

Revisions to Telemedicine Credentialing and Privileging Rules



Tatiana Melnik is an associate with the Dickinson Wright law firm. Ms. Melnik sits on the Michigan Bar Information Technology Law Council and the Automation Alley Healthcare Information Technology Committee. Ms. Melnik holds a JD from the University of Michigan Law School, a BS in Information Systems, and a BBA in International Business, both from the University of North Florida.



Brian Balow is a member of the Dickinson Wright law firm and chairs the firm's IT Law Group. Mr. Balow was the firm's Business Technology and Telecommunications practice department manager from 2003 to 2008. Mr. Balow has nearly 20 years of experience in IT law-related matters, including health care IT.

Telemedicine Made Easier for Rural and Small Hospitals

While telemedicine is not new, with the refocus on cost savings in the health care industry it has received renewed attention. Numerous studies have found substantial cost savings when using telemedicine over traditional health care delivery practices.¹ Substantial obstacles, however, exist to widespread adoption of telemedicine.

One set of obstacles was recently minimized on May 5, 2011, when the Centers for Medicare & Medicaid Services (CMS) released the final rule addressing credentialing and privileging requirements related to telemedicine at hospitals and critical access hospitals (CAHs). The final rule is to become effective on July 4, 2011, which is 60 days from its publication in the *Federal Register*.

ABOUT TELEMEDICINE

The first reference to telemedicine appeared in medical literature in 1950.² Telemedicine is defined as “the provision of clinical services to patients by practitioners from a distance via electronic communications.”³ Telemedicine is a subset of telehealth, which involves a wide variety of long-distance health care activities. CMS defines telehealth as “the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.”⁴

The field of telemedicine has grown tremendously since 1950 and has continued to grow as the federal government as well as various state entities have invested in telemedicine infrastructure development and research. In a 1997 report to Congress, the U.S. General Accounting Office reported that between 1994 and 1996 nine federal departments and independent agencies had invested an

aggregate of at least \$646 million in telemedicine projects.⁵ More recently, the Federal Communications Commission launched its Rural Healthcare Pilot Program, the Department of Agriculture launched its Rural Development Telecommunications Program, and the Department of Health and Human Services (HHS) is administering a variety of telehealth grant programs.

CREDENTIALING AND PRIVILEGING: AN OBSTACLE TO ADOPTION

These requirements have, unsurprisingly, impeded and apparently were not crafted with telemedicine in mind. Telemedicine adoption, credentialing, and privileging requirements which are the minimum health and safety standards that providers must meet to be Medicare and Medicaid certified are outlined in the Medicare conditions of participation (CoPs).⁶

Under the current CMS regulations, hospitals must implement a credentialing and privileging process for all physicians and practitioners providing services to their patients. The hospital's medical staff must evaluate each practitioner individually using CMS regulations and make a recommendation to the hospital's governing body, which then decides whether to grant privileges.

Similarly, the current CoPs for CAHs require that every rural health network member CAH must "have an agreement for review of physicians and practitioners seeking privileges at the CAH."⁷ This "arrangement must be with a hospital that is a member of the network, a Medicare Quality Improvement Organization (QIO), or another qualified entity identified in the State's rural health plan."⁸ Additionally, each doctor providing services to the "CAH must be evaluated by one of these same three types of outside parties."⁹ The current process applies equally to traditional health care delivery practitioners and telemedicine practitioners, who are already credentialed and have privileges at the distant-site hospital.

As best stated by CMS:

Upon reflection, we came to the conclusion that our present requirement is a duplicative and burdensome process for physicians, practitioners, and the hospitals involved in this process, particularly small hospitals and CAHs, which often lack adequate resources to fully carry out the traditional credentialing and privileging process for all of the physicians and practitioners that may be available to provide telemedicine services. In addition to the costs involved, small hospitals and CAHs often do not have in-house medical staff with the clinical expertise to adequately evaluate and privilege the wide range of specialty physicians that larger hospitals can provide through telemedicine services. The public comments we received on the proposed rule...overwhelmingly reinforced this perception.

THE OBSTACLE MINIMIZED

In the final rule, CMS permits hospitals and CAHs to implement proxy credentialing with Medicare-certified hospitals as well as other telemedicine entities regardless of whether they are a Medicare-certified hospital.

Medicare-Participating Hospital Distant-Site

For distant-site hospitals that are Medicare-participating hospitals, the final rule requires that the hospital or CAH receiving the telemedicine services (the "originating site hospital") have a written agreement specifying that it is the responsibility of the distant-site hospital to meet the credentialing requirements of 42 C.F.R. 482.12(a)(1)-(a)(7) for hospitals or 42 C.F.R. 485.616(c)(i)-(c)(vii) for CAHs. The medical staff of the originating site hospital may rely on information from and credentialing decisions of the distant-site hospital when making its recommendations on telemedicine privileges *so long as it ensures through the writ-*

ten agreement that all of the following provisions are met:

1. The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.
2. The individual distant-site practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site practitioner's privileges at that distant-site hospital.
3. The individual distant-site practitioner holds a license issued or recognized by the state in which the originating site hospital is located.
4. The originating site hospital conducts and maintains records of an internal review of the distant-site practitioner's performance of the telemedicine services and sends the distant-site hospital these reviews for the distant-site hospital's periodic appraisal of the practitioner. Such reviews must include all adverse events that result from the telemedicine services provided by the distant-site practitioner to the originating sites' patients and all complaints the originating site hospital has received about the distant-site practitioner.

