On May 5, 2011, the Centers for Medicare and Medicaid Services (CMS) released its final rule making changes to CMS’s Conditions of Participation (CoPs) as they pertain to the credentialing and privileging of telehealth providers. The final rule permits both hospitals and critical access hospitals (CAH) to utilize a new process to credential and privilege telehealth providers.

This final rule is the culmination of more than a year-long effort by CMS and the telehealth industry to establish a workable procedure to permit originating-site hospitals (the location of the patient) to rely upon and accept the credentialing and privileging decisions of the distant site entity (the location of the practitioner).

Had this rule not been proposed by CMS, originating-site hospitals would have been required to fully credential and privilege each telemedicine practitioner, just as if that practitioner was present physically in the facility, in order to comply with CMS’s CoPs.

CMS issued its proposed rule nearly one year ago (May 26, 2010) and invited public comment through the rulemaking process. The final rule reflects the CMS response to the public comments received through the rulemaking process. The effective date of the provisions in this rule is July 5, 2011.

The final rule can be found at:

CMS Final Rule
Credentialing and Privileging Telehealth Practitioners

Overview

CMS will add new provisions to the credentialing and privileging process to require the originating site’s governing body (or the CAH’s governing body or responsible individual)
“to ensure that the distant-site telemedicine [hospital or] entity, acting as a contractor of services, furnishes its services in a manner that enables the hospital (or CAH) to comply with all applicable conditions of participation and standards for the contracted services, including, but not limited to, the credentialing and privileging requirements regarding its physicians and practitioners providing telemedicine services.”

Through a required written agreement, the new CMS provisions will allow the originating-site hospital to rely upon the decisions made by the “distant-site telemedicine entity” when making credentialing and privileging decisions for individual, distant-site practitioners providing telemedicine services.

The originating-site hospital, through this written agreement, must ensure that the medical staff’s credentialing and privileging processes and standards at the distant-site telemedicine entity “meets or exceeds the [CMS] standards.”

CMS took an additional step in the final rule, largely in response to the comments they received to the proposed rule. The proposed rule limited the use of credentialing and privileging decisions to those between Medicare-participating hospitals. Recognizing the contributions of non-Medicare participant entities to the delivery of telehealth services, such as teleradiology, teleICU, and teleneurology, CMS now provides that these entities may be included in the optional, credentialing and privileging process with originating site hospitals and CAHs.

**Hospital Conditions of Participation**

CMS provides for these credentialing and privileging changes to be made in two separate CoPs: §482.12 (Governing Body) and §482.22 (Medical Staff).

Regarding changes to the Governing Body CoPs, the final rule includes a new paragraph [§482.12 (a) (8)] which allows the originating site’s governing body “to grant privileges based on its medical staff recommendations, which would rely on information provided by the distant-site hospital.”

This paragraph also stipulates that the agreement between the originating-site hospital and the distant-site hospital must specify that “it is the responsibility of the governing body of the distant-site hospital providing telemedicine services to meet the existing requirements in §482.12 (a) (1) through (a) (7) with regard to its physicians and practitioners who are providing telemedicine services.”

The final rule also makes changes to the Medical Staff CoPs [§482.22 (a) (3)] by allowing the originating-site’s governing body “to have its medical staff rely upon information furnished by the distant-site hospital when making recommendations on privileges for the individual physicians and practitioners providing such services.”

This provision allows the originating-site’s medical staff to rely upon the distant-site hospital’s credentialing and privileging decisions rather than follow the current regulations which require that the medical staff conduct individual appraisals and examine each candidate’s credentials before making a privileging recommendation to the originating-site’s governing body.

It is important to note that this rule does not preclude use of any credentialing and privileging option, including conducting periodic appraisals of telemedicine practitioners or using the traditional credentialing and privileging process.
Hospitals choosing to use this new option for privileging must provide for the following:

1. The distant-site hospital is a Medicare-participating hospital.
2. The distant-site practitioner is privileged at the distant-site hospital.
3. The distant-site hospital provides a current list of the practitioner’s privileges.
4. The distant-site practitioner holds a license issued or recognized by the state in which the originating-site hospital is located.
5. The originating-site hospital has an internal review of the distant-site practitioner’s performance and provides this information to the distant-site hospital.
6. Information sent from the originating-site to the distant site must include all adverse events and complaints from telemedicine services provided by the distant-site practitioner to the originating-site hospital’s patients.

