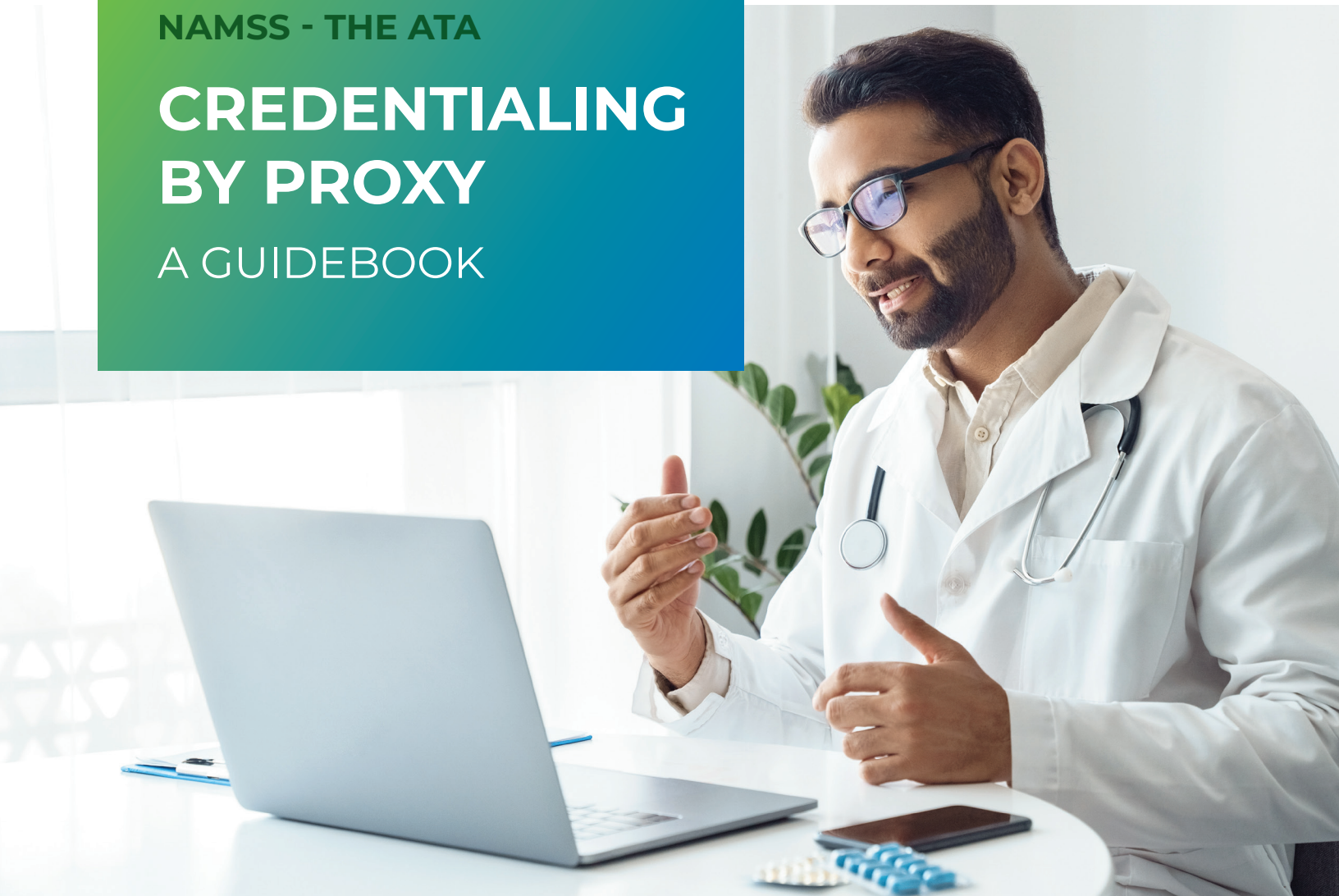


NAMSS - THE ATA

# CREDENTIALING BY PROXY

A GUIDEBOOK



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EDUCATION. ADVOCACY. PATIENT SAFETY.

## EXECUTIVE SUMMARY

### CREDENTIALING

The National Association Medical Staff Services (NAMSS) NAMSS-American Telemedicine Association (ATA) Credentialing by Proxy (CBP) Guidebook provides an efficient and comprehensive pathway for hospitals to credential practitioners for telemedicine services. Credentialing medical practitioners is an essential part of providing healthcare and is an integral component to ensuring patient safety. As demand for telemedicine increases, the number of credentialing applications and associated administrative burdens of traditional credentialing and privileging processes also increase as more telemedicine practitioners seek privileges at more hospitals. CBP allows for more rapid onboarding of practitioners and reduces the administrative burden (and associated financial costs) on practitioners, credentialing professionals, and medical staff leaders.

### BACKGROUND

Prior to 2011, the federal government and hospital accrediting bodies began to recognize that traditional credentialing processes at hospitals were not well suited to the credentialing of increasing numbers of telemedicine practitioners. Traditional credentialing processes were cumbersome and expensive, and hospitals seeking to bring on telemedicine services for the benefit of their patients (called Originating Site hospitals, see “Definitions” below) sometimes did not have adequate numbers of personnel or the specialty expertise to process and evaluate the increasing numbers of telemedicine applications from multiple practitioners, who were often sub-specialists in fields that were new to or rarely present on the medical staffs of those hospitals. The federal government and the accrediting bodies established CBP as an alternative, more streamlined process for the credentialing of telemedicine practitioners—a process that offers benefits to both the Originating Site hospitals that are responsible for the credentialing functions, and the telemedicine practitioners seeking to deliver telemedicine services at those hospitals.

