DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
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IN REPLY REFER TO
BUMEDINST 6300.20
BUMED-M6
31 Dec 2012

BUMED INSTRUCTION 6300.20

From: Chief, Bureau of Medicine and Surgery

Subj: NAVY MEDICINE POLICY ON CLINICAL VIDEO TELECONFERENCING

Ref: (a) The Joint Commission Comprehensive Accreditation Manual for Hospitals
(b) The Joint Commission Comprehensive Accreditation Manual for Ambulatory Care
(c) National Defense Authorization Act of 2012, Title VII, Section 713
(d) Department of Defense (DoD) Telemental Health Guidebook, Version 1, 9 Jun 2011
(e) Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines, Version 3.5, June 2012
(f) The Joint Commission Pre-Publication Telemedicine Requirements of 9 Dec 2011
(g) SECNAV Manual 5210.1 of Jan 2012

Encl: (1) The Joint Commission Pre-Publication Telemedicine Requirements of 9 Dec 2011

1. Purpose. To establish policy and procedures for patient care using video teleconferencing (VTC) and Web conferencing.

2. Scope. This applies to all Navy Medicine activities.

3. Discussion

a. Telehealth is a proven method of delivering safe and effective care where provider shortages or geographic barriers exist. Telehealth, as defined by The Joint Commission (TJC), is 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. Telemedicine is 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.

b. Due to high demand for clinical services for all populations served by Navy Medicine, chronic provider shortages in areas such as behavioral health, uneven distribution of providers, and the need to deliver care to beneficiaries worldwide, Navy medical treatment facilities (MTFs) 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, improve patient and provider

satisfaction, and potentially reduce the rate of "no-show" patient appointments. MTFs must ensure that the selection of services to be provided via VTC is based on patient safety considerations, patient and provider comfort levels, the ability of a clinic to identify a physical space conducive to a proper telehealth visit, and with equipment suitable for clinical services provided and reliable connectivity.

4. VTC use cases

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, marital, family, and group counseling,

(6) Evaluation, diagnosis, and treatment of behavioral health disorders and neuropsychological disorders, including cognitive testing,

(7) Case management services,

(8) Supervision and peer review, and

(9) Distance learning.

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.

5. Web conferencing. Defense Connect Online may be used for consultations provided that no personally identifiable information or protected health information is communicated. The use of commercial online meeting services such as Go to Meeting, Skype, or WebEx are not approved for patient care in Navy Medicine.

6. Accreditation standards. TJC telemedicine standards for ambulatory and hospital settings are found in the Human Resources and Medical Staff chapters for references (a) and (b). MTF leadership will review and stay current on these standards. In addition, MTF leaders will ensure telemedicine is integrated in the command's TJC-mandated management plans as appropriate. VTC equipment and cameras used for patient-provider VTC visits or as peripheral devices for VTC equipment (e.g., a special camera for teledermatology) must be accredited by the Joint Interoperability Test Command (JITC) or receive an authority to operate. A list of JITC-approved devices can be found at https://aplits.disa.mil.

7. Credentialing and privileging. Providers at the location remote from the patient (known as the distant site) must be credentialed and privileged at the site where the patient is located (known as the originating site). Providers at the distant site must have their credentials forwarded to the originating site. This process can be accomplished via an inter-facility credentials transfer brief. The originating site must review the credentials and agree to the provider exercising existing privileges from the distant site. Enclosure (1) contains the most recent guidance for telehealth credentialing and privileging. Uniformed and civil service licensed providers must have a current, valid, unrestricted license to provide care, but the license does not have to be from the state where the remotely treated patient is located. Reference (c) waives the requirement for licensed personal services contact providers to be licensed in the state where the patient is located if they are providing telehealth services within the scope of authorized federal duties.

