CMS Changes the Process Hospitals Use to Credential and Grant Privileges to Physicians and Other Practitioners Who Provide Care Through Telemedicine

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Telemedicine is a rapidly developing application of clinical medicine whereby medical information is exchanged from one site to another via electronic communications. Telemedicine is often used to connect physicians at large hospitals and academic medical centers with patients in smaller hospitals or critical-access hospitals ("CAH"s) in remote places, thereby providing these patients with the specialized care that they otherwise could not obtain in a timely manner. Although the benefit of providing timely care through the use of telemedicine cannot be overstated, a significant deterrent to some hospitals or CAHs in providing such services is the inability to meet the Centers for Medicare and Medicaid Services ("CMS") conditions of participation ("CoP") with respect to credentialing and privileging the telemedicine physicians. Barriers to meeting the CoP have included the costs involved in the traditional credentialing and privileging process for all of the potential telemedicine physicians and the fact that small hospitals and CAHs often do not have in-house medical staff with the clinical expertise to adequately evaluate the wide range of specialty physicians that larger hospitals can provide through telemedicine services. These deterrents and barriers no longer exist.

In May 2011, CMS published its final rule to streamline the process that Medicare-participating hospitals and CAHs partnering to deliver telemedicine services use to grant privileges to telemedicine physicians (the "Final Rule"). The stated goals in

implementing this Final Rule include (1) increasing patient access to specialty services; and (2) reducing the burden on small hospitals and CAHs.

Prior to the Final Rule, regulations had required hospitals and CAHs to grant privileges to remote-site physicians who were already credentialed in distant-site facilities only after they considered qualifications on a practitioner-by-practitioner basis. In other words, hospitals were required to apply the credentialing and privileging requirements as if all practitioners were onsite. CMS finally recognized this as a "limited approach" which failed to "embrace new methods and technologies for service delivery that may improve patient access to high quality care." Now, under the Final Rule, a hospital that provides telemedicine services to its patients via an agreement with a "distant-site" hospital would be allowed to rely upon information furnished by the distant-site hospital (often a larger medical center) in making credentialing and privileging decisions for the distant-site hospital's physicians who provide the telemedicine services. The rule will reduce the burden and duplicative nature of the traditional privileging process while still assuring accountability to the process. The new rule will go into effect on July 5 of this year.

Notably, in issuing the Final Rule, CMS recognized that including the medical staff of a distant-site telemedicine entity (which is not a Medicare-participating hospital), as part of the new optional and streamlined privileging process, would increase the overall effectiveness of the Final Rule. Under the Final Rule, a "distant-site telemedicine entity" is defined as one that (1) provides telemedicine services; (2) is not a Medicare-participating hospital; and (3) provides contracted services in a manner that enables a hospital or CAH using its services to meet all applicable CoP, particularly those related

to the credentialing and privileging of practitioners providing telemedicine services. The governing body of the hospital or CAH using telemedicine services is responsible for ensuring that the distant-site hospital or entity meets CMS credentialing and privileging standards. One way of ensuring that CMS standards are being complied with is the Final Rule's clarification that an agreement for the provision of telemedicine services be ***in writing.*** These agreements must be provided, upon request, when a hospital or CAH is surveyed.

Thus, if a telemedicine arrangement is entered into with a distant-site hospital, the governing body of the hospital or CAH must ensure, through its written agreement, that the following provisions are met in order to allow its medical staff to rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the physicians providing such services:

(1) The distant-site hospital is a Medicare-participating hospital;
(2) The distant-site physician/practitioner is privileged at the distant-site hospital providing the telemedicine services, and a current list of those privileges are provided;
(3) The individual holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located;
(4) With respect to a distant-site physician/practitioner who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital has evidence of an internal review of the distant-site physician/practitioner's performance of these privileges and sends the distant-

site hospital such performance information for use in the periodic appraisal of the distant-site physician/practitioner.

If a telemedicine arrangement is entered into with a distant-site telemedicine entity (as opposed to a Medicare-participating hospital), the governing body of the hospital or CAH must ensure, through its written agreement, that the distant-site telemedicine entity, acting as a contractor of services, furnishes its services in a manner that enables the hospital or CAH to comply with all applicable CoP and standards. Thus, again, responsibility is placed on the hospitals and CAHs to ensure that contracted services fully enable them to meet the CoP. The final three requirements are the same as with a Medicare-participating hospital.

Of particular significance under the written agreement is that hospitals or CAHs that rely on this new so-called proxy credentialing will need to share what is generally considered privileged peer review information with the distant-site hospital or distant site entity for those practitioners who exercise telemedicine privileges at the hospital or CAH. Thus, it is advisable for the written agreements to include language that will assure ongoing protection of this peer review information.

The Final Rule does not require, but allows, the "providing" hospital to decide, in its own discretion, whether to rely on credentialing and privileging decisions of the distant-site telemedicine entity/hospital or follow its traditional procedures. Hospitals and CAHs that choose to use this new streamlined proxy credentialing approach should (1) takes steps to ensure that their medical staff bylaws permit credentialing for telemedicine privileges consistent with the Final Rule and (2) have written agreements in place.