Hello. My name is Greg Billings. I am Executive Director of the Center for Tele-Health and E-Health Law in Washington, DC. I’m very pleased today to have three of the key players involved with the Telehealth and Privileging by proxy issue that came before CMS and The Congress. We’re pleased to have today Commander Scott Cooper from the Centers of Medicare and Medicaid Services, Jeannie Miller also from CMS. And a person who doesn’t need much of an introduction to the Telehealth community, Dr. Karen Rheuban of the University of Virginia.

First of all, let me thank our sponsors here at Drinker Biddle & Reath for their technical assistance in making our Brown Bag Seminars possible. We appreciate the services they provide to us here at CTeL.

Let me begin by telling you just a little bit about CTeL’s history. CTeL was founded in 1995 to provide information to the Telehealth community on the legal and regulatory barriers impacting the utilization of Telehealth and related E-Health services. We provide a number of services to the Telehealth community, including extensive publications, consultation services, fact sheets and other information that is a value to the Telehealth community in the legal and regulatory area. Since 2006, CTeL has operated the National Telehealth Resource Center through the funding from the Office of the Advancement of Telehealth in HRSA, we are pleased to provide you with this vital support to the Telehealth community on legal and regulatory topics.

I also want to mention to you that we have scheduled for July 18th our next Brown Bag Telehealth Seminar. It’s on mHealth and what the legal and regulatory barriers to providing Telehealth through mHealth. We hope that you’ll mark your calendar and be sure to attend this Webinar as well.

The participants may use the Q&A feature on your Live Meeting Client and submit questions at any time during the presentation. I will hold the questions until the
end of our presenters to present them for their response. However, you may enter those questions at any time. For those of you in the audience, please leave your papers and your movement to a minimum because the microphones are very sensitive. It’ll help us in having a clean presentation for our audience.

I’m going to go ahead and introduce all three of our guests and then I’m going to turn the program over to Dr. Rheuban. Following her comments, given her history with these issues, we’ll hear from Commander Scott Cooper to describe the final rule for credentialing and privileging a Telehealth provider that’s due to be effective on July 5th.

Commander Cooper is the lead analyst for the Medicare Regulations for hospitals within CMS Standards Group of the Office of Policy Standards. He’s a physician assistant officer in the United States Public Health Commission Service Corps. He has experience working in private sector hospitals primarily in the specialty of cardiac surgery and has over 14 years of experience as a physician assistant. Also on the line and she’ll be chiming in at various points during the presentation I’m sure, Jeannie Miller, Deputy Director of Clinical Standards Group in the Office of Clinical Standards and Quality at CMS. She is responsible for the oversight and regulation and development of policy interpretation for hospitals, access hospitals, organ procurement organizations and transplant centers. She was the program’s administrator specializing in hospital oversight at the West Virginia State Survey Agency. Ms. Miller also has served as a hospital nurse for over 20 years.

Last, but to use the famous phrase, not least, we have Dr. Karen Rheuban on the line. She was a stalwart during this entire process, working to provide the technical and on-the-ground input that the policy makers needed to have in order to get this rule fashioned in a way that would be effective and useful for the Telehealth community. Dr. Rheuban is a senior associate for external affairs and continuing medical education at The University of Virginia and a pediatric cardiologist who provides care to patients with congenital and acquired heart disease. She’s a fellow of the American College of Cardiology and the American Academy of Pediatrics. Dr. Rheuban is the president of the Virginia Telehealth Network and also the second immediate past president of the American TeleMed Association. We wouldn’t want to forget Dr. Dale Alverson who is the immediate past president. Both are board members of the Center for Telehealth and E-Health Law here in Washington. Dr. Rheuban, I’d like to turn the microphone over to you. We definitely want to hear any comments that you have to say to set the plate, if
you will, and then I will suggest that you introduce Cmdr. Cooper and he’ll take it from there.

Rheuban: Okay, thank you. Can you hear me, Greg?

Billings: I can hear you.

