AHC Media

October 27, 2016

Telemedicine, the Cost-Effective Alternative *CMS, TJC & DNV Standards*

Speaker

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Objectives

- Describe the regulations for TJC and CMS hospital telemedicine credentialing.
- Explain the responsibilities of the distant-site hospital to meet the credentialing requirements.
- Explain new and revised standards, regulations, and laws put forth by CMS, DNV, TJC and the federal government.
- Evaluate compliance requirements and penalties.

Telemedicine in 2016

- There is a lot of activity regarding telemedicine currently
- Recognized as a strategic tool to grow revenue, drive efficiency, and improve patient safety and outcomes
- Hospitals using telemedicine report higher profits according to a recent study
  - Study of 16 hospitals and revenues went from 2.4 million to $4 million
- Hospitals need to make sure they understand the regulatory requirements such as the **federal law** and the **CMS hospital conditions of participation** (CoPs)

What Can Telemedicine Do For Your Hospital?

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What can telemedicine do for your hospital?

Increases in profit, patients and ease of access are all possible with telemedicine.

By Michael Sherman | Posted: August 14, 2013

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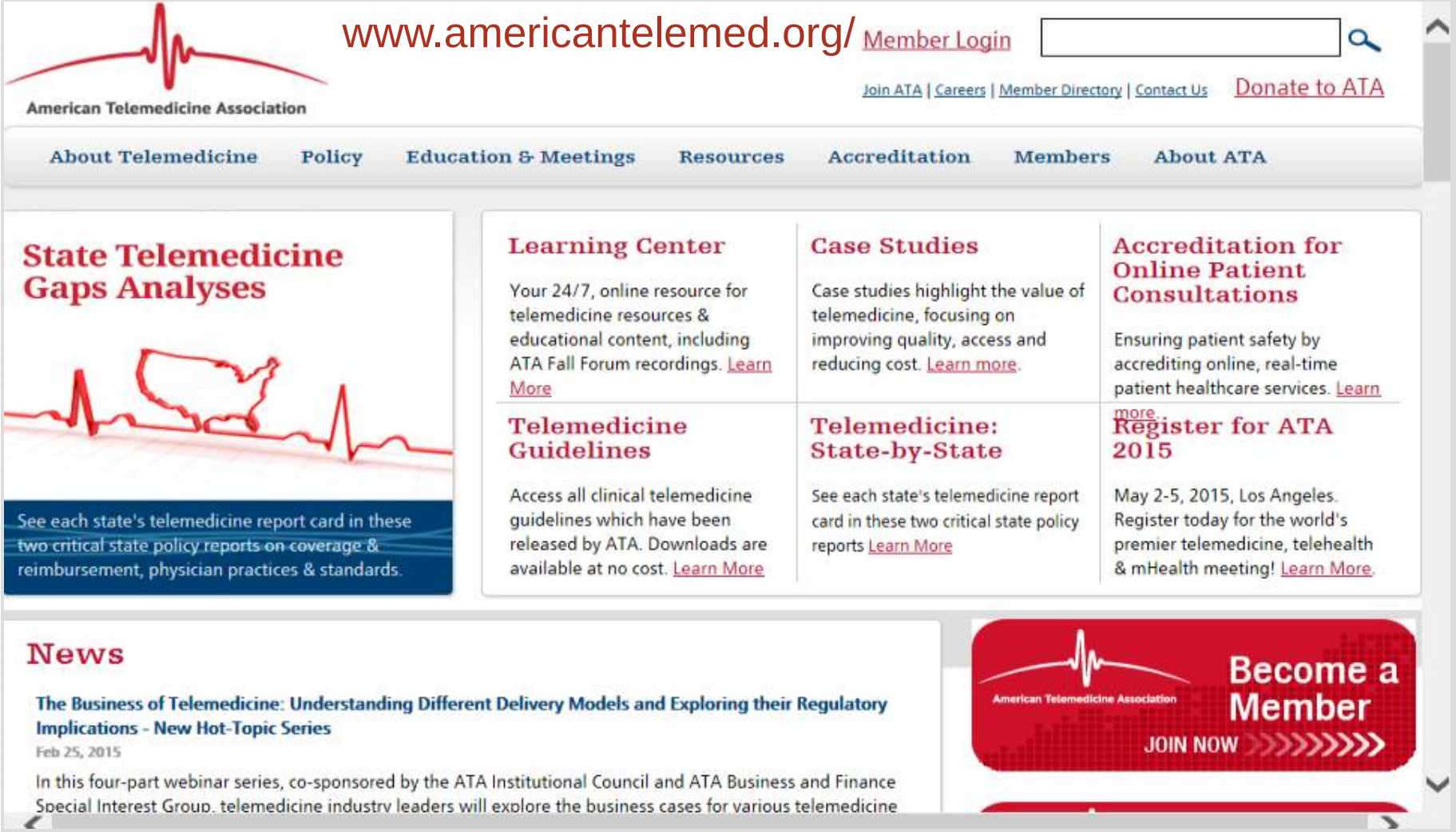
www.healthcarecommunication.com/Mobile/Articles/What_can_telemedicine_do_for_your_hospital_11384.aspx

Standards & Guidelines

- CMS CoP states that hospitals should follow national standards of care and practice
- CMS can cite hospitals for being out of compliance
- Examples include standards and guidelines for:
  - Mental health services, Rehab, eICU
  - Videoconferencing based telepresenting
  - Recommendations for diabetic retinopathy, telestroke, telerehabilitation guidelines, teledermatology, home telehealth clinical guidelines, and telepathology
  - Working on wounds and burns, remote prescribing, urgent care, telepathology, etc.

Many Tele-Medicine Organizations

American Telemedicine Association



Standards & Guidelines and CMS

Telemedicine Practice Guidelines

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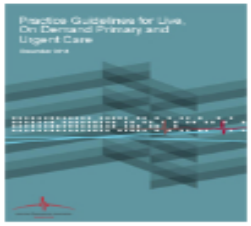
ATA's practice guidelines for telemedicine are the critical foundation for the deployment of telemedicine services. Practice guidelines form the basis for uniform, quality patient care and safety, grounded in empirical research and clinical experience. The establishment of such guidance also accelerates the adoption of telemedicine by payers, administrators and providers who are full partners with ATA in their development along with industry, government agencies, medical societies and other stakeholders.

Completed ATA Practice Guidelines

The following Guidelines have been released by ATA. All documents are available to download, at no cost.



Practice Guidelines for Live, On Demand Primary and Urgent Care
Published December 2014

These guidelines cover the provision of direct-to-patient, primary and urgent care services delivered by licensed healthcare providers using online, real-time videoconferencing and audio technologies. Technologies include mobile devices such smart phones, laptops, or tablets where regulatory conditions permit.

Details | Download

Clinical Guidelines for Telepathology
Published August 2014
This document is an update to the original ATA telepathology guideline and provides new and updated guidance on specific applications, practice, benefits, limitations, and regulatory issues that may arise in the practice of telepathology. This guideline covers clinical applications of telepathology to include primary diagnosis, intraoperative consultations, secondary consultations, and quality assurance that may result in amended cases.

Guidelines for TeleICU Operations

Published May 2014

The TeleICU Guidelines were developed to assist practitioners in providing assessment, medical intervention, continuous monitoring and/or consultation to the critical care population using telecommunication technologies.

Details | Download

Core Operational Guidelines for Telehealth Services Involving Provider-Patient Interactions

Published May 2014

These guidelines provide an update to the previously published *Core Standards for Telemedicine Operations* (Nov. 2007) and cover fundamental requirements to be followed when providing healthcare services using telecommunications technologies, and other electronic communications between patients, practitioners and other healthcare providers.

Details | Download

A Lexicon of Assessment and Outcome Measures for Telemental Health

Published Nov. 2013

This lexicon is a research tool developed to aid telemental health professionals in the selection of assessment and outcome measures. This resource will help grow understanding in the field, allow for broader comparisons, and support better generalization of findings.

Details | Download

Practice Guidelines for Video-Based Online Mental Health Services

Published May 2013

Covering the provision of mental health services when using real-time videoconferencing services transmitted via the Internet, including a personal computer with a webcam or a mobile communications device (e.g., "smart phone", laptop, or tablet) with two-way camera capability

Clinical Guidelines & Position Statements

- **ACR–AAPM–SIIM Practice Guideline for Digital Radiography**
  American College of Radiology | Published September 20, 2012
  This guideline is applicable to the practice of digital radiography. It defines motivations, qualifications of personnel, equipment guidelines, data manipulation and management,and quality control (QC) and quality improvement procedures for the use of digital radiography that should result in high-quality radiological patient care.

- **ACR–AAPM–SIIM Technical Standard for Electronic Practice of Medical Imaging**
  American College of Radiology | Published September 20, 2012
  For the purpose of this technical standard, the images referred to are those that diagnostic radiologists would normally interpret, including transmission projection and cross-sectional X-ray images, ionizing radiation emission images,and images from ultrasound and magnetic resonance modalities.

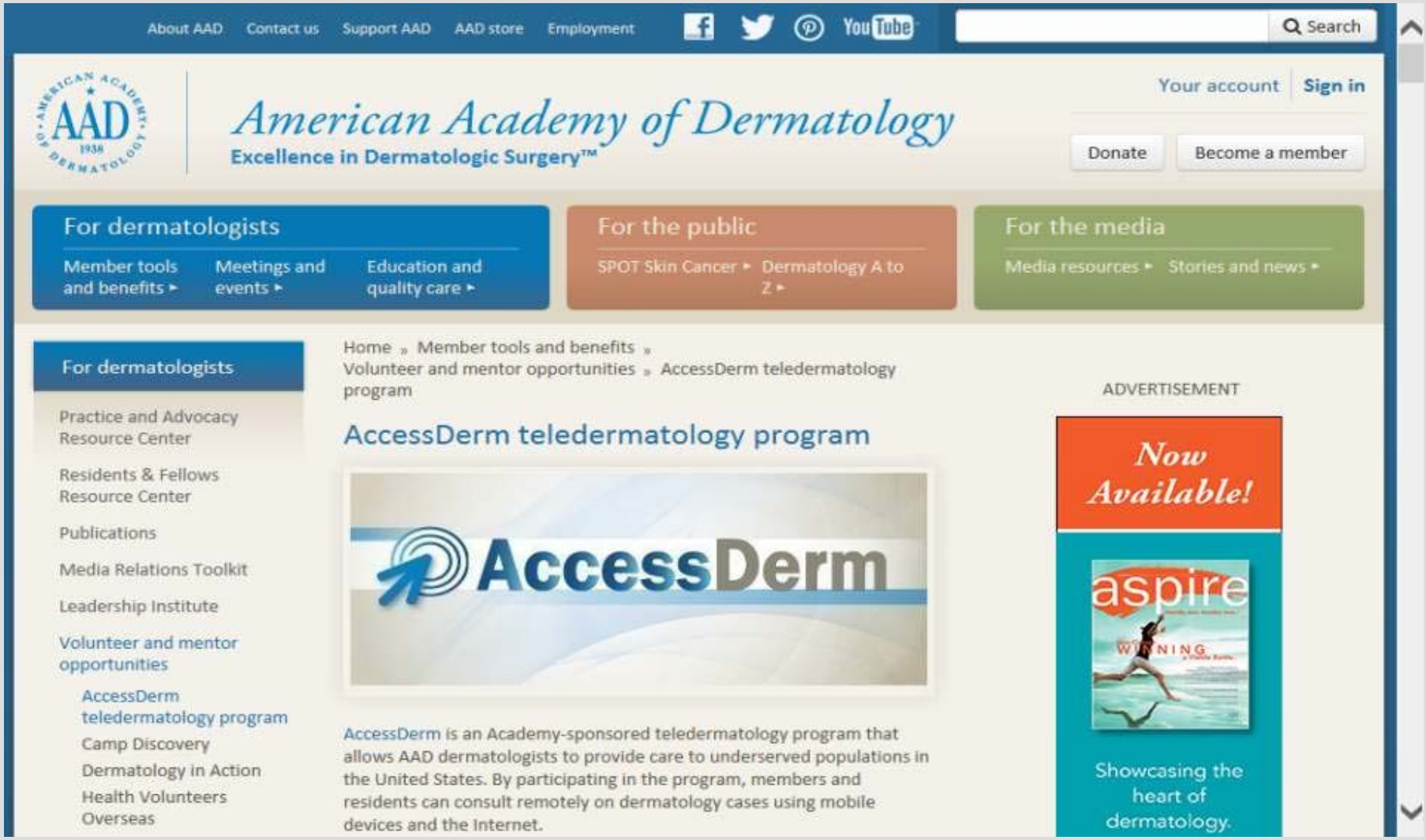
- **ACR–AAPM–SIIM Practice Guideline for Determinants of Image Quality in Digital Mammography**
  American College of Radiology | Published September 20, 2012
  For purposes of this guideline, digital mammography is defined as the radiographic examination of the breast utilizing dedicated electronic detectors to record the image (rather than screen-film) and having the capability for image display on computer monitors.

- **FSMB Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice**
  Federation of State Medical Boards | Published 2012
  Ethical and professional guidance to the FSMB membership with regard to the use of electronic and digital media by physicians (and physician assistants, where appropriate) that may be used to facilitate patient care and nonprofessional interactions. Such electronic and digital media include, but are not limited to, e-mail, texting, blogs and social networks.

- **Guidelines For Electronic Medical Information Privacy and Security**
  American College of Radiology | Published 2012
  These practice guidelines are designed to address privacy and security of electronic medical information for telemedicine and telehealth services. In May 2010, the ATA board of directors approved adoption of the ACR Practice Guideline for Electronic Medical Information Privacy and Security.

- **AAD Position Statement on Telemedicine**
  American Academy of Dermatology Association | Published 2004
  Practitioners who wish to integrate teledermatology into their practice will likely choose between two fundamentally different care delivery platforms (Store and Forward vs. Live Interactive). Both platforms have strengths and weaknesses. What follows is a definition of each platform and the respective AADA

Teledermatology Program AAD



AMA Telemedicine Policy

- AMA has 10 page document on Telemedicine
  - Discusses set of principles for coverage and payment for telemedicine
- Discusses evolving standards of care (SOC) and practice guidelines (CPGs)
  - Number of medical specialty societies have developed these along with position statements on telemedicine
- Mentions ATA or American Telemedicine Association's activities with guideline development
  - AMA notes the need for safeguards and standards

AMA Telemedicine Policy

- Physicians should verify medical liability insurance policy covers before doing
- Physicians should make sure can provide care across state lines
  - Must be licensed in state where patient is located
- AMA wants to ensure patient safety, quality of care, and confidentiality in telemedicine
  - Discusses 1996 IOM (National Academy of Medicine) report on “Telemedicine: A Guide to Assessing Telecommunication for Health Care”
  - Discuss Balanced Budget Act 1997 and Telemedicine Communication Act of 1996

IOM Telemedicine Book

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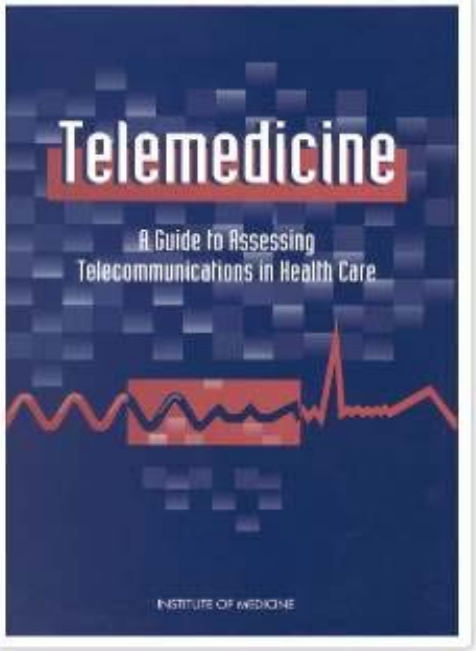

Telemedicine:

A Guide to Assessing Telecommunications for Health Care (1996)

Purchase Options

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AMA Telemedicine Policy

- Discusses that Medicare paid about 6 Million for telemedicine services and other payers
- AMA surveyed the national medical specialty societies and state medical associations regarding practice guidelines
- Discusses case studies in telemedicine
- Discusses AMA policy on payment, clinical standards, licensure, scope of practice requirements and ethical guidance
- Also provides many recommendations

AMA Telemedicine Policy

AMA
AMERICAN MEDICAL ASSOCIATION

http://mb.cision.com/Public/373/9600400/99c2f1db96d7fec3.pdf

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-14)
Coverage of and Payment for Telemedicine
(Reference Committee A)

EXECUTIVE SUMMARY

Telemedicine, a key innovation in support of health care delivery reform, is being used in initiatives to improve access to care, care coordination and quality, as well as reduce the rate of growth in health care spending. The evolution of telemedicine impacts all three strategic focus areas of the American Medical Association (AMA): improving health outcomes, accelerating change in medical education, and enhancing physician satisfaction and practice sustainability by shaping delivery and payment models.

