



Telemedicine Credentialing

Authors: Pam Lewis; Mandy Bell, BA; Deanna Larson, RN, BSN; Jay Weems, MBA

I. Executive Summary

Background: In the area of telehealth, the Centers for Medicare & Medicaid Services (CMS) requires full credentialing and privileging at each telehealth originating site (remote site where the patient is located). Facilities receiving telehealth services have to fully credential the telehealth physician as well as approve for privileging.

Issue: The time and cost of this process has a crippling effect on telehealth throughout the country and may prevent some hospitals and clinics from using telehealth services for their patients because of the undue cost and duplicative work affiliated with credentialing procedures.

Recommendation: CMS needs to adopt a policy to allow telemedicine providers to receive deemed status and to allow for health care facilities receiving telehealth services to perform credentialing by proxy (delegated credentialing). If a provider is already credentialed at a Medicare-participating facility (usually his or her home site), that credential would be sufficient for providing telemedicine services at another facility. The privileging process would still be conducted by the originating health care facility.

II. Background

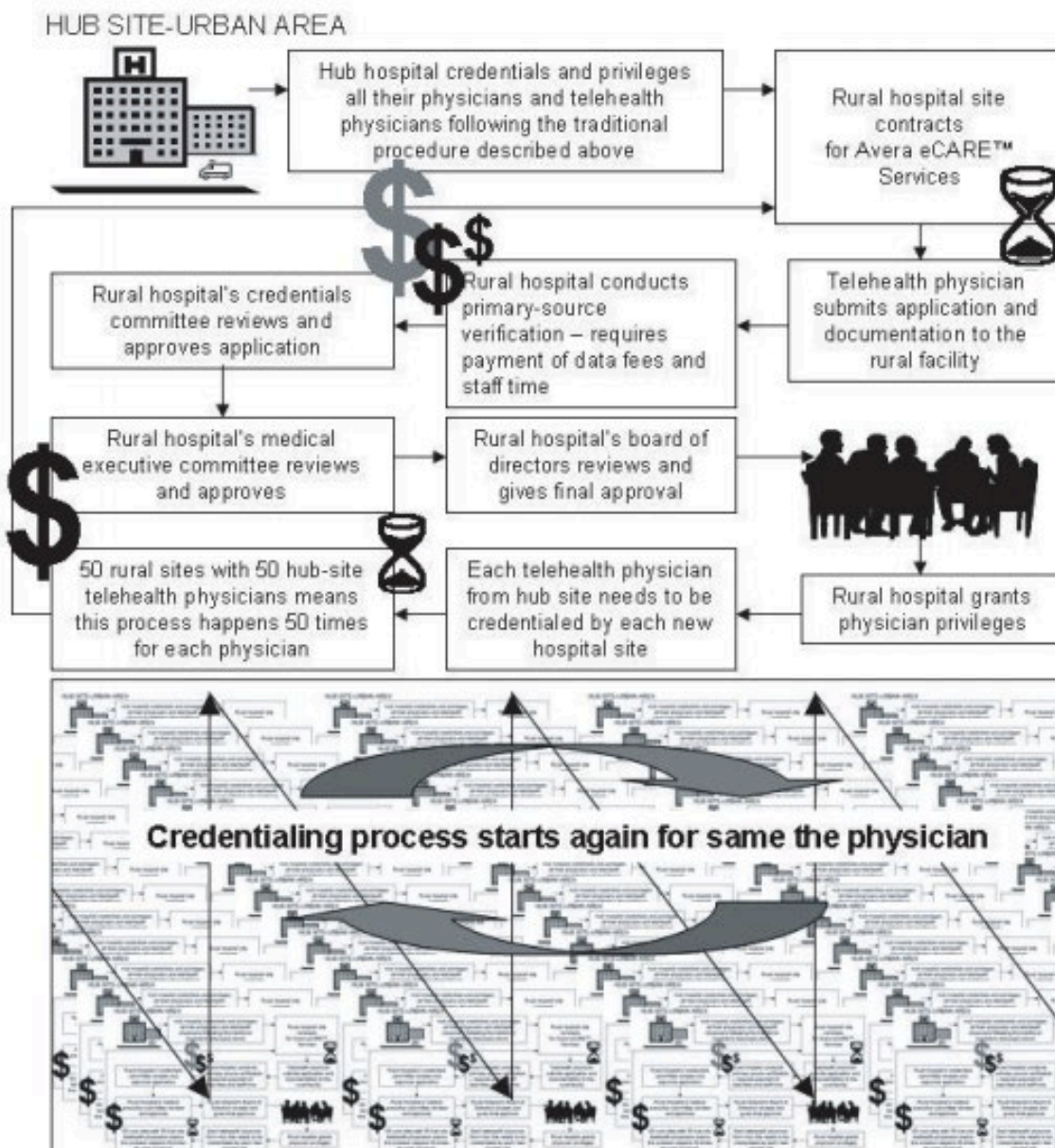
Rural health care facilities are often served by a small group of general practitioners. They may contract for specialty outreach services, but generally rural patients lack local access to many types of specialty care. To solve this access issue, some facilities have adopted telemedicine programs that link specialists to their rural patients or provide remote intensive-care monitoring or emergency department support. The difficulty for the rural facility is in finding specialists who have the capacity and desire to deliver telehealth. Several best practices have been developed to make this process as convenient as possible for the provider, however, the barrier of credentialing still remains.