This Guidebook will provide Medical Services Professionals (MSPs) and other interested readers information about the basics of CBP, its advantages over the traditional credentialing process, and the legal and regulatory landscape for credentialing.

The Guidebook also includes information on state, hospital accrediting body, and National Practitioner Data Bank rules, standards and regulations pertaining to CBP, identifies specific CBP responsibilities for Originating Site hospitals and the entities (Distant Site Hospital, “DSH”, and Distant Site Telemedicine Entity, “DSTE”) that initially credential the telemedicine practitioners that are the focus of this document.

NAMSS and the ATA are proud to present the NAMSS-ATA Credentialing by Proxy Guidebook and will continue to monitor telemedicine and credentialing developments. If you have questions about the Guidebook, NAMSS, or ATA, please contact:

- [Info@NAMSS.org](mailto:Info@NAMSS.org)
- [Info@AmericanTelemed.org](mailto:Info@AmericanTelemed.org)

A special thanks to the NAMSS-ATA Credentialing by Proxy Task Force who contributed their expertise to develop the CBP Guidebook.

## ABOUT THIS GUIDEBOOK

The National Association Medical Staff Services (NAMSS) and the American Telemedicine Association (ATA) formed a Joint Task Force to create an industry manual addressing “credentialing by proxy” for telemedicine practitioners. The Task Force was made up of industry experts from both organizations, who provided their knowledge and experience to develop this guide. As telemedicine continues to expand, it is important that medical staff and other healthcare professionals become familiar with the CBP process for credentialing telemedicine practitioners, the opportunities CBP creates to streamline credentialing for those practitioners, and how CBP can increase access to care.

NAMSS is committed to enhancing the professional development and recognition of professionals in the medical staff and credentialing services field. The medical services profession has evolved over the past 50 years to where we are a true profession that spans a wide range of employment settings and requires

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a specific knowledge base and professional competencies. The NAMSS membership includes more than 5,000 medical staff and credentialing services professionals from hospitals, medical group practices, managed care organizations, and Credentials Verification Organizations (CVO). Through its education, advocacy, and commitment to patient safety, NAMSS continues to support medical services professionals (MSPs), NAMSS members, and the healthcare industry. Learn more at [namss.org](http://namss.org).

As the only organization completely focused on advancing telehealth, the American Telemedicine Association is committed to ensuring that everyone has access to safe, affordable, and appropriate care when and where they need it, enabling the system to do more good for more people. The ATA represents a broad and inclusive member network of leading healthcare delivery

systems, academic institutions, technology solution providers and payers, as well as partner organizations and alliances, working to advance industry adoption of telehealth, promote responsible policy, advocate for government and market normalization, and provide education and resources to help integrate virtual care into emerging value-based delivery models. Learn more at [americantelemed.org](http://americantelemed.org).

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# INTRODUCTION

## CREDENTIALING

Credentialing medical practitioners is an essential part of the provision of healthcare and integral to ensuring patient safety. The expansion of telemedicine has led to an increase in the number of credentialing inquiries, as more practitioners seek telemedicine privileges at more facilities, resulting in added administrative responsibilities for the Medical Staff Administration (MSA) at those hospitals. As indicated above, the federal government and hospital accrediting bodies have recognized this problem

**This guide will provide Medical Services Professionals (MSPs) and other interested readers information about the basics of CBP, its advantages over the traditional credentialing process, and the legal and regulatory landscape for credentialing.**

and have created a pathway for streamlined credentialing for telemedicine practitioners, known as Credentialing by Proxy (CBP). This guide will provide Medical Services Professionals (MSPs) and other interested readers information about the basics of CBP, its advantages over the traditional credentialing process, and the legal and regulatory landscape for credentialing.

As organizations working to serve their members and improve the healthcare industry, NAMSS and the ATA are proud to offer this resource to our members and the public. We hope that you will find it useful and informative and will continue to support knowledge-building and professional development for healthcare practitioners, staff, and patients.

## TELEMEDICINE

Telemedicine encompasses a broad variety of technologies and strategies to deliver medical care, health, and education services. Fundamentally, telemedicine is a tool through which medicine can be practiced. Currently, the primary modalities of this tool are:

- Synchronous Communication: Interactive audio-only and audio-video involving real-time interaction between patients and practitioners using secure telecommunications technology, and interactive audio with store-and-forward in which health history is transmitted through a secure electronic communications system from a patient to a practitioner, and then the patient and practitioner have an interactive audio consult without video;
- Asynchronous Communication: Store-and-forward in which health history and medical data are transmitted through secure e-communications system from a patient to a practitioner; and
- Remote Patient Monitoring (RPM): Personal healthcare and medical data is collected on an automatic and recurring basis from an individual in one location via electronic communication technologies and transmitted to a practitioner in a different location for use in care and related support; and
- E-Consultation in which clinicians exchange relevant health data with each other in a secure environment to ensure patients are receiving optimal care.

<sup>1</sup> The term “telemedicine” is used in this Guidebook when referring to traditional clinical diagnoses and monitoring that are delivered by technology. The term “telehealth” more broadly describes the wide range of diagnosis, management, education, and other related aspects of health care. See more in the glossary (chapter 5).

## BENEFITS OF TELEMEDICINE

There are multiple benefits to telemedicine that have become increasingly evident during and after the recent global pandemic. These include improved patient access, as well as extended geographical reach of provider expertise; cost efficiencies for providers as well as patients; improved quality of care; risk reduction, and positive effects on patients in terms of convenience, more positive patient experience, and meeting the demand for more and varied virtual healthcare services. Telemedicine makes it possible to provide quality and timely specialty care in areas without specialized locally-based practitioners, so patients do not have to choose between convenience and quality. RPM allows practitioners to track healthcare data for patients after they are released to their home, or after they are discharged from a care facility, thereby reducing readmissions and complication rates.