The definition of telemedicine, as well as telehealth, has continued to evolve, and there is no consensus on the definition of either of the two terms. Today, there are three broad categories of telemedicine technologies: store-and-forward, remote monitoring, and (real-time) interactive services. The coverage of and payment for telemedicine services vary widely. While public and private payers have continued to develop formal mechanisms to pay for telemedicine services, inconsistencies remain that create barriers to the further adoption of telemedicine.

The standards of care and practice guidelines relevant to telemedicine are evolving and vary based on specialty and service provided. A number of national medical specialty societies have developed clinical guidelines and position statements addressing telemedicine while others have initiated steps to do so. Besides the specialty societies, the American Telemedicine Association (ATA)—an organization comprised of a cross-section of stakeholders including, for example,

AMA Council Recommendations

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That American Medical Association (AMA) policy be that telemedicine services should be covered and paid for if they abide by the following principles:

   a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
      - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine;
      - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
      - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

   Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

   b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.

   c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.

   d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.

   e) The delivery of telemedicine services must be consistent with state scope of practice laws.

   f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.

Federation of State Medical Board Policy

Approved guidelines, April 2014 publication, to help ensure the safety and quality of medicine practiced using telemedicine technology

- Model policy provided a road map to state boards to ensure patients are protected from harm
- Model policy states that the same standards of care apply to medical care provided electronically
- Must establish a credible patient doctor relationship
- Ranges from telephone, email, and videoconferencing

Federation of State Medical Board Policy

Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine

Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup

www.fsmb.org/pdf/FSMB_Telemedicine_Policy.pdf

Introduction

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)[1] and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

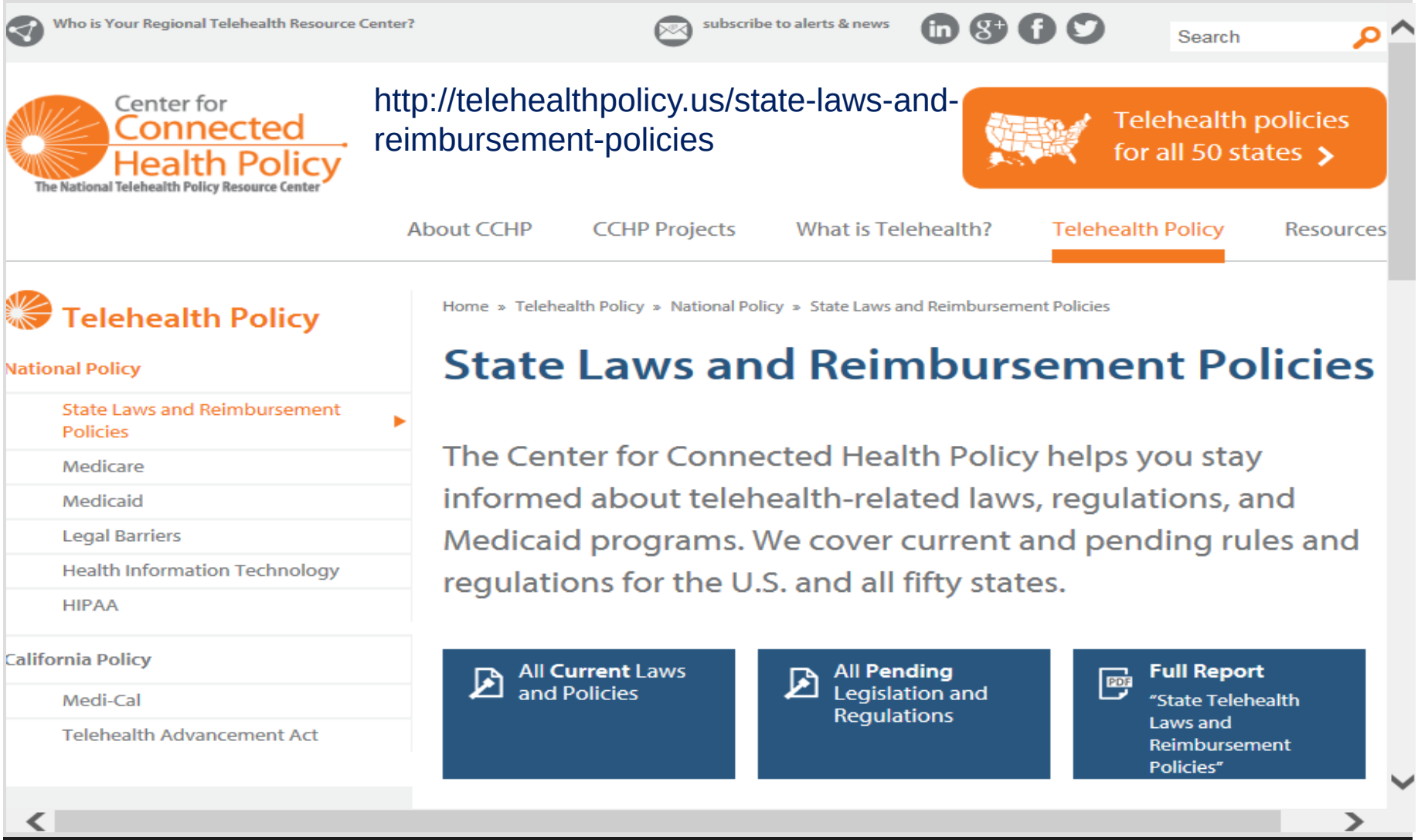
This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients[2] via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of

Federation of State Medical Board Policy

- Providers should adhere to well-established principles guiding privacy and security of records, informed consent, safe prescribing and other key areas of medical practice
- Document is 11 pages long
- Official title is “Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine”
- Must be licensed where the patient is located
- Must have a documented medical evaluation and relevant history

Center for Connected Health Policy



National Conference of State Legislatures

CMS MLN Fact Sheet Telehealth

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network
Official Information Health Care Professionals Can Trust

Telehealth Services

RURAL HEALTH FACT SHEET SERIES

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information on calendar year (CY) 2015 Medicare telehealth services:

- Originating sites;
- Distant site practitioners;
- Telehealth services;
- Billing and payment for professional services furnished via telehealth;
- Billing and payment for the originating site facility fee;
- Resources; and
- Lists of helpful websites and Regional Office Rural Health Coordinators.

When "you" is used in this publication, we are referring to physicians or practitioners at the distant site.

Medicare pays for a limited number of Part B services furnished by a physician or practitioner to an eligible beneficiary via a telecommunications system. For eligible telehealth services, the use of a telecommunications system substitutes for an in-person encounter.

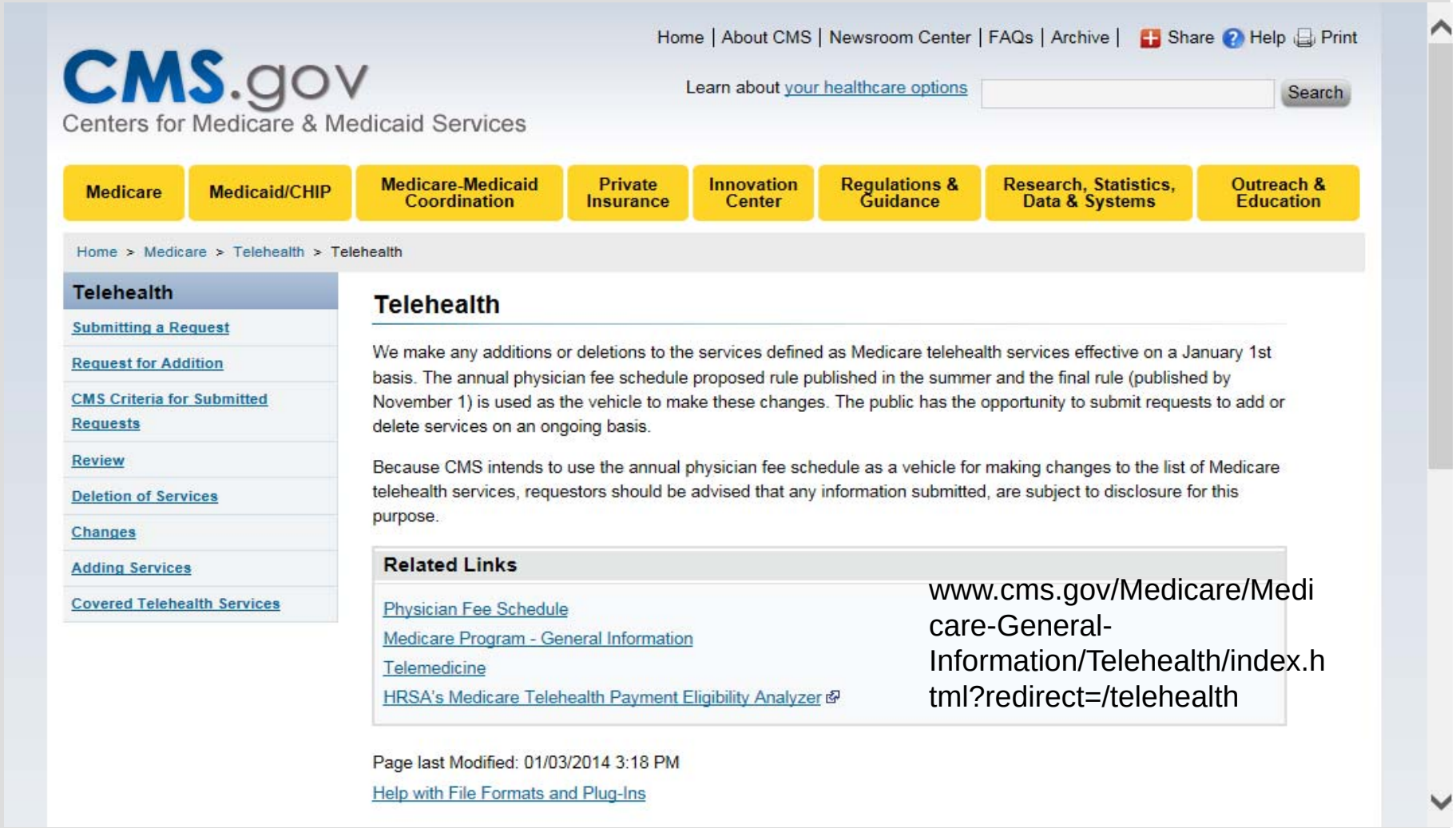
ORIGINATING SITES

An originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:

- A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract; or
- A county outside of a MSA.

ICN 901705 December 2014

CMS Telehealth Website



www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html?redirect=/telehealth

Medicaid Telemedicine Website

Summary of Law and IG from CMS

- Telemedicine rules allow hospitals and critical access hospitals (CAH) to provide telemedicine services to their patients through written agreements with a
  - Distant-site hospital (DSH) or a
  - Distant-site telemedicine entity (DSTE)
- Streamlines credentialing and privileging (C&P) for physicians and practitioners to allow hospitals to rely on the privileging decisions of a DSH or DSTE with which they have a written agreement that meets the Medicare requirements

The Joint Commission (TJC) Telemedicine Standards

TJC Telemedicine Standards

- Joint Commission (TJC) has telemedicine standards in two separate chapters LD & MS
  - LD.04.03.09 under contract management
  - MS.13.01.01 LIPs who are responsible for the care and treatment of patients via telemedicine link are subject to the credentialing and privileging process of the originating site
  - MS.10.01.03 MS must recommend which clinical services may be delivered by LIPs through telemedicine
- TJC made changes **three** times to ensure they are aligned with the CMS hospital CoP requirements

TJC Telemedicine Standards

- Actually, TJC has always had a credentialing by proxy standards
  - Allow credentialing by proxy by allowing use of information from distant site or other accredited facility to be used
- CMS was more stringent with the full C&P requirements
  - Hard for critical access hospitals and small rural hospitals to do full C&P
- Many hospitals wrote CMS and their congressional representative asking for the change

TJC Telemedicine Standards

- TJC issues news release on May 6, 2011 called "The Joint Commission Applauds CMS' Revised Telemedicine Requirements"
- TJC Issues article in June 2011 Perspective called "Joint Commission to Review Its Telemedicine Requirements"
  - Applauds CMS for taking a giant step to remove unnecessary barriers
  - Upholds TJC current practice to allow hospital to use information from distant-site hospital or accredited tele-medicine entity to make C&P decisions

TJC Applauds CMS Telemedicine Standards

LD.04.03.09 EP 23

- EP 23 When telemedicine services are provided to hospital patients
- The originating site has a written agreement with the distant site that includes the following:
- The distant site is a contractor of services to the hospital
- The distant site furnishes services in a manner that permits the originating site to be in compliance with the CMS hospital CoPs

LD.04.03.09 EP 23

- The originating site makes certain through the written agreement (contract) that all distant-site telemedicine providers' credentialing and privileging (C&P) processes meet, at a minimum, the CMS hospital COPs
- Board of the distant site is responsible to C&P with a process that is consistent with the TJC MS chapter which is MS.06.01.01 to MS.06.01.13
- Board of the originating hospital grants privileges to distant site LIPs based on the originating site's MS recommendations, why relying on information provided by the distant site

LD.04.03.09 EP 23 Final Telemedicine

- CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4).
- See also MS.13.01.01, EP 1
- The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the “MS chapter (MS.06.01.01-.13)
- The board of the originating site grants privileges to a distant-site licensed independent practitioner based on the originating site’s medical staff recommendations, which rely on information provided by the distant site

CMS Telemedicine Standards

CMS Telemedicine

- The CMS Telemedicine Credentialing and Privileging (C&P) requirements provide some unique opportunities and challenges for hospitals
- Previously, concerns from hospitals regarding CMS previous requirements for full C&P
  - Placed an undue burden on hospitals and costly
  - Added no improvement in the quality of care to patient
  - Added no increased accountability of physicians or LIPs

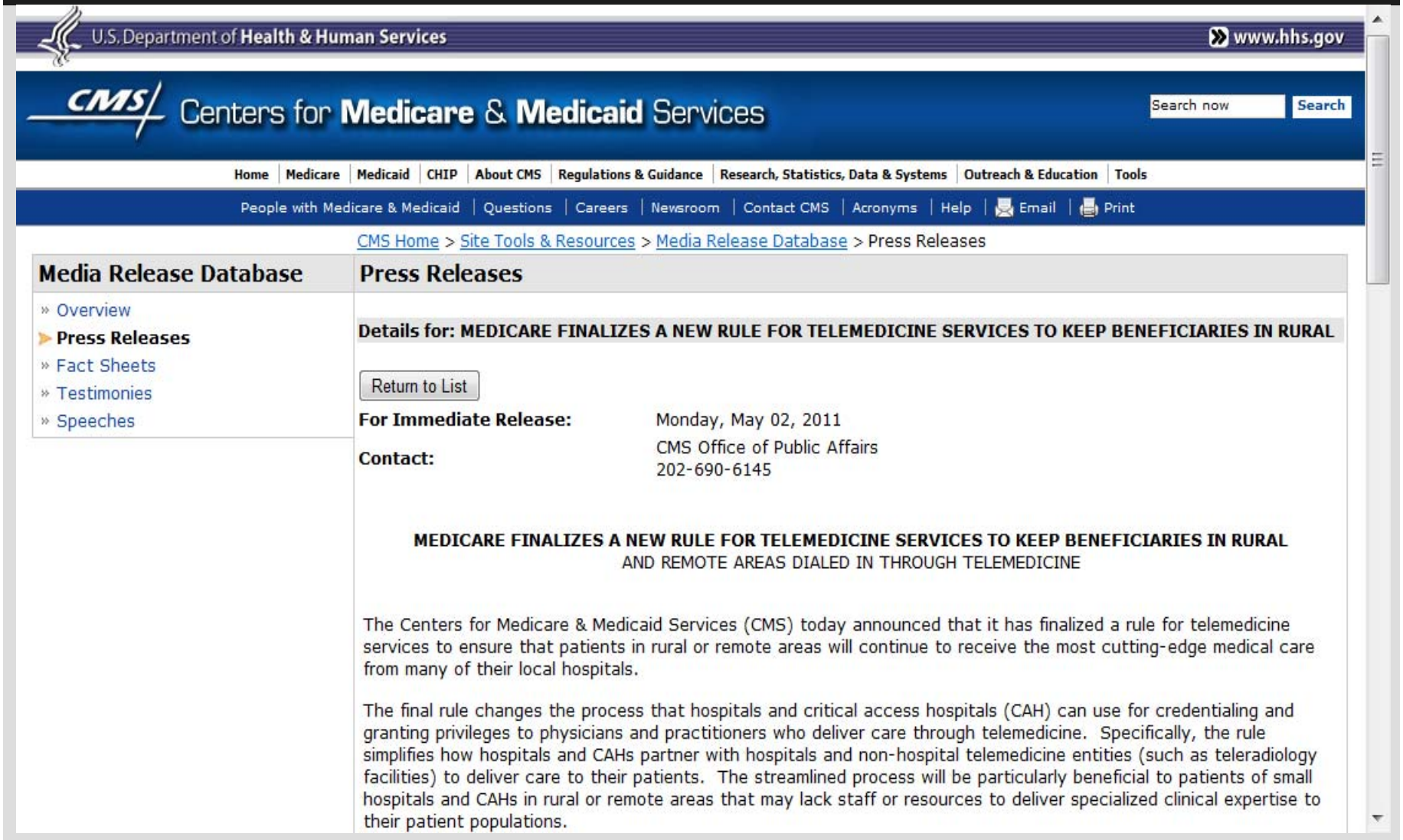
CMS Telemedicine Guidelines

- Removes credentialing barrier to telemedicine
- The new rules are easier for critical access and small hospitals who in the past had to do full C&P
  - When they lacked in-house medical staff with the clinical expertise to adequately evaluate and
  - Privilege the wide range of specialty physicians that were needed
  - Note the standard is telemedicine and not just tele-radiology