Credentialing is the process of obtaining and reviewing provider data such as licensure, training, certifications, insurance, National Practitioner Data Bank queries, sanction queries and references. In the area of telehealth, the hub site for the telehealth provider conducts the credentialing process or uses an outsourced credentialing service. Facilities receiving telehealth services have to fully credential the telehealth physician as well as approve for privileging. Privileging is the process whereby the originating (receiving) site conducts its own assessment of the provider's current competence and capacity to perform the medical care requested. This assessment is reviewed by the credentials committee (if the medical staff has one); then, recommendation is given by

the medical executive committee, and finally be approval by the governing board is required.

TELEHEALTH CREDENTIALING

The credentialing application process requires primary source documentation of all licensure (state, DEA, CDS), education, training, current and previous hospitals staff privileges, malpractice insurance coverage for last five years, claim(s) history (for last 10 years), work history (since finishing training) any sanctions with Medicare or Medicaid. Some hospitals may also require TB testing, finger printing, rubella titers or reference letters.





Credentialing and privileging are important processes for ensuring high-quality patient care. In the case of telehealth, however, providers must complete this process for each of their outreach sites. A provider with 50 telemedicine sites must be credentialed and privileged 50 times, although the information provided to each facility is almost exactly the same. To add to the pain of this duplication, primary-source documentation is required and most facilities have their own unique credentialing form that requests slightly different information.

In 2004, The Joint Commission began allowing acceptance of credentialing and privileging decisions by another Joint Commission-accredited facility as an efficient means of vetting and privileging telehealth practitioners. However, since then CMS has taken a position requiring that all Medicare practitioners must undergo full credentialing and privileging at each originating site. The result is that, effective July 15, 2010, Joint-Commission-accredited hospitals must credential and privilege licensed independent practitioners (LIP) “who are responsible for the patient’s care, treatment or services,” which mirrors the CMS requirement.¹ The process for credentialing and privileging providers that fall into the telehealth category must meet all of the standards required for credentialing and privileging any other LIPs on the medical staff.

The current Joint Commission process has been in place since 2004, and there have not been any cases identified where patient safety was jeopardized by the use of remote credentialing and privileging. In addition, the CMS validation survey has never identified remote credentialing and privileging as an issue.²

III. Issue

The telehealth credentialing process is more than an annoyance; it is a deterrent for providers and hospitals and a barrier to expanding health care access. The cost affiliated with credentialing and privileging is burdensome, particularly when Medicare and Medicaid payments are being reduced, and the cost of providing health care is rising. Since a telehealth provider can administer health care services to patients anywhere in the country, the issue becomes one of who is responsible for credentialing and privileging and why a provider would want to pay for credentialing at every site at which he or she may provide services.