Importantly, telemedicine has been shown to reduce the cost of healthcare and increase efficiency through better management of chronic diseases (which account for about 75% of healthcare costs); by allowing shared health professional staffing, reduced travel times, fewer admissions, and shorter lengths of stay.

Telemedicine can also significantly reduce the likelihood of medical error, and of attendant malpractice liability, even in high-risk, remote locations. As an example, remote patient monitoring, which is now being utilized in tele-ICUs throughout the country, enables a patient to be cared for and monitored by both a bedside (local) practitioner and a remote practitioner who is supported by a tele-ICU platform. The result is an enhanced level of care, wherein local practitioners backed by targeted specialists can immediately recognize and respond to problems as they arise.

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1 American Telemedicine Association. (n.d.). Telehealth: Defining 21st century care. [www.Americantelemed.Org](http://www.Americantelemed.Org). Retrieved July 15, 2022, from <https://www.americantelemed.org/resource/why-telemedicine/>

2 20% of Americans live in rural areas, but only 9% of physicians practice in these areas. (Yang T., Health Policy Brief, August 15, 2016. Available at [healthaffairs.org](http://healthaffairs.org))



## C.1 | THE TRADITIONAL CREDENTIALING PROCESS

As MSPs know, traditional practitioner credentialing in healthcare is governed by the bylaws and specific policies and procedures of each individual hospital or healthcare facility. The process can be arduous as it involves the gathering, verifying, and analyzing of key information from or about each applicant, including education and training, work and affiliation history, current clinical competency, and criminal background. The demands of this process can quickly become overwhelming when MSPs are confronted with the need to credential multiple telemedicine practitioners who may each have dozens of current and past affiliations across multiple states. Since both the Originating Site hospital

(where the practitioner seeks privileges) and the DSH or DSTE (where the telemedicine practitioner is actually located or primarily credentialed) are obliged to comply with the same or similar accreditation standards, the traditional credentialing process also creates an unnecessary repetition of credentialing functions for telemedicine applicants, which in turn creates unnecessary credentialing delays and added costs.

In addition, many hospitals have a limited number of MSPs who often have competing priorities. This limited bandwidth creates another barrier to expanding telemedicine services and efficiently implementing them, which can create significant frustration for telemedicine applicants and their organizations. The verification process for a standard practitioner privilege request can take about 15 to 30 days in a traditional credentialing context, depending on the time it takes for affiliates and references to return their verifications. The verification process is detailed, comprehensive and delves into all aspects of a practitioner's professional life. A hospital seeking to verify the credentials of unknown, remotely located telemedicine applicants pursuant to a traditional credentialing process, is under great pressure to take the time to be thorough for the

### LAYERS OF THE TRADITIONAL CREDENTIALING PROCESS

Here are some of the elements that must be verified for credentialing each practitioner.

- **Affiliation History**
- **Background Check**
- **Board Certification(s)**
- **DEA Registration**
- **ECFMG Registration**  
*(foreign applicants)*
- **Education & Training**
- **Exclusion Screening**
- **Malpractice Insurance and History**
- **NPDB Queries**
- **Peer References**
- **State License(s)**
- **Work History**

benefit and safety of the hospital's patients. When applicants also have multiple affiliations and licenses, as telemedicine applicants often do, even more time is required. And this is just for the verification component of the credentialing process.

Once the MSP receives all initial verifications, the information is reviewed to determine if additional follow-up will be required. This follow-up may include obtaining more information from the practitioner or reaching out to peers or affiliation sites. Any delay will lengthen the review process—and such delays are not uncommon due in some cases to the failure of applicants, their references, or others to respond timely, or to respond at all. When the MSP receives all required information, the application is ready for

**There is now a streamlined process available that can accelerate credentialing of telemedicine practitioners and provide efficiencies to the MSA, freeing up much-needed staff time for other matters.**

Medical Staff review. As outlined in The Joint Commission's (TJC) standard MS.06.01.07, in a traditional credentialing process the organized Medical Staff reviews and analyzes all relevant information relating to the following from each applicant/practitioner:

- Current licensure status,
- Training,
- Experience,
- Current competence,
- Ability to perform requested privileges.

This review process can take an additional 30 to 60 days at the medical staff level, depending on the committee review structure (which often includes both credentials committee and medical executive committee review, and may involve further inquiries to the practitioner and others to address concerns or apparent inconsistencies). The governing body then makes the final credentialing decision.

This process, while important for evaluating practitioners to protect patient safety, can quickly become unmanageable at a facility using, or wishing to use, multiple telemedicine practitioners. There is now a streamlined process available that can accelerate credentialing for telemedicine practitioners, enabling MSPs to focus on other matters. This process, CBP, is outlined in detail in the next chapter.



## C.2 | CREDENTIALING BY PROXY

Prior to 2011, the Medicare Conditions of Participation (CoPs) did not distinguish between hospital credentialing of practitioners providing in-person or onsite services versus practitioners who provided services solely via telemedicine from a distant site. Consequently, hospitals were required to utilize traditional credentialing and privileging processes for all practitioners wishing to provide services for the hospitals' patients, whether onsite or telemedicine-based. This meant that hospital governing bodies could only make privileging decisions after their medical staffs thoroughly and independently verified and examined the credentials of each practitioner applying for privileges, and after the medical staff applied its specific criteria to determine if the individual applicants should be privileged at the hospital. For telemedicine-based services, this traditional credentialing and privileging process is costly and burdensome for both practitioners and hospitals, particularly small hospitals, and critical access hospitals (CAHs). These hospitals often lack the resources and specialty expertise to fully or effectively carry out the traditional credentialing process for every telemedicine practitioner who would like to provide telemedicine services to the hospitals' patients. The result: a shortage of specialist practitioners for patients at small hospitals and CAHs due to a costly and burdensome privileging process.