CMS Telemedicine

- It would affect the oncologist of a tertiary hospital who interacts with a patient via teleconference at a small critical access hospital
- Dr. Don Berwick, CMS Administrator at the time, said he wants to
  - Devise policies that reflect the most innovative practices in delivering care to all patients,
  - Especially patients in rural or remote parts of the country through telemedicine and
  - To ensure they receive cutting edge medical care

CMS Press Release on Telemedicine



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Press Releases

Details for: MEDICARE FINALIZES A NEW RULE FOR TELEMEDICINE SERVICES TO KEEP BENEFICIARIES IN RURAL

Return to List

For Immediate Release: Monday, May 02, 2011

Contact: CMS Office of Public Affairs
202-690-6145

MEDICARE FINALIZES A NEW RULE FOR TELEMEDICINE SERVICES TO KEEP BENEFICIARIES IN RURAL
AND REMOTE AREAS DIALED IN THROUGH TELEMEDICINE

The Centers for Medicare & Medicaid Services (CMS) today announced that it has finalized a rule for telemedicine services to ensure that patients in rural or remote areas will continue to receive the most cutting-edge medical care from many of their local hospitals.

The final rule changes the process that hospitals and critical access hospitals (CAH) can use for credentialing and granting privileges to physicians and practitioners who deliver care through telemedicine. Specifically, the rule simplifies how hospitals and CAHs partner with hospitals and non-hospital telemedicine entities (such as teleradiology facilities) to deliver care to their patients. The streamlined process will be particularly beneficial to patients of small hospitals and CAHs in rural or remote areas that may lack staff or resources to deliver specialized clinical expertise to their patient populations.

CMS Telemedicine

- The federal regulations were published in the May 5, 2011 Federal Register
  - 16 pages long and effective on July 5, 2011
  - Discussed comments to the proposed rules
- These were placed in the hospitals Conditions of Participations (CoPs)
  - CMS published the interpretive guidelines to the regulations became effective July 15, 2011
  - Section for hospitals and critical access hospitals

Final Telemedicine Regulations

apply to the navigable waters in the San Pablo Bay, and will encompass an area beginning at position 38°01′44″ N, 122°27′06″ W; 38°04′36″ N, 122°22′06″ W; 38°00′35″ N, 122°26′07″ W; 38°03′00″ N, 122°20′20″ W (NAD 83) and back to the starting point.

(b) *Enforcement.* The Coast Guard will notify the public via a Broadcast Notice to Mariners prior to the activation of this safety zone. The safety zone will be activated on average two times per month, but could be activated up to six times per month. It will be in effect for approximately three hours from 9 a.m. to 11:59 p.m. If the exercises conclude prior to the scheduled termination time, the Coast Guard will cease enforcement of this safety zone and will announce that fact via Broadcast Notice to Mariners. Persons and vessels may also contact the Coast Guard to determine the status of the safety zone on VHF–16 or the 24-hour Command Center via telephone at (415) 399–3547.

(c) *Definitions.* As used in this section, designated representative means a Coast Guard Patrol Commander, including a Coast Guard coxswain, petty officer, or other officer operating a Coast Guard vessel and a

Centers for Medicare & Medicaid Services

42 CFR Part 482 and 485

[CMS–3227–F]

RIN 0938–AQ05

Medicare and Medicaid Programs: Changes Affecting Hospital and Critical Access Hospital Conditions of Participation: Telemedicine Credentialing and Privileging

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule will revise the conditions of participation (CoPs) for both hospitals and critical access hospitals (CAHs). The final rule will implement a new credentialing and privileging process for physicians and practitioners providing telemedicine services. Currently, a hospital or CAH receiving telemedicine services must go through a burdensome credentialing and privileging process for each physician and practitioner who will be providing telemedicine services to its patients.

make its recommendations. CMS requirements do not take into account those practitioners providing only telemedicine services to patients. Consequently, hospitals apply the credentialing and privileging requirements as if all practitioners were onsite. This traditional and limited approach fails to embrace new methods and technologies for service delivery that may improve patient access to high quality care.

This final rule will permit hospitals and CAHs to implement a new credentialing and privileging process for physicians and practitioners providing telemedicine services. The removal of unnecessary barriers to the use of telemedicine may enable patients to receive medically necessary interventions in a more timely manner. It may enhance patient follow-up in the management of chronic disease conditions. These revisions will provide more flexibility to small hospitals and CAHs in rural areas and regions with a limited supply of primary care and specialized providers. In certain instances, telemedicine may be a cost-effective alternative to traditional service delivery approaches and, most

www.access.gpo.gov/su_docs/fedreg/a110505c.html

CMS Interpretive Guidelines on Telemedicine

- Were published in the Policy and Memos to States and Regions website on July 15, 2011
  - www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
- 27 pages long
- Hospitals can still choose to do full C&P of practitioners with telemedicine privileges
- Hospitals can still choose to use a third party credentials verification organization or CVO
  - Board is still legally responsible for privileging decisions

CMS Final Interpretive Guidelines

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7000 Security Boulevard, Mail Stop 02-02-38
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C: 11-32- Hospital/CAH

DATE: **July 15, 2011**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPag

SUBJECT: Telemedicine Services in Hospitals and Critical Access Hospitals (CAHs)

Memorandum Summary

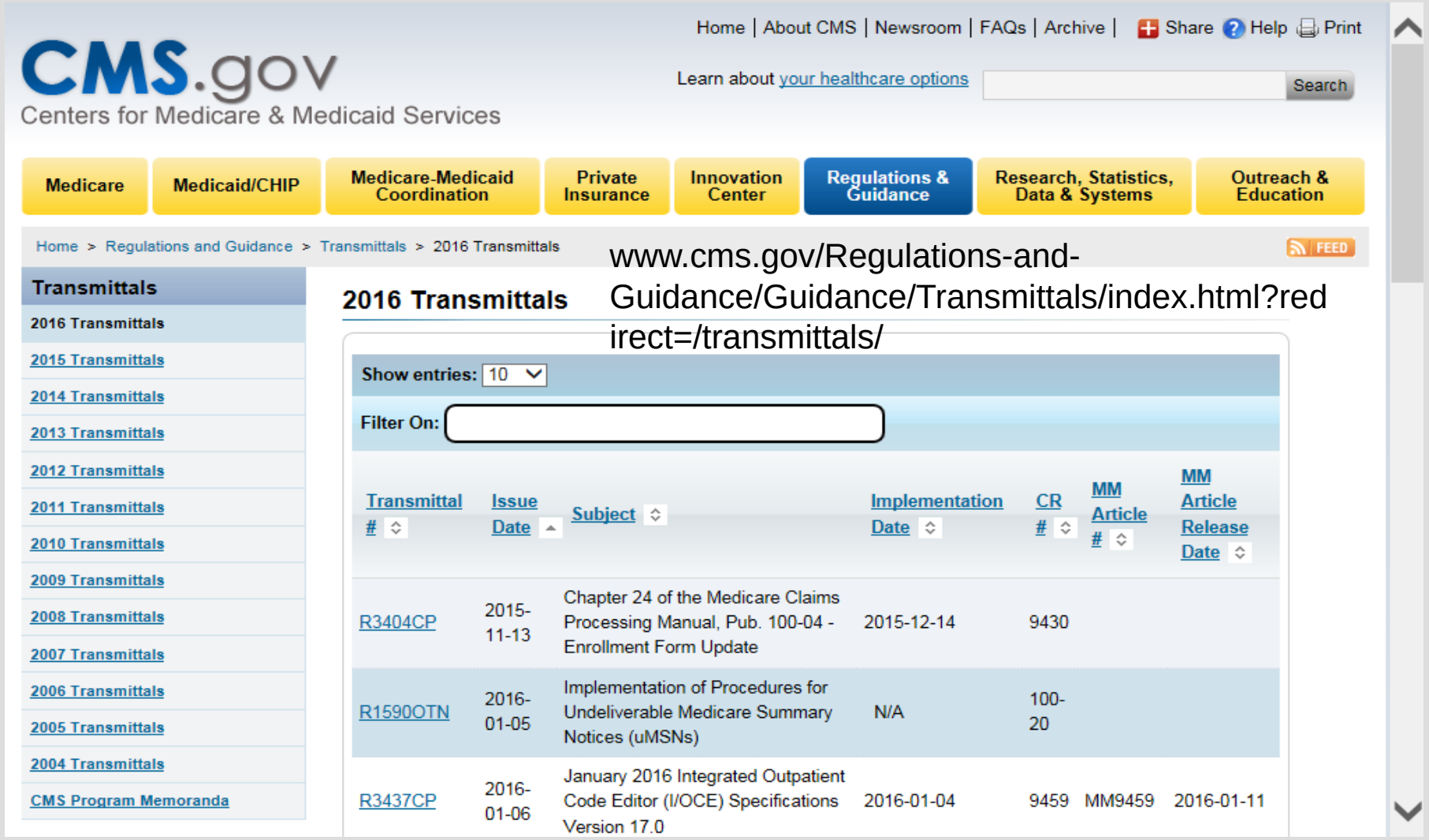
- ***Telemedicine Rules Adopted for Hospitals/CAHs:*** New and amended rules effective July 5, 2011 permit hospitals and CAHs to provide telemedicine services to their patients through written agreements with a distant-site hospital or a distant-site telemedicine entity
- ***Streamlined Credentialing & Privileging for Telemedicine Physicians & Practitioners.*** Hospitals and CAHs may rely, when granting telemedicine privileges, upon the privileging decisions of a distant-site hospital or telemedicine entity with which they have a written agreement that meets Medicare requirements.

On May 5, 2011, the Centers for Medicare & Medicaid Services (CMS) published a final rule (76 FR 25550), effective July 5, 2011, governing the agreements under which a hospital or CAH may provide telemedicine services to its patients. "Telemedicine," as the term is used in this rule, means the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications. The distant-site telemedicine physician or practitioner provides clinical services to the hospital or CAH patient either simultaneously, for example, as in teleICU services, or non-simultaneously, as is the case with many teleradiology services.

CMS Transmittal and Updated CoP Manual

- CMS issues the survey memo and then a transmittal on telemedicine which had the final changes
  - The CMS transmittal was published on December 22, 2011 and manual updated that same day
  - A transmittal is published with the final wording so it can be included in the CMS hospital CoP manual
- CMS updates Hospital CoP manual more frequently now
  - Amends 6 tag numbers 45, 52, 339, 342, 343 and 363 on telemedicine under Appendix A
  - The manual has tag numbers that go from 0001 to 1164

Transmittals



CMS Issues Transmittal

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

www.cms.gov/Transmittals/01_overview.asp

A-0045

(Rev. 78, Issued: 12-22-11, Effective/Implementation: 12-22-11)

[The governing body must:]
§482.12(a)(1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;

Interpretive Guidelines §482.12(a)(1)

The governing body must determine, in accordance with State law, which categories of practitioners are eligible for appointment to the medical staff.

The medical staff must, at a minimum, be composed of physicians who are doctors of medicine or doctors of osteopathy. In addition, the medical staff may include other *types of health care professionals* included in the definition *of a physician* in Section 1861(r) of the Social Security Act:

- Doctor of medicine or osteopathy;
- Doctor of dental surgery or of dental medicine;
- Doctor of podiatric medicine;
- Doctor of optometry, and
- a Chiropractor.

CMS CoP Board Section

- Amends the CoP under the governing body or board section and the medical staff section
  - Board section starts at Tag A-0043 for PPS Hospitals of Appendix A
    - Paid through the Prospective Payment System and these are the larger hospitals
  - Board section starts at Tag C-0241 of Appendix W
    - Critical access hospitals or those smaller than 25 beds or less
  - CAH with up to 10 bed rehab or behavioral unit follow Appendix A standards and not Appendix W

CMS CoP Tag Numbers

- Hospital CoP amends tag numbers under Appendix A and email questions to **hospitalscg@cms.hhs.gov**
  - Board section on MS Tag numbers 45 and 52
  - MS Tag numbers 339, 342, 343, 363
- CMS CAH amends or adds 4 tag numbers under Appendix W (email questions **CAHscg@cms.hhs.gov**)
  - Tag numbers 196 and 197 on agreements for C&P of telemedicine physicians
  - Tag number 285 on services provided through agreements
  - Tag number 340 on Quality Assessment
- Hospitals regulation is 42 CFR 482.12(a) and CAH is 42 CFR 482.22(a)

Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
- Updating quarterly
  - Available under downloads on the hospital website at www.cms.gov

Access to Hospital Complaint Data

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-21- ALL

DATE: March 22, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Access to Statements of Deficiencies (CMS-2567) on the Web for Skilled Nursing Facilities, Nursing Facilities, Hospitals, & Critical Access Hospitals

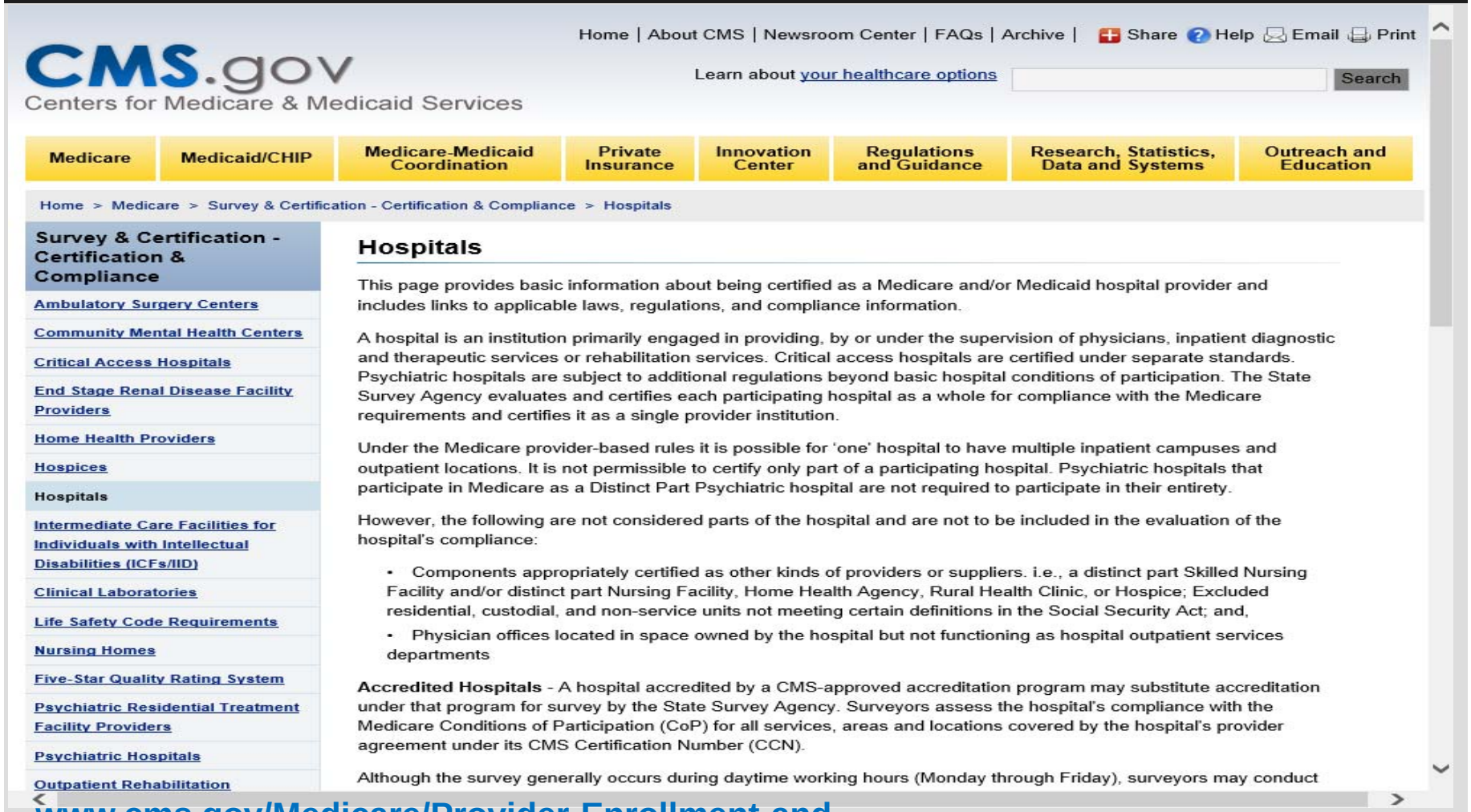
Memorandum Summary

- ***Survey Findings Posted on*** *http://www.cms.gov:* In July 2012, the Centers for Medicare & Medicaid Services (CMS) began posting redacted Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on *Nursing Home Compare*. In March 2013, CMS began posting CMS-2567s for short-term acute care hospitals and critical access hospitals (CAHs) for surveys based on complaint investigations. This memorandum describes the contents and location of these files.
- ***Other Web-based Tools Based on These Data:*** At least two additional websites, provided by private parties (*ProPublica* and the Association for Health Care Journalists), publish information based on the CMS-2567 data. These websites are independent of CMS. CMS does not endorse or sponsor any particular private party application.
- ***Plans of Correction (POC):*** The posted CMS data do not contain any POC information. State Survey Agencies (SAs) and CMS Regional Offices (RO) may see an increase in requests for both the CMS-2567 and any associated POCs.
- ***Question & Answers:*** We plan to issue an update to this memorandum that will include an attachment of frequently asked questions in order to provide answers to other queries that may arise.