Non-Medicare-Participating Distant-Site

CMS also allows an originating site to use telemedicine services of non-Medicare-participating entities, called distant-site telemedicine entities (DSTEs), which CMS defines in the commentary as an entity 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 CoPs.

For DSTEs, the final rule requires that the originating site hospital have a written agreement specifying that the DTSE must provide services in a manner allowing the hospital to meet the credentialing requirements of 42 C.F.R. 482.12(a)(1)-(a)(7) for hospitals or 42 C.F.R. 485.616(c)(i)-(c)(vii) for CAHs. The originating site hospital's medical staff may rely on information

from and credentialing decisions of the DTSE when making its recommendations on telemedicine privileges so long as it ensures through the written agreement that all of the following provisions are met:

1. The DSTE's medical staff credentialing and privileging process and standards must at least meet the standards set forth in 42 C.F.R. 482.12(a)(1)-(a)(7) and 42 C.F.R. 482.22(a)(1)-(a)(2) for originating-site hospital or the standards in 42 C.F.R. 485.616(c)(1)(i)-(c)(1)(vii) for originating-site critical access hospital.
2. The individual distant-site practitioner is privileged at the DSTE providing the telemedicine services, which provides a current list of the distant-site practitioner's privileges at the DSTE.
3. The individual distant-site practitioner holds a license issued or recognized by the state in which the originating site hospital's patients receiving the telemedicine services are located.
4. The originating site hospital has evidence of an internal review of the distant-site practitioner's performance of the telemedicine services and sends the DSTE performance information for use in the DSTE's periodic appraisal of the distant-site practitioner. Such reviews must include all adverse events that result from the telemedicine services provided by the distant-site practitioner to the originating site's patients and all complaints the originating site hospital has received about the distant-site practitioner.

CONCLUDING THOUGHTS

Medicine-participation distant-site hospitals and DSTEs desiring to use this proxy credentialing process must review their agreements to ensure that they follow the requirements of the final rule. As CMS made clear, it is "the responsibility of the medicine-participation distant site using the services to ensure that the specifics of the proposed requirements in this rule are explicitly laid out before entering into such an arrangement." Additionally, while this

final rule is a step in the right direction, the telemedicine services are principally limited to in-state services because the final rule requires that the distant-site practitioner be licensed in the state where the originating site's hospital is located.

Telemedicine services crossing state lines, therefore, will continue to run into the traditional barriers with delivery of these services. Finally, under both scenarios, originating sites relying on proxy credentialing must share peer reviews of the distant-site practitioner, which are generally privileged. Hospitals and DSTE's should review state laws governing peer review privilege and incorporate necessary language into their agreements to assure protection from liability associated with this information exchange.

Endnotes:

1. See e.g., Ryan Spaulding et al., *Cost Savings of Telemedicine Utilization for Child Psychiatry in a Rural Kansas Community*, 16 TELEMEDICINE & E-HEALTH 867 (2010) (lowered from \$168.61 to \$30.99 when using telemedicine, when accounted for travel time and other expenses); Press Release, Univ. Rochester Med. Ctr., *Telemedicine Could Eradicate Many Expensive ED Visits* (May 6, 2008), available at www.urmc.rochester.edu/news/story/index.cfm?id=1978 (upstate New York community-wide study found that about 28 percent of all visits to the pediatric emergency department could have been replaced by online doctor visits because visits were non-emergency); John Morrison et al., *Telemedicine: Cost-Effective Management of High-Risk Pregnancy*, MANAGED CARE, Nov. 2001, available at www.managedcaremag.com/archives/0111/0111.peer_highrisk.pdf ("The total mean cost per pregnancy was \$7,225 for the telemedicine group and \$21,684 for the control group, which] represented average savings of \$14,459 per pregnancy using telemedicine services.")
2. Marilyn J. Field, ed., *Evolution and Current Applications of Telemedicine 36* (in *Telemedicine: A Guide to Assessing Telecommunications for Health Care*) (1996), available at www.ncbi.nlm.nih.gov/books/NBK45448/pdf/TOC.pdf ("The article described the transmission, beginning in 1948, of radiologic images by telephone between West Chester and Philadelphia, Pennsylvania, a distance of 24 miles.")
3. Dept. of Health & Human Services (HHS), *Medicare and Medicaid Programs: Changes Affecting Hospital and Critical Access Hospital Conditions of Participation: Telemedicine Credentialing and Privileging, Final Rule*, 76 FR 25551 (2011).
4. HHS, *Telehealth*, www.hrsa.gov/ruralhealth/about/telehealth/ (last visited May 7, 2011).
5. US Gen. Acct. Office, *Telemedicine: Federal Strategy Is Needed to Guide Investments 3* (1997), available at www.gao.gov/archive/1997/n397067.pdf.
6. HHS, *Overview: Conditions for Coverage (CfCs) & Conditions of Participations (CoPs)*, www.cms.gov/CfCsAndCoPs/ (last visited May 7, 2011).
7. Final Rule, 76 FR 25551.
8. *Id.*
9. *Id.*