Responding to industry needs, the Centers for Medicare and Medicaid Services (CMS) concluded that then-current regulations were a barrier to the widespread use of telemedicine at hospitals and it promulgated new regulations, in the form of CoPs, designed to expedite the credentialing of telemedicine-based practitioners. These regulations, which authorized the process of CBP, were intended to facilitate innovative approaches to patient-service delivery through telemedicine, particularly for small hospitals and CAHs in need of specialty-practitioner expertise.

CBP can be an effective time- and cost-saving tool for hospitals using telemedicine, but implementation of CBP requires careful attention to legal and regulatory considerations. To operate a successful CBP program, hospitals must abide by the CBP requirements in the CoPs, as well as requirements in state regulations (in particular in the states where the Originating Site is located), in applicable hospital accreditation program standards, and in their own medical staff bylaws (see C.3). CBP is now permissible and feasible, but it is essential that hospitals understand and follow these requirements as they establish or modify CBP programs.

**Responding to industry needs, the Centers for Medicare and Medicaid Services (CMS) concluded that prior regulations were a barrier to the widespread use of telemedicine at hospitals and promulgated a set of new regulations designed to expedite the credentialing of telemedicine-based practitioners.**

## **STREAMLINED CREDENTIALING FOR TELEMEDICINE PRACTITIONERS**

The CMS regulations (CoPs) allow an Originating Site to use CBP when (i) the telemedicine services are provided by a practitioner affiliated with and credentialed by either a Medicare-participating DSH or an entity that qualifies as a DSTE; and (ii) the Originating Site hospital and the DSH or DSTE enter into a written agreement that satisfies certain requirements that are enumerated in the regulations.

A DSTE is an entity that: 1) provides telemedicine services; 2) is not a Medicare-participating hospital; and 3) provides contracted services in a manner that enables the Originating Site to meet all applicable CoPs, particularly those requirements that relate to practitioner credentialing and privileging. A DSTE may be a physician group, a non-Medicare-participating hospital, or a non-hospital telemedicine practitioner. The DSTE rules can be used for telemedicine practitioners who are not affiliated with a Medicare-participating hospital.

### **I. CREDENTIALING BY PROXY WRITTEN AGREEMENT**

According to the CoPs, to utilize CBP the Originating Site must enter into a written agreement with the DSH or DSTE reflecting and confirming the following requirements:

- 1) The DSH (which must be Medicare-participating) or DSTE uses a credentialing or privileging program that meets or exceeds the Medicare standards that hospitals have traditionally been required to use.
- 2) The individual practitioners seeking to provide and/or providing services via telemedicine to the Originating Site have been privileged at the DSH or DSTE.
- 3) The DSH or DSTE provides the Originating Site with a list of the current approved privileges for the telemedicine practitioners seeking and/or exercising privileges at the Originating Site.
- 4) The individual practitioners seeking and/or providing telemedicine services at the Originating Site are licensed or otherwise authorized to practice in the state where the Originating Site is located.
- 5) The Originating Site periodically reviews the services provided to its patients by the telemedicine practitioners and submits reports about those services to the DSH or DSTE for use in performance evaluations. At a minimum, these reports must include all adverse events and all complaints related to each telemedicine practitioner's services provided at the Originating Site.
- 6) For contracts with DSTE only, the agreement must also state that the DSTE is a contractor of services to the Originating Site that furnishes contracted telemedicine services in a manner that permits the Originating Site to comply with all applicable CoPs.

The CBP agreement requires the parties to share information regarding credentialing decisions, as well as periodic updates of practitioner reviews and assessments. These requirements are set forth in federal regulations (the CoPs), but CBP participants should also be cognizant of state laws regarding peer-review processes, peer review and credentialing decisions, and peer review confidentiality.

It should also be noted that, even if a hospital enters into a CBP agreement, it is not required to use the CBP process for all (or any) telemedicine practitioners. It can retain the option to use the traditional credentialing process for individual telemedicine practitioners, or all telemedicine practitioners, if desired. The credentialing and privileging information provided by the DSH or DSTE may be utilized, but does not have to be relied upon, by the Medical Staff at the Originating Site.

## II. ADDITIONAL CONSIDERATIONS

Even when using CBP, the governing body of the Originating Site retains the ultimate authority over privileging decisions regarding telemedicine-based practitioners who will be providing services at that site. The Originating Site's medical staff bylaws should include provisions that recognize CBP. Hospitals can create a separate medical staff category for distant site telemedicine practitioners, if desired (with accompanying limits on telemedicine staff responsibilities and rights, as considered appropriate).

As described below, CBP standards adopted by many of the major hospital accreditation organizations closely mirror the Medicare CoPs. And as indicated above, hospitals must also work within the requirements of state laws when implementing CBP (see Exhibits & Resources, p. 44 for resources to examine your own state laws).