Background – Nursing Home Survey Findings

In July 2012, CMS began posting nursing home statements of deficiencies, derived from the Form

Updated Deficiency Data Reports



www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html

Can Count the Deficiencies by Tag Number

	A	B	C	D	E	F	G	H	I	J	
240	DOCTORS' HOSPITAL OF MICHIGAN	23(	461	MI	48341	Short Term	A	0364	AUTOPSIES	7/18/2012	Based on record review and interview, the facility failed to ensure that 1
241	MARTHA JEFFERSON HOSPITAL	49(	500	VA	22911	Short Term	A	0364	AUTOPSIES	9/8/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
242	SAINT LOUISE REGIONAL HOSPITAL	05(	940(	CA	95020	Short Term	A	0364	AUTOPSIES	1/18/2012	Based on interview and record review, the hospital failed to have a syste
243	EDGERTON HOSPITAL AND HEALTH SERVICES	521	111(	WI	53534	Critical Access H	C	0201	AVAILABILITY	10/2/2012	Based on review of MR, review of staffing guidelines, review of P&P, and
244	HOLZER MEDICAL CENTER JACKSON	361	500	OH	45640	Critical Access H	C	0205	BLOOD AND BLOOD PRODUCTS	1/20/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
245	BRANDON REGIONAL HOSPITAL	10(	119	FL	33511	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/8/2011	Based on clinical record review, staff interview and review of policy and
246	CHRISTUS ST PATRICK HOSPITAL	19(	524	LA	70601	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	3/9/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
247	COLUMBUS REGIONAL HEALTHCARE SYSTEM	34(	500	NC	28472	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/13/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
248	DANA-FARBER CANCER INSTITUTE	22(	450	MA	02115	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	9/7/2011	Based on review of documentation and confirmed by staff interviews, tw
249	GOOD SAMARITAN MEDICAL CENTER	10(	130(	FL	33401	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	2/12/2013	Based on clinical record review and staff interview the facility failed to e
250	LONG BEACH MEDICAL CENTER	33(	455	NY	11561	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	12/22/2011	Based on record review, the facility failed to ensure that the patient ' s te
251	MANATEE MEMORIAL HOSPITAL	10(	206	FL	34208	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/16/2012	Based on record review, policy review and staff interview it was determi
252	MISSOURI BAPTIST MEDICAL CENTER	26(	301(	MO	63131	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/11/2012	Based on observation, interview, and record review, the facility failed to
253	NORTHWEST MEDICAL CENTER	10(	280(	FL	33063	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	8/2/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
254	RESTON HOSPITAL CENTER	49(	185(	VA	20190	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	11/2/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
255	SAINT AGNES HOSPITAL	21(	900	MD	21229	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	2/22/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
256	SAINT CATHERINE REGIONAL HOSPITAL	15(	220(	IN	47111	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	12/13/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
257	SOUTHEASTERN REGIONAL MEDICAL CENTER	34(	300	NC	28359	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	12/14/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
258	STANFORD HOSPITAL	05(	300	CA	94305	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	3/15/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
259	WAKEMED, CARY HOSPITAL	34(	190(	NC	27518	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	3/14/2013	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
260	WILKES-BARRE GENERAL HOSPITAL	39(	575	PA	18764	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	1/14/2013	Based on review of facility policy, facility documents, medical records (M
261	WILSON MEDICAL CENTER	34(	170(	NC	27893	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	2/10/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
262	RIVERSIDE GENERAL HOSPITAL	45(	320(	TX	77004	Short Term	A	0063	CARE OF PATIENTS	11/9/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
263	CIVISTA MEDICAL CENTER	21(	5 GA	MD	20646	Short Term	A	0067	CARE OF PATIENTS - MD/DO ON CALL	8/4/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
264	MILFORD HOSPITAL, INC	07(	300	CT	06460	Short Term	A	0067	CARE OF PATIENTS - MD/DO ON CALL	9/22/2011	Based on review of hospital documentation and interviews with facility
265	PLAZA MEDICAL CENTER OF FORT WORTH	45(	900	TX	76104	Short Term	A	0067	CARE OF PATIENTS - MD/DO ON CALL	7/1/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
266	CLARA MAASS MEDICAL CENTER	31(	ONE	NJ	07109	Short Term	A	0068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE	6/2/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
267	GEISINGER - COMMUNITY MEDICAL CENTER	39(	182(	PA	18510	Short Term	A	0068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE	6/14/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
268	SENTARA NORTHERN VIRGINIA MEDICAL CEN	49(	230(	VA	22191	Short Term	A	0068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE	12/6/2012	Based on a complaint investigation, document review and interview, the

Sheet1

Number of Deficiencies May 13, 2016

Tag Number Telemedicine Sections	Number of Deficiencies
Tag 45 Medical Staff and categories for appointment amended 9-26-14	3
Tag 52 Board and telemedicine agreements DSTE	0
Tag 339 Eligibility for appointment to MS amended 9-26-2014	5
Tag 342 Agreements for C&P or Telemedicine Physicians & LIPs	12
Tag 343 Telemedicine agreements with DSH and reliance on	2
Tag 363 Services Provided Through Agreements or Arrangements& C&P	9 Total 31

CMS Manual

- Currently, the CMS telemedicine transmittal of December 22, 2011 are incorporated into both the current PPS and CAH manuals
- Manuals are updated more frequently now
  - All hospitals should have a current copy of their hospital CoP manual
  - Consider placing on hospital intranet
- Changes were made to the telemedicine tag numbers June 7, 2013 with final IGs issued in 2014 changes and two tags revised 9-26-2014

Location of CMS Hospital CoP Manuals

Medicare State Operations Manual

Appendix

Email questions to hospitalscg@cms.hhs.gov

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the "Download" column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers

CMS Hospital CoP Manuals **new** address

www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

App. No.	Description	PDF File
A	Hospitals	2,185 KB
AA	Psychiatric Hospitals	606 KB

CoP Manual Also Called SOM

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents
(Rev. 151, 11-20-15)

www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.p

Transmittals for Appendix A

Survey Protocol

Introduction

- Task 1 - Off-Site Survey Preparation
- Task 2 - Entrance Activities
- Task 3 - Information Gathering/Investigation
- Task 4 - Preliminary Decision Making and Analysis of Findings
- Task 5 - Exit Conference
- Task 6 – Post-Survey Activities

Psychiatric Hospital Survey Module

Psychiatric Unit Survey Module

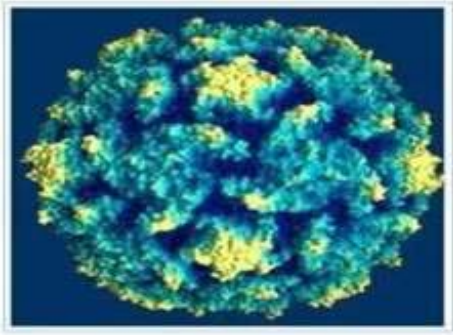
Rehabilitation Hospital Survey Module

Inpatient Rehabilitation Unit Survey Module

Hospital Swing-Bed Survey Module

Regulations and Interpretive Guidelines

Email questions **hospitalscg@cms.hhs.gov**



Also Called State Operation Manual SOM

State Operations Manual
Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

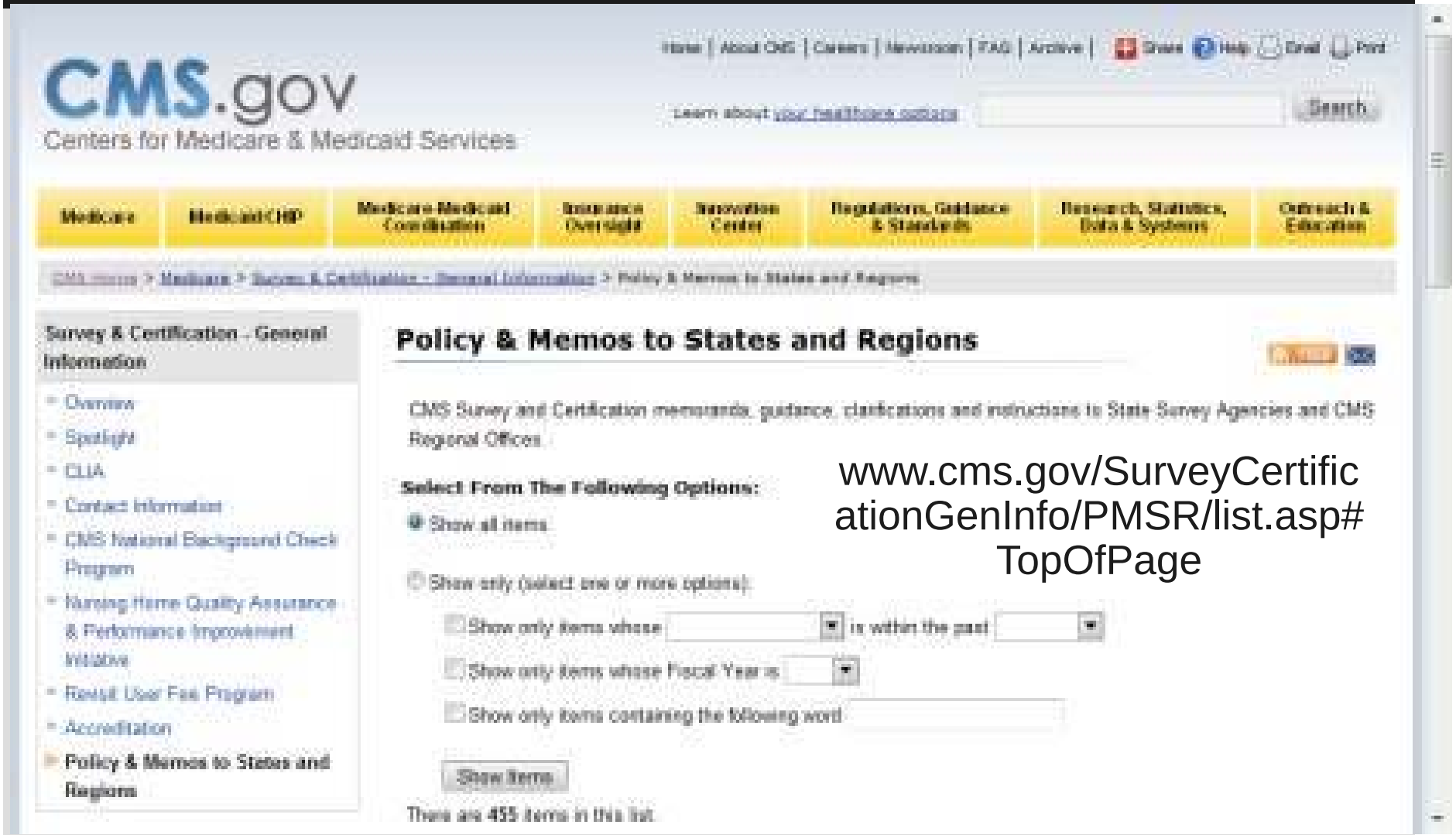
(Rev. 149, 10-09-15)

Transmittals for Appendix W

INDEX

Survey Protocol

CMS Survey and Certification Website



www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Show entries: 10

Filter On:

Title	Memo #	Posting Date	Fiscal Year
Community Mental Health Center (CMHC) Frequently Asked Questions (FAQs)	15-28-CMHC	2015-02-27	2015
Contacting End Stage Renal Disease (ESRD) Networks for survey related facility information	15-29-ESRD	2015-02-27	2015
Administrative Changes for Two Centers for Medicare & Medicaid Services (CMS) - Approved Accrediting Organizations (AOs) The	15-30-ALL	2015-02-27	2015
Potential Adverse Impact of Lower Relative Humidity (RH) in Operating Rooms (ORs)	15-27-Hospital, CAH & ASC	2015-02-20	2015
Emergency Medical Treatment and Labor Act (EMTALA) and Ebola Virus Disease (EVD) – Questions and Answers (Q+A)	15-24-Hospitals	2015-02-13	2015
MDS / Staffing Focused Surveys Update	15-25-NH	2015-02-13	2015
Nursing Home Compare "3.0" - Five Star Quality Rating System - Expanded and Strengthened	15-26-NH	2015-02-13	2015

Telemedicine and EMTALA

- CMS issues survey memo June 7, 2013
- Discusses CAH, telemedicine and EMTALA
- Some CAH do not have a physician in the ED
- May be staffed with NP or PA with emergency care training in states that allow this scope of practice
- Must have physician (MD/DO) who is available by phone or radio contact
- This requirement can be met by the use of telemedicine as well as by the MD/DO who practices on site in the CAH

Telemedicine and EMTALA

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-38-CAH/EMTALA

DATE: **June 7, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Critical Access Hospital (CAH) Emergency Services and Telemedicine: Implications for Emergency Services Condition of Participation (CoPs) and Emergency Medical Treatment and Labor Act (EMTALA) On-Call Compliance

Memorandum Summary

- ***The Center for Medicare & Medicaid Services (CMS) Welcomes use of Telemedicine by CAHs:*** Telemedicine has great potential to expand availability of specialty care services, including emergency medicine services, to rural populations. However, misconceptions about CAH CoP and EMTALA requirements may cause unnecessary concerns about, or create barriers to, using telemedicine.

- ***The CAH Emergency Services CoP does not Require a Physician to Appear On-site Whenever an Individual Comes to the Emergency Department (ED):***
  - Under 42 CFR 485.618(d), a doctor of medicine (MD), a doctor of osteopathy (DO), a physician assistant (PA), a nurse practitioner (NP), or a clinical nurse specialist (CNS), with training or experience in emergency care, must be immediately available by telephone or radio, and available on-site within 30 minutes (60 minutes for CAHs in frontier areas that meet certain conditions). Under the CAH CoPs an MD or DO is *not* required to be available *in addition* to a non-physician practitioner.
  - Under the CoP at §485.618(e), an MD or DO must be immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients. This requirement can be met by the use of a telemedicine MD/DO as well as by an MD/DO who practices on-site at the CAH.

