Telemedicine Credentialing and Privileging
Protecting Patient Privacy, Avoiding Fraud and Abuse Liability, Ensuring Quality of Care

THURSDAY, AUGUST 23, 2012

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

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Telemedicine Credentialing and Privileging: 
Complying with the New CMS Rule

Protecting Patient Privacy, Avoiding Fraud and Abuse 
Liability, Ensuring Quality of Care

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OUTLINE OF PRESENTATION

I. CMS’ Final Rule and Lessons Learned from the First Year

II. Impact on Healthcare Facilities and Practitioners

III. Complying and Implementing the Final Rule
I. CMS’ FINAL RULE AND ASSOCIATED REGULATIONS

Reliance on Credentialing and Privileging Decisions is A-OK!

The New Rule:

permits a governing body of a hospital or CAH to rely on credentialing and privileging decisions made by distant-site hospitals or telemedicine entities when making privileging decisions for practitioners who provide telemedicine services, as long as certain conditions are met

Effective Date was July 5, 2011
Prior CMS Telemedicine Rule:

Required the governing body of the hospital or CAH to make all privileging decisions based upon the recommendations of its own medical staff after its medical staff had thoroughly examined and verified the credentials of every single practitioner applying for privileges irrespective of whether that practitioner was providing services in person and onsite at the hospital or remotely through a telecommunications system.
CMS’ RATIONALE FOR NEW RULE

1. **Duplicative Credentialing**: required each hospital seeking to use telemedicine services to credential practitioners, who were already credentialed at their “home” institutions.

2. **Burdensome Credentialing**: required hospitals, which often lacked adequate resources to fully carry out traditional credentialing, to take on the financial burden of providing much needed care to its patients.
3. Conflicting Requirement with TJC: TJC was permitting “privileging by proxy” for all TJC-accredited hospitals.

*Privileging by Proxy* allowed for one TJC-accredited facility to accept the privileging decisions of another TJC-accredited facility utilizing a streamlined independent determination process, rather than making an individualized decision based on the practitioner’s credentials and record.
DOES THE FINAL RULE EVEN APPLY TO YOU?

1. Are you engaging in telemedicine?

2. Are you providing or receiving the services through “telemedicine?”

3. How does the Final Rule apply to you?
WHAT IS TELEMEDICINE?

**CMS Definition:**

Telemedicine is “the provision of clinical services to patients by practitioners from a distance via electronic communications.”
WHAT IS TELEMEDICINE?

The Joint Commission Definition:

- **Telehealth**: the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.

- **Telemedicine**: the use of medical information exchanged from one site to another via electronic communication to improve patients’ health status. Telemedicine is a subcategory of telehealth.
**WHAT IS TELEMEDICINE?**

**State of California Definition:**

Telehealth is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.
WHAT IS TELEMEDICINE?

Types of Telemedicine:

1. **Non-simultaneous**: involve after-the-fact interpretation or assessment, such as teleradiology services (or according to California “asynchronous”)

2. **Simultaneous**: involve “real-time” interpretation or assessment, such as teleICU services (or according to California “synchronous”)

**NOT Telemedicine**: informal consultations between practitioners
BREAKING DOWN CMS’ NEW RULE: WHO ARE THE PARTIES & WHAT ARE THEY DOING?

Definitions:

1. **Distant-Site Hospital**: a Medicare-participating hospital that provides the practitioner who is providing the telemedicine services.

2. **Distant-Site Telemedicine Entity**: can include a non-Medicare participating hospital or entity that provides contracted services in a manner that enables a hospital or a CAH using telemedicine services to meet all applicable CoPs. These entities often include teleradiology providers, telepathology providers, and ASCs.

3. **Originating Sites**: the hospital or entity where the patient is located, who is receiving medical care via telemedicine
To rely on a distant-site hospital’s credentialing and privileging decisions, the hospital or CAH must have a **written agreement** that establishes the following:

1. The distant-site hospital is a Medicare-participating hospital
BREAKING DOWN CMS’ NEW RULE:
DISTANT-SITE HOSPITALS

2. The distant-site practitioner is privileged at the distant-site hospital as evidenced by a current list of the practitioner’s privileges provided by the distant-site hospital.