8. Training. Commands will ensure that clinicians and support staff are trained consistent with their clinical role. Licensed independent providers will be trained in local procedures (see paragraph 7), basic equipment operation such as camera and volume adjustment, and procedures to restore lost connections. Reference (d) provides a basis for local telehealth training. Additionally, providers must be aware of age-specific issues affecting the quality of the telehealth visit. For example, children may require a table to draw, perform basic tasks required

during the visit, or to use as a surface for playing with toys to remain engaged in the session, while older patients may require accommodations for sensory or physical deficits. Support staff will be proficient in placing and receiving VTC calls, controlling volume and cameras, managing lighting and seating, restoring lost connections, and basic troubleshooting.

9. Patient intake. The originating site will ensure information is provided for the encounter through the SF 513, authorization to record the session if recording is being proposed, psychological and neurocognitive testing results, etc., and 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 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 (d) includes an overview of managing a VTC visit, and can be found at http://www.t2health.org/programs-telehealth.html.

10. Documentation and coding. Distant site providers may enter clinical notes for visits involving direct care since privileges at the originating site are required for both patient care and Armed Forces Health Longitudinal Technology Application (AHLTA) access. 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 is responsible for ensuring clinical documentation reaches the AHLTA record. Coding guidance is found in reference (e) and is periodically updated. Current guidance for telehealth coding is as follows:

a. Provider-to-provider telephone calls, images transmitted via facsimile machines, and text messages without visual images are not considered telehealth and cannot be coded.

b. Coding is permitted for interactive audio, video, or other electronic media permitting real-time communication between the distant site provider and the patient. The originating site will not use an evaluation and management (E&M) code unless a separately identifiable E&M service is documented on the same day. For encounters involving patient-provider interaction the visit will be entered as an office visit (e.g., 99201 or 99211).

c. Consultations occur as a result of the originating site asking for advice from a distant site provider. A written request and written report are required. Consultations should be coded with the appropriate E&M code for services, or 88321 through 88325.

d. Referrals occur when a provider at a remote site evaluates a patient for a specific problem or condition. The referral includes a history, vital signs, diagnosis, and care plan. Referrals should be coded by the remote provider as an office visit with modifier (GQ for asynchronous

services, GT for real-time services). The originating site may code a 99211 for each episode of care as appropriate. Mental health current procedural terminology codes 90804 through 90809 and 90862 are available for telemedicine visits.

e. Coding is permitted for store-and-forward telecommunication that permits asynchronous transmission of medical information to be reviewed later by a provider at the distant site. When the distant site provider provides an interpretation and report of a diagnostic study (e.g., laboratory or radiology test), the service is reported with the "-26" modifier for the professional component of the procedure. The originating site would report the procedure with the "-TC" modifier if no interpretation and report is rendered at their site.

f. Originating sites may code telehealth episodes with Q3014, "Telehealth Originating Site Facility Fee."

11. Recording VTC sessions. 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 shall be documented on an OF 522 or State-mandated form.

12. Responsibilities

a. Deputy Chief, Bureau of Medicine and Surgery (BUMED), Medical Operations (BUMED-M3), shall:

(1) Ensure regions and MTFs remain current on coding guidance related to telehealth to ensure accuracy of workload capture.

(2) Ensure regions and MTFs remain current on credentialing and privileging requirements regarding telehealth.

b. MTF commanders, commanding officers, and officers in charge shall:

(1) 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 locally. The privileging authority of the facility where the patient is located may choose to use the Inter-facility credentials transfer brief (ICTB) process as a source to rely upon the privileging determinations of the facility where the provider is located. The originating and distant site facilities must be accredited by The Joint Commission (TJC), the Accreditation Association for Ambulatory Healthcare (AAAHC), or other appropriate accrediting entity designated by Chief Medical Officer of the TRICARE Management Activity. The distant site provider must be privileged at the distant site facility to provide the identified services and is authorized to 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 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 HIPAA training. 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 telehealth services, for use in the periodic appraisals.

(2) Ensure appointing and scheduling processes are managed to clearly identify telehealth visits.

(3) Audit local coding of telehealth visits to ensure compliance with reference (e).

(4) Establish and test alternative communication procedures between originating and distant sites in the event of VTC communications terminate unexpectedly.