- ***EMTALA is Not a Barrier to Using Telemedicine to Extend CAH Emergency Services:***
  - If using telemedicine for emergency and other services, a CAH is not required to include the telemedicine physicians on its physician on-call list mandated under the EMTALA regulations at 42 CFR 489.20(r)(2) and §489.24(j), nor would it be advisable

Telemedicine and EMTALA

- Some CAH are so small may not have any patients in the ED but will have a RN to initially assess patients
- Hospital must have a physician, PA, NP, or CNS on call though who can respond if necessary and be on site within 30 minutes
- This requirement cannot be met by telemedicine
- A CAH MD/DO is not required to be available in addition to the non-physician practitioner (PA, NP) but must be practicing within their scope of practice and as allowed by state law

CMS Telemedicine Credentialing

- The proposed regulations would have only allowed a hospital to contract with another Medicare participating hospitals for telemedicine services
  - But this was changed in the final regulations
- The final regulations have two pathways or processes that a hospital can use for credentialing and to grant physicians privileges
  - Hospitals that want to use proxy credentialing with Medicare certified hospital (called a distant-site hospital)
  - Hospitals that want to use proxy credentialing with an other telemedicine entity (distant-site telemedicine entity)

CMS Telemedicine Credentialing

- Any hospital that wants to contract with another hospital or entity must have a written agreement or contract
  - A contract or written agreement must be in place whether the hospital has contracted with a Medicare certified hospital (DSE) or an other telemedicine entity (DSTE or distant site telemedicine entity)
  - The board or governing body of the distant site is responsible to make sure there is a written agreement that meets all the requirements
  - CMS specifies what must be in the contract or written agreement

Definition of Telemedicine

- CMS **defines** telemedicine to be the
  - Provision of clinical services to patients
  - By practitioners from a distance
  - Via electronic communications
- Can be provided **simultaneously** as with tele-ICU services
- Can be **non-simultaneously** as with teleradiology or an after the fact interpretation of a diagnostic test

CMS Telemedicine Contract

- The contract or written agreement of the distant-site must state that the distant site telemedicine entity (DSTE) is a contractor of services to the hospital
  - Must say that the contracted services are provided in a manner that permits the CAH or small and rural hospital to meet all the required conditions of participation
  - CMS struggled with allowing contracts with someone other than a Medicare-certified hospitals
  - Ended up just requiring an entity that is not a hospital to just agree contractually that they will follow all of the CMS required regulations as if they were a hospital

Sample Telemedicine Agreement

- This agreement is entered into between Hospital A and Hospital B, under the laws of the State of Ohio
- Whereas, Hospital A has established a telemedicine program that provides patients and hospital professionals at other hospitals and clinics access to Hospital A's physicians and other non-physicians practicing in a number of other clinical specialties
- Whereas, the Medical Staff may rely on the privileging and credentialing decisions made by Hospital A when granting privileges

Contract Provision for Telehealth

- The contract should state that the DSH providing the service is a Medicare participating hospital
  - Unless the hospital is contracting with a DSTE then want to specify they agree to follow the CMS hospital CoPs in C&P
- The distant site physician or practitioner that is providing the telemedicine service is privileged at that hospital
- That a list of their privileges is provided to the hospital
- That they are licensed in the state where the patient is located

Contract Provision for Telehealth

- The DSH board is responsible for meeting the CMS CoPs on telemedicine which require
  - Determination of what categories of physicians and other non-physicians are eligible for appointment to the medical staff or are otherwise eligible for privileges
  - That they are appointed with the recommendation of the medical staff
  - That the Medical Staff maintain and enforce the bylaws and rules and regulations
  - That the medical staff are selected based on individual character, competence, training, experience, and judgment and selection is not based on certification or membership in a specialty body or society

Have a Contract With the Required Terms

PHYSICIAN CREDENTIALING AND PRIVILEGING AGREEMENT BETWEEN HOSPITALS

THIS PHYSICIAN CREDENTIALING AND PRIVILEGING AGREEMENT (**Agreement**) is entered into as of the _____ day of _____, 2011 (**Effective Date**), by and between ABCD Originating Site Hospital (**OS**), and WXYZ Distant Site Hospital (**DS**) (collectively the Parties).

The parties hereby agree as follows:

1. **OS Relationship**. OS is an acute care hospital which participates in the Medicare program and desires to engage DS which also participates in the Medicare program, to provide certain clinical services from distance via electronic communications to patients physically located at OS (**Contracted Services**). For purposes of this Agreement, each physician affiliated with DS providing or anticipated to provide Contracted Services is a **Physician** (collectively **Physicians**). OS and DS shall agree on a process by which DS may obtain, or have access to, all the necessary patient records from OS.

2. **Compliance with Conditions of Participation**. The OS governing body shall ensure that the DS, acting as an independent contractor, is a Medicare-participating hospital and furnishes its services in a manner that enables the OS to comply with all applicable Medicare conditions of participation for Contracted Services. These areas of compliance shall include, but not be limited to, the requirements for the DS medical staff, governing body, and credentialing and privileging regarding DS physicians providing telemedicine services (42 CFR 482.12(a)(1) through (a)(7); 482.12(a)(1)-(2); 42 CFR 485.616(c)).

3. **Practice Credentialing and Privileging**. DS warrants that each Physician (i) will be credentialed and privileged according to the credentialing and privileging processes and standards, which meet or exceed the OS Standards; and (ii) shall render Contracted Services within the scope of the Physician's respective privileges.

4. **State or Territorial Licensure.** At all times while providing Contracted Services to OS, each Physician will hold a license issued or recognized by the state in which OS is located.

5. **Decision of Governing Body**. OS's governing body has chosen to rely on DS's credentialing and privileging decisions for purposes of OS's medical staff determining whether or not to recommend that privileges be granted to a Physician.

6. **DS to Provide Current List of Privileges**. DS has supplied OS with Schedule 1, a list identifying each Physician and the scope of privileges granted by DS. It is anticipated that this complement of physicians may change from time to time. In that event the following procedures shall apply:

(a) ***Action by DS:*** DS shall provide OS with a revised Schedule 1 indicating the name of any new Physicians and an accompanying delineation of privileges. If DS has removed a Physician from the roster of physicians anticipated to provide Contracted Services going forward or if the DS telemedicine entity physician loses privileges, DS will provide a revised Schedule 1.

(b) ***Action by OS upon Receipt of New Schedule from DS:*** OS shall confirm the physicians listed on Schedule 1 can provide Contracted Services by signing and faxing the updated Schedule to DS.

If the only changes were removals, OS agrees that DS may remove the Physician(s) without waiting for a signed Schedule 1 to be returned.

(c) ***Action by OS to Initiate Removal of a Physician.*** If OS no longer wishes to receive Contracted Services from a Physician for reasons not requiring a hearing, OS will request that DS remove the Physician from the roster, following which, DS will supply an updated Schedule 1 as described in Section 6(a).

7. **Credentialing-Related Materials.** DS shall provide electronic copies of credentialing materials and other reasonable evidence of DS's compliance with the OS Standards. However, DS will not provide OS or its agent a copy of any information it receives from the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank.

8. **Provision and Confidentiality of Quality Related Data.**

(a) ***OS Duties.*** OS shall provide DS evidence of its internal review of each DS-affiliated physician's performance of the privileges, for use in DS's periodic appraisal of the physicians. The governing body of the OS shall, in its sole discretion, determine the frequency of such periodic assessments of DS telemedicine services hereunder. At a minimum, this information must include:

(i) all adverse events that result from a physician's Contracted Services provided to OS patients, and

(ii) all complaints OS has received about the Physician.

If OS is a critical access hospital, OS is responsible for periodic evaluation and quality assurance reviews that comply with 42 CFR 485.641(b)(4)(v).

(b) As required by law, the OS shall make such periodic assessments available to the DS upon reasonable request, in a time and manner consistent with clinical quality and patient safety.

9. **Confidentiality**. The parties shall treat all credentialing information shared pursuant to Section 6 and all quality-related information shared pursuant to Section 8 as privileged and confidential. Such information is to be used for credentialing, quality improvement, and peer review activities only. Each party shall ensure that no portion of any materials or information received from the other party are disclosed by it or its agents to any employee or third party for reasons unrelated to evaluating the physician's quality and credentials to provide Contracted Services, except as required by law. It is understood that disclosure of such OS peer review documents to DS does not waive any privileges or protections afforded such documents by law.

10. **Term and Termination**. This Agreement shall continue from the Effective Date until terminated by either party as provided, below:

(a) ***Upon Notice.*** Either party may terminate without cause on at least 30 days prior written notice to the other party.

(b) ***Termination upon Material Breach***. A non-breaching party may terminate this Agreement for cause at any time upon 30 days' written notice of intent to terminate. In the event the defaulting party cures such default within such 30 day notice period, the non-breaching party may elect, at its discretion, to rescind the termination notice in writing, in which case this Agreement shall continue in full force and effect.

11. **Legislative/Regulatory Modification.** If any law, regulation or standard is enacted, promulgated, or modified in a manner that, in the opinion of a party's legal counsel (i) prohibits, restricts or in any way materially affects this Agreement; (ii) subjects either OS or DS to a fine or penalty in connection with its representations or responsibilities hereunder, or (iii) subjects either party to a loss of Medicare or Medicaid certification or other accreditation bodies because of the existence of this Agreement or the applicable party's representations or performance of obligations hereunder, then within 30 days following notice from one party to the other, the parties shall complete the good faith negotiation of an amendment to this Agreement or a substitute agreement that will carry out the original intention of the parties to the extent possible in light of such law, regulation or standard and each party shall execute such amendment or new agreement.

If the parties cannot reach agreement on new terms within 60 days following the notice provided hereunder or such earlier date as necessary to avoid substantial penalties or fines, then this Agreement shall immediately terminate, following written notice of termination from either party.

12. **Indemnification**. Each of the parties shall indemnify and hold the other harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards, or other expenses, of any kind or nature whatsoever, including, without limitations, attorneys' fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any breach or alleged breach of this Agreement by either of the Parties, or by their respective employees, subcontractors or agents.

13. **Notice**. Any notice required by this Agreement shall be in writing and shall be deemed to have been properly given to a party (i) if hand delivered, (ii) if delivered overnight by courier service, effective on the first business day following delivery to such carrier, or (iii) if sent certified mail, return receipt requested, effective three (3) days after deposit in the United States mail, addressed to the address below or as the parties may designate by giving notice pursuant to this Section:

ABCD Originating Site Hospital	WXYZ Distant Site Hospital
5555 First Street	1111 Main Avenue
Public City, ND 00000	Anytown, NY 00000

14. **Third-Party Beneficiaries**. This Agreement shall not confer any benefit or rights upon any person other than OS and DS, and no third party shall be entitled to enforce any obligation, responsibility or claim of any party to this Agreement.

15. **Other Agreements**. This Agreement, including all exhibits hereto, contains the entire understanding and agreement of the parties with respect to the credentialing and privileging of DS radiologists. In the event of a conflict between a provision contained in this Agreement and a provision contained in an agreement or arrangement that existed prior to the Effective Date of this Agreement, the terms of this Agreement shall control and govern the actions of the parties.

16. **Services Not Applicable**. This Agreement only applies to Contracted Services provided directly to the patient and does not apply to informal consultation among physicians or practitioners, by whatever communications media the physicians or practitioners choose to use.

17. **Counterparts**. This Agreement may be executed by facsimile signature or encrypted, digital signature, and by either of the parties in counterparts, each of which will be deemed to be an original, but all such counterparts will constitute a single instrument.

IN WITNESS WHEREOF, the undersigned parties hereto have executed this Physician Credentialing and Privileging Agreement effective as of the latter of the dates signed.

ABCD Originating Site Hospital	WXYZ Distant Site Hospital
_____	_____
Signature	Signature
_____	_____
Print Name and Title	Print Name and Title

List of Physicians Privileged

The undersigned accept, attach, and incorporate this Schedule 1 into the Credentialing Agreement executed between OS and DS. This Schedule 1 replaces the previous Schedule 1.

List of Physicians Privileged

NAME	A—Added via this Schedule R- Removed via this Schedule	NAME	A—Added via this Schedule R- Removed via this Schedule

Privilege Delineation

Privilege Delineation

Date_____

The Ohio State Medical Center Medical Staff

The following Ohio State Medical Center Staff credentialed practitioners are privileged to provide clinical services within the scope of their department specialty and within the scope of their practice using telemedicine to deliver those services.

_____

Credentialed Practitioner Department/Specialty

_____

Telemedicine Evaluation Form

Telemedicine Professional Practice Evaluation

Individual Proctored: _____
Date of review: _____
Proctor: _____
Patient name: _____ Patient MRN:_____
Diagnosis: _____
Based on my review of the consultation provided in this case, I make the following evaluation:

1. **Patient Care:** is compassionate, appropriate and effective
   Acceptable ☐ Marginal ☐ Unacceptable ☐ Unable to assess ☐
2. **Medical / Clinical Knowledge:** Demonstrates knowledge of established and evolving sciences and applies it to patient care
   Acceptable ☐ Marginal ☐ Unacceptable ☐ Unable to assess ☐
3. **Practice-Based Learning and Improvement:** Uses scientific evidence and methods to investigate, evaluate, improve care
   Acceptable ☐ Marginal ☐ Unacceptable ☐ Unable to assess ☐
4. **Interpersonal and Communication Skills:** Establishes and maintains professional relationships with patients, families
   Acceptable ☐ Marginal ☐ Unacceptable ☐ Unable to assess ☐
5. **Systems-Based Practice:** Understands the contexts and systems in which care is provided and applies this knowledge
   Acceptable ☐ Marginal ☐ Unacceptable ☐ Unable to assess ☐
6. **Professionalism:** Demonstrates a commitment to professional development, ethical practice, diversity and responsibility to patients, profession and society
   Acceptable ☐ Marginal ☐ Unacceptable ☐ Unable to assess ☐

Overall Impression:
Acceptable ☐ Marginal ☐ Unacceptable ☐

Proctor's signature _____ Date_____

Proctor's printed name _____

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CENTER FOR TELEHEALTH & e-HEALTH LAW

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- **CTeL's 50 State Survey on Medicaid Reimbursement Policies** (July 2013)
- **BYOD and Privacy: Does Your Institution Have a Policy? What if It Doesn't?** (May 2013)
- **Does your Telemedicine Equipment Configuration Meet FDA Standards** (April 2013)
- **FCC Officials Discuss Healthcare Connect Fund Order** (February 2013)
- **The FCC's Telemedicine Funding Initiative–What Could It Mean for You?** (January 2013)
- **FCC Program to Reduce the Cost of Broadband for Health Care: What's New?** (December 2012)
- **How Can You Minimize Risk and Avoid Liability Under Health Care Fraud and**

The Day Telehealth Saved Baby MaLea

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Every week, CTeL mails out an e-newsletter full of latest tips and trends in the telehealth,

CMS Telemedicine Credentialing

- For example, a small critical access hospital wants to contract with a distant-site telemedicine entity for teleradiology or mental health services
  - The contract could be with a Medicare certified hospital (which are usually the larger hospitals) or
  - It could be with a teleradiology facility, ASC, imaging center, group of psychiatrist, ENT physicians or dental offices
- The agreement with the required provisions are signed
  - The process would be as follows depending on which one was selected to contract with

Hospital A Contracts with Medicare Hospital

- Example 1 is where the CAH or a small and rural hospital contracts with a Medicare-certified hospital
  - Usually distant-site hospital (DSH) is a big hospital or Medical Center
  - The agreement or contract will state that the distant site hospital providing the telemedicine services is a Medicare participating hospital
  - Some additional sample language will be provided that should be included in the contract

Hospital A Contracts with Medicare Hospital

- Step 1: The CAH or small hospital's board makes sure there is a written agreement with the distant-site hospital
  - The written contract or agreement must state that it is the responsibility of the distant-site hospital to meet the credentialing requirements in the hospital CoPs regulations
- For PPS hospitals this is section 42 CFR 482.12(a)(1) through (a)(7) and for CAH is 42 CFR 485.616(c)(i) through (c)(vii)

Hospital A Contracts with Medicare Hospital

- Step 2 The Medical Staff from the small or CAH makes its recommendations on telemedicine privileges
  - The staff at the small hospital may rely on the information from and the credentialing decisions of the big distant-site hospital
  - The DSH or DSTE uses a C&P process that meets the Medicare standards that hospitals have traditionally used

Hospital A Contracts with Medicare Hospital

- The distant-site practitioner must be credentialed and privileged (C&P) at their distant-site to provide telemedicine services and the contract should say this
- And the big distant-site hospital gives the small hospital a copy of that physician's current privileges and the contract says this
- Step 3 The practitioner from the distant-site has to be licensed in the state in which the CAH or small hospital is located or be recognized by that state to do telemedicine

Hospital A Contracts with Medicare Hospital

- The written agreement must also state the physician or practitioner holds a license or is recognized by the Medical Board in that state
- Usually not an issue if both hospitals are in the same state
- Many states (State Medical Board) now have a stream lines process for telemedicine providers who practices in many states

- Step 4 The Board approves the recommendations from the Medical Staff for C&P

Example of State Law on Telemedicine

LAWriter® Ohio Laws and Rules

Search ORC Go

Ohio Administrative Code Home Help

Route: Ohio Revised Code » Title [47] XLVII OCCUPATIONS - PROFESSIONS » Chapter 4731: PHYSICIANS; LIMITED PRACTITIONERS

Go To: Go

Prev | Next

4731.296 Telemedicine certificate.

(A) For the purposes of this section, "the practice of telemedicine" means the practice of medicine in this state through the use of any communication, including oral, written, or electronic communication, by a physician located outside this state.

