

CHAPTER 2
HEALTH CARE AND FACILITIES

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CHAPTER TWO – HEALTH CARE AND FACILITIES**A. Health Care for Active Duty & Reserve Personnel.****1. Care at Uniformed Services Medical Treatment Facilities (USMTF).**

- a. Authority for Health Care. Title 10 U.S.C. § 1074(a) provides that under joint regulations to be prescribed by the Secretary of Defense and the Secretary of Homeland Security, a member of a uniformed service who is on active duty is entitled to health care in any facility of any uniformed service. Members of the reserve components who are on active duty (including active duty for training) for periods prescribed for more than 30 days are entitled to the same health care in any facility of the uniformed services as that provided for active duty members of the regular services. Authority for health care entitlements for reserve personnel can be found in the Reserve Policy Manual, COMDTINST M1001.28 (series). Additional information can be found on the Commander (PSC-RPM-3) website.
- b. Use of Own Service Medical Treatment Facilities. Under ordinary circumstances, AD and Reserve personnel (on AD orders for more than 30 days) shall be enrolled in AD TRICARE Prime, assigned a Primary Care Manager (PCM) and receive health care at that organization to which the member is assigned. However, COs may request assignment to another USMTF through HSWL SC. Members away from their duty station or on duty where there is no USMTF of their own service may receive care at the nearest USMTF. Reserve personnel (on orders less than 30 days) can be seen at a CG clinic if they incur or aggravate a pre-existing injury, illness or disease. Commander (PSC-RPM-3) should be contacted for additional guidance for Reserve personnel.
- c. Use of Other Services Medical Treatment Facilities and/or Civilian Facilities. The closest USMTF having the appropriate capabilities shall be used for non-emergency health care. Health care in civilian medical facilities for non-emergent conditions is not authorized without prior approval from HSWL SC. All health care received at other treatment facilities (military/civilian) shall be recorded in the CG health record. Commander (PSC-RPM-3) should be contacted for additional guidance for Reserve personnel.
- d. Medical Readiness & Health Assessments.
 - (1) Medical Readiness. The CO/OIC of the unit is responsible for ensuring the medical and dental readiness of their unit. All CG members are required to be medically ready for deployment. All Individual Medical Readiness (IMR) requirements that are delineated in the CG Periodic Health Assessment Policy, COMDTINST M6150.3 (series), are required to be met by CG AD and Reserve members (to include Direct Commission Officers). For the purposes of fulfilling medical and dental readiness data

entry requirements, all AD and Reserve members (via their assigned unit) will be assigned to a CG clinic or sick bay based on the district or sector of their unit location. The following web page lists the units and their assigned CG clinic responsible for entering their medical and dental readiness entries in the current medical readiness tracking system (e.g. Medical Readiness Reporting System (MRRS)).

http://www.uscg.mil/hq/cg1/cg112/cg1121/docs/pdf/Clinic_Unit_list.pdf

(Exceptions may be granted on a case-by-case basis, in writing, by the HSWL SC). CO/OIC of units with a CG clinic or sickbay shall support the medical readiness data entry requirements of those units assigned to their clinic/sickbay by ensuring the appropriate entries are made in the current medical readiness tracking system (e.g. MRRS). When an individual goes to a civilian or military clinic to complete IMR requirements (e.g, immunizations), the information shall be sent to the supporting clinic or sickbay for entry into the current medical readiness tracking system (e.g, MRRS).

- (2) Periodic Health Assessments. All AD and Reserve personnel must have an annual PHA completed during their birth month period in accordance with Coast Guard Periodic Health Assessment, COMDTINST M6150.3 (series).
 - (a) CG Reserve personnel who will be issued active duty orders for 30 days or more, must be current with their required PHA and be in compliance with Commandant weight and body fat standards (CG Weight and Body Fat Standards Program Manual, COMDTINST M1020.8 (series). A current PHA must be fully completed before the AD orders are issued.
 - (b) CG Reserve personnel found to have a pre-existing condition within 30 days of accepting AD orders shall be removed from the set of AD orders and a line of duty (LOD) determination shall be completed. CG Medical Officers shall assess the impact on ability to execute duties for rate and rank, amend current duty status and initiate a medical evaluation board in accordance with Chapter 3 of this Manual, if the member's condition or injury is found in the line of duty. Reserve personnel can only enter the Physical Disability Evaluation System after a LOD has been completed.
- (3) Medical Evaluations. A completed PHA and Report of Medical Assessment, Form DD-2697, shall be used in four scenarios described below. CG members in these four scenarios are authorized to complete their evaluations at CG clinics. CG Medical Officers shall clearly annotate in Block 20 of the Report of Medical Assessment, Form DD-2697 whether the member meets retention standards in accordance with Chapter 3 Paragraph F of this Manual. There is no requirement to

document the PHA and Report of Medical Assessment, Form DD-2697 in the current medical readiness tracking system (e.g, MRRS) if used in the four scenarios documented below. However, the PHA can be used as the member's current PHA if it's completed within the member's birth month period (which will be documented in the current medical readiness tracking system (e.g, MRRS). The four scenarios in which the PHA and Report of Medical Assessment, Form DD-2697 shall be used in conjunction are:

- (a) Reserve members who are being released from active duty orders (greater than 30 days) a new PHA must be completed within 10 days from being released from active duty orders. For members deployed outside of the United States, the PHA should be completed upon return to the United States.
 - (b) IRR members who are changing status to the SELRES or AD (IRR members must be on orders using one Readiness Management Period (RMP) in order to complete their evaluation at a CG clinic. IRR members need to contact the In Service Transfer Team (ISTT) at (703) 235-1731. The ISTT will verify that the member is looking to come out of the IRR and will need a medical evaluation (PHA and Report of Medical Assessment, Form DD-2697). The ISTT will contact the CG Personnel Service Command Reserve Personnel Management (PSC-RPM-3). PSC-RPM-3 will issue RMP orders to IRR members once the member has received a date and location for an evaluation.
 - (c) AD members changing status to the Ready Reserve (SELRES or IRR).
 - (d) Retired members being recalled to AD or Reserve duty.
- (4) Periodic examinations. CG AD & Reserve personnel are eligible to receive annual dental Type-II exams and comprehensive physical examinations for accession, retirement, Medical Evaluation Boards, and confinement reasons, at CG MTFs. For separation and retirement examinations, the Report of Medical History, Form DD-2807-1 and Report of Medical Examination, Form DD-2808:
- (a) Shall be used for both Reserve personnel (on active duty orders for greater than 30 days) and Active Duty (AD) members who are leaving the Coast Guard, retiring, or not planning on rejoining a military service. The separation and retirement examination consists of the Report of Medical History, Form DD-280-1 and Report of Medical Examination, Form DD-2808. Objections to assumption of fitness at separation or retirement are addressed in the Physical Disability Evaluation System, COMDINST M1850.2 (series).
 - (b) May be used by Reserve personnel (on orders for 30 days or less) who are separating or retiring from the Ready Reserve (Selected Reserve

(SELRES) or Inactive Ready Reserve (IRR)). Separation or retirement examinations are optional for Reserve personnel on orders for 30 days or more.

- (5) Deployment Health & Mental Health Assessments. All AD and Reserve personnel on expeditionary deployments must complete all required deployment health assessments and mental health assessments as discussed in Chapter 6 of this Manual.

e. Definitions.

- (1) Uniformed Services are the Army, Navy, Air Force, Marine Corps, CG, Commissioned Corps of the Public Health Service, and the Commissioned Corps of the National Oceanic and Atmospheric Administration.
- (2) Active Duty means full-time duty in a Uniformed Service of the United States, to include full-time training duty; annual training duty, and attendance, while in the service, at a school designated as a service school by law or by the Secretary of the Uniformed Service concerned.
- (3) Active Duty for Training is defined as full-time duty in a uniformed service of the United States for training purposes.
- (4) Inactive Duty Training.
 - (a) Duty prescribed for reservists by the Secretary concerned with 37 USC 206 or any other provision of law.
 - (b) Special additional duties authorized for reservists by an authority designated by the Secretary concerned and performed by them on voluntary basis in connection with the prescribed training or maintenance activities of the units to which they are assigned.
- (5) Disability. A temporary or permanent physical impairment resulting in an inability to perform full military duties or normal civilian pursuits.
- (6) Employed. Reservists are employed on duty during the actual performance of duty, while engaged in authorized travel to or from active duty for training, and while on authorized leave or liberty.
- (7) Line of Duty. An injury, illness, or disease shall be deemed to have been incurred in line of duty, if a reservist at the time of debilitating incident is performing active duty or active duty for training, or is on authorized leave or liberty, provided the disability is not the result of misconduct. While health officials may make an interim line of duty determination in order to provide timely care, the determination of whether an injury/illness was sustained or aggravated in the line of duty is a unit leadership responsibility. The provisions of Chapter 5, "Line of Duty and Misconduct", Administrative Investigations Manual, COMDTINST

M5830.1 (series) apply. Continued entitlement to health care requires this level of documentation.

- (8) Protected Health Information (PHI). Some of the purposes for which the PHI may be used or disclosed relate to the execution of a member's military mission. These include disclosures needed when determining the member's fitness for duty, determining the member's fitness to perform any particular mission, and to report on casualties. The PHI that is released to a command authority is on a need to know basis. Appropriate military command authorities include all commanders who exercise authority over an individual who is a member of the Armed Forces, or other person designated by such a Commander to receive PHI in order to carry out an activity under the authority of the Commander. They can only be provided information that is necessary to assess the AD or Reserve member's ability to carry out a specific duty.
 - (9) Health Care means outpatient and inpatient professional care and treatment, nursing care, diagnostic tests and procedures, physical examinations, screenings, immunizations, prophylactic treatment, medicines, other similar medical services, and ambulance service. Prostheses, hearing aids, spectacles, orthopedic footwear, and similar adjuncts to health care may be furnished only where such adjuncts are medically indicated.
- f. Application for Care. CG AD and Reserve members (on orders for 30 or more days) may be provided health care by a USMTF when requested by appropriate CG authority, a Public Health Service Medical Officer, or by the member presenting a Geneva Convention Identification Card.
 - g. Subsistence Charges. All AD members and Reserve members (on orders for 30 or more days) of the uniformed services are required to pay subsistence in a USMTF at a rate prescribed by the DoD.
 - h. Loss of Entitlement. A member of the CG who is separated from AD for any reason other than retirement, is not eligible for health care at a USMTF by reason of that previous service unless otherwise noted on the Certificate of Release or Discharge from Active Duty, Form DD-214.
- 2. Emergency Care.
 - a. Definition of Emergency Condition.
 - (1) An emergency medical condition exists when the patient's condition is such that, in a Medical Officer's opinion, failure to provide treatment or hospitalization would result in undue suffering or endanger life or limb.

- (2) In an emergency, the patient's safety and welfare, as well as that of the personnel around the patient, must be protected. When a USMTF cannot render immediate care, other local medical facilities, Federal or civilian, may be used. The decision to admit the patient to any of these facilities shall be made by the command with regard for only the health and welfare of the patient and the other personnel of the command.

b. Responsibilities.

(1) Patient.

- (a) The patient is responsible for notifying the civilian or military physician or dentist that he or she is in one of the following:
 - [1] AD CG.
 - [2] CG Reservist on active duty or active duty for training.
 - [3] CG Reservist in an inactive duty training drill or appropriate duty status.
- (b) It is also the responsibility of the patient or someone acting in the patient's behalf to request that the physician or dentist notify the member's command or the closest CG organization and PCM that he or she is undergoing emergency treatment at a civilian or military medical facility.
- (c) The patient shall provide, to their PCM, all information needed to verify the course of treatment received and authorize release of all records associated with the episode of care.

(2) Commanding Officer.

- (a) When notified that a member of the CG is hospitalized, in either a civilian hospital or MTF, transferred to another facility, or discharged from an inpatient status, the unit CO or designated representative shall notify HQ and HSWL SC via e-mail within 24 hours. The e-mail address is HQS-DG-HSWL Inpatient Hospitalization. No other individuals shall be included or copied on this e-mail. This e-mail will only be viewed by command designated individuals at HSWL SC and HQ on a need to know basis. If you cannot access this e-mail site contact the HSWL SC or Commandant (CG-1121) for assistance.
- (b) Use the following format when sending the e-mail, including the statement at the end of the e-mail.

