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United States Coast Guard

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COMDTINST 6300.3
19 SEPTEMBER 2017

COMMANDANT INSTRUCTION 6300.3

Subj: TELEMEDICINE

- Ref: (a) Military Health System, Professional Services and Medical Coding Guidelines, Version 5, April 2015
 (b) Department of Defense, Telemental Health Guidebook, Version 1, June 2011
 (c) Use of Imaging and Recording Devices in USCG Healthcare Facilities, COMDTINST 6010.6 (series) (FOUO)
 (d) Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS), DoDM 6025.13
 (e) Title 42, Code of Federal Regulations, Section 482.12(a)(1) through 482.12(a)(7)
 (f) Title 42, Code of Federal Regulations, Section 482.22(a)(1) through 482.22(a)(2)
 (g) Information and Life Cycle Management Manual, COMDTINST M5212.12 (series)
 (h) Disposition of Health Records, COMDTINST 6150.4 (series)

- PURPOSE.** To establish policy and procedures for patient care using telecommunication across state lines, video teleconferencing (VTC) or similar technology and web conferencing.
- ACTION.** All Coast Guard unit commanders, commanding officers, officer-in-charge, deputy/assistant commandants, and chiefs of headquarters staff elements who choose to employ telemedicine must comply with the provisions of this Instruction. Internet release is authorized.
- DIRECTIVES AFFECTED.** None.
- BACKGROUND.** Due to limited clinical specialty services and the need to deliver care in isolated areas, areas with limited resources and OCONUS locations, Coast Guard clinics are strongly encouraged to adopt the practice of delivering clinical services via VTC. This will increase access to care, prevent delays in care, facilitate provider-to-provider consultation, avoid unnecessary travel for patients and providers, and improve patient and provider satisfaction. Coast Guard clinics must ensure that the selection of services to be provided via VTC is based on patient safety

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considerations, patient and provider comfort levels, the ability of a clinic to identify a physical space conducive to a proper telemedicine visit, and with equipment suitable for clinical services provided and reliable connectivity.

5. DISCLAIMER. This guidance is not a substitute for applicable legal requirements, nor is it itself a rule. It is intended to provide operational guidance for Coast Guard personnel and is not intended to nor does it impose legally-binding requirements on any party outside the Coast Guard.
6. IMPACT ASSESSMENT.
 - a. PERSONNEL RESOURCES REQUIRED. Medical Officers and Independent Duty Health Services Technicians (IDHSs) will perform tasks associated with this Instruction.
 - b. TRAINING REQUIRED. Medical Officers and IDHSs will complete requisite training as developed by the Health, Safety, and Work-Life Service Center in coordination with Force Readiness Command.
7. ENVIRONMENTAL ASPECT AND IMPACT CONSIDERATIONS.
 - a. The development of this Instruction and the general policies contained within it have been thoroughly reviewed by the originating office in conjunction with the Office of Environmental Management, and are categorically excluded (CE) under current USCG CE #33 from further environmental analysis, in accordance with Section 2.B.2 and Figure 2-1 of the National Environmental Policy Act Implementing Procedures and Policy for Considering Environmental Impacts, COMDTINST M16475.1 (series).
 - b. This Instruction will not have any of the following: significant cumulative impacts on the human environment; substantial controversy or substantial change to existing environmental conditions; or inconsistencies with any Federal, State, or local laws or administrative determinations relating to the environment. All future specific actions resulting from the general policies in this Instruction must be individually evaluated for compliance with the National Environmental Policy Act (NEPA), DHS and USCG NEPA policy, and compliance with all other environmental mandates.
8. DISTRIBUTION. No paper distribution will be made of this Instruction. An electronic version will be located on the following Commandant (CG-612) web sites. Internet: <http://www.dcms.uscg.mil/Our-Organization/Assistant-Commandant-for-C4IT-CG-6-/The-Office-of-Information-Management-CG-61/aboutCGDS/>, and CGPortal: <https://cgportal2.uscg.mil/library/directives/SitePages/Home.aspx>.
9. RECORDS MANAGEMENT CONSIDERATIONS. This Instruction has been thoroughly reviewed during the directives clearance process, and it has been determined there are no further records scheduling requirements, in accordance with Federal Records Act, 44 U.S.C. 3101 et seq., National Archives and Records Administration (NARA) requirements, and the Information and Life Cycle Management Manual, COMDTINST M5212.12 (series). This policy does not have any significant or substantial change to existing records management requirements.