(B) A person who wishes to practice telemedicine in this state shall file an application with the state medical board, together with a fee in the amount of the fee described in division (D) of section 4731.29 of the Revised Code and shall comply with sections 4776.01 to 4776.04 of the Revised Code. If the board, in its discretion, decides that the results of the criminal records check do not make the person ineligible for a telemedicine certificate, the board may issue, without examination, a telemedicine certificate to a person who meets all of the following requirements:

(1) The person holds a current, unrestricted license to practice medicine and surgery or osteopathic medicine and surgery issued by another state that requires license holders to complete at least fifty hours of continuing medical education every two years.

(2) The person's principal place of practice is in that state.

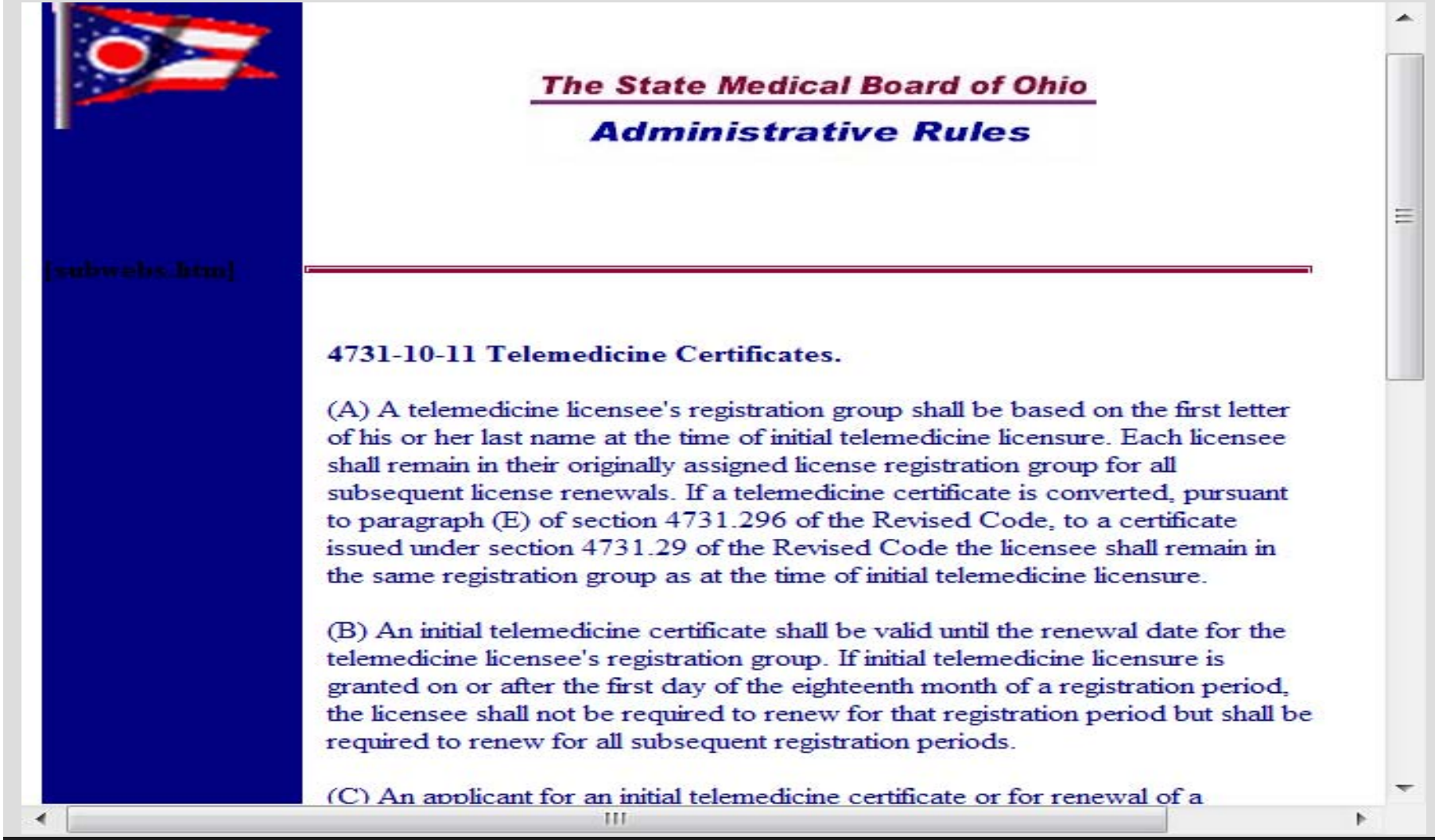
(3) The person does not hold a certificate issued under this chapter authorizing the practice of medicine and surgery or osteopathic medicine and surgery in this state.

(4) The person meets the same age, moral character, and educational requirements individuals must meet under sections 4731.08, 4731.09, 4731.091, and 4731.14 of the Revised Code and, if applicable, demonstrates proficiency in spoken English in accordance with division (E) of section 4731.29 of the Revised Code.

(C) The holder of a telemedicine certificate may engage in the practice of telemedicine in this state.

http://codes.ohio.gov/orc/4731.296

Telemedicine Certificates for Physicians



The State Medical Board of Ohio

Administrative Rules

[subwebs.htm]

4731-10-11 Telemedicine Certificates.

(A) A telemedicine licensee's registration group shall be based on the first letter of his or her last name at the time of initial telemedicine licensure. Each licensee shall remain in their originally assigned license registration group for all subsequent license renewals. If a telemedicine certificate is converted, pursuant to paragraph (E) of section 4731.296 of the Revised Code, to a certificate issued under section 4731.29 of the Revised Code the licensee shall remain in the same registration group as at the time of initial telemedicine licensure.

(B) An initial telemedicine certificate shall be valid until the renewal date for the telemedicine licensee's registration group. If initial telemedicine licensure is granted on or after the first day of the eighteenth month of a registration period, the licensee shall not be required to renew for that registration period but shall be required to renew for all subsequent registration periods.

(C) An applicant for an initial telemedicine certificate or for renewal of a

Hospital A Contracts with Medicare Hospital

- Step 5 The small or CAH has evidence of an internal review of the distant-site practitioner's performance or privileges
- Step 6 The small or CAH must send the big distant-site hospital performance information so the large distant-site hospital can use this information in the periodic appraisal of the distant practitioner
  - This must include any adverse event that result from services provided to the CAH or small hospital
  - This includes any complaints the small hospital has received about the distant practitioner

Hospital A Contracts with Medicare Hospital

- Hospitals need to make sure their agreement meets the provisions of telemedicine law
- CMS discussed in the comment section that the written agreement or contract with the distant-site should also allow the CAH or small or rural hospital
  - Access to the complete credentialing and privileging file
  - Upon request for each practitioner who is covered by the agreement

Privileging and Credentialing Agreement

- This Agreement is entered into by and between Hospital A, a non-profit corporation under the laws of the State of Ohio and Hospital B.

RECITALS

- WHEREAS, Hospital A has established a telemedicine program ("Program") that provides patients and health care professionals at outlying hospitals and clinics access to Hospital A physicians and other providers practicing in a broad array of clinical specialties

Privileging and Credentialing Agreement

- WHEREAS, Hospital B has determined that its Medical Staff may rely on the privileging and credentialing decisions made by Hospital A when granting privileges to Hospital A Providers; and
- WHEREAS, FACILITY desires to efficiently credential and privilege Hospital A Providers who provide program services for the benefit of its patients.
- THEREFORE, Hospital A and Hospital B agree as follows:
  - Hospital A's Responsibilities

Privileging and Credentialing Agreement

- Hospital A confirms that is a Medicare participating hospital
- That Hospital A providers that are identified in Exhibit A are members of the Medical Staff
- That each of the Medical Staff identified in Exhibit A are C&P in their perspective specialties
- That Hospital A will amend the list of providers in Exhibit A as necessary and such amendments will be available on the website and will be provided by sending a copy to the email address listed and ensuring acceptance of the email

Privileging and Credentialing Agreement

- That all of the Hospital A providers are licensed in the State where Hospital B is located or otherwise legally permitted to practice in the State where Hospital B is located
- The Hospital A Medical Staff credentialing process complies with all of the standards required under 42 CFR 482.12(a)(1) – (a)(7)

Hospital B's Responsibilities

- The Board of Hospital B has chosen to have its Medical Staff rely on the C&P decisions of Hospital A in recommending physicians and other qualified

Privileging and Credentialing Agreement

Licensed independent practitioners provided for Medical Staff privileges at Hospital B

- CMS amended the Medical Staff section in September 2014 and notes that some states allow other LIPs to be C&P but may not be members of the Medical Staff such as pharmacists or dieticians

- Hospital B complies with all governing body responsibilities as required under the hospital conditions of participation at 42 CFR 482.22(a) [Hospitals] or 42 CFR 485.616(c) [Critical Access Hospitals]

Privileging and Credentialing Agreement

- Hospital B shall review the updated list of Hospital A providers have privileges and are members of the Medical Staff at Hospital A prior to granting privileges
- Hospital B will perform a periodic internal review of the Hospital A provider's performance and complete the Telemedicine Professional Practice Evaluation ("Evaluation Form") attached hereto as Exhibit B
- Hospital B must also provide specific details regarding any complaints received about the Hospital A Provider and/or any adverse events that occurred

Privileging and Credentialing Agreement

- The Evaluation Form and any additional information shall be sent to the Hospital A's Medical Staff for use in its periodic appraisal of the Hospital A providers

General Terms

- This contract can be terminate in writing by either party by giving 30 days written notice to the other
- This contract will be effective on the date signed
- This agreement constitutes the entire understanding of the parties and any changes must be in writing

Distant-site Telemedicine Entity DSTE

- There is no definitions in the final regulation of distant-site telemedicine entity of DSTE (but there is in the interpretive guidelines)
- However, there was a definition in the introductory commentary section (Page 4 of 16)
- A DSTE is an entity that
  - Provides telemedicine services
  - Is not a Medicare-certified hospital and
  - Provides contracted services in a manner to enable the CAH or hospital using their services to meet the required CMS CoP requirements

Distant-site Telemedicine Entity DSTE

- An example could be a freestanding large teleradiology practice
- Similar to the process with a Medicare-certified hospital
- Example Number 2 would be a CAH or small and rural hospital that contracts or has a written agreement with a DSTE
- Step 1: Step 1: The CAH or small hospital's board makes sure there is a written agreement with the DSTE

Distant-site Telemedicine Entity DSTE

- Step 1 The written agreement (Continues)
  - The written contract or agreement must state that it is the responsibility of the DSTE or distant-site telemedicine entity to meet the credentialing requirements in the hospital CoPs regulations
  - For PPS hospitals this is section 42 CFR 482.12(a)(1) through (a)(7) and for CAH is 42 CRF 485.616(c)(i) through (c)(vii)

Distant-site Telemedicine Entity DSTE

- Step 2 The Medical Staff from the small or CAH makes its recommendations on telemedicine privileges
  - The staff at the small hospital may rely on the information from and the credentialing decisions of the DSTE
  - The distant-site practitioner must be privileged at the distant site to provide telemedicine services and the DSTE gives the small hospital a copy of the physician’s privileges

Distant-site Telemedicine Entity DSTE

- Step 3 The practitioner from the DSTE has to be licensed in the state in which the CAH or small hospital is located or be recognized by that state to do telemedicine
  - Usually not an issue if both the hospital and the DSTE are in the same state
  - Many states now have a stream lines process for telemedicine providers who practices in many states
- Step 4 The Board approves the recommendations from the Medical Staff for C&P

Distant-site Telemedicine Entity DSTE

- Step 5 The small or CAH has evidence of an internal review of the distant-site practitioner's performance or privileges
- Step 6 The small or CAH must send the DSTE performance information so they can use this information in the periodic appraisal of the distant practitioner
  - This must include any adverse event that result from services provided to the CAH or small hospital
  - This includes any complaints the small hospital has received about the distant practitioner

Distant-Site Telemedicine Entity DSTE

- In the case of an agreement with a distant-site telemedicine entity
- The agreement must also state that the entity is a contractor of services to the hospital or CAH
- Which furnishes contracted telemedicine services in a manner that permits the hospital or CAH to comply with all applicable CoPs
  - This is important because CMS does not have any jurisdiction over many of the DSTE and they do not participate in Medicare unlike a hospital that is Medicare certified

CMS Telemedicine Standards

- Board decides what categories of practitioners are eligible candidates for appointment to the MS (45)
  - Such as physicians, podiatrist, dentist, CRNA, PA, NP, CNS, clinical social worker, clinical psychologist, dietician, etc.
  - Must be consistent with any state laws and within the person's state scope of practice
- Surveyor is suppose to ask to see a copy of the written telemedicine agreement
- Will look for documentation indicating that privileges have been granted to each telemedicine practitioner

CMS Telemedicine Standards

- Need an order like any other test (363)
- Bylaws include criteria for determining privileges to be granted to individual physicians including telemedicine and a procedure for applying the criteria to individuals requesting privileges (363)
- Surveyor is suppose to make sure that telemedicine physicians and practitioners are operating under an agreement approved by the board when MS have opted to rely on C&P decisions of the DSTE or DSH

Blue Box Advisory Members of the MS

For Information Only – Not Required/ Not to be Cited

CMS expects that all practitioners granted privileges are also appointed as members of the medical staff. However, if State law limits the composition of the hospital's medical staff to certain categories of practitioners, e.g., only physician practitioners, there is nothing in the CoPs that prohibits hospitals and their medical staffs from establishing certain practice privileges for those specific categories of non-physician practitioners excluded from medical staff membership under State law, or from granting those privileges to individual practitioners in those categories, as long as such privileges are recommended by the medical staff, approved by the governing body, and in accordance with State law. (79 FR 27114 - 27115, May 12, 2014)

Additional Information

- CMS C&P requirements do not apply in circumstances where the hospital's telemedicine equipment is used, but the patient is not a hospital patient
- The following documents may need to be amended to implement telemedicine: MS bylaws and R/R, MS administrative P&P, board report, and OPPE/FPPE P&P
- Can have one credentials file for telemedicine docs
- Contract should be approved by the Board, MS, and administration

Additional Information

- List of distant site hospital practitioners may be approved by the credentials committee, MEC, and the board
- Be sure to include in the contract that the board and the Medical Staff can rely on the credentialing and privileging decisions made by the distant site telemedicine entity (or DSH) when granting privileges for telemedicine services
- Surveyor may ask to see your contract
  - Again in the six hospital tag numbers for Appendix A hospitals and four in CAH, CMS has a section in some of the tag numbers called survey procedure

Additional Information

- Medical Staff should do an annual review and approve the telemedicine list
- Medical Staff should monitor adverse events and complaints
  - Be aware of the grievance requirements by CMS and ensure the consumer advocate is aware of the telemedicine requirement
- Make sure events are reported to the distant site facility
- Report compliance to the relevant committees (board, MEC, credentials, etc.)

Have a Policy on Telemedicine

- Have a policy on Telemedicine Services
- AHIMA has recommendation on what should be in the policy
  - Called Telemedicine Services and the Health Record
  - Located at www.ahima.org under body of knowledge dated 5/15/2013
  - AHIMA stands for Health Information Management Association
- Make sure staff are educated on what is in the policy
- Ensure compliance with the policy

AHIMA Telemedicine Practice Brief

Telemedicine Services and the Health Record (Updated)

*Editor's Note: This practice brief **supersedes** the April 1997 practice brief "Telemedical Records."*

Telemedicine is a rapidly growing industry in the medical practice. Telemedicine is defined as telecommunications systems that link healthcare organizations and patients from diverse geographic locations and transmit text, data, and images for (clinical) consultation and treatment. This is seen as a cost-effective alternative to treating patients face-to-face, especially for patients living in rural communities. Telemedicine presents challenges to healthcare providers in ensuring that integrity and confidentiality are maintained, as well as ensuring the physician's scope of practice is within the legal statutes set forth by the state where the physician is practicing medicine. Providers must determine the individual responsible for documenting the information and how that information is shared.