SUBJ: INPATIENT HOSPITALIZATION – (Initial, update or Final)

1. RATE/RANK, FIRST NAME LAST NAME, EMPLID, USCG/USCGR.
2. UNIT
3. DATE AND FACILITY WHERE MEMBER ADMITTED.
4. DIAGNOSIS (use plain language i.e., appendicitis)
5. ESTIMATED DURATION
6. POC RATE/RANK NAME, PHONE # AND E-MAIL ADDRESS

This communication and its attachments are confidential to the Coast Guard Health Care Program and to the intended recipient(s). Information contained in this communication may be subject to the provisions of the Privacy Act of 1974 and Health Insurance Portability and Accountability Act. If you have received this email in error, please advise the sender immediately and delete the entire message together with all attachments. All unintended recipients are hereby notified that any use, distribution, copying or any other action regarding this email is strictly prohibited.

- (c) Chain of command notification. COs shall utilize a separate e-mail to notify other personnel on a need to know basis. The information contained in this e-mail shall only be the minimum necessary to accomplish the intended goal. Information sent shall be considered PHI and the guidelines provided in (i.e. (8)) of this Section shall be followed. Use the following format when sending the e-mail to include the statement at the end of the e-mail.

SUBJ: INPATIENT HOSPITALIZATION

1. RATE/RANK, FIRST NAME LAST NAME, EMPLID, USCG/USCGR
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- (d) Reservists

- (a) A Reservist needing emergency treatment while on orders and engaged in active duty training shall be taken to the nearest appropriate medical facility. If outpatient follow-up treatment is required, (i.e., office visits, tests, etc.) such treatment must be

preauthorized by HSWL SC after issuance of a Notice of Eligibility by the local command.

- (b) The CO of the reserve member shall comply with Chapter 6 of the Reserve Policy Manual, COMDTINST M1001.28 (series) in notifying the Commander, HSWL SC and the local command when a Reservist engaged in active duty training is admitted to a civilian hospital or USMTF, and subsequent follow-up.
- (3) CO, Health, Safety, and Work-Life Service Center (HSWL SC). When notified that a member of the CG is hospitalized, HSWL SC shall:
- (a) Assure the confidentiality of inpatient e-mails.
 - (b) Be responsible for coordinating additional inpatient care at a civilian medical facility prior to transferring the patient to a USMTF. Nothing in the above should be construed as precluding the necessary care for the patient concerned. HSWL SC shall notify the member's unit of any transfer action.
 - (c) Assist in ascertaining all necessary background information about the case, whether the patient should be moved, and the location of the nearest USMTF which can accept the case. Patients shall be transferred in accordance with the provisions of Medical Regulating to and Within the Continental U.S., COMDTINST M6320.8 (series).
- (4) Government Responsibility. Non-adherence to these notification directives cannot limit the Government's liability to pay bills for emergency medical and dental treatment to authorized CG beneficiaries. However, if prior approval is not obtained for NON-EMERGENT treatment in nonfederal facilities, the member receiving the care will be liable for payment.
- c. Emergency Care Outside the Continental United States. CG AD and Reserve personnel (on orders for 30 days or more) outside the continental limits of the United States are entitled to health care at USMTFs, where available. If such facilities are not available, emergency health care may be obtained at CG expense without prior authorization.
 - d. Absentees or Deserters. Charges incurred by CG personnel for civilian health care when absent without authority or in desertion is the sole responsibility of the individual. However, charges for civilian health care after actual or constructive return of the individual to CG or military control may be paid from CG funds. Refer questions on payment of health care in regards to constructive return to HSWL SC.
 - e. Appellant Leave. CG personnel in appellant leave status shall obtain health care and enroll in TRICARE Prime at the nearest USMTF to their appellant leave address (residence). CG personnel on appellant leave are not eligible

for TRICARE Prime Remote because they lack a permanent assignment to a TPR location. CG personnel may transfer their enrollment to another USMTF at the direction of HSWL SC.

3. Dental Care and Treatment.

a. Extent of Dental Services.

- (1) Active Duty CG and Reserve personnel (on orders 30 days or more) are entitled to emergency, routine, and accessory dental treatment at all USMTFs. Dental care from ADDP participating dentists is authorized only as prescribed in Chapter 11 of this Manual. When a CG member goes to a non-ADDP dentist or to a DoD dentist for an exam or treatment, the Department of Defense Active Duty/Reserve Forces Dental Examination, Form DD-2813 shall be filled out and sent via fax to the supporting clinic or sickbay for entry into the current dental readiness tracking system (e.g., the Dental Common Access System, DENCAS).
- (2) Reserve CG personnel ordered to active duty with their consent for less than thirty days are eligible for emergency dental treatment only, and are also subject to the following modifications:
 - (a) Reserve personnel are responsible for all dental diseases and conditions in existence prior to the initiation of or call to active duty. They must be in a class 1 or 2 dental status. (See Chapter 4 of this manual).
 - (b) Reserve personnel shall not be eligible for routine or accessory dental treatment, which cannot be completed prior to termination of or release from active duty status.
 - (c) Reserve personnel are responsible for maintaining their dental fitness for duty while on inactive status or during periods of active duty less than 30 days.
 - (d) CG Reservists ordered to active duty for 30 days or more are eligible for emergency, routine, and accessory dental treatment at all USMTFs, and are also subject to the modifications listed above.
 - (e) Reservists who are not on extended active duty are required to obtain an annual dental exam to facilitate readiness. These exams can be obtained from a Coast Guard clinic, the Reserve Health Readiness Program (RHRP), or the reservist's civilian dentist. Payment for civilian dental examinations is covered by the reservist's dental insurance. In the event the member does

not have dental insurance, the HSWL SC will provide payment for the annual dental exam only.

- (f) All dental visits shall be entered in the current dental readiness tracking system (e.g., DENCAS) whether the care is received at a CG clinic or other treatment facility. AD and Reserve members are responsible for ensuring that dental care recorded at a facility other than a CG health care facility is recorded in the current dental readiness tracking system (e.g, DENCAS). ADDP and RHRP will ensure entry in the dental readiness system (e.g, DENCAS) for the exam visits.

b. Definitions of Types of Dental Treatment.

- (1) Emergency Dental Treatment. Emergency dental treatment includes those procedures directed toward the immediate relief of pain, uncontrolled bleeding, orofacial trauma and/or swelling, the removal of oral infection which endangers the health of the patient, and repair of prosthetic appliances where the lack of such repair would cause the patient physical suffering.
- (2) Routine Dental Treatment. Routine dental treatment reflects those procedures listed as, required primary core privileges, on the Request for Clinical Privileges – Dentist, Form CG-5575B, which includes but is not limited to: examinations, radiographs, diagnosis and treatment planning, amalgam and resin restorations, prophylaxis, scaling and root planning, surgical periodontal procedures, cast and ceramic restorations, removable partial and complete dentures, extractions, non-surgical root canal therapy, vital and non-vital bleaching, mouth guards, sealants, and removable and fixed retainers.
- (3) Accessory Dental Treatment. Accessory dental treatment reflects those procedures listed as, supplemental privileges, on Request for Clinical Privileges – Dentist, Form CG-5575B which includes but is not limited to: implant restorations, limited orthodontics (Invisalign® is not authorized except at the member's expense), molar uprighting, guided tissue regeneration, free soft tissue and connective tissue grafts, mucogingival surgery, and surgical root canal therapy.
 - (a) Implant restorations placed by CG Dental Officers (DOs) shall be performed by one of the following:
 - [1] Those DOs specifically privileged to do so by DOD facilities.
 - [2] Those DOs who have received implant training as part of a residency program.

[3] Those DOs who have had extensive training and experience restoring implants may be privileged to restore implants on an individual basis.

(b) Implant maintenance is the responsibility of all DOs. Each DO shall be familiar with the techniques and armamentarium of implant maintenance, as well as diagnosis of successful and unsuccessful implants.

(c) Requests for implants from non-Federal providers for active duty members shall be submitted for review and approval to the Active Duty Dental Plan prior to initiation of treatment. Factors to be considered include:

[1] Oral hygiene.

[2] Treatment alternatives.

[3] Feasibility and expectations for long-term success.

[4] Length of service and anticipated rotation date.

c. Dental Care of Recruits. Only emergency dental treatment should be provided to those recruits who are to be separated from the CG prior to completing recruit training. It is important that recruits in this category do not have teeth extracted in preparation for prosthetic treatment and then be separated from the CG prior to the time prosthetic appliances are provided.

d. Emergency Dental Treatment in Nonfederal and Non-contract Facilities.

(1) If an Active Duty Dental Plan (ADDP) dentist is not available, emergency dental treatment required for the immediate relief of pain or infection may be obtained by AD CG members from any available dentist. Once the emergency has been alleviated, all follow-up treatment must be from a USMTF or ADDP dentist unless preauthorized by ADDP.

e. Criteria To Be Followed When Requesting Orthodontic/Orthognathic Surgical Care.

(1) Orthodontic/orthognathic surgical treatment can affect release from active duty, rotation dates, and fitness for duty. Therefore, written authorization to commence all orthodontic/orthognathic surgical treatment (whether elective or not, and whether provided by Federal or Nonfederal practitioners) must be requested from Commander (PSC-epm) for enlisted and (PSC-opm) for officers via HSWL SC prior to its initiation. Command endorsement must include a copy of Administrative Remarks, Form CG-3307. Request for nonfederal care from HSWL SC must follow the established guidelines:

- (a) DTF completes the attached DTF Orthodontic Referral and UCCI DTF Referral Request form which may be found at:
<https://secure.ucci.com/non-ldap/forms/addp/forms/referral-form.pdf>.
 - (b) DTF forwards completed forms to TRICARE Management Activity Dental Service Point of Contact (DSPOC) via fax at 703-681-9090.
 - (c) The DSPOC will review the 2 forms submitted by the DTF and either approve or disapprove the referral or request additional info. The DSPOC will notify the DTF Point of Contact of the decision.
 - (d) If approved, the DSPOC will scan and securely e-mail the approved DTF Referral Request to UCCI. The UCCI Dental Care Finder will then initiate the scheduling of the appointment.
 - (e) If disapproved, the DTF may appeal through their respective Dental Chain of Command.
- f. Submit a memo from the member requesting Orthodontic treatment detailing the end of enlistment and rotation dates, treatment plan from Orthodontist detailing reason for and length of treatment, and Service Record Administrative Remarks, Form CG-3307 documenting command approval for treatment.
 - g. Preexisting conditions are the member's responsibility.
 - h. Treatment not required to maintain the member's fitness for duty is elective in nature and is not authorized for payment by the CG. If the member's condition does not impair job function, the treatment shall be considered elective.
 - i. Elective care may be obtained, if available, from an MTF or nonfederal provider. Any payments may be the responsibility of the member. In addition, the member is financially responsible for any care arising from complications that require additional treatment. Because complications could lead to subsequent action by the Physical Disability Evaluation System (PDES), and to protect the interests of both the service member and the CG, the member's command is responsible for Service Record Administrative Remarks, Form CG-3307 documentation detailing:
 - (1) Command approval and the personnel action to be taken by the command regarding the granting of absence.
 - (2) That the service member was instructed regarding the provisions contained herein and other applicable directives.