(5) Report concerns or issues in implementing this instruction to BUMED-M6 via the Navy Medicine Region commander.

(6) Develop local written procedures for:

(a) Implementation of this policy at the parent facility and branch health clinics.

(b) Ensuring a secondary method is identified for immediately contacting the patient and staff at the originating site in case of equipment failure.

(c) Ensuring immediate access to emergency contact numbers (e.g., local law enforcement, facility security, and emergency medical response teams) in the event of an emergency.

(d) Management of referrals and patient selection for appropriateness (see paragraph 3).

(e) Movement of patient health information prior to and following telehealth encounters.

(f) Scheduling new and follow-up visits, and

(g) Inclusion of VTC care in the peer review and performance improvement programs.

13. Records Management. Records created as a result of this instruction, regardless of media and format, shall be managed per reference (g).

14. Forms

a. SF 513 (REV. 4-98), Medical Record, Consultation Sheet is available at: http://www.gsa.gov/portal/forms/type/SF.

b. OF 522 (REV. 7-2008), DoD Exception to the OF 522, Request for Administration of Anesthesia and for Performance of Operations and Other Procedures is available at: http://www.med.navy.mil/directives/Pages/OtherForms.aspx.

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The Joint Commission

# Telemedicine Requirements

Hospital Accreditation Program

## Standard LD.04.03.09

Care, treatment, and services provided through contractual agreement are provided safely and effectively.

**Element of Performance for LD.04.03.09**

1. Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement.
2. The hospital describes, in writing, the nature and scope of services provided through contractual agreements.
3. Designated leaders approve contractual agreements.
4. Leaders monitor contracted services by establishing expectations for the performance of the contracted services.
   Note 1: In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS) chapter.
   Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:
   - Verify that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.
   - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.
   Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body.
5. Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services.
   Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it.
6. Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations.
7. Leaders take steps to improve contracted services that do not meet expectations.
   Note: Examples of improvement efforts to consider include the following:
   - Increase monitoring of the contracted services.
   - Provide consultation or training to the contractor.
   - Renegotiate the contract terms.
   - Apply defined penalties.
   - Terminate the contract.
8. When contractual agreements are renegotiated or terminated, the hospital maintains the continuity of patient care.
9. For hospitals that do not use Joint Commission accreditation for deemed status purposes: When using the services of licensed independent practitioners from a Joint Commission–accredited ambulatory care organization through a telemedical link for interpretive services, the hospital accepts the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider only after confirming that those decisions are made using the process described in Standards MS.06.01.03 through MS.06.01.07, excluding MS.06.01.03, EP 2. (See also MS.13.01.01, EP 1)





Enclosure (1)

10. Reference and contract laboratory services meet the federal regulations for clinical laboratories and maintain evidence of the same. * Footnote *: For law and regulation guidance on the Clinical Laboratory Improvement Amendments of 1988, refer to 42 CFR 493.

23. For hospitals that use Joint Commission accreditation for deemed status purposes: The originating site has a written agreement with the distant site that specifies the following:
- The distant site is a contractor of services to the hospital.
- The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation
- The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4). (See also MS.13.01.01, EP 1)
Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.
If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply:
- The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13).
- The governing body of the originating site grants privileges to a distant site licensed independent practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site.

## Standard MS.13.01.01

For originating sites only: Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

**Element of Performance for MS.13.01.01**

1. All licensed independent practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:
   1. The originating site fully privileges and credentials the practitioner according to Standards MS.06.01.03 through MS.06.01.13.
   Or
   2. The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited organization. The distant-site practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.
   Or
   3. The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:
   - The distant site is a Joint Commission–accredited hospital or ambulatory care organization.
   - The practitioner is privileged at the distant site for those services to be provided at the originating site.
   - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of licensed independent practitioners' privileges.
   - The originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site. (See also LD.04.03.09, EP 9)
   Note: This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.
   - The distant-site practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.
   Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care.
   Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.





Enclosure (1)