This practice brief outlines the challenges of telemedicine, the planning for these services, and the best practices to ensure the clinical integrity of telemedical records. It is designed to support and guide organizations, health information management (HIM) professionals, and providers to understand, support, and execute best practices managing the telemedicine process.

Background

Telemedicine is a two-way, real time interactive communication between the patient and the physician at a remote site.

The delivery mechanisms include networked programs to link hospitals and clinics; point-to-point connections to deliver services directly or outsourced to independent providers; monitoring center links for in-home monitoring and other patient care services; and web-based e-health patient service sites for consumers.

"Closely associated with telemedicine is the term 'telehealth,' which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth."[1]

Recommendations for P&P

Policy and Procedures
Develop appropriate policies and procedures for telemedical services before starting a program to ensure consistency in the documentation by both the physician and patient. A sample outline follows:

For Hospital or Physician

- Introduction
- References
- Scope
- Procedures
- Orientation/Training of Staff
- Using the Equipment
- Orienting the Member to Telemedicine
- Confidentiality/Privacy
- Video Recording of Telemedicine Services
- Clinical Record Keeping
- Medication Prescriptions
- Appropriate Telemedicine Services
- Reporting Telemedicine Statistics
- Technical Quality of Telemedicine
- Prioritization of Clinical Telemedicine
- Monitoring

For Provider

- Application
- Overview
- Reimbursement
- Telehealth services
- Modifiers
- Telephone Calls
- Internet Services
- Definitions
- Q & A
- Codes & Explanation
- Attachments
- References

CAH

- CMS makes an exception for CAH
- CAH requirement use to state that all agreements for clinical services may be made **only** with a Medicare-participating provider or supplier
- Since some telemedicine entities do not participate in Medicare, an exception was created so CAH could participate
- This also includes the outside quality review that would be done by the outside entity that conducts the review of the distant-site physicians who are providing the telemedicine services

CAH CoPs

- Added some of the same language on C&P that is present in the PPS manual in the board section,
- Added to the Provision of Services and Quality Assessment section
- The CAH decides what categories of individuals are eligible for appointment to the medical staff
  - Physicians who are MDs and DOs, podiatrists, dentists, etc.
- The board appoints eligible candidates to the medical staff after considering the recommendations of the MS
- Board is to make sure MS has MS by-laws

CAH CoPs

- Board must approve both the MS by-laws and the MS rules and regulations (R&R)
- The MS is accountable to the board or governing body for the quality of care provided to the patients
- Must make sure the criteria for selection to the MS is based on individual character, competence, training, experience, and judgment
  - And not on staff membership or the fact there are board certified or membership in a specialty body or society
  - Similar to language in hospital CoP manual

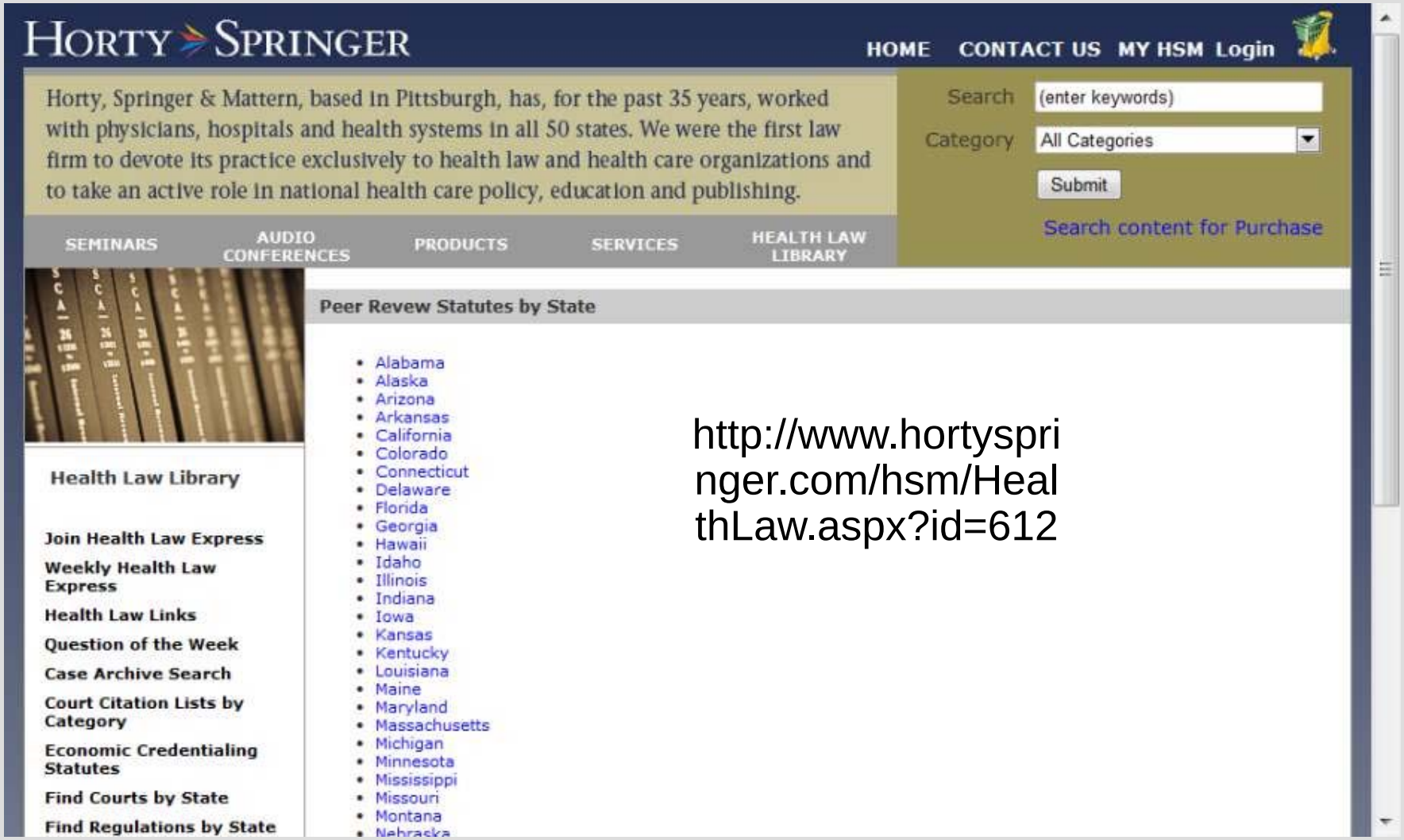
Peer Review Issue

- Step 6 talks about the agreement with both a Medicare-certified hospital or a distant-site telemedicine entity
- Both require the small rural or CAH to send the distant-site performance information that the distant-site will use in the periodic performance of the practitioner
- This must include adverse event and complaints
- This information is what is generally considered to be peer review protected material

Peer Review Issue

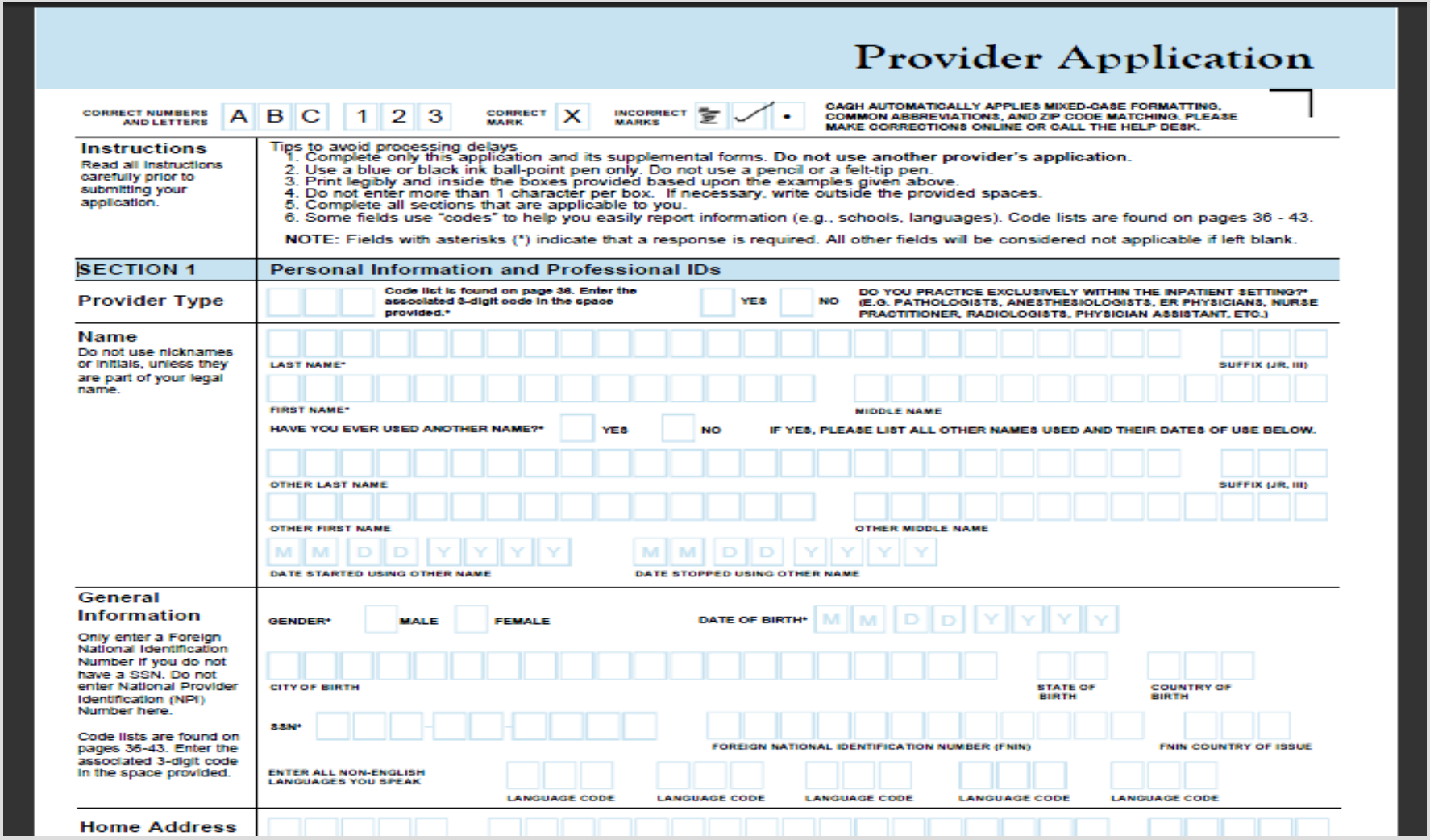
- Peer review protections vary from state to state
- Hospitals should review their specific state peer review statute and case law in your state
- Hospitals should consult with their in-house legal counsel or outside legal counsel
- The written agreement should include language to assure ongoing protection of the peer review information
- Attached is a website that lists all the state's peer review laws

List of Peer Review Statutes by State



http://www.hortyspringer.com/hsm/HealthLaw.aspx?id=612

So How Do You C&P Providers?



Provider Application

CORRECT NUMBERS AND LETTERS: A B C 1 2 3 | CORRECT MARK: X | INCORRECT MARKS: ✓ •

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions
Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays
1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 — Personal Information and Professional IDs

Provider Type
Code list is found on page 36. Enter the associated 3-digit code in the space provided.* | YES | NO | DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name
Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME* | SUFFIX (JR, III)
FIRST NAME* | MIDDLE NAME
HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.
OTHER LAST NAME | SUFFIX (JR, III)
OTHER FIRST NAME | OTHER MIDDLE NAME
DATE STARTED USING OTHER NAME (M M D D Y Y Y Y) | DATE STOPPED USING OTHER NAME (M M D D Y Y Y Y)

General Information
Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER* MALE FEMALE | DATE OF BIRTH* (M M D D Y Y Y Y)
CITY OF BIRTH | STATE OF BIRTH | COUNTRY OF BIRTH
SSN* | FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) | FNIN COUNTRY OF ISSUE
ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Home Address

Pursuant to Texas Insurance Code § 1452.052, LHL234 Rev. 01/07 is promulgated by the Texas Department of Insurance. Please send this application to the carrier with whom you wish to become credentialed.

Texas Standardized Credentialing Application

(Please type or print)

Section I-Individual Information

TYPE OF PROFESSIONAL			
LAST NAME	FIRST	MIDDLE	(JR., SR., ETC.)
MAIDEN NAME	YEARS ASSOCIATED (YYYY-YYYY)	OTHER NAME	YEARS ASSOCIATED (YYYY-YYYY)
HOME MAILING ADDRESS			
CITY	STATE/COUNTRY		POSTAL CODE
HOME PHONE NUMBER	SOCIAL SECURITY NUMBER	☐ Female ☐ Male	
CORRESPONDENCE ADDRESS			
CITY	STATE/COUNTRY		POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL	
DATE OF BIRTH (MM/DD/YYYY)	PLACE OF BIRTH	CITIZENSHIP	
IF NOT AMERICAN CITIZEN, VISA NUMBER & STATUS		ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES? ☐ Yes ☐ No	
U.S. MILITARY SERVICE/PUBLIC HEALTH ☐ Yes ☐ No	DATES OF SERVICE (MM/DD/YYYY) TO (MM/DD/YYYY)	LAST LOCATION	
BRANCH OF SERVICE	ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY? ☐ Yes ☐ No		

Education

PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.)

Grievance and Complaints

- The CAH or small or rural hospital has a duty to notify the distant-site hospitals of any complaints
- PPS hospitals currently have a regulation in the current CoP regarding grievances which starts at Tag 118
- Hospitals should be familiar with the grievance sections and the proposed changes
- CMS calls them grievances
- TJC calls them complaints under RI.01.07.01

Grievance Process A-0118

- The hospital must have a process for prompt resolution of patient grievance
- Patients should have a reasonable expectation of care and service
- Hospital must inform each patient where to file a grievance
  - Consumer advocate, risk management department etc.
  - Provide phone number to contact designated person
- Patients have the right to have their concerns addressed in a timely, reasonable, and consistent manner

A-0118

(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.13(a)(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.

Interpretive guidelines §482.13(a)(2)

The patient should have reasonable expectations of care and services and the facility should address those expectations in a timely, reasonable, and consistent manner. Although 482.13(a)(2)(ii) and (iii) address documentation of facility time frames for a response to a grievance, the expectation is that the facility will have a process to comply with a relatively minor request in a more timely manner than a written response. For example, a change in bedding, housekeeping of a room, and serving preferred food and beverage may be made relatively quickly and would not usually be considered a "grievance" and therefore would not require a written response.
The hospital must inform the patient and/or the patient's representative of the internal grievance process, including whom to contact to file a grievance (complaint). As part of its notification of patient rights, the hospital must provide the patient or the patient's representative a phone number and address for lodging a grievance with the State agency. The hospital must inform the patient that he/she may lodge a grievance with the State agency (the State agency that has licensure survey responsibility for the hospital) directly, regardless of whether he/she has first used the hospital's grievance process.

A "**patient grievance**" is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient's representative, regarding the patient's care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation (CoPs), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489.

- "Staff present" includes any hospital staff present at the time of the complaint or who can quickly be at the patient's location (i.e., nursing, administration, nursing

Hospital Grievance Procedure 122

- Hospital must have a P&P on grievance
- Specific time frame for reviewing and responding to the grievance
- Grievance resolution that includes providing the patient with a written notice of its decision, IN MOST CASES
- The written notice to the patient must include the steps taken to investigate the grievance, the results and date of completion

CMS Interpreters

- Remember CMS has a patient rights section
- There are 90 million Americans with low health literacy
  - Remember to write things in a manner patients can understand
  - Many read at a sixth grade level
- There are 55 million Americans whose primary language is not English
  - Have an interpreter when needed
  - Be sure to document use of an interpreter

Additional Resources

- Attached you will find additional resources which include
  - The Joint Commission standards under both the leadership chapter and the Medical Staff chapter
  - Slides to show the changes from CMS in each section for both PPS hospitals and critical access hospitals
  - The CoPs memo on telemedicine amends the current hospital CoP manuals

The End! Questions?

