The 2017 Credentialing Resource Center Symposium

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Five Steps for Effective Telemedicine Credentialing, Privileging, and Peer Review

WHITE PAPER

The United States could experience a shortage of 61,700–94,700 physicians by 2025, according to a 2016 report from the Association of American Medical Colleges (AAMC). The projected deficit within this time frame has risen since 2015, when the AAMC estimated that the country would be under by 46,100–90,400 physicians.

As this physician shortage looms, rural patients' care needs are intensifying and technology is advancing at a rapid-fire pace. Given these growing trends, experts predict medical staffs will increasingly bolster their ranks with telemedicine practitioners. In fact, the telemedicine market is expected to more than double by 2021, climbing from around $20 billion today to nearly $50 billion, according to an August 2016 Research and Markets analysis.

For MSPs and medical staff leaders across the country, this swift rise gives ever-greater urgency to efforts to adapt vetting and competency assessment approaches for the growing ranks of remote practitioners. This special white paper from the Credentialing Resource Center's team of first-class industry experts provides step-by-step guidance on performing compliant credentialing, privileging, and peer review in the age of telemedicine.

Step 1: Choose your credentialing route

When taking the initial plunge into telemedicine or retooling an existing program, one of the top considerations is whether to credential telemedicine practitioners in-house through the standard process or whether to instead take advantage of the credentialing-by-proxy arrangement promulgated by the Centers for Medicare & Medicaid Services (CMS). This approach, delineated in a 2011 final rule, allows a hospital or critical access hospital (CAH) seeking telemedicine services for its patients (the originating site) to use the credentialing and privileging decisions of the facility dispatching the remote practitioner (the distant site).

Given the inherent challenges in outfitting traditional services with telemedicine options and varying positions on viable credentialing paths, medical staffs should weigh the pros, cons, and logistics of each approach to determine the best fit.

Credentialing by proxy

Adopting a credentialing-by-proxy approach can significantly reduce the burden on MSPs to vet telemedicine practitioners, who are often enlisted en masse and come bearing numerous affiliations. Under this redistributed vetting burden, the distant site shares a comprehensive list of contracted telemedicine practitioners and their respective privileges with the originating

site, which, in turn, can rely on those decisions in granting privileges. This transference simplifies the onboarding process.

In addition, because telemedicine contracts require originating sites to provide distant sites with quality information on the dispatched practitioners, a distant site's credentialing and privileging decisions are theoretically based on the most comprehensive repository of affiliation and performance information, says **Catherine M. Ballard, Esq.,** partner in the law firm of Bricker & Eckler based in Columbus, Ohio, and executive director of its affiliated consulting company, The Quality Management Consulting Group. With this dynamic, originating sites should be able to put greater stock in the vetting work, which is based on a more complete picture of practice.

Credentialing in-house

Stances on telemedicine credentialing options can run the gamut. "Some medical staffs are completely comfortable with using the credentialing and privileging decision of another entity," says **Kathy Matzka, CPMSM, CPCS, FMSP,** a medical staff consultant in Lebanon, Illinois. A small, rural facility, for example, might put great stock in a major, regional telemedicine partner's credentialing chops, given the larger hospital's expansive resources and strong reputation.

St. Jude Medical Center in Fullerton, California, is on the other end of the spectrum. **Cindy Radcliffe, CPMSM,** the hospital's director of medical staff services, and her five-person team credential St. Jude's telemedicine practitioners as they would any applicant for clinical privileges—an approach that Radcliffe spearheaded several years ago during the rollout of St. Jude's teleradiology program, the facility's first foray into telemedicine. Since then, the hospital has launched teleneurology and telepsychiatry programs. Between the three programs, Radcliffe's team credentials 25 telemedicine practitioners.

For Radcliffe, firsthand credentialing ensures consistent vetting standards for all privileged practitioners and alleviates doubts about potential conflicts of interest stemming from the distant site's business interest in clearing practitioners for telemedicine practice.

Plus, given the increasing automation of credentialing activities and St. Jude's modest roster of privileged telemedicine practitioners, doing the vetting work from scratch is a manageable undertaking, says Radcliffe.

Beyond a deliberate decision to forgo a credentialing proxy, less intentional factors may also prevent application of CMS' rulemaking in certain situations or, depending on a facility's jurisdiction, at all. For example, Ballard points to the following limiting circumstances:

- At least one of the telemedicine partners is located in a state whose laws prohibit credentialing by proxy.
- The telemedicine entity with which the originating site seeks to contract

doesn't qualify for proxy status under relevant accreditation and regulatory stipulations. CMS requires distant sites to be Medicare-participating hospitals or to provide services in a manner that facilitates compliance with all applicable *Conditions of Participation*. Some accreditors grant less latitude. The Joint Commission (TJC), for example, only permits an originating site to enter into a credentialing-by-proxy arrangement with another TJC-accredited entity. Such restrictions can prove especially tricky when partnering with non-hospital telemedicine entities (e.g., a radiology group), which are less consistently accredited, says Ballard.

