Telehealth Credentialing: From Teleradiology to Telepsychiatry to eICU

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Overview

1) What is Telehealth/Telemedicine – Why it Matters (and will continue to Matter)
2) Beyond Credentialing – A More Complete Picture
3) Telehealth Credentialing and Privileging
4) Telehealth Quality Assurance – FPPE/OPPE
5) Practical Takeaways

Objective

Context is Everything: Better position you to “issue spot” and identify the most pertinent telehealth considerations for your organization

WHAT IS TELEHEALTH/TELEMEDICINE
Telehealth/Telemedicine

- Telemedicine is routinely defined as the use of medical information exchanged from one site to another via electronic means to improve patients’ health status i.e., direct patient care.
- Telehealth is a broader term that encompasses non-clinical services such as education and administration.
- The terms are often used interchangeably, and the precise definition will vary based on the source and purpose of the definition (e.g., Medicare payment vs. state licensure laws).
- Telemedicine is not a distinct medical specialty.

The Scope of Telehealth

- Remote Monitoring and Surveillance
  - Connected Diabetes Monitors
  - Medication Management
- Patient and Provider Education
- Mhealth – Mobile Apps: individual patients and public health
- Internet Based Visits
- eICU Coverage
- Remote PACS viewing
- Other forms of telemedicine and more

Eye of the Beholder

- Regardless of what we intend when using the terms telehealth or telemedicine, federal and state laws may have very a specific meaning depending on the circumstance.
- For example, Medicare does not consider telemedicine to include most provider/patient communications such as telephone, e-mails, etc.
- But some states or industry organizations may use more broad definitions.
Types of Telemedicine

- Store–and–forward
  - Acquiring medical data and transmitting the data to a medical specialist at a convenient time for assessment offline (e.g., radiology, ophthalmology)
- Active Remote Monitoring
  - Enables a professional to monitor patients remotely using various technologies
  - Primarily used for managing chronic diseases or specific conditions
- Interactive Services/Systems
  - Real-time interactions between patient and provider

Benefits

- Improved Access:
  - Enables more convenient access to a wider range of health services, resulting in more timely diagnosis and treatment
  - Particularly beneficial for elderly and rural residents
- Reduced Costs:
  - Reduce re-admissions, more efficient use of specialists
  - Increased payment and reimbursement from both Governmental and Private Payers? Not yet…
- Patient Demand – convenient

Telehealth Today and Tomorrow

- For some, telehealth simply means that your organization has a “nighthawk” service
- Some advanced health care systems, and this is a relative few, offer nearly 30 specialty care services, ranging from behavioral health and dermatology to audiology and ophthalmology
- Telestroke and eICU seem to be the most common under development: both are resource and expertise intensive
Telehealth Today and Tomorrow

• A Paradigm Shift is Underway:
  – Providers of all types are redesigning themselves to pursue “value” / not “volume”
  – Our current infrastructure was built on a different, now somewhat obsolete model
  – Greater alignment among a range of providers around quality, cost and efficiency → clinical integration
  – Provider shortages – How long is it taking at your organization to recruit certain specialties?
  – Tremendous emphasis on primary care and outpatient services (pre-acute/post-acute) in all communities

Telehealth Today and Tomorrow

• This shift is driving substantial advancements in all things telepresence: from specialty clinics of all types to even telesurgery
• All forms of real-time interaction between the patient and the provider or between two providers
  – HD cameras, stethoscopes, otoscopes, scales, ultrasound
• Internet-based systems: The internet will likely become the principal communication medium for transferring medical information between providers, patients and providers, and other services needed to provide optimal interactive telemedicine services

Telehealth is Getting Attention

• H.R.3306 : Telehealth Enhancement Act of 2013
• H.R.3750 : Telehealth Modernization Act of 2013
• S.2662 : A bill to promote and expand the application of telehealth under Medicare and other Federal health care programs, and for other purposes.
• H.R.2001 : Veterans E-Health & Telemedicine Support Act of 2013
• H.R.3077 : TELE-MED Act of 2013
• FSMB: April 2014 Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine
• FSMB: July 2014 press release re Draft Interstate Compact for Physician Licensure
Many Considerations Beyond Credentialing and Privileging

• Our business friends move quick; sometimes quicker than the facts will support
• Consider the following:
  - Interaction with existing systems/EHR
  - Internet "bandwidth" – local network capability?
  - Provider adoption?
  - Patient adoption?

