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Health Law Alert

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CMS Releases Final Rule on Telemedicine Credentialing and Privileging

On May 2, 2011, The Centers for Medicare & Medicaid Services ("CMS") issued a final rule (the "Final Rule") that amends the Medicare Conditions of Participation (the "CoPs")[1] for hospitals and critical access hospitals[2] and changes the process hospitals can use for credentialing and granting privileges to practitioners who deliver care through telemedicine. Previously, the CoPs required hospitals to fully credential all providers in the same manner regardless of whether the services were to be provided onsite at the hospital or through a telecommunications system.

The Final Rule now allows the hospital receiving the telemedicine services to rely upon credentialing and privileging information from a "distant-site facility" (defined as the location of the provider of the telemedicine services) so long as certain conditions are met, including a written agreement with the distant-site facility. In addition, and in a change from the May 26, 2010 proposed rules (see 75 FR 29479), the Final Rule sets forth a mechanism for hospitals to use a form of "proxy credentialing" with (a) Medicare-certified hospitals; and (b) other telemedicine entities regardless of whether they are a Medicare-certified hospital.

When the distant-site facility is a Medicare-certified hospital, the final regulations require that the hospital have a written agreement that specifies that it is the responsibility of the distant-site hospital to meet the credentialing requirements of 42 C.F.R. 482.12(a)(1) through (a)(7). In such case, the medical staff of the hospital may rely on information provided by, and credentialing decisions of, the distant-site hospital when the medical staff is making its recommendations on telemedicine privileges, provided that it ensures through the written agreement that all of the following provisions are met:

- The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.
- The individual distant-site practitioner is privileged at the distant-site hospital providing the telemedicine services, and that the distant-site hospital provides a current list of said practitioner's privileges.
- The individual distant-site practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located.
- With respect to a distant-site 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 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 practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site practitioner to the

1 For your reference, we have also included a set of the amended CoPs which reflects and highlights the additional and/or amended provisions provided for by the Final Rule. Click here to view the rules or visit http://www.shipmangoodwin.com/files/upload/COPsRules.pdf.

2 Please note that this Client Alert does not address the changes to the rules applicable to critical access hospitals.

Questions or Assistance?

If you have further questions about this alert, please feel free to contact one of the following members of our Health Law Practice Group.

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hospital's patients and all complaints the hospital has received about the distant-site physician or practitioner.

If the distant-site facility is not a Medicare-certified hospital, the distant-site facility is then classified as a distant-site telemedicine entity ("DSTE"). While there is no definition of what qualifies as a DSTE in the final regulations, the DSTE must have a medical staff credentialing and privileging process that complies with the hospital's CoPs as described below.

When the distant-site facility is a DSTE, the final regulations require that the hospital have a written agreement that specifies that the DSTE must provide services in a manner that allows the hospital to meet the credentialing requirements of 42 C.F.R. 482.12(a)(1) through (a)(7). In such cases, the medical staff of the hospital may rely on information provided by, and credentialing decisions of, the DSTE when the medical staff is making its recommendations on telemedicine privileges, provided that it ensures, through the written agreement, that all of the following provisions are met:

- The DSTE's medical staff credentialing and privileging process and standards at least meet the standards in 42 C.F.R. 482.12(a)(1) through (a)(7) and 42 C.F.R. 482.22(a)(1) through (a)(2).
- The individual distant-site practitioner is privileged at the DSTE providing the telemedicine services, and that the DSTE provides a current list of said practitioner's privileges at the DSTE.
- The individual distant-site practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located.
- With respect to a distant-site 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 practitioner's performance of these privileges and sends the DSTE such performance information for use in the periodic appraisal of the distant-site practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site practitioner to the hospital's patients and all complaints the hospital has received about the distant-site physician or practitioner.

In conclusion, please note that hospitals are not required to implement this new proxy credentialing mechanism described in the Final Rule, and can choose instead to fully credential telemedicine providers in the same manner as before. For those providers interested in this new credentialing process for telemedicine providers, they can start doing so on July 5, 2011. In preparation for that, we recommend that providers: (1) take steps to ensure that their Medical Staff Bylaws permit telemedicine privileges credentialing consistent with the Final Rule; (2) have written agreements with distant-site hospitals or DSTEs that conform to these requirements; and (3) should check their state[3] licensure laws with respect to licensure requirements relating to telemedicine as the state licensure standards may remain more onerous.

1. For example, in Connecticut, Conn. Gen. Stat. § 20-9(d) states that: "The provisions of subsection (a) of this section shall apply to any individual whose practice of medicine includes any ongoing, regular or contractual arrangement whereby, regardless of residency in this or any other state, he provides, through electronic communications or interstate commerce, diagnostic or treatment services, including primary diagnosis of pathology specimens, slides or images, to any person located in this state. In the case of electronic transmissions of radiographic images, licensure shall be required for an out-of-state physician who provides, through an ongoing, regular or contractual arrangement, official written reports of diagnostic evaluations of such images to physicians or patients in this state. The provisions of subsection (a) of this section shall not apply to a nonresident physician who, while located outside this state, consults (A) on an irregular basis with a physician licensed by section 20-10 who is located in this state or (B) with a medical school within this state for educational or medical training purposes. Notwithstanding the provisions of this subsection, the provisions of subsection (a) of this section shall not apply to any individual who regularly provides the types of services described in this subsection pursuant to any agreement or arrangement with a short-term acute care general hospital, licensed by the Department of Public Health, provided such agreement or arrangement was entered into prior to February 1, 1996, and is in effect as of October 1, 1996."

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