## BENEFITS OF CREDENTIALING BY PROXY

Implementing a CBP program at your facility can provide a broad range of benefits to your credentialing process for telemedicine applicants and can make life easier for your MSPs and medical staff. Some of the potential benefits include:

- 1) Expedited Availability of New/Augmented Services: With an efficient credentialing and privileging process for telemedicine applicants, your facility can offer telemedicine services sooner. CBP can cut down on long waiting periods for access to telemedicine practitioners who offer specialty and/or augmented services, especially in medically underserved areas.
- 2) Expanded Access to Practitioners: Many small or rural hospitals are unable to recruit or retain certain categories of specialists. Some categories of specialists may be in limited supply, or the local population may not be large enough to support a specific specialty. CBP can help hospitals promptly and efficiently secure needed medical expertise via telemedicine when that medical expertise would not otherwise be available to those hospitals or their patients.
- 3) Decreasing Costs: In many cases, especially for small or rural hospitals or within facilities that can only offer limited specialty services due to staffing, space limitations, or cost limitations, adding on-site specialty expertise or back-up by traditional means is cost-prohibitive and impractical. Using CBP to efficiently expand such facilities' access to telemedicine services, without unduly burdening MSPs and traditional hospital credentialing systems, can provide a cost-effective alternative to traditional credentialing and on-site staffing at these facilities.

- 4) Improved Patient Experience: Telemedicine services have been largely heralded as an avenue to improve patient quality of care and patient satisfaction, enabling patients to access care in their communities. Allowing expanded access to telemedicine may improve outcomes and the patient experience by allowing facilities to draw upon expertise and clinical knowledge beyond their immediate area, while saving patients the cost, inconvenience and dislocation associated with having to obtain certain types of care in other communities. CBP enables facilities to provide that access on a more expedited, efficient, and cost-effective basis.

Overall, CBP has the potential to dramatically increase the speed and efficiency with which your MSA can credential and privilege remote telemedicine practitioners, saving time and money, and providing timelier, expanded care and services to patients. While there may be a learning curve to adopting CBP, this Guide will act as a roadmap to implement these processes and gives you the knowledge needed to launch a successful CBP program at your facility.

## **HOSPITAL ACCREDITATION ORGANIZATIONS**

Most hospital accreditation bodies have amended their standards to align with CMS' CBP requirements, including the Accreditation Commission for Healthcare (ACHC), DNV, and TJC.

### **ACCREDITATION COMMISSION FOR HEALTHCARE (ACHC)**

ACHC requires telemedicine practitioners to be licensed in both the state where they are located and the state where the patient is located (01.00.04). To allow for CBP, ACHC applies standards 3.00.02 and 3.00.03, which cover DSH and DSTE agreements, respectively.

For DSH agreements, ACHC allows the governing body of the hospital whose patients are receiving the telemedicine services to choose to have its medical staff rely on the DSH's credentialing and privileging decisions when making privileging recommendations. They require the DSH to: 1) participate in Medicare; 2) provide the Originating Site a list of all practitioners covered by the agreement and outline their privileges at the DSH; and 3) ensure that all covered practitioners hold a license or other appropriate authorization in the state where the Originating Site is located. ACHC requires the Originating Site to periodically review the telemedicine services provided and share feedback for the DSH's use in its own appraisals of the practitioners (at minimum, all information on adverse events and complaints relating to the telemedicine services). ACHC requires the same provisions for DSTE agreements (other than (1)) and has the additional requirement that the DSTE furnish services that permit the Originating Site hospital to comply with all applicable CoPs for the contracted services.

### **DNV-GL**

DNV-GL accredits hospitals through its National Integrated Accreditation for Healthcare Organizations (NIAHO) program. The relevant standards can be found in the Exhibits and Resources (Hospital Accreditation Body Standards and Guidelines on Credentialing by Proxy). DNV-GL has similar requirements to ACHC.

For DSH agreements, DNV-GL allows the governing body of the hospital whose patients receive the telemedicine services to choose to have its medical staff rely on the DSH's credentialing and privileging decisions when making its privileging recommendations. They require the DSH to: 1) participate in Medicare; 2) provide the Originating Site a list of all practitioners covered by the agreement and outline their privileges at the DSH; and, 3) ensure that all covered practitioners hold a license or other appropriate authorization in the state where the Originating Site is located.

DNV requires the Originating Site to periodically review the telemedicine services provided and share feedback for the DSH's use in its own appraisals of the practitioners (at minimum, all information on adverse events and complaints relating to the telemedicine services). As with ACHC, DNV requires that the same provisions are met for DSTE agreements (other than (1)), and also has the additional requirement of a written clause specifying that the DSTE is a contractor of services to the Originating Site and furnishes the services in a manner that permits the Originating Site to comply with all applicable CoP requirements.

### **THE JOINT COMMISSION**

When TJC initially published telemedicine by proxy standards following CMS' adoption of the CBP CoPs in 2011, TJC required both the Originating Site and any DSH or DSTE with which the Originating Site contracted for telemedicine services to be accredited by TJC to implement CBP. This TJC accreditation requirement was not contained in the CMS regulations relating to CBP and was considered an inhibition for TJC-accredited hospitals to fully utilize CBP. After much discussion and anticipation, TJC modified its CBP standard, effective July 1, 2021, to provide that physicians or licensed practitioners could be credentialed and privileged to do so at a TJC accredited Originating Site if:

- The Originating Site uses credentialing and privileging decisions from a DSH or DSTE that is Joint Commission accredited or a Medicare participating organization,
- Consistent with the CBP CoPs, the practitioners are privileged at the distant site for the services to be provided at the Originating Site,
- The distant site provides the Originating Site with a current list of the practitioners' privileges at the distant site, and
- The Originating Site has evidence of an internal review of the practitioners' performance of the privileges at the Originating Site and sends the distant site information that is useful to assess the practitioners' quality of care, treatment and services.