- (3) That the service member must obtain copies of all treatment records from the provider for inclusion into the CG dental record, including (e.g. initial evaluation, treatment plan, progress notes, and follow-up care).
 - (4) Member must be evaluated by a Dental Officer and given a duty status prior to returning to work.
- j. If elective treatment is approved, PDES processing shall be suspended pending the outcome of the elective treatment. CG aviation personnel, divers and cadets are required to have a waiver request approved by PSC (opm or epm). In addition, members whose duties preclude regular visits to an orthodontist (e.g., icebreakers crews, isolated LORAN duty, etc.) fall under this category.
 - k. If the condition is service-related, the CG shall be responsible to acquire care sufficient to return the member to a fit for full duty status (e.g., that which existed at the time of the member's entry to the service), but not necessarily to ideal conditions not impacting on performance of duties. If treatment is not available at a local MTF, use of ADDP provider(s) may be authorized.
 - l. If orofacial pain is the only symptom causing the member to be not fit for full duty, then it must be treated. Treatment may include, but is not limited to physical therapy, stabilization splints, stress management, and medications. Since orthodontic treatment is of long duration, it is not an appropriate method to relieve acute pain.
 - m. All treatment must be completed, inactivated, or terminated prior to transfer or release from AD. CG members who are being transferred or released from AD, and who request inactivation of orthodontic appliances, shall sign an entry in the Dental Record / Continuation, Form SF-603/603-A, stating their intention to seek orthodontic therapy at their own expense.
 - n. Orthodontic treatment utilizing a series of clear removable aligners such as Invisalign® does not require written authorization. These aligners are removable so treatment is inactivated when appliances are no longer used.
 - o. Third Molar Extraction Criteria.
 - (1) The management of third molars can be complicated by a CG member's age and the seagoing and isolated nature of CG service. A growing body of evidence suggests that prophylactic removal of all pathology-free non-erupted third molars results in unnecessary morbidity and cost. Nevertheless, there are several conditions associated with third molars, which warrant prompt intervention.
 - (2) Criteria for extraction of third molars include:

- (a) Symptomology.
 - (b) Associated pathology includes follicular cyst development, external or internal resorption of third molar, recurrent episodes of pericoronitis or single episode of pericoronitis that was unresponsive to treatment, caries in second or third molar not amenable to restorative measures, and third molar contributing to periodontal disease.
 - (c) Communication with oral cavity, including being able to be probed.
4. Consent to and Refusal of Treatment.
- a. Regulatory Restrictions. United States Coast Guard Regulations, COMDTINST M5000.3 (series), state in Section 8-2-1 that:
 - (1) "Persons in the Coast Guard shall not refuse to submit to necessary and proper medical or dental treatments to render them fit for duty, or refuse to submit to a necessary and proper operation not endangering life."
 - (2) "Persons in the Coast Guard shall permit such action to be taken to immunize them against disease as is prescribed by competent authority."
 - b. Policy Concerning Refusal of Treatment.
 - (1) Policy.
 - (a) It is the Commandant's policy that compulsion is not permissible at any time to require CG members to submit to various types of medical or dental treatment, diagnostic procedures, or examinations.
 - (b) Surgery will not be performed on persons over their protest if they are mentally competent.
 - (c) Individuals who refuse to submit to measures considered by competent Medical or Dental Officers to be necessary to render them fit for duty may be processed for separation from the CG in accordance with applicable regulations unless granted a medical or administrative exemption. Individuals may be subjected to disciplinary action for refusal of necessary treatment or surgery if the refusal is determined to be unreasonable. Refusal of medical care by vegetative or comatose individuals in accordance with a Living Will shall not be considered unreasonable.
 - (d) Refusal of mandatory immunizations will be processed for separation from the Coast Guard unless granted a medical or

administrative exemption as per Immunizations and Chemoprophylaxis, COMDTINST 6230.4 (series).

- (2) Non-Emergent Operations on Minors. A minor who enlists or otherwise enters active duty with parental or guardian consent is considered emancipated during the term of enlistment. There is therefore, no legal requirement that the consent of any person, other than the minor, be obtained prior to instituting surgical procedures.
- (3) Refusal of Emergency or Lifesaving Treatment or Emergency Diagnostic Procedures. The refusal of recommended emergency or lifesaving treatment or emergency diagnostic procedure required to prevent increased level of impairment or threat to life is ordinarily determined to be unreasonable. However, refusal of medical care by vegetative or comatose patients under the authorization of a Living Will is not considered unreasonable. A medical board shall be convened in accordance with the Physical Disability Evaluation System, COMDTINST M1850.2 (series) for unreasonable refusal of emergency or lifesaving treatment or emergency diagnostic procedures.
- (4) Refusal of Non-Emergent Treatment. If a member of the CG refuses non-emergent medical, surgical, dental, or diagnostic procedures that are required to maintain a fit for full duty status, a determination of reasonable basis for this refusal is required. A medical board shall be convened in accordance with Physical Disability Evaluation System, COMDTINST M1850.2 (series).

c. Advance Directives (Living Wills).

- (1) Federal law enacted in 1993 requires hospitals to ask about advance directives at the time of admission and provide patients with information to create advance directives. Advance directives, commonly known as living wills, express a person's wishes regarding certain aspects of treatment and care, including but not restricted to CPR, mechanical life support measures, etc., which may arise in the course of hospitalization.
- (2) CG health care facilities are not required to provide such information under the law. Clinics may elect to provide standardized information to patients on request. Information given out shall conform to the implementing laws of the state in which the clinic is located. Clinics providing such information shall notify patients of its availability either by posted notice or via patient handout materials.

- (3) Clinic staff members usually do not have the required training and experience to advise patients on the legal issues concerning creation of advance directives. Patients shall be referred to the appropriate source of legal support, e.g., command or district Legal Officers.
- (4) Clinic staff members, where allowed by state law, may serve as witnesses to advance directive signatures.
- (5) Advance directive documents shall be held by the member and/or the member's next of kin. Advance directive documents shall not be filed in the member's health record since health records are not universally available 24 hours a day, seven days a week, for reference by a treating hospital.

5. Elective Surgery for Pre-Existing Defects.

- a. General. Elective surgery for defects that existed prior to entrance (EPTE) have often resulted in long periods of convalescence with subsequent periods of limited duty, outpatient care, and observation which render the Government liable for benefits by reason of aggravation of these defects.
- b. Criteria. The following conditions must be met before attempting surgical correction of an EPTE defect.
 - (1) The procedure being considered is an accepted one, carries a minimal risk to life, and is not likely to result in complications.
 - (2) There should be a reasonable certainty that the procedure will correct the defect and restore the member to full duty within a reasonable time (three months) without residual disability. If the defect does not meet the above conditions and the member is, in fact, unfit to perform the duties of grade or rate, action shall be taken to separate the member from the Service.
- c. Discussion. Whether elective medical/dental care should be undertaken in any particular case is a command decision which should be decided using the above guidelines. In questionable cases, the member may be referred to the Physical Disability Evaluation System for final decision prior to undertaking elective treatment for an EPTE defect.

6. Women's Health Care.

- a. Coast Guard practice sites are appropriately equipped, and medical officers are professionally privileged to perform well-woman and family planning services for beneficiaries.
- b. Due to the intimate and personal nature of pap smear testing of female members and with migration to a patient centric focus, referral for

gynecologic preventive services to the nearest military treatment facility (preferably), or civilian gynecologist (secondarily) is authorized following consultation/discussion with the CG Primary Care Manager (PCM) for those members assigned to CG HSWL Regional Practices.

- c. CG members receiving a referral to non-CG medical providers for gynecologic preventive services are required to provide a copy of their medical documentation from the encounter for incorporation into their CG medical record.
- d. Abnormal findings identified on the screening pap smear test will require additional referral from the PCM for further evaluation or treatment.

7. Elective Health Care.

- a. Definition. Medical or Dental treatment not required to maintain the member's fitness for duty is elective in nature and is not authorized for payment by the CG. If the member's condition does not interfere with their ability to perform duty, the treatment shall be considered elective.
 - (1) Elective care may be obtained, if available, from USMTFs. In accordance with the Health Affairs (HA) Policy 05-020 "Policy for Cosmetic Surgery" expenses incurred in obtaining elective care or follow-up care at USMTFs may be the responsibility of the member.
 - (2) If obtained from nonfederal providers, payment is the member's responsibility. In addition, the member is financially responsible for any care arising from complications that require additional treatment, even if it is non-elective.
 - (3) Because complications could lead to subsequent action by the Physical Disability Evaluation System and to protect the interests of both the service member and the CG, the member's health record must contain a Chronological Record of Care, Form SF-600 entry detailing:
 - (a) Command approval and the personnel action taken regarding the granting of absence.
 - (b) That the CG member was counseled regarding the provisions contained herein and other applicable directives. Counseling will be provided at the local CG primary care facility, or if there is no nearby CG primary care facility, then HSWL SC will provide counseling via phone. A Chronological Record of Care, Form SF-600 will be faxed to HSWL SC for appropriate entries, then faxed or mailed back to the unit for incorporation into the member's health record.
 - (c) That the service member must obtain copies of all treatment records from the provider for inclusion into the CG health

record, including initial evaluation, treatment plan, progress notes, and follow-up care.

- (d) Members must be evaluated by a Medical Officer and given a duty status prior to returning to work.
- (4) Members shall understand that once they have received an elective treatment or procedure, they may be adversely affected for present or future assignments or specialized duty.
- (5) Liposuction and paniclectomy are elective procedures that are allowed if the member otherwise is compliant with weight and body fat standards. Bariatric surgery including gastric banding and/or bypass is not authorized.

8. Other Health Insurance (OHI).

- a. General. In some situations a member may desire to utilize their spouses' health insurance (OHI) to obtain health care outside of the Military Health System (MHS). Whether elective health care or all other areas of health care, this decision has an impact on the command and possibly on a member's access to the Physical Disability Evaluation System (PDES).
- b. Criteria. The following conditions must be met before utilizing a spouse's health insurance or OHI:
 - (1) ALL payments are the member's responsibility. In addition, the member is financially responsible for any care arising from complications that require additional treatment, even if it is non-elective.
 - (2) Because complications could lead to a loss of access to the Physical Disability Evaluation System, and to protect the interests of both the service member and the Coast Guard, the member's CG health record must contain a Chronological Record of Care, Form SF-600 entry detailing:
 - (a) Command approval and the personnel action to be taken by the command regarding the granting of absence. That the service member was instructed regarding the provisions contained herein and other applicable directives. Counseling will be provided at the local CG primary care facility, or if there is no nearby CG primary care facility, then HSWL SC will provide counseling via phone. An Chronological Record of Care, Form SF-600 will be faxed to HSWL SC for appropriate entries, then faxed or mailed back to the unit for incorporation into the member's health record.
 - (b) That the service member must obtain copies of all treatment records from the provider for inclusion into the CG health

record, including initial evaluation, treatment plan, progress notes, and follow-up care.

9. Procedures for Obtaining Non-Emergent Health Care from Nonfederal Sources.

- a. Nonfederal sources for active duty. Nonfederal sources for active duty care are intended to supplement and not substitute for care that is available through the federal system. USMTF's or Department of Veterans Affairs (DVA) facilities, if located within a 40 mile radius of the member's unit (except a 30 mile radius for maternity care), shall be used first for non-emergent, non-elective health care before nonfederal sources are used. Each case must be evaluated for:
 - (1) Appropriateness of care.
 - (2) Urgency of treatment.
 - (3) Time and cost factors associated with obtaining such care from a USMTF.
 - (4) The member's anticipated length of stay at the given station.
 - (5) Operational need of the unit for the member.
 - (6) Before active duty members are treated in a nonfederal medical facility for non-emergent conditions, prior approval from HSWL SC must be obtained. Non-elective conditions are those which, without repair or treatment, would render the member unfit for duty.
- c. HSWL SC. HSWL SC may approve requests for nonfederal health care (both medical and dental) and may delegate, in writing, limited authority to Health Services Administrators.
- d. Requests for non-Federal health care beyond a Health Services Administrator's authority. Requests for nonfederal health care beyond a Health Services Administrator's authority will be submitted by following HSWL SC policy. Telephone authorization will not be provided without a hard copy of the request. At a minimum, the following information must be provided, as applicable:
 - (1) Name, grade/rate, social security number.
 - (2) Anticipated rotation date and expiration of enlistment.
 - (3) Whether care will be completed before transfer or separation.
 - (4) Diagnosis reported by International Classification of Diseases, (current edition) Revision, Clinical Modification (ICD-CM) code number and a brief explanation.