Many Considerations (cont.)

• Limited Reimbursement – biggest deal breaker
  - Medicare: only for limited CPT codes, certain providers and sites located in a rural HPSA
  - Medicaid: State-specific; generally broader than MCR
  - Other payers?
    o Varies by state and payer
    o Some states have enacted telehealth parity laws that mandate commercial payer coverage
    o Some national payers hold to the standard that no services will be reimbursed without face to face contact
Many Considerations (cont.).

- Peer review confidentiality
  - The format or medium generally doesn’t affect whether information can qualify for your state’s peer review privilege
  - But consider this in advance - particularly when information will be shared across state lines
  - Ensure that agreements and policies consider the purpose, handling and confidential status of information intended to qualify for each applicable state’s peer review privilege

Many Considerations (cont.)

- HIPAA Compliance
  - Patient consent
  - Access controls
  - Individual authentication
  - Transmission security
  - Business associate controls
- Fraud and abuse - $ arrangements and benefits
- Social media use
- Mobile device use
- FDA and related regulatory oversight

TELEHEALTH CREDENTIALING AND PRIVILEGING
Credentialing and Privileging

1) Licensure Issues
2) Credentialing
3) Privileging
4) Risks

Licensure Issues

• Licensure is state specific with the intent of protecting citizens by ensuring the minimum qualification of providers
• Professionals are licensed to provide services within their scope of practice
• Licensure is generally needed where a patient relationship exists
• Historically, a patient relationship existed where an in-person evaluation or treatment occurred
• Telehealth challenges this traditional definition due to the lack of an in-person evaluation

Licensure cont.

• Most states require a provider to be licensed in the state where the patient resides/is receiving care
• Common exceptions to licensure:
  - Physician-to-physician consultations
  - Educational purposes
  - Border states
  - Medical emergencies
  - Trailing patient
  - Remove prescribing!
  - Licensure compact? Maybe some day…
The Long and Winding Road of Telemedicine Credentialing

- History of Credentialing Telemedicine Providers
  - 2001: TJC adopted a standard that required practitioners to be credentialed at the facility where care was delivered
  - 2003: TJC introduced "credentialing by proxy"
    - CMS disagreed and said telemedicine providers were subject to the same standards as all other providers

Long Road (cont.)

- 2008: Credentialing by proxy called into question by MIPPA
  - MIPPA revoked TJC’s unique statutory deeming status and required TJC to periodically reapply for deeming authority
- 2009: TJC revised standards consistent with CoPs
- 2010: CMS Proposed Regulations released; did not go as far as original TJC credentialing by proxy
- May 2011: CMS reversed course and allowed credentialing by proxy or so called “reliance credentialing”
- 2011 and 2012: TJC realigned standards with CMS but retains some differences
Telemedicine Credentialing

- The Joint Commission
  - Aligned with the Medicare CoPs
- HFAP and DNV
  - Largely identical to CoP requirements
- But what about state law?
  - Most state hospital licensure laws still do not affirmatively adopt the reliance or delegated credentialing approach
  - A handful of states have adopted standards equivalent or similar to CMS
  - Risk management assessment if state law silent

Credentialing (cont.)

Methods for Credentialing Telemedicine Providers

1) Go through the entire credentialing process as you would for any other member of the medical staff
2) Rely on the credentialing decision of the distant-site hospital or telemedicine entity
3) Request information from the distant-site where the telemedicine provider is already privileged and use that information to make a decision to grant the practitioner privileges (shared approach)

Credentialing (cont.)