At minimum, this information is to include all adverse outcomes related to sentinel events considered reviewable by TJC that result from telemedicine services, and patient and staff complaints about the distant site practitioners.

### **NATIONAL PRACTITIONER DATA BANK (NPDB)**

Utilizing CBP for credentialing telemedicine practitioners does not change the requirements for Originating Sites to query the National Practitioner Data Bank (NPDB). If the Originating Site is granting privileges to a practitioner, no matter where the practitioner is physically located, it is still required to query the NPDB about that practitioner. MSPs should follow their usual process for querying the NPDB.

## STATE REGULATIONS

While the accreditation organizations and CMS have largely aligned on CBP, each state has its own regulations regarding hospital licensure and many states' regulations include regulations governing the structure and/or operation of the medical staff. It is essential that MSPs and their facilities are aware of any additional requirements or standards relating to credentialing and privileging that are imposed by the states in which they operate. The relevant standards can be found in the Exhibits and Resources (State Regulations on Credentialing by Proxy).

## RESPECTIVE SITE RESPONSIBILITIES

When developing a CBP agreement, the Originating Site and Distant Site should clearly define their respective responsibilities.

## DISTANT-SITE RESPONSIBILITIES

### COMPLIANCE WITH CONDITIONS OF PARTICIPATION

The Originating Site must be a Medicare-participating hospital. If the Originating Site is contracting with a DSH, the DSH must also be Medicare-participating. If the Originating Site is contracting with a DSTE, the Originating Site must ensure, through the CBP agreement, that the DSTE furnishes its services in a manner that permits the Originating Site to comply with all applicable CoPs. Those CoPs include 42 C.F.R. § 482.12(a)(1) through (a)(7) and 42 C.F.R. § 482.22(a)(1) through (a)(4), meaning that the DSTE is expected to:

- Determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff.
- Appoint medical staff members after considering existing medical staff members' recommendations.
- Ensure that the medical staff has bylaws.
- Approve medical staff bylaws and other medical staff rules and regulations.
- Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.
- Ensure the criteria for selection are individual character, competence, training, experience, and judgment.
- Ensure that under no circumstances is the accordance of staff membership or professional privileges dependent solely upon certification, fellowship, or membership in a specialty body or society.
- Ensure that the medical staff periodically conducts appraisals of its members.
- Ensure that the medical staff examines the credentials of all eligible candidates for staff membership and makes recommendations to the governing body on appointment in accordance with state law.

## **CREDENTIALING**

The DSTE is also responsible for evaluating and, if appropriate, approving applications for clinical privileges of DSTE practitioners who seek to provide telemedicine services at the Originating Site.

- The DSTE shall provide to the Originating Site a current list of privileges for each telemedicine practitioner who is seeking, or has obtained, telemedicine privileges at the Originating Site.
- The DSTE should be prepared, upon reasonable request and subject to State law limitations, to provide the Originating Site with a copy of its policies and procedures related to telemedicine credentialing, as reasonable evidence of the Originating Site's compliance with the CoPs (and, as applicable, the Originating Site's accreditation body standards).

## **CONTRACT RENEWAL - RECREDENTIALING**

The DSTE is responsible for conducting recredentialing of its distant site telemedicine practitioners in accordance with its established policies and procedures, which must satisfy CBP requirements set forth in the CoPs and the standards of the Originating Site's accreditation body. As part of its re-credentialing process, the DSTE must consider information provided to the DSTE by the Originating Site with respect to each of the DSTE distant site practitioners who exercise privileges at the Originating Site.

## **CHANGES IN PRIVILEGES; DISCIPLINARY ACTION**

The DSTE is responsible for notifying the Originating Site as soon as reasonably practicable of any change in privileges of a distant site telemedicine practitioner who is privileged to exercise telemedicine services at the Originating Site. The DSTE shall also notify the Originating Site if any action classified as disciplinary action has been taken against a distant site telemedicine practitioner and of any action taken by a state or federal agency or authority that restricts or limits the practice or professional prerogatives of a DSTE telemedicine practitioner.

## **AREAS OF SUPPORT DSTE<sub>s</sub> MAY CHOOSE TO PROVIDE THE ORIGINATING SITE**

A DSTE may choose to:

- Offer the Originating Site the opportunity to perform a site visit at the DSTE credentials office if the Originating Site is uncertain or needs clarification regarding DSTE compliance with CMS- (or accreditation organization-) approved credentialing practices.
- Offer to assist the Originating Site with responses to CMS or accreditation body inquiries about the DSTE's credentialing process and credentialing actions.
- Assist the Originating Site's MSA with drafting of bylaw revisions that accommodate CBP, and with strategies to explain and promote acceptance of CBP.
- Offer its availability for regular communication with the Originating Site to address any issues that arise.



## **ORIGINATING SITE RESPONSIBILITIES**

### **CREDENTIALING BY PROXY**

The governing body and the medical staff of the Originating Site are responsible for approving bylaws and/or policies that enable the Originating Site medical staff to rely upon the DSTE's telemedicine credentialing information and decisions when making their own credentialing and privileging recommendations to the Originating Site governing body regarding distant-site telemedicine practitioners. To that end, the Originating Site must comply with applicable CoPs and accreditation standards relating to the CBP process.

The Originating Site must ensure that each distant site telemedicine practitioner granted privileges at the Originating Site holds a license issued or recognized by the state where the Originating Site is located.