3. The practitioner holds a license issued or recognized by the state in which the hospital or CAH whose patients are receiving telemedicine services is located.

4. The hospital that credentials and privileges the distant-site practitioners shares the practitioner’s performance review information with the distant-site hospital.
To rely on the credentialing and privileging decisions by a distant-site telemedicine entity, the hospital or CAH must have a written agreement that establishes the following:

1. The entity’s process and standards for assessing the qualifications of its practitioners at least meet those standards set forth in the CoPs
BREAKING DOWN CMS’ NEW RULE: DISTANT-SITE TELEMEDICINE ENTITIES

2. The distant-site practitioner has the experience and expertise as represented by the distant-site telemedicine entity

3. The practitioner holds a license issued or recognize by the state in which the hospital or CAH is located

4. The hospital or CAH that credentials and privileges the distant-site practitioner shares the practitioner’s performance review information with the entity
The Joint Commission worked with CMS to align its telemedicine requirements for hospital and CAH accreditation.

**Leadership Standard:**
**LD.04.03.09**

**Element of Performance 23:** Requires hospitals that use Joint Commission accreditation for deemed status purposes to have written agreements with distant sites.
Medical Staff Standard:
MS.13.01.01

For originating sites only: Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.
1. Hospitals are required, by law, to have detailed written agreements with a distant-site hospital or telemedicine entity to rely on the distant site’s credentialing and privileging decisions.

2. Written agreements are required to include:
   - Specific responsibilities of telemedicine provider’s governing body or other responsible decision-makers
   - All provisions required by the CoPs
Written agreements *should also* include:

- Any additional standard with which a distant site’s credentialing and privileging process should comply

- Adequate *representations and warranties* regarding the quality of services and credentialing/privileging processes provided by the distant-site and any entity with which the distant-site subcontracts
Written agreements *should also* include:

- Tight, protective *indemnification and risk-sharing provisions*

- Requirement that distant-site telemedicine entity has sufficient *liability insurance*
Additional Considerations to Minimize Risk:

- Address greater oversight concerns that arise when contracting with a distant-site telemedicine entity rather than a licensed, distant-site hospital.
Additional Considerations to Minimize Risk:

- Require additional assurances if a distant site subcontracts with a telemedicine entity.
  - Avoid relying solely on representations and warranties.
  - Consider requiring separate written agreements.
  - Review agreements between distant site and its subcontractors.
II. THE IMPACT ON HEALTHCARE FACILITIES & PRACTITIONERS

STRATEGIC PLANNING

1. Telemedicine NOT just another service
2. Telemedicine a modality to deliver many types of services
3. Strategic because:
   • A tool to determine where and how to provide services
   • An alternative to brick and mortar
   • Full service delivery or used to supplement services already in place
1. Strategic planning requires:
   - Assessment of relevant markets and environment
   - Understanding of competition
   - SWOT analysis

2. Important for counsel to “be at the table” early in the planning process

3. Requires an understanding of strategic elements of telemedicine AND the underlying legal issues

4. Consider Exit Strategies
REASONS FOR THE GROWTH OF TELEMEDICINE

1. Advances in technology
2. Academic medical centers asked to assist other hospitals
3. Mission driven-hospitals seek to assist their communities
4. Physician shortage, especially in rural areas
5. Aging patient population and an increase of patients with chronic diseases
6. Current regulatory environment with an emphasis on care coordination and shifting care settings
7. Global health care
TELEMEDICINE PITFALLS

1. Lack of reimbursement
2. Difficult to oversee and regulate with expanding technology
3. Patient safety issues
4. Potential decrease patient satisfaction
5. Quality of care and communication
6. Fraud and abuse
SO MANY TERMS . . .

Are the following “telemedicine”?