Rheuban: Okay great. Well, thank you so much to CTeL for hosting this Webinar and brown bag and special, huge gigantic thanks to our colleagues at CMS for helping to advance this in warp speed. I’ve been in Telehealth long enough to, as has many of our colleagues around the nation, to have watched the evolution of the Telehealth standards from the Joint Commission. This began with Dr. Bob Wise who did a wonderful presentation at CTeL in around 2000-2001 where the new Telehealth standards from the Joint Commission were shared with our group. Those standards, in an effort to protect the public and the patients, were pretty significant and required credentialing and privileging of Telehealth providers of all the sites. We spoke extensively – “we” being ATA, CTeL and providers around the country – worked with our colleagues at the Joint Commission to convince them to change the standards to allow for credentialing and privileging by proxy. And that didn’t happen until 2004.

Flash forward to 2008 with MIPPA, which required the Joint Commission – and I hope I have the language correctly articulated – to come into align with the CMS standards, the medical staff standards and conditions of participation standards, which put in jeopardy the previous standards that had been put in place by the Joint Commission.

For many of us as Telehealth providers who provide services throughout our state and in many cases in other states as well, the thought of credentialing and privileging at every remote cite was, we believed, the death toll of the telemedicine programs that we had worked so hard to try and develop across our states. These networks were challenges in many ways and to bring forward a requirement of credentialing and privileging of every Telehealth provider at every hospital and critical access hospital which was what was being debated and discussed, represented a major, major challenge. And so we are incredibly grateful to Commander Cooper, Jeannie Miller, Jonathan Blum and Barry Straub for their willingness to tackle this issue and, of course, Greg, I want to thank you for telling me that my own friend, Marilyn Tavenner had left Virginia and became a principal deputy administrator at CMS. I’m sitting here, actually, around the table with some colleagues from the eastern shore of Virginia and they have a great familiarity but with who was, at the time, Secretary Tavenner in Virginia.

So, to flash forward just a bit, I guess Secretary Tavenner moved to Washington in February, 2010 and we did reach out to her and she immediately connected us with
her colleagues, with Dr. Barry Straub who was the past medical director at CMS, and Jeannie, Scott and John from the Office of Standards and Quality and they very generously made a trip to Virginia with our colleagues from ATA and our colleagues from CTEL. We also invited representation from critical access hospitals as well as our colleagues at UC Davis who had considerable expertise in credentialing and privileging as well. And so that really got the ball rolling and that was April, 2010 and I cannot tell you how grateful we are to both Dr. Straub and his team Paula Gan and Denise Wagner and your entire group so thank you so much. You had posted a request for comments, I guess that common period ended in late July and now, less than a year later, you have a new rule. So thank you so much on behalf of the entire Telemedicine community. We’ve become great friends with CMS and we are so looking forward to further collaborations with CMS, with Marilyn Tavenner and Don Berwick who also are both champions for Telehealth as well. So with that, Scott, it’s a privilege to introduce you. Commander Cooper, please share with us the process of the new rule.

Scott, can you hear me?

Cooper: I hear … thank you Dr. Rheuban. I appreciate that. We lost some audio there for a while so we didn’t get to hear all of your comments but …

Billings: We’ve got it recorded so we’ll make sure you’ll be able to hear all the very favorable and positive things she said about you.

Cooper: Okay, good.

I did hear the end of that and we do appreciate that and I just wanted to pass on myself and Jeannie Miller here our appreciation to Dr. Rheuban and to Greg and to CTeL and all the members on line for having us here to discuss this rule so I’m going to jump right into it.

The... I’ll start with actually the rule on telemedicine credentialing and privileging published just a little over a month, May 5, in the Federal Register, and the link is right there. I have to preface this slide with why we changed the CoP. We recognize it really was a very long process as I think Dr. Rheuban touched on there that started with Joint Commission and their credentialing and privileging by proxy standards. When I took over, the hospital CoPs in 2006 already were heating up and becoming a major issue. The fact that we recognize that something needs to be done to change our credentialing and privileging requirements was something that was part of a long process and really was the result of stakeholders like ATA, Dr. Rheuban, University of Virginia and CTeL, some of the telemed industry that we had discussions with and the audit background material that helps us prepare for the rule making.
process. So, CMS recognized that our requirements for credentialing and privileging [inaudible] for as many hospitals that had telemedicine service agreements and for particularly for those small hospitals and critical access hospitals lacking resources in clinical expertise to credential all the specialty physicians and practitioners that telemedicine could provide to them. [Inaudible] The cost and resources denied them under our standards the ability to have a way of credentialing and privileging. Sometimes it could be anywhere from 30-40 all the way up to 250 specialty physicians. It really was limiting access in rural areas. It was nice that our rule kind of dove-tailed with the president’s executive order in January of this year about improving regulations, regulatory review. We had already proposed our rules but we felt like the revisions there met the spirit of that executive order by making any federal requirements more flexible for rural and small hospitals and for critical access hospitals and also provide care for patients for service delivery.