- (5) History of patient's condition.
 - (6) Total amount of local and/or HSWL SC approved nonfederal expenditures to date for this condition.
 - (7) The necessity of treatment to maintain fitness to perform duty.
 - (8) Treatment plan: length, type of therapy/treatment, and estimated cost (cost estimates must include total scope of care not just primary provider or hospital costs).
 - (9) Name of facility where treatment will be done.
 - (10) Attending physician's prognosis with and without treatment, including likelihood of medical board action.
 - (11) Name of nearest USMTF capable of providing care:
 - (a) Distance to facility (miles).
 - (b) Earliest appointment available (not available is unacceptable).
 - (c) Travel/per diem cost.
 - (d) Estimated total lost time.
 - (e) Other factors for consideration, e.g., travel time, road conditions, operational impact, etc.
 - (12) Indicate date of original submission and reason for resubmission, if previous requests were submitted for this procedure.
- e. If approval is granted. If approval is granted, HSWL SC will provide the requester with an authorization number. This authorization number must be noted on all invoices submitted. Invoices will be submitted to HSWL SC. If approval is denied, HSWL SC will outline the appropriate appeals process to follow in their denial transmittal.
- f. Personnel transferred prior to completing the approved care. When personnel are transferred prior to completing the approved care, the request is canceled. Personnel are required to submit another request after reporting for their new assignment.
- g. Authorization of funds. Amounts authorized shall not be exceeded without further authorization from HSWL SC which requires additional justification.
- h. Inpatient hospitalization. Inpatient hospitalization in nonfederal facilities shall be monitored closely by HSWL SC. Normally, an inpatient stay will not exceed seven days duration without consideration of movement to a USMTF. Cases suspected to extend past the seven-day limit shall not be placed in a civilian facility, but shall be initially referred to a USMTF. When notified

that a member of the CG is hospitalized, transferred to another facility, or discharged from inpatient status, the unit CO shall notify Commandant (CG-112) and HSWL SC via e-mail as noted in 2.c of this section.

- i. Penalties for non-approved care. If prior approval is not obtained for non-emergent treatment in nonfederal facilities, the member receiving the care will be liable for payment.
 - j. Emergency treatment. EMERGENCY health care does not require prior approval.
10. Obtaining Vasectomies and Tubal Ligations from Nonfederal Providers.
- a. Preauthorization is required. Submit all requests for vasectomies and tubal ligations by nonfederal providers to HSWL SC following the guidelines for requesting above. Request must show the provider of care decided on the procedure based upon applicable local and state guidelines.
 - b. Counseled and consent. Request must contain evidence that the patient has been counseled by a physician and has given informed consent to the procedure.
 - c. Chronological Record of Care, Form SF-600. The request must contain evidence that the patient has completed a Chronological Record of Care, Form SF-600 entry acknowledging that the CG will not pay for reversal of this procedure in a non-federal facility. The request must contain current information concerning the availability of the requested procedure from federal sources.
 - d. Tubal Ligations. Request for a tubal ligation to be performed at the time of delivery should be submitted with the request for nonfederal maternity care.
 - e. Sick leave. Sick leave may be granted for procedures.
11. Care at Department of Veterans Affairs (DVA) Medical Facilities. From time-to-time, acute medical, surgical, or psychiatric facilities are required for CG members when transportation to the nearest USMTF will place the individual's health or welfare in jeopardy. To preclude this and other similar situations, and to provide the best possible medical care for all active duty members, a support agreement between the CG and the DVA was completed in 1979 and remains in effect.
- a. Department of Veterans Affairs (DVA) care. DVA care must be requested by the member's Commanding Officer. The agreement is limited to active duty CG members and does not include dependents.
 - b. Local contact with DVA. Area Commanders and COs should establish local contact with DVA facilities to determine mission and facility capabilities and patient admission procedures.

- c. Billing procedures. Forward all bills received from DVA facilities to the service member's unit for certification prior to forwarding to HSWL SC for payment.
- d. USMTF versus DVA. When a USMTF and a DVA facility are co-located, the USMTF shall be used unless it cannot provide the required services.

12. Uses and Disclosures of Health Information of Active Duty & Reserve Personnel.

- a. Intended uses or disclosures. The CG has published the required Federal Register notice detailing five intended uses or disclosures of personal medical information.
 - (1) The first intended use and disclosure is “to determine the member’s fitness for duty, including but not limited to the member’s compliance with standards and all other activities carried out under the authority of Weight /Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series) for the health and well-being of CG military personnel; the Physical Disability Evaluation System, COMDTINST M1850.2 (series), and similar requirements pertaining to fitness for duty.”
 - (2) The second is “to determine the member’s fitness to perform any particular mission, assignment, order, or duty, including any actions required as a precondition in the performance of such a mission, assignment, order, or duty.”
 - (3) The third is “to carry out activities under the authority of this manual, Chapter 12 (Occupational Medical Surveillance & Evaluation Program).”
 - (4) The fourth is “to report on casualties in any military operation or activity according to applicable CG Regulations or procedures.”
 - (5) The final use is “to carry out any other activity necessary to the proper execution of the mission of the Armed Forces.”
- b. HIPAA Considerations. The Health Insurance Portability and Accountability Act (HIPAA) contains a series of regulations, developed by the Department of Health and Human Services, and enacted into law, which are designed to provide patients with access to their medical records and provide more control over how their personal health information is used and disclosed. The rule also contains a “military exception” which allows health care entities, under certain circumstances, to disclose protected health information of military members without prior approval. The CG is subject to HIPAA regulations in its role as a health care program for active duty military personnel. It is noted, however, that the CG's role as a first responder and MEDEVAC provider is not considered part of the health care program and thus, those activities are not subject to HIPAA requirements. For additional guidance, the CG HIPAA policy can be found in Chapter 13 of this manual. CG clinics are required to

account for disclosures made to command authorities, unless the CG member voluntarily gives his/her health information to a command authority.

- c. First disclosure. The first disclosure listed is designed to protect the Physical Disability Evaluation System (PDES) procedures for review of medical information. While health care professionals are permitted to continue disclosing medical information to the PDES without obtaining authorization from the member, 45 CFR 164.502b1 now requires that only the “minimum necessary to accomplish the intended purpose of the [request]” may be disclosed. More specifically, while in the past, health care professionals may have routinely disclosed a member’s entire medical record to the PDES process, HIPAA regulations now require that they release the minimum necessary to the medical board (which may be the entire medical record) and the medical board may release only the information related to the injury or condition which prompted the convening of a medical board.
- d. Second disclosure. The second disclosure listed is designed to protect a CO’s ability to access necessary medical information about crewmembers. COs need this ability because they are responsible under the United States Coast Guard Regulations 1992, COMDTINST M5000.3 (series), for the well-being of the personnel in the command. This includes a CO’s responsibilities to “excuse from duty any person in the command who is unable to perform because of illness or disability,” “see that proper provision is made and that comforts are provided for the sick and disabled in the command” and “safeguard the health of all personnel by careful supervision of the sanitation of the unit by preventing unnecessary exposure to disease or unhealthy conditions afloat or ashore.” The only constraint on a CO’s access to a military member’s private health information is the language of 45 CFR 164.502(b)(1). This section of the HIPAA regulations requires medical professionals to limit disclosures to the “minimum necessary to accomplish the intended purpose of the request.”
- e. COs and Health Care Providers (HCP). In an effort to balance the CO’s legitimate need for medical information with the HCP’s duty to protect that information, the following guidance is offered:
 - (1) COs shall, at a minimum, be entitled to a fully completed Status Profile Form, CG-5460A. Where the visible condition of the patient and the information contained in the “Duty Status” block of form CG-5460A do not provide sufficient information about a crewmember’s abilities, the CO may request, and an HCP may provide, amplifying information directly related to the condition or injury specified on the form. Unrelated prior injuries or treatment and pre-existing health conditions need not be disclosed; however, medical conditions that directly aggravate the member’s current condition or prognosis for recovery may be disclosed. In addition, a CO is entitled to inquire about any

medication prescribed by a HCP, including any known side effects which may affect fitness for duty.

- (2) Military commanders will be required to identify their designated representatives in writing and the medical provider will have to establish procedures to validate the identity of the person making the request. If a service member presents for health care to a HCP and their supervisor, who is not their CO or CO's designee, calls to find out the member's diagnosis or their duty status, they should not be told without the service member's authorization. A Fitness for Duty chit given directly to the member who then takes it to his/her supervisor themselves is not considered disclosure of medical information.
- (3) A HCP may also disclose protected health information as required by law. This includes court orders, subpoenas or summons (issued by a court, government Inspector General, or other authorized administrative body), authorized investigative demand (e.g., CGIS), or other statute or regulatory demand. The disclosure should be limited in scope to the purpose for which the information is sought.
- (4) In addition, a HCP may disclose protected health information for administrative or judicial proceedings in relation to courts-martial procedures (any order from a military judge in connection with any process under the Uniform Code of Military Justice).

13. Non-Covered TRICARE Purchased Health Care Services.

- a. Definition. Active Duty Service Members (ADSM) are entitled to care included with the TRICARE Prime Benefit as per 10 U.S.C. § 1074(c)(2)(a). Any health care that is not included within the TRICARE Prime Benefit (also known as the TRICARE Basic Program) is considered a Non-Covered TRICARE Health Care Service, hereafter referred to as a non-covered service.
- b. Background. Coverage of medical care purchased from civilian or private facilities for Service member shall be comparable to coverage for medical care under the TRICARE Prime program. When non-covered care, necessary to ensure a member's fitness for duty, is sought within TRICARE's purchased care sector (i.e. outside a USMTF), The Director of TRICARE Management Activity (TMA) is authorized, under Title 32, CFR, Part 199 to exercise discretionary authority to waive any requirements of TRICARE regulations, including the TRICARE Basic Program Benefits, except those specifically set forth in statute, based on "a determination that such waiver is necessary to assure adequate availability of health care to Active Duty members." At the request of the Coast Guard, the Director of TMA may waive limitations on care not provided for under the TRICARE Basic Program Benefits.

- c. Process. All requests for non-covered services provided within purchased care (i.e. care outside of CG facilities or USMTF) shall be processed as follows:
- (1) The member's Primary Care Manager (PCM) shall ensure recommended care is appropriate and necessary to ensure fitness for duty; completion of the waiver form is required, as per the information below, and shall be forwarded to HSWL SC upon completion. All incomplete forms will be returned with no action.
 - (a) If the ADSM PCM is serving within a CG health care facility, the PCM is required to fill out the HSWL SC provided waiver form, which includes directions for completion. It is the responsibility of the PCM to fill out the form completely and accurately.
 - (b) If the ADSM PCM is serving within a non-Coast Guard USMTF, the ADSM shall follow the process for the Service operating the USMTF. The form shall be forwarded to and endorsed by CG HSWL SC prior to forwarding to TMA for review. If the USMTF refuses to take action, the member's unit assigned IDHS and DMOA may assist the member in gathering all information required to complete the form.
 - (c) If the ADSM PCM is a civilian, the member's unit assigned IDHS and DMOA will assist member in gathering all information required to complete the form and act as initial review prior to forwarding waiver request to HSWL SC.
 - (d) If the Coast Guard member's assigned Coast Guard PCM or DMOA deems the specific non-covered service unnecessary for continued fitness for duty, the waiver request shall not be forwarded to HSWL SC for approval.
 - (2) HSWL SC will review the waiver form for accuracy and completeness. If approved by HSWL SC, the waiver will be forwarded to TMA for approval/denial. IF denied by HSWL SC, the form will be returned to the member's PCM or DMOA with no action taken.
 - (a) If approved, waiver will be returned to HSWL SC and the appropriate MCSC will be notified to issue authorization.
 - (b) If denied, the waiver will be returned to HSWL SC with no action.
 - (3) If HSWL SC receives a denial from TMA and still believes the non-covered Service is appropriate to ensure the ADSM continued fitness for duty, HSWL SC will initiate a determinations and finding (D&F), as per Commandant (CG-11) guidance, and will forward to Commandant (CG-11) for approval/denial. Commandant (CG-11) has the authority to expend CG funds as per 14 U.S.C. § 93(a)17 on appropriate medical and/or dental services, even those that are not covered within TRICARE, to ensure ADSM fitness for duty.