- The originating site is in the market for only a few individual telemedicine practitioners, who don't constitute a telemedicine entity and who therefore aren't eligible for credentialing by proxy.

Consider the pros and cons

CMS' promulgation of credentialing by proxy in 2011 injected much-needed flexibility, practicality, and robustness into vetting for telemedicine services—a process that can get hairy when recruiting multiple remote practitioners with countless affiliations.

"Credentialing by proxy is the smartest way to go—if you can—when you're dealing with groups," says Ballard.

However, despite the significant efficiency boons in credentialing by proxy, some stakeholders, like Radcliffe, worry that departing from tried-and-true credentialing approaches could compromise the medical staff's confidence in its inherited privileging decisions, the organization's oversight of affiliates, and the safety of patients.

Beyond these immediate concerns, some experts wonder about the practice's big-picture implications.

"It hasn't really been transformative in terms of expanding access to telehealth as we had hoped," says **Mario Gutierrez**, executive director of the Center for Connected Health Policy, though he qualifies that this relationship could change over time. "More and more, I think people are starting to recognize telehealth as part of mainstream medicine, and I think that will accelerate the process for using this streamlining tool of credentialing by proxy."

Step 2: Vet prospective telemedicine partners

When deciding whether to enlist a proxy, gaining widespread support for the chosen route is key. Hospital leadership may have the last word in telemedicine implementation and governance strategy, but medical staff leaders, who are responsible for making recommendations regarding appointment of involved practitioners, should have a major say in the credentialing approach, says

Matzka. MSPs, as the resident credentialing pros, should also have a voice in the conversation, adds Radcliffe.

If all stakeholders have agreed to a proxy approach, the next step is ensuring prospective telemedicine partners' credentialing and privileging processes jibe with relevant requirements, including CMS regulations, accreditation standards, state laws, and the originating site's established protocol. This task, which often falls to the medical staff services department, can take a variety of forms, such as requesting a copy of the distant site's bylaws or conducting a small-scale audit of the site's credentials files for contracted telemedicine practitioners. This latter approach is ideal when partnering with a telemedicine entity that has gone digital.

"Ask them if you can have remote access to their credentialing software to be able to go in and look at those specific credentials files," says Matzka.

After the medical staff settles on a methodology for confirming that a telemedicine partner's vetting practices are up to snuff, make sure everyone is aware of the decision, says Matzka. Two months after issuing the 2011 final rule on telemedicine, CMS released a memo directing surveyors to quiz hospitals and CAHs in credentialing-by-proxy arrangements on how they determine whether their telemedicine partners' credentialing and privileging procedures pass muster.

Step 3: Let the contract negotiations commence

To kick off the delivery of telemedicine services, prospective partners must sign a written agreement that outlines key responsibilities for each entity. Once the originating site is confident in the vetting approaches of its distant partner, the contract negotiations can begin. Matzka recommends that hospital executives, medical staff leaders, and MSPs work together to determine a reasonable number of contracted telemedicine practitioners. Arriving at a feasible figure is especially important for those who opt to do the credentialing and privileging themselves.

Credentialing by proxy

For Joint Commission–accredited facilities, collaboration between hospital and medical staff leadership is not just a best practice, but a necessity, says Matzka. Prior to starting down the credentialing-by-proxy path, the accreditor requires medical staffs to confirm that a given service is well suited for telemedicine delivery.

"It can't just be the CEO of the hospital saying, 'We're going to contract for this service from now on,' " says Matzka. "The medical staff has to make that determination of whether or not that's an appropriate service to be provided via telemedicine."

Organizations that opt for the proxy also shouldn't lose sight of other state and federal laws governing appointment activities.

"Even though the CMS regulations have specific requirements that allow for certain things to happen, you may have state regulations that are stricter, and there are other federal regulations that would apply as well," says Matzka.

In particular, she points to the Health Care Quality Improvement Act of 1986, which requires healthcare entities to query the National Practitioner Data Bank before granting privileges to a practitioner. Applying the credentialing and privileging decisions of an approved telemedicine partner doesn't exempt organizations from this responsibility, Matzka notes.