To break it out, let’s talk about what was finalized from what we proposed and deal with that and then get into what was really different in the final rule from the proposed rule. I’m going to start with obstacles and then move into the critical access hospitals because, as you can see here, the requirements are in two different conditions of participation — the governing body CoPs contained requirements related to credentialing and privileging. What we proposed and what we finalized with regard to hospitals is the governing body of the hospital had to be sure that their agreement with a distant site hospital who was providing telemedicine services the governing body of that distant site hospital in that agreement that all governing body requirements were met with regard to having physicians or practitioners providing telemedicine services and also, I want to emphasize here that procedures that would streamline the process was provided as an option. In no way were small hospitals using this streamline process obliged to use that. They could certainly use the more traditional and labor intensive and burdensome privileging process and that would be up to each hospital to decide but, as an option to grant privileges based on the recommendations of its medical staff which could rely upon information and privileging decisions the distant site hospital who was providing the telemedicine services regarding the privileges they had granted to their individual physicians and practitioners.

The requirement that we proposed and finalized with regard to medical staff, CoP, stated that the hospital could rely on privileging decisions but that there were certain things that had to be in place at the distant hospital and what was included in the agreement with the distant hospital. Those had to do with it being a Medicare participating hospital that was providing the telemedicine services. That the privileges of all the individual physicians and practitioners who would be providing those telemedicine services at the distant site hospital would have to provide a current list of
the privileges for each of those practitioners, that there was a state license that each of
the practitioners with regard to the state that the patient was in that was receiving
services in the hospital who was receiving services or would be the hospital where the
patient was would have an internal review in place sending that information back to the
distant site hospital so that they could do re-privileging and a periodic appraisal of
practitioners services.

Moving into the CAH hospital CoPs, I wanted to point out here that they are
separate and distinct from the hospital CoPs. They are under 485 where as hospitals are
under Section 482. Up until this rule and finalized that pretty much the term
“credentialing” was used throughout the CAH CoP and wasn’t much mention of
hospital privileges and, in fact, CoPs for the CAH with regard to credentialing and
privileging because they’re not really structured the same way and there isn’t a formal
section so as we looked at this we really had to put performance for credentialing and
privileging under different areas that were already existing under the CAH CoP. You
can see it’s under Agreements and also periodic evaluation and performance review.

Similar to the hospital CoPs, agreement had to exist between the distance site
hospital and the CAH. Again, the ability of the CAH governing body that the distance
site hospital requirements for its physicians and practitioners with regard to having a
credentialing and privileging process in place and again the option was there that they
could rely on this credentialing and privileging decision made by the distance site
hospital and then also with regard to the periodic appraisal that they would need to
have sending that information back to the distance site hospital to do re-privileging
practitioners.

As we said, similar to the hospitals they are really designed to make the CAH
credentialing and privileging consistent with the current hospital requirement so where
appropriate, that would be the application of and which category the practitioners may
be appointed the medical staff, appointment of members and current members and,
again, that would kind of also be relied upon the privileging decision of the distance a
hospital. Basically it’s really the requirements that are already contained under the
hospital CoPs with regard to by-laws, accountability of medical staff, the governing
body provided for selection including that hospital’s CoP that it can’t be based solely on
certification fellowship or membership in any body or society. What I was mentioning
that this didn’t really up until this rule didn’t exist in the CAH so we into there to make
it consistent with the hospital CoP to have it in critical access hospital.

We also added, as I mentioned, a new paragraph [inaudible] hospital to evaluate
the quality and the appropriateness of the services provided by physicians and
practitioners services consistent with [inaudible] in the relationship that CoP has with larger hospitals, process.