- d. Counseling. Prior to forwarding the waiver request to TMA, HSWL SC will ensure that the member has been counseled regarding the provision contained herein and other applicable directives. Counseling will be provided at the local CG primary care facility, or if there is no nearby CG facility, the responsible DMOA or HSWL SC will provide counseling via telephone. A Chronological Record of Care, Form SF-600 will be faxed or scanned to HSWL SC for appropriate documentation, then faxed, scanned, or mailed back to the unit for incorporation into the member's health record. The counseling verbiage must include the following verbiage: "I have been counseled as required and understand that should a waiver be granted and the treatment remains a non-covered TRICARE benefit, any follow-on care, including care for complications, may not be covered by TRICARE once I, the ADSM, separate or retire, and that I may then be financially responsible for the costs of such follow-on care."
- e. Follow-Up. After receiving non-covered private sector care, the ADSM must ensure that copies of all treatment records from the provision of non-covered care are included in the CG health record, including the initial evaluation, treatment plan, progress notes, and additional follow-up care.

B. Health Care for Retired Personnel.

1. Care at Uniformed Services Medical Treatment Facilities. As set forth in 10 U.S.C. § 1074(b), retired members of the uniformed services, as specified in that Act, are entitled to required medical and dental care and adjuncts thereto to the same extent as provided for active duty members in medical facilities of the uniformed services. However, access to care is subject to mission requirements, the availability of space and facilities, and the capabilities of the medical staff as determined by the HSWL SC. Patients enrolled in TRICARE Prime Options are not eligible for non-emergent care in CG clinics. These patients shall be referred to their TRICARE primary care manager (PCM). The PCM is responsible for appropriate care and referral of such patients.
2. Care Under TRICARE Standard and Extra. Subject to the cost sharing provisions set forth in 10 U.S.C. §1086, retired members who are not qualified for benefits under Title I of the Social Security Amendments of 1965 (Medicare) are entitled to receive inpatient and outpatient care from civilian sources.
3. Care at Veterans Administration Medical Facilities.
 - a. Eligibility for DVA Hospitalization. CG military personnel are eligible for hospitalization in DVA facilities after separation from active duty or while in retirement under one of the following circumstances:
 - (1) For injuries or diseases incurred or aggravated while on active duty during any war, the Korean conflict period 27 June 1950 through 31 January 1955 or the Vietnam conflict period (5 August 1964 through 7 March 1975).
 - (2) For service-connected or nonservice-connected disabilities, if receiving disability compensation from the DVA, or if entitled to receive disability compensation from the DVA, but has elected to receive retirement pay from the CG instead of compensation from the DVA.
 - b. Medical Care Benefits. Eligible veterans may receive hospitalization, outpatient medical care, outpatient dental care, prosthetic appliances, etc., from the VA.

C. Health Care for Dependents.

1. Care at Uniformed Services Medical Treatment Facilities.

a. Authority for Health Care. Title 10 U.S.C. § 1076 provides basic authority for medical and dental care for:

- (1) Dependents of active duty members and dependents of members who died while serving on active duty.
- (2) Dependents of retired members and the dependents of members who died while in a retired status.

b. Availability of Care.

- (1) Medical and dental care for dependents in Uniformed Services Medical Treatment Facilities is subject to the availability of space and facilities and the capabilities of the medical and dental staff. With the approval of HSWL SC, the Senior Health Services Officer (SHSO) is responsible for determining the availability of space and capability of the medical and dental staffs in CG clinics. These determinations are conclusive. Patients found enrolled in TRICARE Prime are not eligible for non-emergent care in CG clinics. These patients shall be referred to their TRICARE primary care manager (PCM). The PCM is responsible for appropriate care and referral of such patients.
- (2) Dependents entitled to medical and dental care under this section shall not be denied equal opportunity for that care because the facility concerned is that of a uniformed service other than that of the sponsor.
- (3) Types of Care Authorized. Subject to the provisions set forth in 10 U.S.C. § 1079 and 1086, dependents who are not qualified for benefits under Title 1 of the Social Security amendments of 1965 (Medicare) are entitled to receive inpatient and outpatient care from civilian sources. Refer to HSWL SC for details and instructions.
- (4) All non-active duty beneficiaries seeking care in CG health care facilities are required to furnish Other Health Insurance (OHI) information to the clinic. Pursuant to Title 10 U.S.C. Sec 1095; EO 9397, beneficiaries are required to complete the Third Party Collection Program Record of Other Health Insurance, Form DD-2569. Failure to provide complete and accurate information may result in disqualification for health care services from facilities of the Uniformed Services.

2. Referral for Civilian Medical Care, Form DD-2161. This form shall be used to refer non-Active duty patients from CG facilities to nonfederal facilities, either for supplemental health care or when the patient is disengaged for care. The Referral for Civilian Medical Care, Form DD-2161 will also be used to disengage non-CG active duty patients from CG facilities when the scope of care is beyond the ability of the CG to provide such care. The CG facility shall contact the parent service to ensure the active duty patient has the proper direction on where to obtain necessary care. A signed Referral for Civilian Medical Care, Form DD-2161 disengaging the patient will accompany the patient when they depart the CG facility and a copy shall be kept on file. The Referral for Civilian Medical Care, Form DD-2161 is used when referring patients for supplemental health care.
3. Rights of Minors to Health Care Services. Where not in conflict with applicable Federal law or regulation, CG MTFs shall follow State law defining the rights of minors to health care services and counseling in substance abuse, contraception, sexually transmitted infection prevention and treatment, and pregnancy. Any protection with regard to confidentiality of care or records afforded by applicable law or regulation will be extended to minors seeking care or counseling for these services or conditions in CG MTFs.

D. Care for Pre-adoptive Children and Wards of the Court.

1. General.

- a. A child placed in a sponsor's home as part of a pre-adoption procedure, or by court-ordered guardianship, is not eligible for care under the Uniformed Services Health Benefits Program unless specific authority has been granted. Such authority may come from the final adoption decree, a court-ordered legal custody determination (for a period of at least 12 consecutive months), or through a Secretary's Designation authorization for limited health care in a USMTF.
- b. Eligibility for TRICARE benefits. The Uniformed Services Family Health Benefits Plan (USFHBP), or the TRICARE Dental Plan is established upon the issuance of a uniformed services dependent ID card and Defense Eligibility Enrollment Reporting System (DEERS) enrollment. Authorization for these health care programs, or for direct care (USMTF use), will be reflected on the ID card and through DEERS.
- c. Prospective dependents must meet the following eligibility rules: be unmarried; have not attained the age of 21 (or 23 if a full-time student); be dependent on the sponsor for over one-half of their support; or be incapable of self-support due to mental or physical incapacity and were otherwise eligible when incapacity occurred.
- d. If legal custody or placement is for 12 months or more, a Uniformed Services dependent ID care, DEERS enrollment, and health care eligibility may be authorized. Personnel are encouraged to contact their servicing personnel office for assistance.

2. Secretary's Designation. The following procedures apply in situations where a pre-adoptive or court ordered guardianship or placement is for less than 12 consecutive months.

- a. Children under a prospective parent or guardians care may use a USMTF by acquiring authority from the Secretary of the Uniformed Service to which the USMTF belongs. This authority is normally called a Secretary's Designation. For example, requests for care in a U. S. Navy facility must be authorized by the Secretary of the Navy or their designee. The same holds true for U. S. Army and U. S. Air Force facilities. When seeking care from a Department of Defense (DoD) MTF, contact that facility's Patient Affairs or Health Benefits Advisor staff for assistance.
- b. In cases involving CG facilities, authority has been delegated to the Commandant by the Secretary of Homeland Security to authorize treatment of pre-adoptive children and wards of the court. Letter requests must be forwarded to Commandant (CG-112) and include the following information:

COMDTINST M6000.1F

- (1) Member's name, grade/rate, Emplid, and duty assignment or retired status if applicable.
 - (2) Address of residence.
 - (3) Name and age of the proposed adoptive child or court-ordered ward.
 - (4) A copy of the court order, legal decree, or other applicable instrument issued by a court or adoption agency which indicates the child has been placed in the house for adoption or with the intent to adopt, or the court order granting guardianship of the ward to the service member and any amounts of income to which the ward is entitled.
- c. Upon approval, the respective Uniformed Service will issue a letter of authority for care in one or more of their USMTFs located in the United States. This letter is the only authority for care (since designees are not DEERS-eligible) and must be presented (or on file) when seeking authorized care. These letters have expiration dates and may require the sponsor to request to reissue. When registering the patient in CHCS use the DEERS override code *10 DEERS enrollment exception* to allow the patient to be registered and to receive care.
- d. When there is a need for medical care outside the United States the sponsor should contact the nearest USMTF requesting humanitarian consideration. The Service Secretaries have limited authority for designation of beneficiaries outside the United States.

E. Health Care for Other Persons.1. Members of the CG Auxiliary.

- a. Authority for Care of CG Auxiliary Members. Basic authority for health care for members of the CG Auxiliary injured while performing CG duty is contained in 14 U.S.C. § 832. Section 5.59 of Chapter 1, Title 33, CFR, states: "When any member of the CG Auxiliary is physically injured or dies as a result of physical injury incurred while performing patrol duty or any other specific duty to which he has been assigned, such member or his beneficiary shall be entitled to the same benefits as are now or as may hereafter be provided for temporary members of the CG Reserve who suffer physical injury incurred in the line of duty. Members of the CG Auxiliary who contract sickness or disease while performing patrol duty or any other specific duty to which they have been assigned shall be entitled to the same hospital treatment as is afforded members of the regular CG." Claims for CG Auxiliary healthcare shall be submitted to:

DEPARTMENT OF LABOR
ATTN OFFICE OF WORKERS' COMPENSATION PROGRAM
1240 E 9th ST RM 851
CLEVELAND, OH 44199-2001

All doctor reports/findings should be submitted to:

DEPARTMENT OF LABOR
ATTN DFEC CENTRAL MAILROOM
PO BOX 8300
LONDON, KY 40742-8300

- b. Compensation under Federal Employee's Compensation Act (FECA) Program. See the Detail of Appropriated Fund Civilian Employees, COMDTINST 12300.7 (series).

2. Temporary Members of the CG Reserve.

- a. Composition of the CG Reserve. The CG Reserve is a component part of the United States Coast Guard and consists of two classes of reservists: Regular and Temporary. Temporary members of the CG Reserve may be enrolled for duty under such conditions as the Commandant prescribes, including but not limited to part-time and intermittent active duty with or without pay, and without regard to age. Members of the CG Auxiliary, officers and members of the crew of any motorboat or yacht placed at the disposal of the CG, and persons (including government employees without pay other than compensation of their civilian positions) who by reason of their special training and experience are deemed by the Commandant qualified for such duty. The Commandant is authorized to define the powers and duties of temporary reserves, and to confer upon them, appropriate to their

qualifications and experience, the same grades and ratings as are provided for regular members of the Reserve.

- b. Authority for Care of Temporary CG Reservists. 14 U.S.C. § 707 contains authority for health care and/or compensation of temporary reserves under conditions set forth therein.
 - c. Care at CG Expense. 14 U.S.C. § 707(d) states: "A temporary member of the Reserve, who incurs a physical disability or contracts sickness or disease while performing a duty to which the member has been assigned by competent authority, is entitled to the same hospital treatment afforded a member of the Regular CG."
 - d. Compensation under Federal Employee Compensation Act (FECA) Program. See Detail of Appropriated Fund Civilian Employee, COMDTINST M12300.7 (series).
3. Members of Foreign Military Services.
- a. General. Members and dependents of foreign services assigned or attached to a CG unit for duty or training (such as Canadian Exchange Officers) or who are on active duty with a foreign military unit within the United States (such as the crew of a vessel being taken over at the CG Yard under the Military Assistance Program) are eligible for health care at DOD MTF's provided by US Code: Title 10, Section 2559. As there are several categories of foreign service members for whom medical care benefits vary, both for themselves and their dependents, if any doubt exists as to eligibility for health care and the authorized sources from which it can be obtained, contact Commandant (CG-112) for advice.
 - b. Care at Uniformed Services Medical Treatment Facilities. Members of foreign military services and their dependents who are eligible, therefore, shall be provided inpatient health care at DOD MTFs upon request of the member's Commanding Officer or consular official, or by application of the member or dependent upon presentation of proper identification.
 - c. Foreign Nationals. Without an existing reimbursement agreement, the CG is only authorized to provide emergency medical services to foreign nationals. Personnel reviewing requests from foreign governments or foreign citizens to attend the CG Academy, a CG training course, or serve on CG units, must ensure individuals are covered by a reimbursable agreement or purchase private health insurance.