10. DEFINITIONS.

- a. The Joint Commission (TJC). An independent, not-for-profit organization that is a standards-setting and accrediting body in healthcare. TJC accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.
- b. Telehealth. Defined by TJC as the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.
- c. Telemedicine. A subset of telehealth, as defined by TJC, and involves the use of medical information exchanged from one site to another via electronic communication to improve patients' health status.
- d. VTC. Usually this entails a two-way interactive video telecommunication in which a provider interacts directly with a patient over a distance. This synchronous communication occurs live and in real-time. Variations of limited interaction (e.g. one-way) and asynchronous communications where medical information data is collected and sent to a provider via electronic communication are possible alternatives. VTC as referred to in this instruction applies to both VTC and similar technology that may be developed in the future.
- e. Originating site. The site where the patient is located.
- f. Distant site. The site where the provider is located.

11. RESPONSIBILITIES.

- a. Director of Health, Safety and Work-Life, (CG-11).
 - (1) Ensure that the Coast Guard Professional Review Committee (PRC) provides oversight on telemedicine credentialing and privileging requirements.
 - (2) Ensure that providers at the distant sites are appropriately credentialed and privileged at that facility, and that the distant site providers' credentials and privileges are accepted by the PRC.
 - (a) The privileging authority may choose to use the Interfacility Credentials Transfer Brief (ICTB) process and rely upon the privileging determinations of the Department of Defense (DoD) Medical Treatment Facility (MTF) for providers located there.
 - (b) The originating and distant site facilities must be accredited by TJC, the Accreditation Association for Ambulatory Healthcare (AAAHC), or other appropriate accrediting entity designated by Commandant (CG-11). The distant site provider must be privileged at the distant site facility to provide the identified services and to also provide telemedicine

services. This provider must request to the originating site facility permission to use current privileges to provide care to patients in the originating site. The request must be documented and attached to the ICTB for DoD distant site providers as appropriate. The distant site facility must provide at a minimum, a copy of the distant site provider's current list of credentials (including background checks as appropriate), privileges, and proof of Health Insurance Portability and Accountability Act (HIPAA) training to the PRC. The originating site facility must have evidence of periodic internal reviews of the distant site practitioner's performance of these privileges and must receive such performance information, including all adverse events resulting from telemedicine services, for use in the periodic appraisals.

- (3) Ensure appointing and scheduling processes are managed to clearly identify telemedicine visits.
- (4) Ensure auditing of local coding of telemedicine visits to ensure compliance with Reference (a).
- (5) Ensure that the involved originating and distant sites and the providers address the following prior to engaging in telemedicine services:
 - (a) Alternate communication procedures are established and tested in the event that VTC communications terminate unexpectedly.
 - (b) Patients and providers are provided with a secure and private setting.
 - (c) Arrangements have been made for appropriate clinical support, including access by local emergency services, should the need arise.
 - (d) The facilities and providers meet applicable current telecommunication and technology guidelines of the American Telemedicine Association.

b. Originating Medical Treatment Site.

- (1) Is familiar with the technology to be used and is capable of establishing a VTC connection and perform basic first line troubleshooting.
- (2) Completes clinical forms with the patient, and coordinates retrieval and transfer of necessary records or documentation to the provider prior to the visit.
- (3) Orients the patient on the nature of the VTC encounter, obtains any required informed consent, and answers any questions the patient may have about the service.
- (4) Informs the patient of all personnel who will see their image during the VTC encounter and lets them know that the encounter transmission is secure and not being recorded (if this is the case).

- (5) Provides administrative oversight to ensure overall effective management of clinical care, including the scheduling of follow-up visits.

c. Distant Medical Treatment Site.

- (1) Is familiar with the technology to be used and is capable of establishing a VTC connection and perform basic first line troubleshooting.
- (2) Collaborates with the originating site on patient treatment and follow-up care.