Now, moving on final rule as opposed to the proposed rule, there were some clarifying revisions I have to point out that needed to make sure this was a written agreement. It couldn’t be a verbal agreement. That’s just a small thing that needed to be changed but really needed to be specified there’s a written agreement between both and as you all probably know, that we received a little over 100 comments that were very supportive of it. There was the idea that we didn’t go far enough; we were only talking about Medicare participating hospitals and CAH’s. We had left out a large segment of the telemedicine community, free standing distant site telemedicine entities, such as tele-radiology, tele-ICU, and other services. So we did add these new provisions to apply to the credentialing and privileging process in agreements between hospitals, CAHs and those telemedicine entities. This slide provides you those.

Now, again, basically we have applied to Medicare participation hospitals, distant site hospitals providing the services and their relationship to the hospitals and CAHs that they were providing services. We had to point out that the distance site telemedicine entities credentialing and privileging process and standards had to at least be equal to CoPs related to credentialing and privileging.

The new provisions, as you can see here, with this slide, basically again there needed to be a written agreement so the governing body of the hospital or the CAHs governing body or individual who was responsible for the CAH, had an agreement with telemedicine entity. The difference here and I’ll explain this in a little bit, is that as a contractor of services, the distant site telemedicine entity was furnishing its services in a manner that enabled the hospital or CAH to comply with all applicable CoPs and services and that would include credentialing and privileging requirements for Physicians and practitioners providing telemedicine services. So basically what affect is the final rule going to have on the CoPs? It really is going to allow hospitals that goes the extra out there in the proposed rule and additional telemedicine services that non-hospital [inaudible] it is still there and hospital and CoPs can get rid of that [inaudible] of the traditional credentialing and privileging they have and used and have this option. Again, I talked about this before that it gives them really three options for the process for credentialing and privileging. They can use the combination receiving the credentialing materials and still doing their privileging process or they can use this process so and then it opens up with [inaudible] for telemedicine services from your participating hospital, non-Medicare participating telemedicine entities or, if they want to have agreement with a combination of those types of service providers. So really we were looking at increasing patient access to care, particularly for small, rural hospitals.
and CAHs and the patients at that those hospitals. Also to reduce some of the regulatory burden. We believe that telemedicine can be realized while still having health and safety protections in place for a credentialing and privileging process that’s accountable, which the hospital is responsible. That we consider in writing the final rule, and this goes back to what was saying that it was a process and one where we really appreciated the input before we even sat down to start writing this rule, the telemedicine community and all the stakeholders, that our most significant challenge was the inclusion of these telemedicine entities as distant site providers without CMS having any regulatory or oversight authority over them. So, again, it really did differ from the proposed inclusion of the Medicare participating hospitals which is because their credentialing and privileging process meets our CoPs since they are either surveyed by state surveyors or they go through accreditation process and we know that they are meeting requirements by being accredited either by one of the three hospital accreditation programs.

So that was really the tough thing to work out in the final rule. The thing was a medicine entity. The term that we use to come to talk about these free standings non Medicare participation telemedicine entities. The definition for this is a different term that was in the Social Security Act. In the rule, not in the regulatory text of the rule but in our discussion in the rule, we define such distance site telemedicine entity as one that is not a Medicare-Participating Hospital. Going back to what we included in the regulatory text that provides contracted services in a manner the hospital using the services would meet all applicable CoPs. They would use those requirements related to credentialing.

So, this is a question that has come up if it was a non-Medicare Participating hospital, not a lot of them but who was providing telemedicine services to a Hospital or CAH, distance site telemedicine into the [inaudible] that they were not a Medicare participating hospital even though [inaudible] hospital. An agreement, I think this really applies to both distance site hospitals that are providing telemedicine services as well as the telemedicine entities between the hospital or CAH receiving the services and then the telemedicine entity and also the distant site hospital. The agreement really is the foundation for accountability on both sides. Hospitals need to really think about what they plan to take and they need to include in those agreements the heart of this requirement.

So, in summary, the proposed rule, May 26, as I said, well over 100 comments. The effective date will be July 5th. It really was the result of outreach efforts by CMS. As you know, it does allow this streamline process in credentialing and privileging and, again, our intent is really to reduce burden, the duplication for credentialing and
privileging efforts, believe that it reduces burden and still assures accountability with regard to the process of credentialing and privileging. Thank you.