One telehealth provider in the mid-Atlantic area estimates that the two-year cost of privileging its telehealth network is \$4.8 million.³ In rural South Dakota, the estimated two-year costs of credentialing physicians who provide remote intensive-care monitoring from the tertiary-care-facility hub site to 22 rural facilities amounts to approximately \$85,536 for just 16 physicians. In the past two years, this health system has added other telehealth services such as eEmergency and eStroke to address growing rural health care needs. Each physician providing care from the hub site must be credentialed at each rural site at a cost of \$160 for the initial credentialing and \$83 for recredentialing



after two years at each site.⁴ The cost, time and duplication of the credentialing process is adding to the rising costs of health care, and causing undue problems in administering telehealth services for rural facilities and their patients.

For specialist providers, the barrier is even greater. High-demand providers such as dermatologists and endocrinologist have little need to provide telehealth to supplement their practices. Those who explore the telehealth option often find there are few prospective patients at any one rural hospital, and they must provide services at several facilities. At this point, they face the daunting task of filling out thick credentialing packets for each site and then tracking and renewing their credentials on a different timeline for each site. For these specialists, there is very little incentive to practice telehealth at small sites with only a handful of prospective patients. Because of these barriers, most providers will not expand their practices into telehealth.

IV. Recommendations

CMS needs to adopt a policy to allow telemedicine providers to receive deemed status and to allow for health care facilities receiving telehealth services to perform credentialing by proxy (delegated credentialing). If a provider is already credentialed at a Medicare-participating facility (usually his or her home site), that credential should be sufficient for providing telemedicine services at another facility. The privileging process would still be conducted by the originating health care facility.⁴

There also needs to be expansion or replication of a Federal Credentialing Program for Health Care Providers, and enhancement of the VetPro program to allow health care facilities in the United States to participate in and utilize the program. The VetPro Federal Credentialing Program for Healthcare Providers was developed in 1997 to specifically address the cumbersome paper-based credentialing system and facilitate sharing of credentials for providers employed by federal agencies. Prior to implementation, the VA had 172 facilities and required re-credentialing of providers every two years or each time a provider needed privileging at a different facility. VetPro, an electronic data-storage and retrieval application, eliminates the time-consuming paper process and incorporates verification procedures. The VetPro user base is continuing to grow with other agencies joining to reduce their own cumbersome paperwork, including: The National Health Service Corps, the United States Public Service's Division of Commissioned Personnel, the Office of Emergency Preparedness, the Immigration and Naturalization Service and the National Aeronautics and Space Administration.⁵

Access to quality, affordable health care is particularly hard in rural communities, and rural residents are more underserved than their urban counterparts. Rural communities need quality telehealth services, and access should not be jeopardized because of undue cost and redundancies within the provider credentialing process.



Bibliography

1. <http://www.hcpro.com/MSL-240524-871/The-Joint-Commission-introduces-MS030101-A-tougher-telemedicine-standard-but-only-for-some.htm>.
2. The Center for Telehealth and E_Health Law (CTel). Credentialing and Accreditation. Retrieved March 3, 2010, from <http://www.telehealthlawcenter.org/?c=125>.
3. The Center for Telehealth and E_Health Law (CTel). Credentialing and Accreditation. Retrieved March 3, 2010, from <http://www.telehealthlawcenter.org/?c=125>.
4. Personal Interview. Dr. David Erickson, Senior Vice President/ Chief Medical Officer, Avera Health. 2/10/2010.
5. Undefined. (April 10, 2003). Interface Online. In VetPro—Federal Credentialing Program for Healthcare Providers. Retrieved March 4, 2010, from <http://datacenter.cit.nih.gov/interface/interface226/vetpro.html>.