Credentialing in-house

For originating sites that plan on credentialing telemedicine practitioners in-house rather than by proxy, Ballard recommends a contract provision requiring the distant site to provide immediate notice in the event that it terminates a telemedicine practitioner who's under contract with the originating site, or when such a practitioner's privileges are summarily suspended at another facility.

Because credentialing-by-proxy agreements address key aspects of the vetting process for telemedicine practitioners, Ballard recommends referencing such a document when developing a contract under which the originating site will credential in-house. Simply reverse the assigned responsibility.

"Everything that you would rely upon the distant site to do is now what you have to do," Ballard explains. "So you need to go through that to see what information they can give you to assist you in fulfilling all of your responsibilities."

Such vigilance will also improve the robustness of the organization's data for professional practice evaluation, which is still required for distant affiliates.

"You have the responsibility for ensuring that only qualified individuals are in fact exercising privileges at your facility," Ballard says. "The fact that they're remote doesn't make any difference."

Step 4: Operationalize the process

With the written contracts squared away, organizations can decide how they will use their chosen process for credentialing telemedicine practitioners. Regardless of the method they ultimately select, each has considerations that must be taken into account.

Credentialing by proxy

For organizations that opt for credentialing by proxy, one of the most needling and long-standing pain points is allying intention and execution. Before enlisting telemedicine practitioners, hospitals should ensure they have the

necessary provisions in their governance documents to operationalize their chosen credentialing approach. When a proxy relationship is in play, the medical staff must update bylaws to reflect the hospital's intent to accept the credentialing and privileging decisions of their distant-site telemedicine partners and their commitment to verifying that those determinations are predicated on compliant procedures.

But all too often, splintered communication forces a reversed order of events, says Matzka. For example, a hospital CEO who is eager to boost his or her facility's service portfolio may identify a promising telemedicine partner, negotiate an arrangement involving scads of remote practitioners, and close the deal—all without seeking input from other stakeholders. Such unilateral decisions deprive medical staff leaders and MSPs of the opportunity to discuss whether to credential in-house or by proxy and to revise their bylaws accordingly. Without these preliminary measures, medical staff leaders and MSPs are forced to credential and privilege all enlisted telemedicine practitioners using their standard method, which, depending on the facility and involved specialty, can mean sifting through 30 or more new applications at once.

To avoid such headaches, Matzka recommends providing proactive and thorough education to medical staff and hospital leaders.

"Make sure that people know what the rules are before they start signing these contracts," she says. "They need to know what the regulations are, and they need to know that they have the ability to use that telemedicine entity's credentialing." This approach is particularly important in smaller facilities, which may not have the same built-in support and ready resources as their larger counterparts.

Beyond overarching rules, stakeholders should understand potential trouble spots in credentialing by proxy. For example, a common risk in adopting the approach is if a distant site offers up a telemedicine practitioner who doesn't have appropriate privileges for the task at hand. For this reason, originating sites should determine what mechanisms distant partners use to make sure they only assign practitioners who have been credentialed and privileged at the originating site for the services in question. The distant site must also verify that a given practitioner has officially been awarded privileges at the originating site before arranging for him or her to provide a teleservice.

This is particularly important when assigning faceless tasks, such as radiological interpretations, where it's not always clear who's at the helm.

"The hospital doesn't really know who's on the other end doing the interpretations," Matzka explains. "They're relying on that contracted company to only have people on the other end at the distant site that actually have privileges at their facility."

Credentialing in-house

If all the trappings of credentialing by proxy don't appeal to the medical staff or uncontrollable factors make adopting the approach unfeasible, organizations may face the prospect of credentialing scores of telemedicine providers in-house. Experts recommend the following best practices to facilitate successful vetting.

Stick to the standard process

When taking the in-house route, subject telemedicine practitioners to the same credentialing process as their on-site counterparts. "You cannot treat them differently," Ballard stresses.

One permissible departure involves affiliation verifications. Accreditors don't require medical staffs to query every single facility that a practitioner lists on his or her privilege application. Therefore, to expedite in-house credentialing for telemedicine providers, who often rack up more affiliations than those who practice exclusively in person, hospitals may decide to set an upper limit for the number of required verifications, Ballard explains. This approach can also influence a hospital's broader credentialing strategy.

St. Jude developed a policy limiting required affiliation queries to the 10 most recent facilities, says Radcliffe. Although St. Jude's decision to credential all telemedicine practitioners in-house was the original driver of the policy, the organization now applies the terms to every prospective appointment and reappointment.

Make necessary modifications

When key medical staff requirements fail to accommodate telemedicine practitioners, consider amending stances or carving out exceptions, says Ballard. For example, if bylaws require a candidate to come on-site for an interview, the medical staff can instead allow for a phone interview or waive the requirement completely for applicants who meet defined criteria.