The Originating Site must also ensure that the privileges it grants each distant site telemedicine practitioner at the Originating Site are consistent with, and do not exceed, the privileges granted to that telemedicine practitioner by the DSH or DSTE. The Originating Site is not required to use the CBP process to credential distant-site telemedicine practitioners, and its CBP agreements with DSHs and DSTEs should so state. The Originating Site may conduct its own traditional, original-source credentialing for some or all of such practitioners.

Whether credentialing telemedicine practitioners through CBP or traditional means, the Originating Site remains ultimately responsible for the credentialing and privileging decisions it makes regarding those practitioners.

### **PERFORMANCE INFORMATION**

The Originating Site is responsible for maintaining evidence of its internal reviews of each distant site telemedicine practitioner's performance at the Originating Site and must provide performance and quality information to the DSH or DSTE for the DSH's or DSTE's periodic appraisals of their telemedicine practitioners, in accordance with 42 C.F.R. § 482.22(a)(3) (iv). At a minimum, this information must include all adverse events that result from the telemedicine services provided by each distant-site telemedicine practitioner to the Originating Site's patients and all complaints the Originating Site has received about each distant-site telemedicine practitioner. The Originating Site must notify the DSH or DSTE as soon as reasonably practicable of any action that the Originating Site takes against a telemedicine practitioner that is classified as disciplinary under the Originating Site's credentialing policies.

### **STATE AND/OR FEDERAL DISCIPLINARY ACTION**

The Originating Site shall notify the DSTE as soon as reasonably practical of any action that a state or federal authority takes that restricts or limits the practice or professional prerogatives of a distant-site telemedicine practitioner in the Originating Site's state, including an involuntary suspension, termination, involuntary change, or reduction in licensure status.

## **OTHER OBLIGATIONS AND/OR RECOMMENDED POLICIES OF ORGINATING SITES**

- The governing body must approve and authorize use of telemedicine clinical services at the Originating Site.
- The Originating Site medical staff determines services appropriate for telemedicine.
- The Originating Site medical executive committee and governing body periodically reaffirm services appropriate for telemedicine.
- The Originating Site maintains a credentials file for each DSH and DSTE with which it contracts, including the CBP agreement for the relevant distant site entity (which agreement satisfies the CBP requirements of the COPs and applicable accreditation body) and the list of telemedicine practitioners provided by the DSH or DSTE, including their current privileges and pertinent licensure information. (The Originating Site may, if it so chooses, instead maintain a separate credentials file for each telemedicine practitioner.)
- The Originating Site queries the NPDB for all relevant telemedicine practitioners prior to granting them privileges.
- The Originating Site CBP process for reviewing and approving telemedicine practitioner privileges should include (i) presenting the CBP agreement for each DSH or DSTE, together with the list of associated telemedicine practitioners (and privilege decision forms), and NPDB results to the Originating Site's medical executive committee for review, and (ii) delivering that documentation, together with the medical executive committee's recommendation, to the Originating Site's governing body for approval.

## C.3 | SETTING UP A CREDENTIALING BY PROXY PROGRAM

The requirements and processes used to establish and implement a CBP program will differ from organization to organization. Contributing factors to these differences may include the array of clinical services that will be incorporated into the scope of telemedicine services at each organization, state laws, institutional bylaws, rules, and regulations, and the willingness of the Originating Site's administration and medical staff to accept CBP. The terms of individual credentialing agreements between Originating Site's and DSHs or DSTE's will also differ depending on the parties involved. The following provides general guidance to assist in the development of your program.

### WHERE TELEMEDICINE MEETS CREDENTIALING

Telemedicine enables practitioners to care for populations of patients in multiple remote locations, in addition to the care they may offer through traditional face-to-face encounters. To care for patients at remote hospitals, however, telemedicine practitioners are obliged to obtain clinical privileges at those hospitals. Sections C.1 and C.2 described some of the challenges that are associated with traditional credentialing when utilized to credential telemedicine applicants, as well as the benefits associated with CBP programs when credentialing such applicants.

The information below compares traditional credentialing and CBP. It also contains practical information relating to the implementation and operation of CBP programs.

**Telemedicine enables clinicians to care for populations of patients in multiple remote locations, in addition to the care they may offer through traditional face-to-face encounters.**

## EFFICIENCIES

TRADITIONAL CREDENTIALING	CREDENTIALING BY PROXY
Periodic Review Cycle	Periodic Contract Review
Focused Professional Practice Evaluation (FPPE)	At Least Report Adverse Events/Complaints
Grant MS Membership	Optional
Grant Privileges	Grant Privileges
Individual Credential Files	Can Have One List for All Practitioners Subject to Each Contract
Individual Privilege Delineation	One Common Privilege Delineation*
Ongoing Professional Practice Evaluation (OPPE)	At Least Report Adverse Events/Complaints
Primary Source Verification	Accept Distant Site Verifications
Query NPDB	Query NPDB
Signed Application for MS Membership	N/A
Signed Privilege Delineation Request	Contract
Signed Reappointment Request	N/A

## MEDICAL STAFF OBLIGATIONS\*\*

TRADITIONAL CREDENTIALING	CREDENTIALING BY PROXY
Committee Service	Not Required
Dues/Fees	Not Required
ED Call Coverage	N/A
Meeting Attendance - Annual	Not Required
Meeting Attendance - Departmental	Not Required
Parking	N/A
Vote MS Actions	Not Required

\*Creating a common list of privilege delineations for telemedicine practitioners is optional but recommended to take full advantage of the efficiencies offered by CBP.

