March 8, 2010

Credentialing Case Study - Telepsychiatry

A major academic medical center in large western city (WAMC) has received significant grant funding (state and federal) to develop a Center for Telepsychiatry to provide telepsychiatry services to individuals in underserved rural communities throughout the western United States. Via videoconferencing equipment that will connect patients at remote local hospital sites to the Center, psychiatrists will provide psychiatric consultation, assessment, diagnosis, therapy, and treatment (including prescription of pharmaceuticals). The goal of the Center is to meet the vast unmet need for mental health services in rural communities.

In addition to state licensure, another issue of concern to the Director of Telemedicine at WAMC is that of credentialing. The process of credentialing refers to the institutional policy and procedures that determine whether a health care professional has the qualifications to be employed or be granted privileges to practice at the institution. This information is used in employment decisions, in granting clinical privileges and in the establishment of a practitioner’s scope of practice (the range of services an individual may perform).

This aspect of health professional regulation is not routinely conducted at the state or Federal level unless the professional is primarily employed by the Federal or state government. In some instances, however, state medical practice acts may specify requirements for credentialing. Traditionally the institutions in which the health professional is providing the service have taken this responsibility. In addition, nationally accepted standards are provided by the Joint Commission. Under the concept of “credentialing and privileging by proxy,” the Joint Commission accepts the credentialing and privileging decisions of another Joint Commission accredited facility as a means of vetting telehealth practitioners so that they can receive the appropriate clinical privileges necessary to deliver patient care, including sub-specialty care. This Joint Commission policy conflicts with longstanding Medicare regulatory requirements and their accredited hospitals have always been at risk of citation by CMS as a result of Medicare complaint surveys conducted by the states for CMS in these hospitals. This has, in fact, happened in some cases.

As of July 15, 2010, the Joint Commission is required to enforce the longstanding CMS credentialing and privileging requirements found in the Medicare Hospital Conditions of Participation (CoPs) by virtue of their deemed status approval. Currently the CMS position is that all Medicare practitioners must undergo credentialing and privileging by each originating site (the hospital where the patient is located). Privileging decisions are always specific to a particular hospital, since they must take into account not only the physician/practitioner’s qualifications, but also the services offered by the hospital. CMS will be clarifying that hospitals may accept credentialing packages from other Medicare-participating hospitals to inform their privileging decisions. Since the gathering of credentials is the more labor-intensive and
potentially duplicative component of the credentialing and privileging process, CMS believes this clarification is expected to reduce potential burdens on hospitals. CMS indicates that critical access hospitals (CAHs) are already governed by CoPs that are designed with the particular needs of small rural hospitals in mind and has stated that these CoPs allow these hospitals to have an agreement with an outside entity to credential physicians. Under prescribed circumstances, the outside entity could even be the distant site (the facility where the telemedicine practitioner is located). The CAH must still, however, render a privileging decision for each physician/practitioner who provides services to the CAH’s patients.

The House health care reform bill contained a provision that would require CMS to issue guidance concerning the ability of hospitals and CAHs to accept a credentialing package from another Medicare-certified hospital or CAH with respect to a physician/practitioner providing telehealth services. Under this amendment, hospitals and CAHs would still have been required to make privileging decisions. On the Senate side, Senator Udall introduced an amendment1 to the Senate health care reform bill that would require CMS to develop regulations to implement both a process for telehealth practitioners to be credentialed and privileged by proxy, as well as a "hold harmless" criteria for those institutions using credentialing and privileging by proxy. The "hold harmless" criteria would remain in effect until CMS’s regulations regarding remote credentialing and privileging were finalized. Neither the House nor Senate provisions appeared in the final Senate bill.

Given the size of the program, the Director of Telemedicine at WAMC is seeking ways to minimize the burden of requiring all WMC providers to be credentialed in all the remote hospital sites in which they consult with patients. The Medical Director at WAMC wants to ensure that patients in remote sites receive appropriate care and argues that the hospitals in which the patients are located may be in the best position consider a physician’s qualifications, scope of services that will be provided and the type of patients seen at the rural location. The Director of Telemedicine at WAMC has arranged a meeting with the directors of the state medical boards as well as the state’s U.S. Senators. What should he recommend?

Consider the above facts as a backdrop to the questions below:

1. What are the pros and cons of credentialing by proxy?
2. Under which model of credentialing is patient safety best protected – traditional or by proxy?
3. What consequences will result from CMS’s decision to cite hospitals and CAHs that make credentialing and privileging decisions for telemedicine practitioners by proxy outside the approved CMS policy?
4. Are rural or critical access hospitals in a position to provide effective credentialing of telemedicine practitioners?

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1 Senator Udall introduced S. 2741, the Rural Telemedicine Enhancing Community Health (TECH) Act of 2009. He also included the credentialing and privileging provisions in that bill as an amendment to the Senate health care reform amendment as SA 3136.
Prior to the roundtable, we would appreciate it if you would jot down your reactions to some or all of these questions. Please limit your comments to 3-5 pages.