with a SMI and who were enrolled in a CM program had fewer hospital admissions
- $38,000 was spent per beneficiary during the time period of the beneficiary's initial enrollment in formal CM
- $19,000 was spent on care for those beneficiaries not enrolled in CM services
- While the initial cost of services for CM-enrolled beneficiaries were initially quite high relative to beneficiaries not receiving formal CM, the

costs of total care for patients enrolled in CM decreased over time while the cost of services for those not enrolled in CM increased fourfold during the same timeframe

- The greater initial costs for health care for CM-enrolled beneficiaries was associated with longer hospitalizations that likely were a result of more complex illnesses or injuries necessitating CM services
- Fifty percent of those beneficiaries diagnosed with a SMI who were enrolled in CM showed documented improvement in meeting challenges in daily living
- Similarly to the civilian health care system, there is still no way to quantify the significant amount of case management furnished by providers in the military health care system who offer this benefit as part of the other professional services they deliver but for which that activity is not specifically documented

OVERVIEW

It has been difficult to assess the value of formal CM for several reasons. First, there is not a collective agreement upon the definition of care coordination and how these activities differ from case management. The DoD has adopted the Case Management Society of America definition of CM that states "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." CM involves six steps: (1) assessment—gathering complete information about the patient, including individual needs, goals, and preferences; (2) planning—developing a care plan that targets the patient's needs, goals, and objectives identified during the assessment; (3) implementation—carrying out the care plan with the aim of meeting the goals; (4) coordination—synchronizing resources and personnel to implement and adhere to the plan of care; (5) monitoring—gathering ongoing information to evaluate adherence to the plan of care; and (6) evaluation—continuously analyzing the patient's response toward meeting the care plan goals.

It is also difficult to assess the utilization of CM when this type of patient care is offered by health care practitioners as part of the care they provide our beneficiaries. Providers often perform case management activities and receive payment for such services as part of the bundled reimbursement of physician services. In other words, administrative data which track the delivery of services cannot be used to track CM unless there is a coding mechanism to specifically track these activities in an electronic data base. Accordingly, the degree of CM being performed is often difficult to identify through review of administrative data; review of the narrative notes of the medical records might provide additional information.

Report No. 111-35, accompanying S.1390, the National Defense Authorization Act for FY 2010, requested this review to analyze the cost and effectiveness of CM services for TRICARE beneficiaries with SMI problems. The report requested the following variables of interest be examined: cost of care; hospital admissions and length of stay; change in mental health symptoms and day-to-day functioning; utilization of community behavioral health services, including associated dropout rates; and beneficiary and family satisfaction with care. To comprehensively address the congressional request, the DoD conducted a two-phased retrospective review. The Phase I Report, submitted to Congress in May 2012, identified the prevalence and demographics of the TRICARE population diagnosed with mental health conditions characteristic of SMI. The report further identified utilization and cost of behavioral health services for each of these mental health conditions.

To track the use of case management, in 2009, the Military Health System directed that formal case management be documented with billing codes that could be identified through administrative claims data. For this Phase II review, two groups of beneficiaries with SMI (one that received documented CM and one that did not) were compared to determine the differences between utilization and cost of behavioral health services. The Phase II report also identified these beneficiaries' quality of daily

functioning through a review of medical records in the direct care system (for example, care provided at military treatment facilities) and assessed CM services through beneficiary and family satisfaction surveys.

METHODOLOGY

A retrospective analysis was conducted of Military Health System (MHS) healthcare encounter data for beneficiaries (no exclusions were made based on age or beneficiary category) who presented for care of a diagnosed SMI in FY 2010. Behavioral health conditions targeted for inclusion were derived from definitions, set forth by: the National Alliance on Mental Illness; the Substance Abuse and Mental Health Services Administration; and the National Institute of Mental Health. The individual diagnostic codes for SMI used in this analysis fall under the following broad categories of mental health conditions: schizophrenia disorders; episodic mood disorders; delusional disorders; other nonorganic psychoses; pervasive developmental disorders; anxiety; dissociative and somatoform disorders; personality disorders; special symptoms or syndromes; acute reaction to stress; adjustment reaction; and depressive disorder disturbance of conduct.

The following sources of data were used in this review: administrative health care encounter data that included the clinical diagnosis codes (for example, International Classification of Diseases (ICD-9-CM Diagnostic Codes, Table 1) for each beneficiary identified with mental illness, the ICD-9 DoD extender codes for case management (for example, V49.89_2, 3,4); direct inspection and evaluation of medical records; and the Healthcare Effectiveness Data and Information Set (HEDIS) Follow-up after Hospitalization data.[1] In addition, beneficiary and family satisfaction surveys were reviewed.

To be included in the cohort for this analysis, the beneficiary had to receive one of the primary diagnoses defined under the SMI conditions listed in the definition table (Table 1) and at least two documented outpatient visits on two separate dates; or one emergency room visit; or one hospital discharge during FY 2010. From the group of beneficiaries who met the criteria for inclusion in the analysis, those who did not receive CM services documented by billing codes were compared with those beneficiaries who did.