12. VTC USES.

a. Situations appropriate for VTC include:

- (1) Medication management for established patients;
- (2) Provider-to-provider and interdisciplinary consultation;
- (3) Medical board evaluations;
- (4) Ongoing evaluation and management of new or established stable patients by providers of any specialty where all necessary information for appropriate care can be obtained remotely;
- (5) Individual psychotherapy for International Classification of Diseases (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders (DSM-5) conditions;
- (6) Evaluation, diagnosis, and treatment of behavioral health disorders and neuropsychological disorders, including cognitive testing; and
- (7) Case management services.

b. Situations and cases that may not be appropriate for VTC include:

- (1) Cases in which the patient requires urgent treatment and stabilization;
- (2) Assessment following restraint or seclusion;
- (3) Cases in which the patient and/or provider are not comfortable communicating remotely;
- (4) Patients who are acutely violent, unstable, or impulsive;
- (5) Patients who are severely decompensated due to delirium, intoxication, medication toxicity, or medication interaction necessitating immediate hospitalization;

- (6) Patients requiring involuntary commitment due to immediate risk for suicide or who pose an immediate danger to others (note: some states do not legally acknowledge telemedicine evaluations for this purpose);
- (7) Patients to whom news should be shared in person (e.g., a positive Human Immunodeficiency Virus (HIV) result); and
- (8) Individuals who have hearing, visual, or cognitive deficits limiting their ability to communicate coherently via VTC.

13. TECHNOLOGY AND EQUIPMENT. VTC technology must ensure patient privacy and security consistent with HIPAA and all DoD and Coast Guard Information Assurance requirements. If VTC is to take place internationally, the provider and/or organization providing the service should also ensure that the privacy laws of that country are understood and followed. Additional requirements for connectivity and use of internet, hardware, equipment are available in Reference (b). VTC equipment and work space(s) will be configured in accordance with MIL STD 1472 (series) and shall be suitable for a medical environment (IEC 60601-1 - Medical Electrical Equipment). VTC communications equipment will be usable by assigned personnel with no more than a brief on-line training session or a simple job aid. As per Reference (c), use of personally owned imaging and recording devices to take images or make recordings of patients, patients' families, or human remains, or to otherwise facilitate any other communication or conveyance of HIPAA- protected health information in healthcare facilities is prohibited.

14. CREDENTIALING AND PRIVILEGING.

- a. The facility where the patient is located (known as the "originating site") may choose to rely on the credentialing and privileging determinations of the facility where the provider is located (known as the "distant site") to make local privileging decisions. This is known as "privileging by proxy," and decisions must incorporate applicable telemedicine standards as identified in Reference (d) to include requirements of the originating site to make final privileging decisions. These modifications are conditional on the following:
 - (1) The originating and distant site facilities are accredited by TJC, AAAHC, or other appropriate accrediting entity designated by Commandant (CG-11).
 - (2) The distant site provider is privileged at the distant site facility to provide the identified services and is authorized to provide telemedicine services. The provider or the distant site facility must request of the originating site facility, permission to use the provider's current privileges to provide care to patients in the originating site. The request and a privileging decision must be appropriately documented at the originating site. The distant site facility must provide at a minimum a copy of the distant site provider's current list of credentials, privileges, and proof of HIPAA training.
 - (3) The originating site facility has evidence of periodic internal reviews of the distant site practitioner's performance of these privileges and receives such performance information,

including all adverse events resulting from telemedicine services, for use in the periodic appraisals.

- (4) The originating site will transmit performance information, including adverse event information and complaints from patients, other providers or staff to the distant site for use by the distant site in periodic performance reviews of the provider.
 - (5) The privileging authority of the originating site may choose to use the ICTB or other credential transfer mechanism approved by Commandant (CG-11) as a source to rely upon the credentialing and privileging determinations of the distant site.
 - (6) If the distant site facility is not an MTF, or otherwise does not have access to the ICTB or other credential transfer mechanism approved by Commandant (CG-11), its medical staff credentialing and privileging process and standards must at least meet the standards in References (e) and (f). Only DoD and U.S. Department of Veterans Affairs (VA) healthcare providers will be used as distant healthcare providers for CG telemedicine.
- b. The use of an originating or distant site that is not a Coast Guard clinic, MTF or VA medical facility, but is a Coast Guard vessel, non-medical fixed Coast Guard location, or a DoD mobile telemedicine platform approved by Assistant Secretary of Defense for Health Affairs (ASD(HA)) for this purpose is permissible unless restricted by Commandant (CG-11) and/or Commandant (CG-6).