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- 614 791-1468
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- Additional slides with each CMS Cop section number

MS.13.01.01 Telemedicine TJC

- Called C&P by proxy
- Original site (where patient is located) is allowed to accept the C&P of the distant site (where the radiologist or practitioner is located)
- Must follow all **state** and **federal laws** such as make sure practitioner is licensed in that state
- Will reduce the C&P burden for original site or the small and rural or CAH hospitals
- Recognized the distant site (big Hospital) has more relevant information to base its C&P decisions

MS.13.01.01 Telemedicine TJC

- Recognized that the small hospitals or originating site may have little experience in privileging these specialties
- Also see EC.02.04.01 and .03 to make sure there is appropriate use of telemedicine equipment and that the equipment is maintained
  - Telemedicine is defined as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services. Source: American Telemedicine Association.

MS.13.01.01 Telemedicine TJC Revised

- MS.13.01.01: LIPs who are responsible for the care, and treatment of the patient via telemedicine link are subject to C&P processes of the originating site:
- EP1 Originating site fully C&P the practitioners under the MS standards according to MS.06.01.01 through MS.06.01.13
- These are the final changes reflected in the January 2012 TJC Perspective

MS.13.01.01 Telemedicine TJC

- EP2 Originating site privileges practitioner using credentialing information from the distant-site if the
  - Distant-site is TJC accredited facility
  - The distant site practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services (revised wording)
- EP3 Originating site may choose to use the C&P decisions from the distant site if all the following are met (new wording)
  - Distant site is a TJC accredited hospital or an ambulatory care organization

MS.13.01.01 Telemedicine

- Distant site must do the following (continued)
- Practitioner is privileged at the distant-site for what they want to do at the originating site
- Distant site provides a list of privileges to the originating site with a current list of LIP privileges (DS)
- Originating site has evidence of internal review done of the practitioner’s performance and sends to the distant site information that is useful to assess the practitioners quality of care and treatment for use in privileging

MS.13.01.01 Telemedicine

- Must include any adverse outcomes related to sentinel events and considered reviewable by TJC
- Must communicate complaints to the distant-site
- The distant-site practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services

MS.13.01.01 Telemedicine TJC

- This must occur in a way consistent with any hospital P&P intended to preserve confidentiality or privilege of information established by law
  - Such as peer review
- If contracting with accredited ambulatory facility the hospital must verify that the distant site made its decisions using the process described in the MS standard discussed above

MS.13.01.01 Telemedicine TJC

- Just like in the leadership standard
- The originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, meet the CMS CoP hospital manual
- This includes section 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4)

PPS Hospital CoP Manual Tag 45

The governing body must ensure the medical staff requirements are met.

A-0045

(Rev. 122, Issued: 09-26-14, Effective: 09-26-14, Implementation: 09-26-14)

[The governing body must:]

§482.12(a)(1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;

Interpretive Guidelines §482.12(a)(1)

The governing body must determine, in accordance with State law, which categories of practitioners are eligible for appointment to the medical staff.

Physicians

The medical staff must, at a minimum, be composed of doctors of medicine or doctors of osteopathy. In addition, the medical staff may include other types of *practitioners* included in the definition of a physician in Section 1861(r) of the Social Security Act:

- Doctor of dental surgery or of dental medicine;
- Doctor of podiatric medicine;
- Doctor of optometry; and

Board Chapter MS Issues A-0045

- The Board determines which categories of practitioners are eligible for appointment to the MS such as physicians, dentists, podiatrists, etc
- Changed this section to say that the MS could include other types of healthcare professionals in the definition besides physicians
- This is here because the Social Security Act when it defines physician it includes podiatrists, dentist, optometrists, chiropractors, and not just an MD or a DO

Board Chapter MS Issues A-0045

- Board have flexibility to determine whether other healthcare professionals are eligible for appointment to the medical staff
- Board can appoint some types of non-physician practitioners to the MS such as PA, NP, CNS (clinical nurse specialist), CRNA, CNMW (certified nurse midwife), CSL (clinical social worker), clinical psychologist, AA (anesthesiology assistant) or registered dietician or nutrition professional
  - Other types of licensed professionals have a more limited scope of practice and are not eligible for hospital MS privileges like PT, OT, or speech language therapist

Hospital CoP A-0052

A-0052

(Rev.)

[§482.12(a) Standard: Medical Staff. The governing body must:]

(8) Ensure that, when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the agreement is written and that it specifies that it is the responsibility of the governing body of the distant-site hospital to meet the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant –site hospital's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(3) of this part, grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital.

(9) Ensure that when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the written agreement specifies that the distant-site telemedicine entity is a contractor of services to the hospital and as such, in accordance with §482.12(e), furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant-site telemedicine entity's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(4) of this part, grant privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital's medical staff recommendations; such staff recommendations may rely on information provided by the distant-site telemedicine entity.

Hospital CoP A-0052 Board

- Tag 52 was a new tag number
- Board must make sure that a **written agreement** is done if telemedicine is furnished
- Written contract or agreement must specify that it is the responsibility of the board of the distant-site hospital to meet all the requirements we have discussed previously
- Board where patients are receiving the telemedicine services may grant privileges based on the MS recommendation and the MS can rely on the information provided to them from the DSH

Hospital CoP A-0052 Board

- Written agreement or contract must say that the DSTE is a contractor of services and as such must furnish it in a manner that permits the hospital to comply with all of the applicable CoPs
- This includes, but is not limited to, the **7** requirements of this section; which categories of practitioners are eligible for MS privileges, appoint MS after considering recommendation of existing members of the MS, have bylaws and R/R, MS is accountable for the quality of care, must be based on character, competence, training and can't base is solely on certification, or fellowship

Hospital CoP A-0052 Board

- The board can then **grant privileges** to the physicians and practitioners at the DSTE or DSH based on the **MS recommendation** and the MS is allowed to rely on the information from that site
- Provides a definition of telemedicine
  - Telemedicine means the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications. The distant-site telemedicine physician or practitioner provides clinical services to the hospital patient either simultaneously, as is often the case with teleICU services, for example, or non-simultaneously, as may be the case with many teleradiology services

Hospital CoP A-0052 Board

- Simultaneously is in real time such as the E-ICU
- Non-simultaneously is not in real time in which services are involved after the fact like reading a CT scan by a radiologist
  - Information is communicated to the attending physician who uses the information to make a diagnosis and plan of treatment
- CMS provides a definition of what is a distant-site telemedicine entity (DSTE)
  - DSTE would include a hospital that does not participate in the Medicare program

Definition of DSTE under Tag A 52

- Definition of distant-site telemedicine entity (DSTE) is 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 using its services to meet all applicable CoPs
  - Particularly those requirements related to the C&P of practitioners providing telemedicine services to the patients of a hospital

Hospital CoP A 52 Board

- Any hospital that enters into an agreement with a DSH or DSTE must be sure it is in writing
- DSH must make sure board satisfies the 7 requirements with respect to the physicians and practitioners who furnish telemedicine services
  - This has to be done even though the other hospital is a Medicare certified hospital and must comply with these standards also

Hospital CoP A 52 Board

- DSTE must specifically say that the board will also satisfy the 7 requirements and must furnish the services in a manner to permit the hospital to comply with the CMS CoPs
- There are other requirements that the board must put in the contract
- These are contained in the MS section
- Remember to have a MS bylaw that allows the medical staff to rely on the decisions of the distant site entity

Hospital CoP A 52 Board

- When the board uses the streamlined process in which the MS made the recommendation based on relying on the distant-site entity and the board approved this, the hospital
  - Does not need to maintain a **separate file** on each practitioner
  - May instead have a file on all telemedicine practitioners providing services to the hospital
- Privileging by proxy is an option and not a requirement
- Hospital can elect to do **full C&P**

Hospital CoP A 52 Board

- Board could require the MS to independently review the credentials and make privileging recommendations (But why would you???)
- Surveyor will ask to see a written copy of the contract if you use telemedicine services
- Surveyor will make sure it contains all of the elements
- Will look to see that hospital has the documentation to show that privileges were granted
- Must show if relied on or if conducted its own review

Composition of the MS A 339

A-0339

(Rev. 122, Issued: 09-26-14, Effective: 09-26-14, Implementation: 09-26-14)

§482.22(a) Standard: *Eligibility and Process for Appointment to* Medical Staff

The medical staff must be composed of doctors of medicine or osteopathy. *I*n accordance with State law, *including scope-of-practice laws, the medical staff* may also *include other categories of physicians (as listed at §482.12(c)(1)) and non-physician* practitioners *who are determined to be eligible for appointment* by the governing body.

Interpretive Guidelines §482.22(a)

The hospital's governing body has the responsibility, consistent with State law, including scope-of-practice laws, to determine which types/categories of physicians and, if it so

Composition of the MS A 339

- The MS must be composed of doctors of medicine or osteopathy, as in accordance with state law, and may be composed of other practitioners as appointed by the board
- Added that MS may also include other healthcare professionals as previously discussed
  - Dentist, podiatrist, chiropractor, or optometrist
- Board has the flexibility to determine whether healthcare professionals other that physicians are eligible for appointment to the MS
  - Such as NP, PA, CNM, CRNA, RD, etc.
  - Must be consistent with state law and scope of practice

Medical Staff Tag A 342

* * *

A-0342

§482.22(a)(3) When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the governing body of the hospital whose patients are receiving the telemedicine services may choose, in lieu of the requirements in paragraphs (a)(1) and (a)(2) of this section, to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the hospital's governing body ensures, through its written agreement with the distant-site hospital, that all of the following provisions are met:

(i) The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.

Medical Staff Tag A 342

- The board can do full C&P or the board can allow the MS to **rely** on the C&P decisions of the other hospital
- Board must have a **written contract** or agreement to do this if all of the following are met;
  - Allowed if DSH is a Medicare hospital
  - The physician is privileged at the other hospital and provides a list of privileges allowed
  - Physician has a license in the state

Medical Staff Tag A 342

- Board must have a written contract or agreement to do this if all of the following are met (continued);
  - Hospital has evidence of an internal review of the performance information of the physician and
  - Sends the performance information for use in the periodic appraisal of the distant-site physician or practitioner
  - This information must include all adverse events and complaints that result from the telemedicine services provided by the distant-site physician

Medical Staff Tag A 342

- It is important to note that if the distant hospital participated in the Medicare program and their Medicare is terminated at any time during the agreement
- Hospital may **no** longer receive telemedicine services
- **List of physicians** providing services must be current and cannot include any physician who no longer is C&P by the distant-site hospital

Medical Staff Tag A 343

A-0343

§482.22(a)(4) When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the governing body of the hospital whose patients are receiving the telemedicine services may choose, in lieu of the requirements in paragraphs (a)(1) and (a)(2) of this section, to have its medical staff rely upon the credentialing and privileging decisions made by the distant- site telemedicine entity when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the hospital's governing body ensures, through its written agreement with the distant-site telemedicine entity, that the distant-site telemedicine entity furnishes services that, in accordance with §482.12(e), permit the hospital to comply with all applicable conditions of participation for the contracted services. The hospital's

Medical Staff Tag A 343

- Repeats similar information as from Board section
- The board can have the MS rely on the decision of the other hospital
- If the board has a written agreement with the distant-site entity
- That permits the hospital to comply with all of the applicable CoPs for the contracted service
- Same requirements as before; meet the standards, licensed, have current list of privileges, internal review of performance and report complaints and AEs

Medical Staff Bylaws A 363

* * *

A-0363

(Rev.)

[The bylaws must:]

§482.22(c)(6) - Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges. ***For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to the requirements in §482.12(a)(8) and (a)(9), and §482.22(a)(3) and (a)(4).***

Interpretive Guidelines §482.22(c)(6)

All patient care is provided by or in accordance with the orders of a *physician or* practitioner who meets the medical staff criteria and procedures for the privileges granted, who has been granted privileges in accordance with those criteria by the governing body, and who is working within the scope of those granted privileges.

Privileges are granted by the hospital's governing body to individual practitioners based on the medical staff's review of that individual practitioner's qualifications and the medical staff's

Medical Staff Bylaws A 363

- The **bylaws** include criteria for determining privileges and a procedure for applying the criteria to individuals requesting privileges
- Need an **order** for patient care by one who meets MS criteria and procedures for privileges
- Criteria for providing distant-site privileges is also governed by this section
- Board can do full C&P or rely on the distant-site entity under an agreement
- Change the bylaws to allow this

Critical Access Hospital C 196

State Operations Manual

Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev.)

* * *

C-0196

[§485.616 Condition of Participation: Agreements]

(c) Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners.

(1) The governing body of the CAH must ensure that, when telemedicine services are furnished to the CAH's patients through an agreement with a distant-site hospital, the agreement is written and specifies that it is the responsibility of the governing body of the distant-site hospital to meet the following requirements with regard to its physicians or

CAH C 196 Agreements for C&P

- Board must make sure it has a written agreement with a distant-site entity in order to do telemedicine
- Must do 7 things;
  - Make sure consistent with state law categories of practitioners eligible for appointment to the MS
  - Board appoints members of the MS
  - Must make sure MS has bylaws
  - Board must approve bylaws and R/R

CAH 196 Agreements for C&P

- Must do 7 things (continued);
  - MS is accountable to the board for the quality of care provided to patients
  - Ensure that MS selected is based on individual character, competence, training, experience, and judgment
  - MS membership can not be based solely upon certification, fellowship or membership in a specialty body or society

CAH C-0196 Agreements for C&P

- Board with written agreement can rely on C&P of distant-entity
- Repeats similar provisions as discussed in the previous slides
  - Board makes sure has current list of privileges
  - Makes sure distant-site physician has a license
  - Must have evidence of internal review of the physician's performance of their privileges
  - Must send information to entity for use in the periodic appraisal of the distant-site physician like AE and complaints

CAH 196 Agreements for C&P

- Includes definition of telemedicine
- Discussed non-simultaneously and simultaneous as previously discussed
- CAH must enter into a written agreement to do telemedicine and must specify that it is the responsibility of the distant-site to conduct the C&P of physicians and practitioners providing telemedicine services
- Must follow state laws, have bylaws, ensure MS is accountable for the quality of care for patients

Agreement for C&P Telemedicine C-197

C-0197

[(c) Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners.]

(3) The governing body of the CAH must ensure that when telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the agreement is written and specifies that the distant-site telemedicine entity is a contractor of services to the CAH and as such, in accordance with §485.635(c)(4)(ii), furnishes the contracted services in a manner that enables the CAH to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in this section with regard to its physicians and practitioners providing telemedicine services.

(4) When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the CAH's governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site telemedicine entity regarding individual distant-site physicians or practitioners. The CAH's governing body or responsible individual must ensure, through its written agreement with the distant-site telemedicine entity, that the following provisions are met:

(i) The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at (c)(1)(i) through (c)(1)(vii).

(ii) The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides a current list to the

Service Provided Thru Agreements C-0285

C-0285

§485.635(c) Standard: Services Provided Through Agreements or Arrangements

(1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including--

(5) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier.

Interpretive Guidelines §485.635(c)(1) ***& (c)(5)***

All agreements for providing health care services to the CAH's patients must be with a provider or supplier that participates in the Medicare program, except in the case of an agreement with a distant-site telemedicine entity for the provision of telemedicine services. The *agreements* should describe routine procedures (e.g., for obtaining outside laboratory tests); and there should be evidence in the agreement or arrangement that the governing body (or responsible individual)

Quality Assurance C-0340

C-0340

[§485.641 (b) Standard: Quality Assurance

The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that--]

(4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by--

(i) One hospital that is a member of the network, when applicable;

(ii) One QIO or equivalent entity;

(iii) One other appropriate and qualified entity identified in the State rural health care plan;

(iv) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site hospital, the distant-site hospital; or

Quality Assurance C 340

- CAH has a effective QA program to evaluate the quality and appropriateness of the diagnosis and treatment provided and of treatment outcomes
- Must have a written agreement to provide telemedicine services
- All CAH must have a arrangement with an outside entity to review the appropriateness of the diagnosis and treatment provided
- This includes physicians who do telemedicine services

Quality Assurance C 340

- Some CAH also prefer to conduct their own internal review in addition to the outside review
- Regulation does not specify the frequency of the outside review
- CAH and the outside entity must reach a mutual agreement as to the frequency of the outside review
  - Entities eligible to provide this outside review include, for MDs and DOs who provide services on-site at the CAH, a hospital that is a member of the same rural health network as the CAH; a Medicare QIO, or its equivalent; or another appropriate and qualified entity identified in the State's Rural Health Plan to perform this function

Quality Assurance C 340

- The distant-entity that is a Medicare hospital is the outside entity responsible for reviewing the quality of care provided by the telemedicine physicians
- If distant entity is a DSTE then the outside entity to review the quality of care for telemedicine is a hospital that is a member of the same rural network as the CAH, a QI or its equivalent, or another appropriate and qualified entity identified in the State's Rural Health Plan

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Thanks for attending!

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