4. Federal Employees.
 - a. Benefits Under Federal Employees Compensation Act (FECA) Program. All Federal Employees assigned to CG vessels, e.g., National Marine Fishery Service (NMFS), Drug Enforcement Agents, etc., are civilian employees of the United States Government, and as such, are entitled to health care and compensation under FECA. See Detail of Appropriated Fund Civilian Employee, COMDTINST M12300.7 (series).
 - b. Care Aboard Ship and Outside CONUS. Federal Employees may be given medical care while serving with the CG in a locality where civilian health care is not obtainable, such as onboard a CG vessel or outside the United States. Outpatient and inpatient care may be provided at Navy medical facilities outside CONUS, if reasonably accessible and appropriate nonfederal medical facilities are not available.
 - c. Civilian Employee Health Care & Occupational Health. Information regarding civilian employee health care and occupational health programs within the CG can be found in Civilian Employee Health Care and Occupational Health Program, COMDTINST M12793.2 (series).
5. Merchant Marine Seamen. Sick and disabled seamen may receive emergency health care aboard Coast Guard vessels.
6. Non Federally Employed Civilians Aboard CG Vessels.
 - a. Authority for Care. There is no statute which either prohibits or authorizes the CG to provide health care to civilians while aboard CG vessels. There is no objection to furnishing emergency health care, but routine care should not be furnished. When these civilians are aboard CG vessels for relatively lengthy periods, the Commanding Officer must determine what treatment is to be given.
 - b. Responsibility. Commanding Officers of vessels deployed for extended periods shall ensure that Non-Federally employed civilians who are carried aboard CG vessels under their cognizance are physically capable of withstanding the trip contemplated and that they are free from medical conditions which could cause an interruption of the vessel's mission. Non-Federally employed civilians must furnish such evidence from a physician at no expense to the CG or Federal Government.
7. Civilians Physical Exams Prior to Entry to the CG. Certain CG programs offer specific, guaranteed training schools to civilian applicants provided they can pass the required physical exam in advance of entry into the CG. Commandant (CG-11) has specifically authorized pre-entry physical exams for prospective Coast Guard members (including but not limited to) Student Aviator (SA) Candidates through the Blue 21 program as well as for pre-identified candidates for guaranteed AET "A" school upon graduation from TRACEN Cape May.

a. Responsibility.

(1) Recruiting command personnel will identify potential candidates and coordinate with the Medical Administration Officer at CG clinics that are capable of performing SNA Candidate, Class 1 and Class 2 aviation or other physical examinations to the standards identified in Chapter 3 of this Manual and the Coast Guard Aviation Medical Manual, COMDTINST M6410.3 (series). Recruiters should allow a minimum of two weeks lead time in order to arrange these PEs. All potential candidates must already have completed a MEPS PE and meet basic CG accession standards.

(2) CG clinics will perform aviation PEs (SA candidate, Class 1 and Class 2) on potential candidates identified by local recruiters. Efforts should be made to perform the PE on a single day, if possible, in order to minimize travel expenses for the potential candidate. These programs are important to the manning needs of CG Aviation, but performing these exams does not take precedence over care of active duty and reserve CG personnel.

b. Reimbursement. HSWL SC shall reimburse sources for expenses that are incurred in carrying out these PEs. (The Regional Practice site completes a referral for the specific service using the Referral for Civilian Medical Care, Form DD-2161 and indicating to send the itemized claim back to the site. Upon receipt of the itemized claim, the HSA validates and attaches a copy of the original Referral for Civilian Medical Care, Form DD-2161 prior to forwarding to HSWL SC for processing & payment). Authorization for reimbursement includes expenses for aviation PEs that the Regional Practice site would normally incur through tests done in the civilian community (e.g. X-rays, Cycloplegic eye exams, etc). Potential candidates having disqualifying conditions are noted to have such on the PE, but no further evaluation, diagnostic testing, or treatment is authorized (except in emergency medical situations).

c. Routing. Once completed, the original PE is sent to the requesting CG Recruiter for further processing. Examining Flight Surgeons will enter aviation physical examination data into AERO and submit to CG PSC PSD MED for authorization.

F. Medical Regulating.1. Transfer of Patients at CG Expense.

- a. Details for the transfer of CG personnel to, from, or between hospitals and the responsibility for the expenses involved are contained in Military Assignments and Authorized Absences, COMDTINST M10000.8 (series).
- b. Information and requirements for the transfer of patients to, from, or between medical facilities is contained in Medical Regulating to and Within the Continental U.S., COMDTINST M6320.8 (series).

2. Travel Via Ambulance of Patients to Obtain Care.

- a. Active Duty Personnel. The CG is responsible for providing ambulance service (Government or civilian), for active duty members when medically necessary. Bills related to ambulance service provided to active duty personnel, shall be processed as outlined in Chapter 11 of this Manual.
- b. Retired and Dependent Personnel. Retired personnel and dependents are not provided ambulance service for initial admission, except that a Government ambulance may be used in an emergency situation as determined by the cognizant medical authority. If an ambulance is ordered by a military hospital, TRICARE Standard cannot pay for it; the military hospital must pay. TRICARE Standard cost-shares ambulances only when medically necessary; that is, the patient's condition does not allow use of regular, private transportation or taxis, "medicabs" or "ambicabs." When ambulance transportation is needed, the medical condition must be a covered TRICARE Standard benefit. Should either the provider or patient have additional questions regarding this issue, check with HSWL SC, the Beneficiary Counseling and Assistance Coordinator (BCAC) or TRICARE Service Center.

3. Aeromedical Evacuation of Patients.

- a. When the condition of the patient requires aeromedical evacuation, the transfer shall be arranged in accordance with Medical Regulating to and Within the Continental U.S. (Joint Pub), COMDTINST M6320.8 (series). If there is no USMTF in the area, a message prepared in accordance with the above instruction shall be forwarded to HSWL SC.
- b. There may be instances where civilian health care must be obtained in foreign countries. TRICARE Overseas coordinates health care of beneficiaries located in remote locations where there are no United States health care facilities through a contract with International SOS (ISOS). This contract includes coordination of urgent and emergency health care for all active duty TAD, deployed or traveling in remote locations not supported by a U.S. Medical Treatment Facility. If urgent or emergent health care is

required, the medical representative should contact the ISOS at www.internationalsos.com. ISOS will require the patient's name and SSN to verify eligibility through DEERS. ISOS will coordinate health care for the patient with a local treatment facility, assist with transportation needs, and guarantee payment to the local facility on behalf of the U.S. Government. If emergency air evacuation is required and military airlift is not available, ISOS will coordinate the air evacuation with the ISOS Regional Office closest to the unit's homeport.

G. Defense Enrollment Eligibility Reporting System (DEERS) in CG Health Care Facilities.

1. Defense Enrollment Eligibility Reporting System. This Section provides guidance for CG health care facilities on the use of the Defense Enrollment Eligibility Reporting System (DEERS) to verify patient eligibility to receive care. DEERS was established in 1979 by the Department of Defense to comply with a Congressional mandate. The two initial objectives of DEERS were to collect and provide demographic and socio-graphic data on the beneficiary population entitled to DOD health benefits, and to reduce the fraud and misuse of those benefits. The original scope of DEERS has since been broadened to include the maintenance and verification of eligibility status for all uniformed services beneficiaries. Worldwide implementation of DEERS and its registration were completed in 1985.
2. Responsibilities.
 - a. Commandant (CG-1123). Commandant (CG-1123) provides overall functional management of the CG DEERS program for health services facilities. In this role, Commandant (CG-1123) provides guidance to field activities, represents the CG to the DEERS Central Systems Program Office (DCSPO), and on the DEERS Central Systems Project Officers Committees.
 - b. Health, Safety, and Work-Life Service Center (HSWL SC). HSWL SC shall appoint a DEERS medical project officer and alternate, who shall ensure that facilities in their respective areas participate in and comply with DEERS program requirements.
3. Performing DEERS Checks.
 - a. Whom to check. All beneficiaries of the military health care system are subject to DEERS eligibility verification, with the following exceptions:
 - (1) CG cadets, officer candidates, and recruits while undergoing training.
 - (2) Active duty personnel receiving dental care at a military facility.
 - (3) Secretarial Designees, including pre-adoptive children and wards of the Court, ARE NOT ELIGIBLE for care under the TRICARE programs. They are also not enrolled in DEERS. Verification of the eligibility of Secretarial Designees for care in a military facility is accomplished through the individual's actual letter of designation. Refer to Section 2-E for further information.
 - b. When to check. CG health services facilities should verify the eligibility of all beneficiaries prior to providing health care. The following minimum eligibility checks shall be made:
 - (1) 100% of all outpatient visits including visits for medical, dental, pharmacy and ancillary services.

- c. How to check. DEERS checks for patient registration and eligibility can be done in a number of ways. The following are the most common ways to verify eligibility:
- (1) DEERS eligibility is automatically verified in CHCS upon entering patient demographics.
 - (2) Use of Servicing Personnel Office (SPO)/Admin RAPIDS Terminals. Personnel in health care facilities are discouraged from performing DEERS checks using the RAPIDS terminal that may be available in their unit's Administration Office or SPO. Using this resource places an unnecessary burden on the SPO/Admin personnel, and using these terminals does not indicate that the required medical checks are being accomplished.
4. Eligibility/Enrollment Questions, Fraud and Abuse.
- a. Eligibility/Enrollment Questions. Beneficiaries of the military health care system, including active duty and retired personnel, their dependents, and survivors must provide positive proof of eligibility before being provided health care. Eligibility is determined by presenting a valid ID Card and verifying enrollment and eligibility in DEERS.
 - (1) If an individual presents an ID card that is no longer valid (expired), the individual should be refused routine care and the ID card confiscated.
 - (2) If the individual has a valid ID card, but is not enrolled in DEERS, they should be refused routine care, and referred to their sponsor and/or service ID card activity to be enrolled in DEERS. Following enrollment into DEERS, the patient may prove temporary eligibility (pending their enrollment showing up in the DEERS computer) by presenting a certified copy of Application for Uniformed Services Identification Card, Form DD-1172 from the ID card activity. Upon presenting of this DEERS enrollment verification, the individual should be considered as fully eligible, and treatment provided.

* Emergency care should be rendered to any individual in need.*
 - b. Fraud and Abuse. If, in the process of verifying eligibility through DEERS, clinic personnel have reason to believe the person requesting care is doing so even though that person is no longer eligible (e.g. a divorced spouse with a valid ID card, but DEERS shows NOT ELIGIBLE), care should be refused, and the details of the situation should be reported to the appropriate personnel activity and investigation office. Clinic personnel reporting suspected fraud should document as much information about the individual as possible (name, former sponsor's name, SSN, service and status, as well as the individual's current address and telephone number if known). Do not attempt to confiscate the ID card or in any way restrict the individual. Recovery of invalid or no-longer-appropriate ID cards is the responsibility of the parent service's

investigation/law enforcement personnel. Reports of possible fraud should be reported to the command of the clinic and to the Defense Manpower Data Center Support Office (DMDC) in Monterey, CA at (800) 361-2508 Monday – Friday, 0600 – 1600 PST.