Clinical data were obtained through review of medical records that were available in the MHS direct care system. For a beneficiary's record to be included in the review, the beneficiary was required to have at least one coded behavioral health visit and be continuously enrolled in TRICARE. Using administrative data, we could identify only 601 new CM cases for behavioral health care in 2010. It should be noted that administrative coding specifically for CM services was not enacted until late in 2009, and implementation of coding for CM services required extensive coordination. As a result, a review of administrative claims data could not fully identify the extent to which CM was actually utilized, and a review of individual charts was needed to confirm the rate of CM utilization. Of the 601 cases identified, 115 cases were located in the direct care system. Of these 115 cases, 31 did not meet the inclusion criteria for this study, as these

[1] HEDIS Follow-up after Hospitalization data were utilized to address community drop-out rates.

beneficiaries did not have a behavioral health visit during this time frame; only 84 cases were eligible for further review. Seven of these 84 cases were not continuously enrolled in TRICARE, resulting in 75 cases available for chart review, data collection and analysis.

Two types of visits were targeted for review in the medical records of those beneficiaries who received documented CM services: (1) CM visits, to collect the assessment of the beneficiaries' ability to function, and the documentation of care coordination activities and (2) behavioral health visits, to collect the assessment of the beneficiaries' ability to function as a result of the change in their behavioral health symptoms. Specifically, we reviewed those cases in which the results of the Global Assessment of Functioning[2] were documented for the beneficiaries receiving CM.

The drop-out rates for those TRICARE beneficiaries diagnosed with a SMI and who received community behavioral health were assessed through examination of the entire MHS population utilizing the HEDIS Follow-up after Hospitalization measure. The HEDIS Follow-up after Hospitalization measure provides the percentage of inpatient psychiatric hospital discharges with an outpatient visit follow-up, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner within 7 days of initial discharge, as well as within 30 days of initial discharge. For this review, behavioral health follow-up appointments after hospitalization were also provided from 7 to 365 days after discharge for all SMI MHS beneficiaries discharged between May 2010 and April 2012.

A final measure evaluated in this report included beneficiary and family satisfaction surveys that, independently of this study, addressed CM services. The surveys identified for inclusion in this review were: The Recovering Warrior Task Force 2010-2011 and 2011-2012 Annual Reports; the TRICARE Management Activity (TMA) Defense Health Cost Assessment and Program Evaluation (DHCAPE) Post Operational Deployment Healthcare Telephone Survey; and the Army Warrior Transition Unit Satisfaction Survey.

RESULTS

Based upon administrative MHS claims data and purchased care encounter data, a total of 539,024 beneficiaries (5.6 percent of the entire MHS population) received a mental health diagnosis. As reported in the Phase I study, the most commonly identified mental health conditions for this population included: adjustment reaction; posttraumatic stress disorder (PTSD); episodic mood disorders; anxiety disorders; and dissociative and somatoform disorders.

In the cohort studied for the Phase II study, $38,000 was spent per beneficiary during the time period of the beneficiary's initial enrollment in CM, versus $19,000 for those not enrolled. While the initial cost of services for CM-enrolled beneficiaries were greater, the costs decreased over time while the cost of services for those not enrolled in

[2] The Global Assessment of Functioning is an assessment tool for examining objective measurements of change in mental health status and functioning.

CM increased fourfold during the same timeframe. The greater, initial cost for CM enrolled beneficiaries was attributed to longer lengths of hospital stays as well as ongoing coordination of care for outpatient follow-on treatment of the beneficiaries receiving CM when compared to the costs for those patients who did not receive this type of care coordination.

Seventy-five charts were identified for direct medical record review to further evaluate improvement in the mental health of those patients receiving CM services. To demonstrate effectiveness, beneficiaries would have to show serial improvement in scores for the Global Assessment Functioning tool. However, of the 75 charts available for review, only 34 charts had serial Global Assessment Functioning scores that could be used to evaluate any change in functional ability. The improvement of functional level from these 34 beneficiaries showed a 50 percent improvement above baseline during the intervention of the CM timeframe. However, this cohort is too small to meaningfully evaluate the effect of CM on the functional level of patients with SMI relative to the patients who did not received CM services.

The drop-out rate for those TRICARE beneficiaries diagnosed with a SMI and who received community behavioral health services were assessed through examination of the entire MHS population utilizing the HEDIS Follow-up after Hospitalization measure. This particular measure is available for case managers to evaluate necessary follow-up care and on-going evaluation post-discharge. Facilitating post-hospitalization stabilization and maintenance of care is critical for continued improvement and for the reduction of hospital readmissions. The 7 day and 30 day follow-up after hospitalization measures have steadily improved since the implementation of the HEDIS Follow-up after Hospitalization measure in 2010. The results of these measures are summarized below:[3]

- The average percent of beneficiaries with follow-up in 7 days rose from 54.5 percent to an average of 60.2 percent from September 2010 to March of 2012.
- The average percent of beneficiaries with follow-up in 30 days rose from 74.5 percent to an average of 77.2 percent from September 2010 to March 2012.