1) Traditional Method
   - Common with "tradition minded" medical staffs
   - Often reference quality oversight as the basis for retaining traditional or complete process
   - It’s important to keep in mind that your bylaws can/should be clear that your options are "optional"
   - E.g., "Applicants seeking appointment to the Medical Staff and/or clinical privileges to perform telemedicine services may, but need not, be processed according to ..."
   - Not unlike your expedited credentialing process, medical staff leadership can direct an application to follow a more complete process
Credentialing (cont.)

Conditions of Participation

2) Relying on a distant-site Hospital

• Written agreement between hospitals
• Agreement specifies responsibility of distant-site to meet credentialing/privileging CoPs
• Agreement specifies distant-site furnishes contracted service to hospital in a manner that permits originating-site hospital to comply with CoPs for contracted services

Credentialing (cont.)

2) Relying on a distant-site Hospital

• Distant-site must be Medicare-participating hospital
• Provider is privileged at distant-site, which provides current list of Provider’s privileges
• Provider holds a license issued or recognized by the state of originating-site hospital
• Originating-site hospital conducts and shares internal reviews of Provider’s performance with distant-site hospital (at a minimum, all adverse events and complaints)

Credentialing (cont.)

Relying on a distant-site Telemedicine Entity

• Similar requirements for the content of the written agreement between the hospital and entity, including the requirement that the telemedicine entity furnish contracted services to hospital in a manner that permits hospital to comply with hospital CoPs for contracted services
• Similar requirements for telemedicine entity to provide information on the privileges of telemedicine practitioners and for hospital to provide evidence of internal review
Credentialing (cont.)

3) Shared Approach
   • CVO-like
   • Common during a period where medical staffs are adjusting to a new world order
     - Contract with distant-site hospital to obtain, maintain and store credentialing information
       o Education and training
       o Malpractice history
       o Professional references
     - Distant-site hospital performs QA/PI and reports information as it occurs, e.g., adverse outcomes
     - Originating-site credentials/privileges based on info received

Credentialing (cont.)

• The concept of scope of practice-specific privileging when a "medical level of care" is being permitted seems to be generally well understood
• For most privileges, the qualifications or criteria will not vary for telemedicine
• Ensure all practitioners are required to demonstrate proficiency in the selected telehealth modality
• 2 common privileging issues with telemedicine:
  - That privileges are unnecessary if the physician or provider is merely "consulting"
  - Forgetting to square up core or DoPs when relying on delegated/proxy credentialing

Credentialing Risks

• Negligent credentialing (a phrase you’ve not heard before I’m sure)
• A majority of states recognize the claim of negligent credentialing (just a few have rejected it)
• Negligent credentialing and telehealth
  - Requesting information from the distant-site hospital/telemedicine entity to make a decision to grant a practitioner privileges is similar to a CVO arrangement
  - CVO is defined by TJC as "Any organization that provides information on an individual’s professional credentials"
  - Any organization basing a decision on information from a CVO should be sure of the completeness, accuracy, and timeliness of the information
  - Even more risk with reliance credentialing
Credentialing Risks (cont.)

- Credentialing Risks
  - You (and your patients) are relying on a distant-site’s credentialing and QA/PI processes so you should be confident that its processes are as demanding as your own
- Common scenarios:
  - Following a below standard or inadequate process; or
  - Had in place an appropriate or adequate process that you failed to follow
- Considerations (and document)
  - Are the processes similar or identical to your own?
  - Request a copy of the credentialing procedures and protocols
  - Request information regarding the frequency of FPPE and OPPE
  - Any history of negligent credentialing claims?
  - Significant number of malpractice lawsuits?
  - Review a sample of QA/PI or OPPE reports?