5. Denial of Nonemergency Health Care Benefits for Individuals Not Enrolled in Defense Enrollment Eligibility Reporting System (DEERS).
 - (1) All CONUS USMTFs will deny nonemergency health care to dependent beneficiaries not enrolled in DEERS. The DOD considers USMTFs located in Alaska, Hawaii, and Puerto Rico as being in CONUS. Patients presenting for care are required to have a valid ID card in their possession and meet DEERS enrollment requirements.
 - (2) This policy affects only the delivery of nonemergency health care. Under no circumstances are CG health services personnel to deny emergency medical care or attention because a patient is not enrolled in DEERS.
 - (3) Health services personnel in CG health care facilities are to conduct the minimum eligibility checks for their facility as set annually by Commandant (CG-1121). Whenever possible, prospective checking should be accomplished soon enough to allow for notifying the patient and correcting enrollment problems before a scheduled appointment.
 - (4) Patients with valid ID cards, but not enrolled in DEERS, presenting for nonemergency medical care at CGMTFs will be denied care and instructed to seek proper enrollment through their cognizant personnel office.
 - (5) Patients, who present for nonemergency treatment without a valid ID card and are in the DEERS data base, will not be provided health care without first providing a statement, signed by a verifying personnel officer indicating that they are eligible and providing a reason why a valid ID card is not in their possession. A copy of this statement will be maintained in the clinical record until the individual's eligibility is determined.
 - (6) If the beneficiary presenting with or without an ID card is suspected of fraud, refer the case to the legal branch for appropriate investigation.
 - (7) Denial of health care benefits represents a serious application of new and complex regulations. Under no circumstances will a person be denied care by the clerk performing the initial eligibility check. The decision to deny care will be made only by Health Services Administrator or by a responsible person so designated in writing by the command.
6. DEERS Eligibility Overrides. The below listed situations will override DEERS data which indicates that a patient is not enrolled or eligible. Unless otherwise stated, all situations assume that the beneficiary possesses a valid ID card:

- a. Dependents Recently Becoming Eligible for Benefits. Patients who have become eligible for benefits within the previous 120 days may be treated upon presentation of a valid ID card. In the case of children under age 10, the parent's ID card may be used. Examples of patients expected to fall under this provision are: spouses recently married to sponsors, newly eligible step children, family members of sponsors recently entering active duty status for a period over 30 days, parents/parents-in-law, or divorced spouses (not remarried) recently determined to be eligible. After 120 days, these beneficiaries will no longer be considered recent.
- b. Application for Uniformed Services Identification Card, Form DD-1172. The patient presents an original or a copy of the Application for Uniformed Services Identification Card, Form DD-1172 used for DEERS enrollment and possesses a valid ID card over 120 days old, but is not enrolled in DEERS. This copy of the Application for Uniformed Services Identification Card, Form DD-1172 should be certified to be a True Copy by the ID Card issuing authority which prepared it. It should also contain a telephone number where the certifying individual can be contacted for verification. The person conducting the DEERS check shall contact the issuing personnel office to verify enrollment.
- c. Sponsors Entering Active Duty Status for a Period of Greater than 30 days. If the sponsor is a reservist or guardsman recently ordered to active duty for a period of greater than 30 days, a copy of the active duty orders may be accepted as proof of eligibility for up to 120 days after the beginning of the active duty period. Additional information concerning Reserve mobilization TRICARE benefits is available at <http://www.tricare.mil>.
- d. Newborns. Newborns born into Active Duty Service Member (ADSM) families or retiree families where one parent/family member is enrolled in TRICARE Prime are deemed enrolled in Prime for sixty (60) days and no Non-Availability Statement (NAS) is required for such newborns. The TRICARE Regional Director (RD) of each TRICARE Regional Office (TRO) and Deputy Director of each TRICARE Area Office (TAO) are granted the authority to extend the deemed period up to 120 days, on a case-by-case or regional basis.
- e. Ineligible due to ID Card Expiration. When the data base shows a patient to be ineligible due to ID card expiration, care may be rendered as long as the patient has a new ID card issued within the previous 120 days.
- f. Sponsor's Duty Station is Outside the 50 United States with an FPO or APO address. Dependents whose sponsors are assigned outside the 50 United States or to a duty station with an APO or FPO address will not be denied care as long the sponsor is enrolled in DEERS.
- g. Survivors. In a small percentage of cases, deceased sponsors may not be enrolled in DEERS. This situation will be evidenced when the MTF does an eligibility check on the surviving beneficiary and does not find the sponsor

enrolled or the survivor appears as the sponsor. In either of these situations, if the survivor has a valid ID card, he/she should be treated and referred to the local personnel support activity to correct the DEERS data base. In some situations, surviving beneficiaries who are receiving Survivor Benefit Plan (SBP) annuities will be listed in DEERS as sponsor and will be found under their own social security number. These are eligible beneficiaries and should be treated.

- h. Foreign Military Personnel. Foreign military personnel assigned via the personnel exchange program are eligible through public law or other current directives, though not enrolled in DEERS they will be treated upon presentation of a valid ID card.

H. Health Care Facility Definitions.

1. CG Health Care Facilities.

- a. Clinic. A CG owned or leased health care facility primarily intended to provide outpatient medical service for ambulatory patients. A clinic must perform certain non-therapeutic activities related to the health of the personnel which are necessary to support the operational mission of the unit, such as periodic health assessments (PHA), physical examinations, immunizations, medical administration, and preventive medical and sanitary measures. A clinic staff consists of at least one permanently assigned physician (Medical Officer), a Health Services Administrator, and Health Services Technicians. The staff may include Dentists, Nurses, Pharmacists, Physician Assistants and other specialists as required. A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital, and for overnight care of patients who do not require complete hospital services (e.g., isolation of patients with communicable diseases). A clinic must participate in the CG's external accreditation program with the Accreditation Association for Ambulatory Health Care (AAAHC) and participate in all aspects of the CG's Quality Improvement Program as outlined in the Chapter 13 of this Manual. A clinic serves as the "parent" DMIS TRICARE enrollment site
- b. Satellite Clinic. A health care facility which is under the operational control (OPCON) of a CG clinic, but is located off-site from the clinic. It is an intermediate size medical care facility (ashore) intended to provide outpatient medical care for active duty personnel. A satellite clinic will perform activities related to the health of the personnel which are necessary to support the operational missions of all units within AOR, such as physical examinations, immunizations, medical administration, and preventive medical and sanitary measures. A satellite clinic will normally be staffed with one Medical Officer and three or more health service technicians. A satellite clinic serves as the "child" DMIS TRICARE enrollment site to the "parent" CG clinic.
- c. Dental Clinic. A facility at a CG unit for the dental care and treatment of AD personnel. Dental clinics are staffed with one or more Dental Officers and HS.
- d. Sick Bay. A small medical treatment facility (afloat or ashore) normally staffed only by Health Services Technicians for the care and treatment of AD personnel. Civilian health care providers contracted to provide in-house services at these facilities, like any facility, may provide care only within the scope of their contracts. The fact that these civilian health care providers are on board will not change the status of the medical facility.
- e. Regional Practice. Regionally located multi-site unit responsible for delivering Health, Safety, and Work-Life services programs within an AOR, thus functioning as a Group Practice. The HSWL SC acts as technical authority and oversees all service delivery. A Regional Manager (CG O-4/LCDR) serves as

the administrator of the Group Practice and Work-Life Supervisor. The Executive Staff is comprised of USPHS dental, medical and pharmacy officers serving with the CG and a CG E-7, E-8 or E-9 IDHS.

- f. Resource Sharing Facility. Is a Department of Defense (DoD) or Veterans Affairs (VA) operated medical facility that provides health care to CG and DoD beneficiaries using CG or PHS Medical Officers through a resource sharing agreement.

2. Department of Defense Medical Facilities.

- a. Nomenclature and Definitions. There are three types of DoD fixed medical treatment facilities: medical centers, hospitals, and clinics. The nomenclature and definitions applicable to the classification of these facilities, as set forth below, are used by the Army, Navy, Air Force, and Marine Corps.
 - (1) Medical Center. A medical center is a large hospital which has been designed, staffed and equipped to provide health care for authorized personnel, including a wide range of specialized and consultative support for all medical facilities within the geographic area of responsibility and post graduate education in the health professions.
 - (2) Hospital. A medical treatment facility capable of providing definitive inpatient care. It is staffed and equipped to provide diagnostic and therapeutic services in the field of general medicine and surgery, preventive medicine services, and has the supporting facilities to perform its assigned mission and functions. A hospital may, in addition, discharge the functions of a clinic.
 - (3) Clinic. A medical treatment facility primarily intended and appropriately staffed and equipped to provide emergency treatment and outpatient services. A clinic is also intended to perform certain non-therapeutic activities related to the health of the personnel served, such as PHAs, physical examinations and preventive medicine services necessary to support a primary military mission. A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital, and for care of cases which cannot be cared for on an outpatient status, but which do not require hospitalization.
- b. Primary Mission. The primary mission of DoD medical facilities is to provide adequate medical care for members of the Uniformed Services on AD.

3. Uniformed Services Military Treatment Facilities (USMTFs).

- a. Former USPHS hospitals. Public Law 97-99 (1981) authorized several former USPHS hospitals (sometimes called Jackson Amendment facilities) to provide health care to active duty and retired members and their dependents. The law was modified in 1991 and the USMTF program was mandated to implement a

managed care delivery and reimbursement model in order to continue as part of the Military Health System (MHS). This managed care plan went into effect on October 1, 1993 and is called the Uniformed Services Family Health Benefit Plan (USFHBP).

- b. USFHBP. USFHBP is a health maintenance organization-type of plan exclusively for the dependents of active duty, retirees and their dependents. Where available, the USFHBP serves a defined population, through voluntary enrollment, and offers a comprehensive benefit package. The capacity at USFHBP sites varies and is limited. Beneficiaries enroll in the USFHBP during a yearly open season, and may disenroll after one year. Enrollment is confirmed by each USFHBP site. Those not accepted during the open season may be enrolled as openings occur on a first come-first served basis. USFHBP enrollees are not authorized to use the TRICARE Program or the direct care system (DoD and CG health care/dental facilities included) while enrolled in the USFHBP.
- c. Not enrolled in the USFHBP. Dependents and retirees who do not enroll in the USFHBP or who are denied enrollment because the USFHBP is at capacity can only be treated at USMTFs on a space-available and fee-for-service basis. All USMTFs are required to be TRICARE preferred providers.
- d. USFHBP is not for active duty personnel. Active duty personnel are not eligible to enroll in the USFHBP, however, they can still be treated at USMTFs under one of the following conditions:
 - (1) For emergency care.
 - (2) When referred by a military treatment facility.
 - (3) When authorized by HSWL SC for non-emergent care.
- e. No bills. When active duty care is rendered, the USMTFs are not authorized to bill or collect payment from active duty members, they must bill the CG instead.

I. Policies and Procedures Required at CG Health Care Facilities.

1. Administrative Policies and Procedures. All facilities shall develop and maintain the following written administrative policies and procedures which shall be reviewed annually and updated as needed.
 - a. Standard Operating Procedure. Standard Operating Procedure (SOP) defining objectives and policies for the facility.
 - b. Organizational Chart. Organizational chart of the Regional Practice components in the District.
 - c. Clinic Protocols. Clinic protocols, posted in the respective department, for pharmacy, medical laboratory, and medical and dental radiology.
 - d. Notices if Pregnant. Notices posted in pharmacy and radiology advising female patients to notify department personnel if they are or might be pregnant or breast feeding (pharmacy only).
 - e. After-Hours Emergency Care. Written guidelines advising patients how to obtain after-hours emergency medical and dental advice or care. These must be readily available and widely publicized within the command and the local eligible beneficiary community.
 - f. Quality Improvement Program. Quality Improvement (QI) program guidelines including assignment of a QI coordinator and QI focus group members in writing. The QI focus group shall meet at least quarterly and maintain written minutes.
 - g. Patient Advisory Committee. Guidelines for a patient advisory committee (PAC) comprised of representatives of the health care facility and each major, identifiable, patient interest group. The PAC shall meet periodically and maintain written minutes.
 - h. Authorized to Deny Care. Persons authorized to deny care shall be so designated in writing by the command.
 - i. Time clocks. All clinics shall maintain a functioning time clock and all contract employees shall clock in and out of work every work day. Health Services Administrators shall verify time cards at every pay period.
2. Operational Policies and Procedures. Facilities shall also develop and maintain the following written operational policies and procedures. These require annual review and signature by all health services personnel:
 - a. Emergency Situation Bill. Emergency Situation Bill including Health Services Division response to fire, earthquake, bomb threat, heavy weather, etc.