- Telehealth
- Virtual Care
- mHealth
- Social Media
EXPANDING SERVICES

Examples of Telemedicine:

• Videoconferencing
• Transmission of still images
• E-health including patient portals
• Remote monitoring of vital signs
• Nursing call centers
• Tele________ [Fill in the blank]

Note: Some are not governed by the Telemedicine Rule
EXPANDING SETTINGS

Variety of practice settings

- Academic medical centers (AMCs)
- Large hospital systems
- Health care clinics
- Ambulatory Surgery Centers (ASCs)
- Home
- Global
EXPANDING TECHNOLOGY

Technology changes drive expansion and access to telemedicine, even globally
IMPLEMENTATION CHECKLIST

1. Accreditation
2. Governance
3. Medical Staff
4. Operational Concerns
5. Insurance and Liability
6. Telemedicine Vendors and Technology
7. State License Requirements
8. Costs and Marketing
9. HIPAA and Medical Records
ACCREDITION

1. “Privileging by proxy” for all TJC-accredited hospitals and CAHs

2. Standards: LD.04.03.09, MS.13.01.01 and MS.01.01.01

3. Goals of TJC Standard
   • Eliminate duplicative credentialing
   • Concerns over impeding patient access to health care services

4. Many agreements already in place under the TJC standards

NOTE: Don’t forget the Joint Commission.
GOVERNANCE

1. Board Bylaws
2. Medical Staff Bylaws
3. Education for Board on its role and what it is delegating
4. Provisions and approval of Agreement with distant site hospital or DSTE
MEDICAL STAFF

Medical Staff Bylaws

• Address any aspect of Bylaws or policies that involve the physical presence of a physician
• Meeting requirements, definition of patient encounters or contacts, minimum number of contacts or encounters, criteria for new members in departments (sometimes based on “need”), emergency room coverage
1. Medical Staff Bylaws

- Describe process and information being relied upon
- Impact on:
  - Department Chiefs
  - Credentials Committee
  - Medical Executive Committee
- Required to monitor quality and risk for distant site practitioner
  - Bylaws, policies or rule changes to describe process
  - How to effectively do so?
  - Communications with DSTE
MEDICAL STAFF

Medical Staff Policies

• Physician Health
• Corrective Action
• Fair Hearing
• Disruptive Behavior

NOTE: Exit strategy in the agreement
1. Defining the “Service”
   - Consults vs. call coverage vs. professional services

2. Staff
   - Not just clinical staff
   - Examples: IT and Scheduling personal

3. Equipment
   - Maintenance
   - Downtimes
   - Replacements

4. Space
   - Description
INSURANCE AND LIABILITY ISSUES

1. Professional liability coverage for distant site practitioner and hospital or DSTE

2. Check hospital’s policies
   • No exclusions or other provisions that could lead to a denial in coverage in working with telemedicine providers
   • No issues by delegating decisions

3. D&O coverage

4. Policies, clinical protocols and education
INSURANCE AND LIABILITY

4. Indemnification of hospital
   • Complete reliance on distant site hospital
   • Need strong a provision

5. Standard of care – Community vs. local?

6. Telemedicine quality standards?

7. Consent issues
TELEMEDICINE VENDORS

Selection process

- Due diligence
- RFPs
- Can it be done in house?

Contracts

- HIPAA issues
- Cyber insurance
- Support levels
- Warranties
- Intellectual property

More expensive is not always better
STATE LICENSING REQUIREMENTS

- State licensing requirements vary
  • Special Telemedicine licenses
- Compact licensing is one answer
- National licensing requirements
LICENSING

Also an issue got global health care . . .
COSTS AND MARKETING

OIG Advisory Opinion No. 11-12

- Who pays for the costs?
- Marketing
- Current or past relationship
- Reduction in volume
- Analysis hinges on no reimbursement
HIPAA AND MEDICAL RECORDS

1. Privacy Rule
   • Often for treatment
   • Physical safeguards

2. Security Rule
   • Encryption?
   • Risk analysis

3. HITECH
   • Breach reporting

4. International Privacy Rules

5. Medical Records
   • Documentation
   • Transfers
III. COMPLYING AND IMPLEMENTING

1. Protecting Privacy & Addressing Privacy Breaches
   *Who is liable for the breach? Who is responsible for curing?*

2. Monitoring the Performance of Providers
   *What happens when something goes wrong? Who is conducting peer review? How is the peer review information shared? Who is responsible for disciplining?*

3. Monitoring the Performance of the Technology
   *What happens when something goes wrong? Who maintains the devices?*
PROTECTING SHARED INFORMATION AND PATIENT PRIVACY: REQUIREMENTS

1. Compliance with the new rule requires sharing of peer review and internal review information between hospitals and distant sites.