The same principle applies to the medical staff structure. When credentialing a high volume of telemedicine practitioners in-house, consider assembling a dedicated subcommittee for the task. This measure is only relevant when the existing structure doesn't support prospective service or specialty additions.

"If whatever [the applicants] are doing doesn't fall within the context of what the medical staff is already doing, then you should give consideration as to whether or not it makes sense to have a special subcommittee that looks at that particular issue," says Ballard. If, however, the hospital is seeking to fortify its considerable in-house ranks for a certain specialty with only one or two new telemedicine practitioners, the current review team can likely absorb the additional application(s).

Put parameters around affiliation

Decide on the extent of telemedicine practitioners' allowed affiliation with the hospital. Will they be eligible for medical staff appointment, or will their relationship be limited to clinical privileges?

Here again, basic requirements may gum up the works. "Nine times out of 10, [telemedicine practitioners] are not going to meet the criteria [for appointment]," says Ballard. She points to the practitioners' physical presence (or lack thereof) as a common stumbling block in this regard.

For example, some hospitals may require their on-site practitioners to live within a certain radius of the relevant facility to provide continuous care to their patients—a criterion that won't work for telemedicine providers based thousands of miles away. The same may be said for other common provisions of medical staff membership, such as on-call coverage, committee attendance, and voting rights.

Given these obstacles, medical staffs that decide to offer appointment (for example, to provide telemedicine practitioners with procedural due process rights or to foster camaraderie among all affiliated practitioners) should consider developing a telemedicine-specific membership category that accounts for distance, says Ballard.

Another consideration for appointment is the corrective action process. If an appointment is granted and a telemedicine practitioner's clinical performance or professional behavior continues to fall short of established standards, the medical staff must initiate corrective action—a process that Ballard says is complicated by remoteness.

However, bypassing appointment to avoid the possibility of long-distance corrective action can backfire. For example, a telemedicine practitioner without a medical staff appointment who disagrees with a hospital's decision to terminate his or her privileges can bring a lawsuit immediately, rather than proceeding through a fair hearing. In addition, due to the lack of a hearing, such circumstances negate the hospital's (and participants') potential immunity from damages granted by the Health Care Quality Improvement Act of 1986.

Although this situation will not arise very often, given that most privilege terminations occur "without cause" in accordance with a contract, once the formal corrective action process begins, there are significant potential reporting and liability issues, says Ballard.

Develop appropriate privileges

Beyond its political and legal implications, distance poses a fundamental problem for the delivery of certain services. For this reason, hospitals must ensure a telemedicine privilege set reflects a scope of practice that's not only clinically appropriate, but also logistically sound. This expectation holds

across regulators and accreditors. "They're all going to say that the privilege set needs to be defined as to what it is that you can or cannot do," Ballard explains.

The steps necessary to achieve alignment between realistic practice and offered privileges vary depending on the nature of the prospective telemedicine services and practitioners.

Affiliated providers who are based locally and who already practice at the facility may wish to supplement their on-site privileges with a modest roster of remote services. In this case, the medical staff may simply tuck the telemedicine tasks into the standard privilege delineation form for the relevant discipline, says Ballard.

St. Jude takes this approach for two of its three telemedicine programs, teleneurology and telepsychiatry, where providers fluctuate between in-person and remote practice and the contrast between on- and off-site services is only moderate.

If, however, feasible practice differs dramatically between telemedicine and on-site practitioners in a given specialty, develop distinct core privilege sets.

For example, in recognition of significant differences in scope, St. Jude has devoted a separate category for teleradiology on its radiology-focused clinical privilege delineation form.

"Our teleradiologists are not our diagnostic radiologists, and they're not our interventional radiologists, so we decided to have a specific privilege set just for them," Radcliffe explains, noting that usage of the dedicated privileges has been smooth sailing. "It's been great—we haven't had any issues with it."

If anything, the privilege's popularity is on the rise. Although most teleradiologists operate exclusively off-site, some practitioners with on-site radiology privileges have begun requesting the telemedicine set.

"Even our diagnostic and interventional radiologists are asking for these privileges because there are times when they're looking at films from home and working through them that way," Radcliffe explains.

As for developing and formatting the teleradiology privileges, St. Jude used its existing template, opening with a core statement followed by a list of typical privileges and minimum threshold requirements. This latter feature is also standard issue, says Radcliffe, highlighting the initial peer review stipulations. "[Teleradiologists] still have to be proctored just like the regular radiologists."