**Telemedicine Entities**

In order to permit originating-site hospitals to rely upon the credentialing and privileging decisions of non-hospital entities providing telemedicine services (e.g. teleradiology, teleICU, and telenurology), CMS added new provisions to address the credentialing and privileging process and the agreements between hospitals or CAHs and distant-site telemedicine entities. [§482.12 (a) (9) and §482.22 (a) (4) for hospitals; §485.616 (c) (3) and (c) (4) for CAHs].

The written agreement between the originating-site and the distant-site telemedicine entity must provide that the telemedicine entity is furnishing its services in a manner that allows the originating-site hospital or the CAH to comply with all applicable conditions of participation and standards.

The governing body of the originating-site hospital must ensure that the contractor of services to the hospital (distant-site telemedicine entity) provides services that comply with all applicable CoPs and standards for contracted services.

**Background on Credentialing and Privileging of Practitioners**

Current CMS regulations require a hospital to have a credentialing and privileging process in place for all practitioners providing services to its patients. CMS regulations do not factor in whether those practitioners are providing only telemedicine services.

Specifically, CMS’s current regulations require a hospital’s governing body to “appoint all practitioners to its hospital medical staff” and to grant privileges using the medical staff’s recommendations. The hospital’s medical staff must follow CMS’s regulations regarding credentialing and privileging to make its recommendations. As a result, CMS’s regulations require hospitals to apply credentialing and privileging requirements as if all practitioners were physically onsite. The hospital governing body is required to make all privileging decisions based on medical staff recommendations after 1) credentials have been examined and verified and 2) staff has determined whether the practitioner should receive hospital privileges. (42 CFR §482.12 (a) (2) and §482.22 (a) (2)
CAH operate in a similar manner by requiring that every CAH, which is a member of a rural health network review all practitioners (whether onsite or practicing telemedicine) seeking CAH privileges by utilizing an agreement between the CAH and a hospital that is a network member, a Medicare Quality Improvement Organization, or another qualified entity in the State’s rural health plan. These CMS requirements can be found at 42 CFR §485.616 (b).

**The Joint Commission Telemedicine Standards**

In 2004, The Joint Commission (TJC or JC) implemented standards for the credentialing and privileging of telehealth practitioners. These standards allowed JC-accredited hospitals to rely on the credentialing and privileging decisions of other JC-accredited facilities for practitioners providing telemedicine services. This process was commonly referenced as “credentialing and privileging by proxy.”

Despite these JC standards being in effect for a number of years, credentialing and privileging by proxy was not recognized by CMS as having met or exceeded the Medicare CoPs. The proposed rule noted, “Hospitals that have used this method to privilege distant-site medical staff technically did not meet CMS requirements that applied to other hospitals even though they were JC-accredited. When CMS learned of specific instances of such noncompliance, through on-site surveys by State Survey Agencies, the hospital was required to change its policies to become compliant.”

Previously, TJC’s statutory “deeming” authority provided that JC-accredited hospitals were “deemed to have met the Medicare CoPs,” including credentialing and privileging. However, in 2008, legislation passed by Congress terminated TJC’s statutorily-recognized hospital accreditation program, effective July 15, 2010 (Medicare Improvements for Patients and Providers Act of 2008--PL 110-275). Because CMS must now approve the standards TJC will use to confer deemed status on hospitals, TJC was required to come into compliance with CMS’s CoPs, including full credentialing and privileging of all telemedicine practitioners.

