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Update on Medicare and Medicaid Payment Issues

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## Streamlined Credentialing and Privileging Process Under the Final Telemedicine Rule

By: [Sarah E. Swank](#) and [Aaron Rabinowitz\\*](#)

On May 2, 2011, CMS released the [final telemedicine credentialing and privileging rule \[PDF\]](#) clearing the way for credentialing agreements for telemedicine services between hospitals, as well as with non-hospital telemedicine entities. The final telemedicine rule follows on the heels of recent regulations promoting health care reform goals including providing cost effective and timely delivery of healthcare services. This telemedicine rule ends years of confusion for hospitals stuck in the middle of feuding between CMS and the Joint Commission (TJC) related to credentialing for telemedicine services. TJC previously allowed for "privileging by proxy" but CMS put its foot down, requiring hospitals after site surveys to change policies inconsistent with CMS Hospital Conditions of Participation. The final telemedicine rule requires that the hospital with patients in need of telemedicine services ensure through a written agreement that the parties meet certain credentialing obligations. Rural communities, which often suffer from a shortage of primary and specialty physicians and practitioners, will benefit from the ability to receive telemedicine services. Telemedicine may become more commonplace as the physician shortage becomes a reality. The effective date of this final rule is **July 5, 2011**.

### Final Telemedicine Rule Overview

One major impediment to telemedicine services was the ability of hospitals to credential physicians and practitioners that provided telemedicine services to hospital patients. Previously, each physician or practitioner needed to be recommended by the hospital's medical staff and approved by the hospital's governing body prior to providing telemedicine services in a hospital. Although this recommendation and approval process is still required, that medical staff recommendation may now be based on information that the medical staff receives from the distant-hospital or distant-telemedicine entity.

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*Editors: [Leslie Demaree Goldsmith](#) and [Carel T. Hedlund](#)*

In addition, the final telemedicine rule now requires that the hospital and the distant-hospital or distant-telemedicine entity enter into an agreement containing particular requirements established by the regulation. The hospital's governing body must ensure that the distant-hospital or distant-telemedicine entity meet the terms of that agreement. This written agreement between hospitals must include all of the following provisions:

- The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.
- The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the privileges for the distant-site physician or practitioner to the hospital.
- The individual distant-site physician or practitioner holds a license issued or recognized by the State where the hospital patients are receiving the telemedicine services.
- The hospital has evidence of an internal review of the distant-site physician or practitioner performance and sends such performance information for use in the periodic appraisal to the distant-site hospital, including all adverse events that result from telemedicine services and all complaints.

Hospitals may also rely on non-hospital telemedicine entities for streamlined credentialing for telemedicine services. In addition, critical access hospitals may also contract for telemedicine services. These agreements require slightly different provisions for non-hospital telemedicine entities and critical access hospital than agreements between two Medicare participating hospitals, due to oversight concerns.

### **Next Steps**

The first step for hospitals considering telemedicine services is to develop relationships with other hospitals and telemedicine entities that partner with or employ physicians licensed in the state where the hospital patients are located. This licensing requirement may limit the relationships that a hospital may develop. Once a hospital decides to provide telemedicine services, it should take the following steps:

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- *Amendment Medical Staff Bylaws.* Hospitals will need to amend their medical staff bylaws to allow for the provision of telemedicine services and the interchange of information with the distant-site hospital or distant-site telemedicine entity that privileged the physician or practitioner. These changes follow recent changes to TJC standards for medical staff bylaws and credentialing manuals.
- *Draft Agreements.* In addition, hospitals will need to develop agreements to meet the new standards in the final telemedicine rule.
- *Education.* Hospitals will need to educate both their medical staff members and governing entities on their evolving roles and obligations for credentialing under the final telemedicine rule. In addition, hospitals should consider education and training on where the final telemedicine rule fits within the framework of health care reform, on the difference between telehealth and telemedicine and on the role of peer review.
- *Implementation.* Hospitals also must be able to facilitate telemedicine services and purchase the equipment needed to ensure high quality services are provided through telemedicine services. This may mean contracting with a vendor to purchase this equipment, such as audio, video and data communications. Hospitals should ensure that the physicians as well as staff understand this new health care delivery method. Hospitals should consider developing a telemedicine policy for its employees.
- *Peer Review.* For concerned physicians, the final telemedicine rule could be evidence of the potential erosion of the peer review privilege. Under the rule, a medical staff could rely on information from another distant-site hospital in determining whether to recommend a physician providing telemedicine services to the hospital's governing body. Under state law, the exchange of this information could be viewed as a waiver of privilege. Hospitals should check their state peer review statutes before implementing this final telemedicine rule.
- *Third Party Payors.* Hospitals and providers should review their managed care agreements prior to the provision of telemedicine services to determine if coverage is available for such services.

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## Ober|Kaler's Comments

*Telehealth vs. Telemedicine.* The term “telehealth” is often used in health care reform discussions without much definition. The difference between telehealth, virtual care and telemedicine is not often made. Telehealth is seen as a broader concept that encompasses telemedicine. Telemedicine often refers to clinical services provided to patients by practitioners over electronic communications. For reimbursement purposes, CMS defines telehealth as professional consultations, office visits and office psychiatry services. That being said, providers are only reimbursed for such telehealth consultations in limited circumstances, such as when these services are provided in areas designated as rural health professional shortage areas or by entities participating in the Federal telemedicine demonstration. Under the final telemedicine rule, CMS expands the definition of telemedicine for credentialing purposes to include patient assessment, diagnosis, treatment, consultation, transfer, data interpretation and patient education.

*Licensing.* In the future, physicians may be able to make home visits without ever leaving their offices or perhaps even their homes. The licensing requirements may need to catch up with changing technology for telemedicine to become more widespread. Under the final telemedicine rule, the physician furnishing telemedicine services must be licensed in the state where the patient is receiving telemedicine services. One way to meet the goal of “nationwide telemedicine” is through a national licensing system or compact licensing between states. Under this rule as written, a physician in California may provide telemedicine services to a patient in a rural hospital in Maine, but only if that physician is licensed in Maine. CMS believes licensing issues must be addressed through the states rather than this regulation.

*Non-Hospital Telemedicine Entities.* CMS acknowledges the existence of telemedicine entities that do not participate in Medicare. CMS failed to include a definition in the body of the final rule, but gave examples in the comments. Hospitals will need to enter into credentialing agreements with these entities similar to those with hospitals. CMS seeks to ease the burden of the hospital credentialing process for telemedicine services and understands that “neuro-health” and other

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types of telemedicine provided by entities not in hospital settings are necessary to expand services to patients.

*Community Standard.* Beyond peer review privilege issues, the question arises if health care professionals should set separate peer review standards for telemedicine services. Generally, the standard for peer review is a community standard, rather than a national standard. It appears with the expansion of medicine across state lines that the standard may need to take into count geographical distances between the physician providing the telemedicine services and the location of the hospital patient. In addition, the insertion of technology between the patient and the physician may require telemedicine health care professionals to develop different standards than those who treat their patients face to face.

*\*Aaron Rabinowitz is a Law Clerk in Ober|Kaler's [Health Law Group](#).*