15. CLINICAL VTC VISIT.

a. Patient intake.

The originating site will ensure information is provided for the encounter through the Medical Record, Consultation Sheet, SF 513, or an equivalent form, authorization to record the session is obtained if recording is being proposed, and medical test results are available to the provider at the distant site at least 72 hours prior to the appointment. Staff at each site will coordinate to ensure that any third parties who need to be present to support the visit for patient safety reasons or to assist in the communication process are identified and available for the visit. All parties will be made aware of who will be in attendance at each site (i.e., family members and medical residents). At the time of the visit, the patient will be placed in the room as soon as possible to allow the patient and any other attendees to acclimatize to the room and for the staff to make adjustments to the lighting, seating, or other conditions that would impede a productive session. Reference (b) includes an overview of managing a VTC visit.

b. Documentation and coding.

Distant site providers must enter clinical notes into the Service Treatment Record (STR)/Non-Service Treatment Record (NSTR) or VA medical record. For consultative sessions, the patient's primary care manager will document the content of the session to support any prescriptions, studies, or referrals that result from the consult. In all cases, the primary care

manager or cognizant IDHS is responsible for ensuring clinical documentation reaches the medical record. Coding guidance is found in Reference (a).

16. PRIVACY, CONFIDENTIALITY, AND INFORMED CONSENT.

- a. Clinical VTC visits should not normally be recorded. In most cases, the only reason to consider recording the visit is to capture information with strong educational value. If recording is desired, the patient's consent will be documented on an Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, OF 522, or State-mandated form.
- b. Consent for traditional face-to-face care does not necessarily extend to a clinical VTC visit. An additional informed consent must be completed prior to providing such services. The informed consent should include the following:
 - (1) Nature of clinical VTC and what it entails;
 - (2) Risks and benefits of clinical VTC;
 - (3) That two sites are participating in the patient's care;
 - (4) That security measures have been taken to ensure compliance with HIPAA and protect patient privacy;
 - (5) That they are not being recorded, and that a separate written approval and consent is needed in order to record a session;
 - (6) That there are policies and procedures in place in case of a technical breakdown or clinical emergency; and
 - (7) That the patient has been informed that they have the right to refuse clinical VTC care and retain the option of receiving face-to-face care.

17. RECORDS MANAGEMENT. Records created as a result of this instruction, regardless of media and format, will be managed per References (g) and (h).

18. EMERGENCY PROTOCOLS. Emergency protocols should include the following:

- a. The provider at the distant site should have a secondary method for immediately contacting the patient and staff at the originating site in case of equipment failure;
- b. The originating site should always be on call as a point of contact to manage patient emergencies that occur while telemedicine care is being delivered; and

- c. Both sites should have immediate access to emergency contact numbers that can respond to the originating site in the event of an emergency (e.g., local law enforcement, facility security, emergency medical response teams).
19. **FORMS/REPORTS.** The forms referenced in this Instruction are available in USCG Electronic Forms on the Standard Workstation or on the Internet: <http://www.uscg.mil/forms/>; CG Portal <https://cgportal2.uscg.mil/library/forms/SitePages/Home.aspx>. Standard Forms may be found here: <https://www.gsa.gov/portal/forms/type/TOP>.
20. **REQUESTS FOR CHANGES.** Units and individuals may recommend changes by writing via the chain of command to: Commandant (CG-112); U. S. Coast Guard Stop 7907; 2703 Martin Luther King Jr. Ave, SE; WASHINGTON, DC 20593-7907.

E. G. Schwartz /s/
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Director of Health, Safety, and Work-Life