Step 5: Exchange performance data in an effective, compliant manner

To comply with CMS' final rule, telemedicine partners must exchange information on any adverse events and complaints associated with a participating practitioner's telemedicine care. Although CMS provides originating sites with

minimum data capture and reporting requirements, medical staffs have some strategic decisions to make when it comes to execution.

Credentialing by proxy

To comply with CMS regulations, telemedicine partners seeking to establish a credentialing-by-proxy relationship must include several key clauses related to peer review in their written agreement. When a hospital is seeking telemedicine services from another hospital, the agreement must include language that speaks to the following CMS regulation:

> *With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital's patients and all complaints the hospital has received about the distant-site physician or practitioner. (42 CFR § 482.22(a)(3))*

The mandatory contract provisions on performance review are very similar for hospitals and CAHs involved in agreements with nonhospital telemedicine entities (e.g., radiology groups).

Although there are a number of options for exchanging performance data with distant sites, consistency in approach and clear delineation in governance documents is key.

The University of Pittsburgh Medical Center (UPMC), which primarily uses the credentialing-by-proxy route for telemedicine practitioners who don't have existing on-site privileges, submits data according to a partner hospital's preferred schedule, which is often defined in the contractual agreement. Typically, this means sharing details annually about any complaints, adverse events, or other issues concerning a remote practitioner's performance within the given facility, says **Natasa Sokolovich, JD, MSHCPM,** the health system's executive director of telehealth. UPMC's in-house credentials verification organization (CVO) facilitates the exchange of performance data with distant sites and tracks remote practitioners' compliance with internal privileging criteria and performance expectations.

In fact, the CVO serves as the hub for all credentialing and privileging activity throughout the health system. Within this collaborative framework, creation of telemedicine governing policies involves MSPs, medical staff leaders, and the program's management team.

"Our staffing and privileging and oversight is all centralized, whether it's telemedicine or in person, and we all collaborate together," says Sokolovich, adding that this integrated environment has facilitated the development of system-wide telemedicine privileging standards and forms.

Credentialing in-house

When in-house credentialing is in play, performance monitoring requires a much more hands-on approach, as originating sites are expected to apply their standard vetting and competence assessment processes, says Ballard.

For example, if medical staff policy states that initial FPPE for a practitioner exercising newly granted privileges includes proctoring for a service-specific number of cases, medical staffs must use this principle to set the proctoring requirements for telemedicine recruits in a given specialty, says Ballard.

Establishing appropriate criteria for telemedicine services, however, is often easier said than done. Remote practitioners may be affiliated with a number of organizations, meaning that their performance within any given facility represents only a fraction of their overall practice—far from a sound foundation for privileging decisions, says Ballard.

Given this complication, originating sites tasked with in-house credentialing should take extra pains to ensure they're not enlisting more remote practitioners than necessary.

"The fewer people you have to deal with, the better shot you have at actually having appropriate monitoring and oversight," says Ballard. "If I have to directly credential 20 doctors, and each one of them is giving me 5% of their day or 10% of their day … not only am I not getting much good data, I'm having a very hard time knowing in terms of, 'Is this doctor good versus that doctor,' because I don't have enough data to be able to say."

Of course, amid escalating physician shortages and increasingly complex patient needs, tempering telemedicine usage is not always a possibility.

For organizations performing their own credentialing on a long lineup of remote practitioners, strong coordination with telemedicine partners becomes essential to achieving well-rounded competency assessment. To encourage smoother exchange of key performance details, telemedicine contracts should establish that the distant site will provide immediate notice in the event that it terminates its relationship with a practitioner, or that the individual's privileges are summarily suspended at another facility, Ballard says. Similarly, contracts should specify that the distant site will share other pertinent information that surfaces during its credentialing activities surrounding a contracted practitioner's performance at other sites, such as adverse findings, reports, or complaints, she adds.

Despite the variety of credentialing considerations at play in a telemedicine partnership, at least one strategy holds across disparate medical staff makeups and credentialing circumstances: Adopt a proactive approach to addressing telemedicine, whose influence will only grow over time.

"It's here to stay, and if you have 10 people doing it, now is a much better time to go ahead and get a handle on it than when you have 100 people," says Ballard. "Stay on top of it so that you can continue to be competitive."

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- **OPPE Lessons Learned:** Even if your organization is not required to complete OPPE, it should have a physician competency evaluation plan in place. Speakers will address the issues that make competency assessment a struggle, such as low-volume practitioners, advanced practice professionals, telemedicine providers, selecting appropriate indicators, and creating meaningful reports. They will also discuss how to deal with conflicting guidance from accreditors and how to prepare OPPE documents for audits.

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