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**The Why and How of Credentialing by Proxy for Telemedicine Providers**

**Why**

For hospitals wishing to expand or support their clinical service offerings by utilizing telemedicine services from distant sites, and for hospitals and other providers wishing to offer those telemedicine services to other hospitals through their practitioners, traditional credentialing mechanisms have proven to be slow, costly and inefficient.

The concept of credentialing by proxy is designed to offer hospitals that wish to expand their services through telemedicine (referred to as “originating site hospitals”, or the sites where patients receiving the telemedicine services are located) a streamlined credentialing process for credentialing distant site telemedicine practitioners.

**How**

In 2011, CMS amended the Medicare conditions of participation (“CoPs”) by authorizing originating site hospitals to use credentialing by proxy to credential telemedicine practitioners who are associated with either (i) a Medicare-participating distant site hospital (“DSH”), or (ii) a “distant site telemedicine entity” or “DSTE” (which may be a physician group, a non-Medicare participating hospital, or another non-hospital telemedicine provider).

Two things are needed to implement credentialing by proxy:

* + a written credentialing agreement between the originating site hospital and the DSH or DSTE, and
	+ Medical Staff Bylaw changes at the originating site hospital to accommodate credentialing by proxy

The written credentialing agreement must contain representations/agreement that:

* + The DSH or DSTE uses a credentialing/privileging process that at least meets Medicare credentialing standards for hospitals.
	+ All practitioners seeking privileges at the originating site have been privileged at the DSH or DSTE.
	+ The DSH or DSTE will provide the originating site hospital with a list of the current privileges for each telemedicine applicant.
	+ The practitioners seeking privileges at the originating site hospital are licensed to practice in the originating site hospital’s state.
	+ The originating site hospital will periodically review the services provided to its patients by the distant site practitioners and report that information to the DSH or DSTE for use in performance evaluations of those practitioners. (These reports are to include all adverse events or complaints related to each telemedicine practitioner’s services provided at the originating site hospital.)

In addition:

* + For credentialing agreements with DSHs, the agreement must state that the DSH is a Medicare-participating hospital.
	+ For credentialing agreements with DSTEs, the agreement must state that the DSTE is a contractor of services to the originating site hospital that furnishes contracted telemedicine services in a manner that will permit the originating site hospital to comply with all applicable CoPs.

With a compliant written credentialing agreement in place, according to the CoPs:

* + the governing body of an originating site hospital, may grant privileges to distant site telemedicine practitioners based on:(i) recommendations of the originating site hospital’s medical staff, (ii) that rely on the credentialing information provided by the DHS or DSTE

In effect, this means that the originating site does not need to undertake its own separate credentialing process for each telemedicine applicant—it can let the distant site do most of that work, and the originating site medical staff can rely on the distant site’s work when making its credentialing recommendations to its governing body.

**Other Considerations**

Accreditation and State Law Requirements

Most U.S. hospitals are accredited by one of several accreditation entities. These accreditation entities may have their own credentialing by proxy requirements or standards. Those requirements or standards may differ in some respects from those described above, and should be both understood and heeded.

Similarly, some states may have credentialing standards or requirements that must be adhered to for licensure purposes, and those standards may also differ from the CoPs credentialing by proxy standards; and some states have not endorse the CoPs credentialing by proxy process.

Medical Staff Bylaws

As noted above, in order to implement credentialing by proxy, the originating site hospital’s medical staff bylaws will have to be amended to reflect the credentialing by proxy process. The elements of the process can vary in a number of respects. Elements to consider include the following:

* + Include/enumerate, and then require for all distant site telemedicine applicants, adherence with the required elements (summarized above) of written telemedicine credentialing agreements with DSHs, DSTEs
	+ Identify the tasks, if any, to be retained/carried out by the originating site hospital’s medical staff office and/or medical executive committee (e.g., NPDB query, confirmation of hospital-required malpractice coverage, etc.)
	+ Identify the processes the originating site hospital will utilize:
		- to review/approve applications (e.g., how much review/analysis will the medical staff do other than checking to ensure that the basic elements of the written credentialing agreement have been satisfied in re each applicant);
		- to determine whether specific applicants’ applications will be referred into the Hospital’s “traditional” credentialing process; and
		- to deny or restrict applications (and what “process” will be available to applicants, if any, in the event of a denial or restriction)
	+ Consider adding a new Medical Staff category for approved distant site telemedicine practitioners, to clarify what such practitioners will (and will not) be obligated to do as members of the medical staff (e.g., voting rights, attendance rights for meetings, adherence to peer review/quality improvement processes, etc.)