2. Develop policies and procedures for sharing information to ensure the privacy of physician peer review and patient information is appropriately protected.
PROTECTING SHARED INFORMATION AND PATIENT PRIVACY: BEST PRACTICES

Additional Considerations to Minimize Risk:

- Develop and implement policies and procedures to comply with federal privacy laws and each state’s peer review and patient privacy laws.
- Determine what information to share—no need to share too much.
- Determine how information should be shared.
Share information in a timely manner.

Determine who should have access to confidential, shared information.

Only disclose information in a manner that preserves all peer review privileges under state law.

Note: A telemedicine entity may not be recognized peer review body under state law and thus not subject to any peer review privilege.
PROTECTING SHARED INFORMATION AND PATIENT PRIVACY: BEST PRACTICES (con’t)

- Understand what information is being collected, communicated, and stored.
- Understand how distant-site telemedicine practitioners will use, store, and maintain patient health records for patient care and healthcare liability purposes.
1. **Hospitals are required**, by law, to monitor distant-site telemedicine practitioners.

2. **THE RULE:** Hospital using telemedicine services of distant-site practitioners must maintain evidence of an internal review of the distant-site practitioner’s performance of privileges and send information to the distant site for use in the periodic appraisal of the practitioner.
The law requires, at a minimum, that the monitored and shared information include:

(1) All adverse events that result from telemedicine services provided by practitioner to patients, and

(2) All complaints the hospital has received about the practitioner
Additional Considerations to Minimize Risk:

- Determine what additional information, if any, to collect as part of monitoring process.
- Determine how to use and act on collected information.
- Identify telemedicine practitioner’s procedural rights.
POTENTIAL PITFALLS WITH MONITORING THE PERFORMANCE OF PROVIDERS

**Fair Hearing Rights:**
What happens if the hospital no longer wants to use a provider from the telemedicine site because of quality issues?

**Subcontractor Issues:**
What happens if a medical group at the hospital subcontracts with another entity to provide telemedicine services; does the hospital need a written agreement with that subcontractor?
ACCOMMODATING THE USE OF TECHNOLOGY FOR PATIENT ASSESSMENT: BEST PRACTICES

Practical Considerations

- Ensure appropriate secure communication channels are in place for sharing information.
- Develop policies for the use and maintenance of telemedicine technologies.
- Identify and communicate purpose of telemedicine technology and when it should be used.
ACCOMMODATING THE USE OF TECHNOLOGY FOR PATIENT ASSESSMENT: BEST PRACTICES

- Identify who is authorized to use telemedicine technologies.
- Have ready access to trained and knowledgeable IT personnel and network support staff.
- Implement test runs.
ACCOMMODATING THE USE OF TECHNOLOGY FOR PATIENT ASSESSMENT: *BEST PRACTICES*

- Practical considerations when contracting with telemedicine technology vendors
  - Protect against liability for equipment failure
  - Ensure access to continued support services
  - Have vendor represent and warrant technology’s compliance with regulatory requirements (e.g. FDA medical device)
How does a hospital realistically keep track of all the “telemedicine” that is occurring within its four-walls? Is it even possible?
IMPLEMENTING BEST PRACTICES TO MITIGATE RISKS

- Communicate regularly with distant-site hospitals and telemedicine entities.
- Be knowledgeable of the roles and responsibilities of all parties involved in the delivery of telemedicine services.
- Understand the purposes and boundaries of all telemedicine technologies or potential technologies.
IMPLEMENTING BEST PRACTICES TO MITIGATE RISKS

- Ensure each written agreement with each party contains appropriate protective provisions.
- Monitor state and federal laws and regulatory guidance.
QUESTIONS?
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