- b. Emergency Response Protocols. Health Services Emergency Response Protocols for suicide attempt/threat, rape/sexual assault, family violence and medical emergencies in the dental clinic.
 - c. Protocol for Managing After-hours Emergencies. Clinics at accession points and at Coast Guard units with on-base family housing shall maintain a 24-hour live watch schedule.
3. Patient Rights. Health care shall be delivered in a manner that protects the rights, privacy and dignity of the patient. Sensitivity to patient needs and concerns will always be a priority.
- a. Patient Bill of Rights and Responsibilities poster. Clinics shall post the Patient Bill of Rights and Responsibilities poster in clear view in all patient waiting and urgent care areas. Copies are available from Commandant (CG-1121).
 - b. Chaperones. Chaperones shall provide comfort and support to patients during exams or treatment. All patients shall be informed of the availability of chaperones.
 - (1) Chaperones are defined as persons who attend patients during medical exams or treatment. Chaperones shall be of the same gender as the patient being examined. Any nursing staff member, HS or volunteer may serve as a chaperone as part of their duties. The Senior Health Services Officer (SHSO) shall ensure that chaperones have appropriate preparation to include familiarization with the procedure and basic HIPAA policy training to enable them to carry out their duties properly. Although a patient's request for a family member or friend to be present during examination may be honored, that person is not a substitute for a chaperone.
 - (2) Patients who request the presence of a chaperone shall have their request honored unless, in the opinion of the Medical Officer, the risk to the chaperone outweighs the benefit to the patient (e.g., during x-ray exposures).
 - (3) Female patients undergoing breast examination or genital/rectal examination or treatment must have a chaperone present during the examination. Male patients may have a chaperone present at the patient's request. If a provider thinks a chaperone is necessary, and the patient refuses to permit the services of a chaperone, the provider must consider whether to perform the examination or treatment or to refer the patient to another source of care.
 - (4) Clinics shall have a written policy for reporting any episode of alleged misconduct during medical/dental examinations to the unit CO. Unit COs shall investigate such complaints in accordance with regulations.

- c. Responsibility of the patient chaperone policy. The SHSO shall enforce the patient chaperone policy and ensure chaperones are qualified to perform their duties.
 - d. Allegations of misconduct. The SHSO shall ensure that allegations of misconduct are forwarded to the command in a timely manner.
 - e. Educational materials. Clinics shall ensure that patient educational materials concerning gender-neutral health issues (dental health, cardiovascular risk factors, colorectal cancer) and gender-related health issues (PAP smears, cervical cancer, breast disease, testicular and prostate cancer, etc.) are readily available.
4. Health Care Provider Identification.
- a. Patients right to know their physician. In accordance with the Patient Bill of Rights and Responsibilities, all patients have the right to know the identity and the professional qualifications of any person providing medical or dental care. The recent addition of Nurse Practitioners and commissioned Physician Assistants to our health care staffs has increased the chances of misidentification. Accordingly, health care providers shall introduce themselves and state their professional qualifications (level of provider) at each patient encounter.
 - b. Health care name tags. The standard CG name tag does not reflect any information concerning the professional qualifications of the health care provider. Additionally, the standard CG name tag is often not visible to patients with poor eyesight, or it may be hidden by the provider's smock or lab coat. In lieu of the standard CG name tag, all health care providers, civilian and military, shall wear a specific health care provider identification tag on their outer smock or lab coat when engaged in direct patient care in CG clinics. The health care provider identification tag shall be worn above the right breast pocket (or equivalent). The following criteria shall be used by local commands and clinics in manufacturing the health care provider identification tags:
 - (1) Size. The identification tag shall be 1" high by 3" wide.
 - (2) Materials. Standard plastic name tag blanks which may be purchased locally or from Government sources.
 - (3) Color. Standard CG blue or black with white lettering.
 - (4) Contents. The identification tag shall contain the following information:
 - (a) The rank, first initial and last name shall be centered on the identification name tag and placed on the top line.

- (b) One of the following professional titles, or any other commonly recognized professional name, centered below the name line. Abbreviations shall not be used.

[1] Physician

[2] Dentist

[3] Physician Assistant

[4] Nurse Practitioner

[5] Pharmacist

[6] Physical Therapist

[7] Optometrist

[8] Registered Nurse

[9] Health Services Technician

J. General Standards of Care.

1. Standard of Care. Patients at CG clinics and sickbays shall be treated in accordance with the following general standards of care:
2. Diagnosis and Therapy. Diagnosis and therapy shall be performed by a provider with appropriate credentials.
3. Basis for Diagnoses. Diagnoses shall be based upon clinical findings and appropriate tests and procedures.
4. Treatment. Treatment shall be consistent with the working diagnosis, and shall be based upon a current treatment plan. Treatment shall be provided using currently accepted clinical techniques.
5. Time Line for Treatment. Treatment shall be rendered in a timely manner. Providers should use their professional judgment in accounting for the specific needs of patients and military readiness obligations while attempting to meet the following goals for timeliness:
 - a. Acute Care (medical). If provided, the patient should be triaged immediately and be seen based on urgency of the condition. The patient should be advised of the wait time to be seen and offered a later appointment if the condition does not warrant immediate attention.
 - b. Urgent Care (medical). The wait time should not exceed twenty-four (24) hours. The condition must be addressed, not necessarily resolved, within this time frame.
 - c. Routine Visit (medical). The wait time should not exceed 1 week (seven (7) days).
 - d. Specialty Care (medical). To be determined by the Primary Care Manager (PCM) making the referral based on the nature of the care required and the acuteness of the injury, condition, or illness, but should not exceed a wait time of 4 weeks (twenty-eight (28) days) to obtain the necessary care.
 - e. Well Visit. The wait time should not exceed 4 weeks. (Check TRICARE access Standards)
 - f. Urgent Care (dental). The wait time should not exceed 1 day. The condition must be addressed, not necessarily resolved, within this time frame.
 - g. Routine Visit (dental). The wait time should not exceed 4 weeks.
 - h. Scheduled Appointment (medical or dental). The wait time should not exceed 30 minutes of appointed time. This may sometimes be delayed by the need to address prior scheduled patients, emergency care, or unforeseen military obligations.
 - i. Pharmacy. Prescription available within 30 minutes.
6. Correct-site Surgery Policy. The purpose of the “Correct Site Surgery Policy” is to ensure that a comprehensive approach is in place to prevent the occurrence of a

wrong site surgery/procedure. All patients having a surgical/operative procedure shall have the surgical/operative site, confirmed by the healthcare team before any procedure is performed. Marking the correct site on radiographs and touching the correct surgical site are two examples of confirmation. Confirmation is not limited to the above examples.

- a. Verify. Verify that the patient and record match. (i.e. that you are performing surgery on the correct person).
 - b. Checklist. A checklist will be used for every surgical/operative encounter to document verification of the surgical site.
 - (1) Review radiograph(s) for surgical/operative site.
 - (2) Review medical/dental record to verify surgical site indicated for treatment.
 - (3) Review actual surgical site in presence of healthcare team.
 - (4) Review informed consent.
 - (5) Confirm surgical site with patient.
 - c. Incomplete Checklist. An incomplete checklist will result in postponement of the surgical/operative encounter until the documentation is completed. Any site discrepancy noted during the verification process will result in an immediate halt to the surgical encounter until the discrepancy can be resolved by members of the healthcare team.
7. Patients Role. Patients shall participate in deciding among treatment alternatives available to them.
 8. Documentation. All diagnosis and treatment shall be appropriately documented, including subjective complaints, pertinent positive and negative history, objective findings, clinical assessment, and plan for treatment, prescriptions, post-treatment instructions, and disposition of patient. Unusual circumstances, including complications of treatment shall be fully documented.
 9. Deaths.
 - a. General. The Military Casualties and Decedent Affairs, COMDTINST M1770.9 (series) contains further guidance concerning casualties and decedent affairs. Chapter 2 of the Administrative Investigations Manual, COMDTINST M5830.1 (series) contains guidance for notifying CGIS about incidents of death or injury to CG military and civilian members.
 - b. Duties of Health Services Department. In the event of a death at a CG unit the Medical Officer or Health Services Department Representative shall report immediately to the scene and:

- (1) Make contact with on-scene law enforcement (e.g., CGIS, other state, local or Federal law enforcement) and advise them of identifying information needed regarding the deceased.
 - (2) Advise the Commanding Officer of the name, grade or rate, and social security number of the deceased.
 - (3) Advise the Commanding Officer of the time and place of death.
 - (4) Advise the Commanding Officer, insofar as possible, as to the cause of death.
 - (5) Ensure notification of the Quarantine Officer or Coroner if required.
 - (6) Arrange with local civilian authorities for issuing a death certificate.
- c. Determining Cause of Death. When an active duty CG member dies aboard a CG vessel or station under unnatural or suspicious circumstances, or when the cause of death is unknown, an administrative investigation shall immediately be convened in accordance with Military Casualties and Decedent Affairs, COMDTINST M1770.9 (series) and Chapter 7 of the Administrative Investigations Manual, COMDTINST M5830.1 (series).
- d. Death Certificates for Deaths Occurring Away From Command or in Foreign Ports.
- (1) Active duty member dies while away from his/her duty station. When an active duty member dies while away from his/her duty station, the Commanding Officer or designated representative shall obtain a death certificate from civilian authorities. CGIS may be able to assist, if necessary. If the civilian death certificate does not furnish all necessary information, the district commander of the district in which the death occurred shall request additional information.
 - (2) If death occurs abroad, request the nearest United States Consular Office to obtain a death certificate from civilian authorities.
 - (3) Missing status. When an active duty member, or a reserve performing inactive duty for training, is in a missing status because of events in international waters and no identifiable remains can be recovered, and no civilian death certificate is issued, a report (including recommendations) shall be made as per Military Casualties and Decedent Affairs, COMDTINST M1770.9 (series).
- e. Relations with Civilian Authorities. As appropriate, CGIS will be the liaison between commands and civilian authorities. When a CG member dies outside the limits of a CG reservation, the body shall not be moved until permission has been obtained from CGIS and/or civilian authorities (e.g., Coroner's office and/or Medical Examiner). In order that there may be full understanding and accord between the CG and civilian authorities, appropriate procedures will be developed for each command area, in consultation with CGIS and the civilian authorities, covering deaths of personnel within and outside the limits of CG

commands. In general, and except where the state has retained concurrent jurisdiction with the United States, civilian authorities have no jurisdiction over deaths occurring on Coast Guard reservations. A transit or burial permit, however, issued by civilian authorities is required for removal of a body from a Coast Guard reservation for shipment or burial.

- f. Reporting Deaths. In conjunction with the action required in Ch. 4-A-6.j of the Manual, verbal briefs are provided to those on a need to know basis (i.e. Commandant (CG-112), HSWL, etc.). CG Investigative Service (CGIS) may also inquire and request to review the health record. The health record shall be forwarded to the HSWL SC for a Quality Improvement (QI) review upon conclusion of local review(s). Findings of the review are forwarded to Commandant (CG-11) via Commandant (CG-112) to determine if additional investigation, process improvement, or adverse privileging action is warranted. The HSWL SC shall forward the original health record to Commander (PSC-mr).
- g. Reporting Deaths to Civilian Authorities. When a death occurs at a CG activity in any state, territory, or insular possession of the United States, the death must be reported promptly to CGIS and civilian authorities. Local agreements concerning reporting and preparing death certificates shall be made between the Commanding Officer, or designated representative, and the civilian authorities.
- h. Death Forms for Civilian Agencies and Individuals. Forward all requests for completing blank forms concerning death of CG personnel to Commander PSC (PSD-fs) for action.
- i. Identification of Remains. Identification of remains may be established by DNA, marks and scars, dental records, fingerprints, and personal recognition. In questionable cases, a Dental Officer shall examine the remains and record observations on a Dental Record, Form SF-503 for comparison with other available records.

K. Patient Centered Wellness Home.

1. Policy.

- a. Based upon the patient centered medical home concept, the HSWL SC Patient Centered Wellness Home (PCWH) will incorporate all HSWL SC services as an encompassing and holistic health care delivery model for all beneficiaries receiving care/services in CG HSWL SC facilities (Ref: HSWLSCINST 6012.1).
- b. HSWL SC maintains authority to issue, modify, and update the PCWH instruction for delivery of health related services.

2. Beneficiaries.

- a. Beneficiaries receiving care at USMTFs should be encouraged to seek Patient Centered Medical Home enrollment.
- b. Beneficiaries receiving care in civilian facilities via Tricare Prime Remote enrollment should be encouraged to seek out Patient Centered Medical Home practices/Primary Care Managers for enrollment.