Billings: You can enter your questions into the Live Meeting Client and I will pose them to Commander Cooper and Jeannie, if she’s still on-line. Here’s the first question: Verifying and restating the obvious is that originating site hospitals where the patient is located still have to grant privileges and do so in complete reliance upon the remote entity, the distance hospital’s privileges, either the telemedicine entities or the telemedicine distant hospital, once the originating site hospital has gotten comfortable, reliance is warranted following the guidelines and the rules and has, most importantly, as you indicated here, executed a written agreement that it can rely upon completely.

Cooper: That would be correct and just wanted to point out that as long as they’re applying type of process to the way its set up, the medical staff has to recommend to the governing body and then the governing body grants this privilege and so we do say the medical staff can rely on the privileging decision, take that forward to the governing body and trust that the governing body make the recommendation so yes, they can rely on it.

Billings: Okay. Does the telemedicine entity need to have a direct contract with the hospital? Can there be a contract between a local practice and a telemedicine entity? Is it sufficient to have a written agreement regarding credentialing and privileging between a telemedicine entity and a hospital?

Yes. And I would ask Jeannie if she has any thoughts on this but yes that would be between the telemedicine entity and the hospital for services.

Ms. Miller: This is Jeannie. The only thing I would add is that the agreement governs the services being provided in general which include the assurance that the credentialing and privileging process is [inaudible] it isn’t just credentialing and privileging for the services provided.

Billings: Right. The next question is related to the presentation. Is there a template or example for written documentation and accepting a privilege by proxy? And I think I’ll go ahead and answer that one. Probably tomorrow morning we will have up on the CTeL website a draft sample written agreement as well as our CTeL cut at merging the technical changes that are made in this final rule with the existing credentialing privileging conditions of participation. It will be on the website tomorrow morning. We’ll announce that by an e-mail to let you know when it’s available so
hopefully that both the draft agreement and those fact sheets will be of some value and help in getting ready for this process.

Miller: This is Jeannie and I would like to add we usually do not use a form or a particular agreement of whatever because we need to allow for the flexibility of hospitals and entities when drafting agreements [inaudible]. [Inaudible] the federal government for the agreement or what the process would look like.

Billings: The question was asked if this slide deck is going to be made available and yes, this is being recorded and will be made available both with the concurrence, of our guests, the recording and slide deck would be made available probably by the end of the week.

When a hospital or critical access hospital uses a distant site or a telemedicine entity for credentialing and privileging, must that critical access hospital do some privileges using existing medical staff credentialing categories or be a separate category for just telemedicine privileges? We may have addressed that in the earlier question but I’ll throw it to you in case you have anything you want to address in here.

Cooper: Right. I would say no. That they would obviously privileges are even for on-site physicians and practitioners are individually so this would be the same matter and that it wouldn’t be a separate category. It would really be based on the category of services being provided and not the umbrella of telemedicine services like a specific services that are being provided so it would really be for privileges and categories that a hospital set up for on-site services allowing for the differences in what could be done through telemedicine and what could be done on-site.

Billings: Can a telemedicine entity with which the hospital contracts be the coordinator of services? Can they arrange services for hospitals by practices that do the credentialing and privileging? You want me to read that one again?

Yeah.

Can a telemedicine entity with which the hospital contracts be the coordinator of services -- arrange services for hospitals by practices that do the credentialing and privileging?

Cooper: I would think so I mean we’re really [inaudible] a lot of the free standing telemedicine entities that the physician that any practitioners they [inaudible] aren’t necessarily void there that there under contract and they’re providing services so the coordinating effort [inaudible] telemedicine entity the standardized process and, as
I pointed out, as long as their credentialing and privileging standards at least meet those of CMS and CoPs that would be okay. We would probably – well, I’ll leave it at that. That would be okay.

Miller: The only thing I would add is the key is – I completely lost my train of thought -- if I come back and say it was related to – nope, I don’t remember. Sorry.

Cooper: Getting back to what Jeannie said earlier about it really is their responsibility not just for credentialing and privileging but as a contractor of services even though they’re subcontracting out with various physician practices, responsible for enabling the hospital and CAH to meet all CoPs that come into play not just credentialing and privileging requirement

So for all services provided.

Miller: This is Jeannie: What I wanted to say is those are the kinds of details that need to be worked out in the overall agreement so it’s crystal clear they’re going to be provided and how.