The final measures reviewed in this report were from extant surveys of patient and family satisfaction with CM services. Satisfaction with CM was surveyed for the Recovering Warrior Task Force (RWTF) 2010-2011 Annual Reports and Service-specific and TMA DHCAPE reports. These survey results provided insight as to how CM services were perceived by those beneficiaries and family members who received them. Overall, CM received very positive satisfaction ratings in each of the surveys. These reports, however, were not limited to CM provided primarily for patients with SMI.

The RWTF 2010-2011 Annual Report states that Recovering Warrior (RW) and family member focus group participants considered medical care case managers, and specifically nurse case managers (NCM), important members of the recovery care team. The majority of the survey responders answered "moderately to extremely helpful" to all the CM-related questions on the survey. In the 2011-2012 annual report, the RWTF Focus groups revealed that NCMs were valued by both RWs and their family members.

[3] Military Health Services Population Health Portal May 2010 – March 2012

RWTF focus group mini surveys indicated a high level of RW and family member satisfaction with NCMs. The majority of the survey responders answered "moderately to extremely helpful" to all of the CM-related questions on the survey. The TMA DHCAPE Post Operational Deployment Healthcare Telephone Survey was administered to wounded, ill, and injured Service members returning from deployment. In January 2012, five CM-related questions were added to the survey for the purpose of assessing satisfaction with CM services. One survey question identified the Service members who were receiving CM services from a clinical case manager. A majority of the responses were either a "1" or "2" (Note: 1=Outstanding, 5=Poor). The Army Medical Command Warrior Transition Unit Satisfaction Survey was conducted monthly and assessed satisfaction with the case manager of the Service member. The survey results for the October 2011 – March 2012 time period reported that there was a steady increase in satisfaction with CM from 90.3 percent to 92.4 percent

CONCLUSIONS

Because of the paucity of data that could be collected about formal CM from DoD administrative claims for FY 2010, very few conclusions can be drawn from this retrospective study. However, several recommendations can be made.

- There must be agreement, not only within the MHS, but in all health care markets as to the definition of "case management."
  - Before any study can be done on CM, or metrics of effectiveness established, there must be a common and accepted definition of case management and how these activities differ from care coordination.
  - Even today (2013), a uniformly accepted definition does not exist outside of DoD.
  - Case management, care coordination, patient advocacy, and support services are a continuum that all overlap.
  - Different facets of case management overlap, and because each facet of case management may be provided by different members of a health care team, specific claims for the reimbursement of case management services by providers are often not made.
  - The provision of this service cannot be reliably documented and tracked.

- Better coding procedures need to be developed for use across all health care markets to allow for the administrative tracking of CM services
  - Only recently has the Common Procedural Terminology (CPT) Coding, the system by which most health care organizations track health care services and utilization, included codes for "care management" activities performed by privileged providers (for example, 99487, 99488, 99489,

http://www.justcoding.com/print/287330/cpt-introduces-new-em-subsections-for-2013).

- Currently, these codes are not separately recognized by the Centers for Medicare & Medicaid Services but are considered "bundled" into other privileged provider services.
- The 99487, 99488, 99489 codes reflect services requiring medical decision making, which can only be done by privileged providers.
- There are no CPT codes for case management services provided by nurses and technicians, resulting in the inability for the DoD to separately reimburse or track these services.
- Similarly to the civilian health care system, there is still no way to quantify the significant amount of case management furnished by health care providers who offer this benefit as part of the other professional services they deliver but for which they are not specifically reimbursed.

Table I

ICD9-CM Diagnostic Codes Used for the Analysis of Potentially Serious Mental Illness

ICD9-CM Diagnostic Codes	Associated Serious Mental Illness
295	Schizophrenia disorders
296.2, 296.3	Major depressive disorders
296.0, 296.1, 296.4, 296.5, 296.6, 296.7, 296.8, 296.80, 296.81, 296.82, 296.89	Bipolar disorders
296.9, 296.90, 296.99	Unspecified episodic mood disorders
299	Pervasive developmental disorders
300.0, 300.00, 300.01, 300.02, 300.09, 300.2, 300.20, 300.21, 300.22, 300.23, 300.29	Anxiety and phobic disorders
300.4	Dysthymic disorder
301	Personality disorders
308	Acute reaction to stress
309.0, 309.1, 309.2, 309.21, 309.22, 309.23, 309.24, 309.28, 309.29, 309.3, 309.4, 309.9	Adjustment disorders
309.8, 309.81, 309.82, 309.83, 309.89	PTSD and other specified adjustment reactions
311	Depressive disorder, not elsewhere classified
313.8, 313.81, 313.82, 313.83, 313.89, 313.9	Unspecified or mixed emotional disturbance of childhood or adolescence
314	Hyperkinetic syndrome of childhood