Anticipating that the final rule would address these issues, CMS twice extended TJC’s authority to continue their telemedicine standards for credentialing and privileging. The current extension runs through July 1, 2011, with time for TJC to transition their accreditation program to meet the new CMS telemedicine credentialing and privileging regulations contained in the final rule.
Health Government Relations Team

Julie Scott Allen
Government Relations Director
(202) 230-5126
Julie.Allen@dbr.com

Brian Altman, JD
Senior Government Relations Manager
(202) 230-5185
Brian.Altman@dbr.com

Greg T. Billings
Senior Government Relations Director
(202) 230-5104
Greg.Billings@dbr.com

Jodie A. Curtis
Senior Government Relations Director
(202) 230-5147
Jodie.Curtis@dbr.com

Hilary M. Hansen
Senior Government Relations Manager
(202) 230-5186
Hilary.Hansen@dbr.com

Rebecca Freedman McGrath, JD
Senior Government Relations Manager
(202) 230-5679
Rebecca.McGrath@dbr.com

Ilisa Halpern Paul, MPP
Managing Government Relations Director
(202) 230-5145
Ilisa.Paul@dbr.com

Rene Y. Quashie, JD
Government Relations Director/Regulatory Attorney
(202) 230-5161
Rene.Quashie@dbr.com

R. Edwin Redfern
Government Relations Director
(202) 230-5151
Edwin.Redfern@dbr.com

Jeremy R. Scott, MA
Government Relations Director
(202) 230-5197
Jeremy.Scott@dbr.com

James W. Twaddell, IV, MA
Government Relations Director
(202) 230-5130
James.Twaddell@dbr.com

Erin Will Morton
Government Relations Manager
(202) 230-5634
Erin.WillMorton@dbr.com
Health Law Practice Group

Kendra M. Allaband
(312) 569-1328
Kendra.Allaband@dbr.com

Matthew P. Amodeo
(518) 862-7468
Matthew.Amodeo@dbr.com

Keith R. Anderson
(312) 569-1278
Keith.Anderson@dbr.com

James A. Barker
(202) 230-5166
James.Barker@dbr.com

Elizabeth D. Battreall
(202) 230-5136
Elizabeth.battreall@dbr.com

Eric M. Berman
(414) 221-6080
Eric.Berman@dbr.com

Jennifer R. Breuer
(312) 569-1256
Jennifer.Breuer@dbr.com

Brett Bush
(518) 452-8787
Brett.Bush@dbr.com

Eileen M. Considine
(518) 862-7462
Eileen.Considine@dbr.com

Stanley W. Crosley
(317) 770-7399
Stanley.Crosley@dbr.com

John J. D’Andrea
(518) 862-7463
John.Dandrea@dbr.com

Jeffrey T. Ganiban
(202) 230-5130
Jeffrey.Ganiban@dbr.com

Stephanie Dodge Gournis
(312) 569-1327
Stephanie.DodgeGournis@dbr.com

Kelley Taylor Hearne
(202) 230-5127
Kelley.Hearne@dbr.com

Kristy M. Hlavenka
(973) 549-7115
Kristy.Hlavenka@dbr.com

Melissa A. January
(312) 569-1283
Melissa.January@dbr.com

Todd D. Johnston
(609) 716-6674
Todd.Johnston@dbr.com

George H. Kendall
(973) 549-7070
George.Kendall@dbr.com

Robert W. McCann
(202) 230-5149
Robert.McCann@dbr.com

Gerald P. McCartin
(202) 230-5113
Gerald.McCartin@dbr.com

Linda S. Moroney
(414) 221-6057
Linda.Moroney@dbr.com

Mark D. Nelson
(312) 569-1326
Mark.Nelson@dbr.com

Brian D. Nichols
(202) 230-5107
Brian.Nichols@dbr.com

Erin Norby
(312) 569-1260
Erin.Norby@dbr.com

Neil S. Olderman
(312) 569-1279
Neil.Olderman@dbr.com

Colleen O. Patzer
(414) 221-6058
Colleen.Patzer@dbr.com

Kenneth C. Robbins
(312) 569-1271
Kenneth.Robbins@dbr.com

Julie M. Rusczek
(414) 221-6060
Julie.Rusczek@dbr.com

Robyn S. Shapiro
(414) 221-6056
Robyn.Shapiro@dbr.com

K. Bruce Stickler
(312) 569-1325
Bruce.Stickler@dbr.com

T.J. Sullivan
(202) 230-5157
TJ.Sullivan@dbr.com

Douglas B. Swill
(312) 569-1270
Douglas.Swill@dbr.com

Jesse A. Witten
(202) 230-5146
Jesse.Witten@dbr.com

Fatema Zanzi
(312) 569-1285
Fatema.Zanzi@dbr.com