Billings: I just tried to respond to a request that was sent out the questions to everybody and it took my question right off of the screen so I unfortunately lost the question by a doctor and so if you can send that one in again. I apologize. I was trying to be helpful in sending the question around and I managed to delete it. We’re getting near the end of the questions here. Are there any further questions from the audience?

I think we’ve reached ...hold on. Here’s a question: In an out of state tele-trauma or tele-emergency, what would define “treatment” specialist at a remote hospital thus requiring licensing and privileging? Let me change that word to credentialing. Let me re-phrase the question: In an out-of-state tele-trauma or tele-emergency, define “treatment” by a specialist at a remote hospital thus requiring credentialing and privileging.

Cooper: Going back to – I think if there’s a service – anything other than a consult between physicians, you know a curb site consultation which isn’t a formal consultation with that remote physician would constitute provision of services. I guess the question is getting at the idea of questioning services in an emergency since we’re dealing with tele-emergency services, tele-trauma and how that would be dealt with, but I’m not sure.
Billings: If I could try to interpret here, I think its coming from if a physician in a tele-trauma unit has to dial-in in the case of an emergency, what would the credentialing and privileging requirements be in that kind of a situation?

Miller: [Jeannie] You just can’t – it would be the same as the others. I think a caveat situation that telemedicine physician is providing the care that’s being provided. In other words, there should be orders and the orders should be followed. The services are being provided based on the orders from that telemedicine physician at the distant site. The caveat here, and please correct me if you think I’m wrong on this, if you’re providing services you are licensed in the state that care is being provided in. That may be part of why that question says licensing. So if a physician was telling the ER nurse to do in Virginia, there’s care being provided based on both physicians orders so physicians should be licensed also in Virginia.

Billings: There’s two different issues here. One is the licensure but then if we think about this question in the context of what if it was all self-contained within one state. In other words, what if a doctor in one hospital within the same state connected to an emergency situation in another hospital in that state; the licensure is not really an issue because he/she is already licensed at that originating sight. How would the credentialing process be in an emergency situation?

Miller: [Jeannie] And I again believe that that would be worked out in an agreement.

Billings: Okay. The question came back in that I sent out. Will there be any discussion in the future regarding home care agencies with clients in numerous states and the requirements of credentialing the nurses in each state?

I believe that’s outside the scope of this rule.

Miller: Yeah.

It is and I’ve not heard anything about credentialing home care at this point at all. But I don’t get in the field of home care all the time so – but I don’t hear about that.

Alright, I think we’re getting close to the end here. I do not see any more questions in cue. This is your last opportunity.

Greg, this is Karen. Can you hear me?

We can hear you, Karen.
I just wanted to make one additional point and that is that the Joint Commission and their Telehealth standards still apply to entities such as non-hospital consult origination sights and the alignment is so important for those of us who are overseeing tele-medicine programs. The alignment was very important so that our agreements with entities can be pretty comparable whether it’s a non-hospital originating sight versus a hospital originating site. So this has made it much more user friendly for everybody.

And I think our friends at CMS deserve a large pat on the back for that.

Absolutely, and I’m harken back to Dr. Berwick’s comment about the montra of improving access, improving quality, improving population health and lowering costs that CMS has moved in this regard really, truly takes us one step further to doing that.

Alright.

Thank you.

Billings: We don’t have any further questions so with that I’m going to close out. The date for our next Webinar is actually July 18th. It’s the third Monday in July: mHealth: What are the Legal and Regulatory Barriers?“ We appreciate very much Dr. Rheuban – can you go on mute, Dr. Rheuban?

We appreciate very much you joining us today. Commander Cooper, Jeannie Miller we appreciate you taking your lunch hour and sitting in on our presentation today and making an excellent presentation. I’m relatively new to the Telehealth world. I was told by some people early on that this is probably not going to change. I can tell you that there were some of the old timers that made that comment who are eating their words today as you all did change. I think maybe some people in the Telehealth community don’t realize what kind of mountains you crawled up to get this thing through but there are some of us in the field who understand and we’ll keep talking about it. We’re very appreciative of what you did to bring it to this point. Thank you very much and we will look forward to seeing you in July at our next Brown Bag. This is Greg Billings. Have a good af