TELEHEALTH QUALITY ASSURANCE

Quality Assurance/Performance Improvement

- Whether driven by regulatory, accreditation or risk management, QA/PI must still be used
- Some hospitals have taken the view that if they are truly relying on a distant site, then ongoing performance review is less important or even unnecessary
- In many circumstances, the same indicators and benchmarks will apply to telemedicine providers
- Ways that telehealth can expand your QA/PI capabilities:
  - TeleCME
  - Case or procedure recording
  - Telecoaching/Teleproctoring
  - Creation of a Specialty "Institute" for regional peer review
QA/PI (cont.)

• Flexibility, please!: Confirm that originating-site’s QA/PI/FPPE/OPPE policy and practices contemplate inclusion of distant-site practitioners and related data types
• Consider using an agreement/arrangement specific assessment that aligns with your current practice.
• Confirm that application disclaimer/attestation of originating-site and distant-site adequately contemplate the sharing of peer review information and access to information for FPPE/OPPE (consistent with state law)

GETTING PRACTICAL

Impacted/Necessary Documents

• Impacted or Necessary Documents
  – Medical Staff Bylaws (in the broadest sense)
  – Credentialing and Privileging Services Agreement
  – Provider Acknowledgement
  – Telemedicine Services Agreement
  – Physician Services Agreement
  – Documented telemedicine specific informed consent!
• “Services” component is subject to the Medicare contracted services CoP
  – Service delivery permits compliance with CoPs
  – QA/PI assessment of services/identified metrics
Medical Staff Bylaws

- Bylaws considerations
  - Providers must be accepting of arrangement for credentialing
  - Distant site and originating site must decide how providers will be credentialed
  - Bylaws must permit credentialing of providers for purposes of telemedicine program being contemplated
  - Build in flexibility – someone will ask for it down the road: physical presence, process, etc.
  - Understand how telemedicine privileges affect membership obligations based on category assignment

Bylaws (cont.)

- Do you need distinct criteria for granting membership/clinical privileges to physicians providing telemedicine privileges?
- Provisions for appointment and reappointment that contemplate an abbreviated approval and recommendation process
- Rules or policies may need to be modified
  - e.g., medical record entries, co-signatures, orders, consent, etc.
- Will you afford full due process rights or handle telemedicine providers similar to exclusive contract arrangements with a "clean sweep"?

Credentialing Services

- A few credentialing issues to keep in mind:
  - Your medical staff is still making a recommendation
  - You are still querying the NPDB
  - Waiving the application fee may or may not be OK; this largely depends on who the arrangement is with among other factors (check with your legal counsel)
Credentialing Services (cont.)

- Credentialing and Privileging Services Agreement
  - Obligation to meet the requirements of 42 C.F.R. 482.12(a)(1)-(a)(7)
  - Right for originating-site to grant clinical privileges based on its medical staff’s recommendation that relies on information provided by the distant site
  - Assignment of distant site as a contractor of services to originating-site
  - Representation that the services are provided in a manner to permit the originating-site to comply with applicable Medicare Conditions of Participation
  - Representation that the distant-site is a Medicare participating hospital
  - Representation that providers are credentialed at distant-site to provide services to the originating-site
  - Representation that the providers are licensed in the state where patients will be receiving services

Credentialing Services (cont.)

- Credentialing and Privileging Services Agreement
  - Include obligation for originating-site to share with distant site evidence of its internal quality/peer review of services provided to patients of the originating-site by providers
  - Include obligation for distant site to provide originating-site written confirmation that each provider has been properly queried against the HHS Office of Inspector General’s List of Excluded Individuals and Entities
  - Include obligation for a Consent to Release for each provider’s file that will address the sharing of peer review information
  - Apply obligations and standards to subcontractors
  - Include adequate indemnification/insurance provisions should distant site not qualify under originating-site’s malpractice protections

Application Content and Privileging (cont.)

- Confirm that the application content is the same or is properly supplemented
- Confirm that general qualifications for membership are the same
- Confirm that both clinical privileges core/delineations and criteria match or that originating-site develops a specialty delineation and corresponding criteria equivalent to distant site
And Don’t Forget:

*Context is Everything:* You are in a position to "issue spot" and bring tremendous value because of your central role in your organization.