\*\*Originating Sites can choose to, but may not wish to, afford distant site telemedicine practitioners membership on their medical staffs, and Originating Sites can, but need not require that telemedicine practitioners serve on medical staff committees, attend certain meetings (telemedicine practitioners may be required to attend, generally remotely, meetings that are reviewing quality or related issues regarding those practitioners), pay dues, etc. Each hospital can have its own process for appointing telemedicine practitioners, including creating a separate category of appointees with its own set of requirements.

## FREQUENTLY ASKED QUESTIONS (FAQS)

As stated above, CBP represents a change from the traditional process by which clinicians are privileged. Below are some FAQs for an Originating Site considering a CBP program:

- **What does the Originating Site need to do to enable it to participate in credentialing by proxy?**

The Originating Site should enter into one or more CBP agreements (compliant with CMS, accreditation body, and state law requirements) with DSH(s) and/or DSTE(s) and amend its medical staff bylaws, to the extent necessary, to accommodate the CBP process.

- **How do we know a distant site telemedicine practitioner is competent and qualified?**

As long as the Originating Site has entered into a compliant credentialing agreement as described above (and that satisfies applicable accreditation requirements and state laws), CBP allows the Originating Site's medical staff to accept the privileging decisions of the DSH or DSTE when making its recommendations for privileging to the Originating Site's governing body without having to repeat credentialing efforts. If, for example, both the DSH (or DSTE) and Originating Site are accredited by TJC, they are both held to the same rigorous standards for credentials verification and evaluation. If the practitioners have received privileges at a TJC-accredited facility, there is a level of confidence (as reflected in the CoPs and TJC standards) that they are qualified and adequately trained to provide telemedicine services at the Originating Site.

The same generally applies when the Originating Site enters into a compliant credentialing agreement with a DSH or DSTE that is accredited by other accepted accreditation bodies, since those accrediting bodies also require the DSH or DSTE to conduct a thorough credentialing review and perform primary source verification of the practitioners' credentials.

- **What is the Originating Site responsible for tracking?**

The Originating Site should consider confirming that the practitioners' medical licenses are up-to-date. The Originating Site should also complete its own NPDB queries, unless they make the DSH or DSTE an authorized agent for such purposes. All other credentials should be tracked and maintained by the DSH or DSTE, although the Originating Site can choose to perform other tracking functions. Also, once the Originating Site approves privileges for a telemedicine practitioner, it must periodically review the telemedicine services that practitioner provides at the Originating Site and share feedback concerning the reviews with the DSH or DSTE (at a minimum, including information on adverse events and complaints). This way, the DSH or DSTE can incorporate that feedback into its own continual credentialing review processes.

- **Who would be liable if credentialing was found to be negligent for a telemedicine practitioner?**

Generally speaking, an entity (whether the Originating Site, or the DSH or DSTE) is only deemed responsible for the proper performance of its own responsibilities—which, in the CBP context, generally means those credentialing responsibilities it is assigned pursuant to the telemedicine credentialing agreement between the originating and distant sites—as long as the credentialing agreement complies with the applicable CoPs, accreditation standards and state laws.

- **Will CBP be a problem during my facility's Joint Commission (or other accreditor) survey?**

It shouldn't be, if the following are available at the Originating Site and in order. Per CMS regulations and accreditor standards, surveyors may ask to see:

- All Telemedicine credentialing agreements
- Current practitioner rosters for all telemedicine services associated with each agreement
- Current medical licenses and DSH or DSTE privilege lists for all telemedicine practitioners on the rosters
- Credentialing body meeting minutes indicating approvals of current rosters

Should additional documents be requested that require input or assistance from a DSH or DSTE, the Originating Site should work with the applicable DSTE. For this reason, it is recommended that Originating Sites keep their DSHs and DSTEs informed about anticipated accreditation surveys so that they can assist with any questions.

- **How does an Originating Site track quality data or FPPE/OPPE on telemedicine practitioners?**

With CBP is utilized, both the Originating Site and the DSH/DSTE have quality-of-care responsibilities. CMS and accrediting organizations require the Originating Site to provide to the DSH/DSTE evidence of internal review of practitioner performance. At a minimum, this should include information about any adverse outcomes related to telemedicine services provided, and any complaints from patients or staff at the Originating Site about a telemedicine practitioner. This information is considered by the DSTE in its ongoing peer review and credentialing and privileging activities relating to its telemedicine practitioners.

- **Will the Originating Site be notified if a practitioner is removed from a DSH's or DSTE's roster for misconduct or quality issues?**

Practitioners at each DSH/DSTE should be monitored carefully by the DSH/DSTE for clinical performance, by taking into consideration information provided by the Originating Sites at which the practitioners are exercising privileges. Should a practitioner's clinical privileges be modified or terminated as a result of an identified concern, the Originating Site should immediately be notified of that change.

- **Why can't the DSH or DSTE provide the Originating Site with more information on these practitioners?**

It can, but whether to request additional information is a balancing process. While some Originating Site requests for additional information are entirely prudent and appropriate, with the rapid growth of telemedicine programs, such requests can quickly become, or be considered, burdensome for a DSH or DSTE, particularly if that DSH or DSTE is contracting for services on behalf of multiple telemedicine practitioners and/or with multiple other Originating Sites.

In instances in which both the Originating Site and DSH or DSTE are members of the same healthcare network or system, requests for “additional” or “non-required” information may be less likely due to an enhanced level of comfort among network providers and with network systems. In other instances, Originating Sites may be more inclined to seek additional information—particularly if they have identified any red flags regarding the DSH’s or DSTE’s processes or information provided.

In such cases, Originating Sites will at least want to ensure that they have all required information as set forth in a compliant CBP agreement and applicable state laws/regulations, and that they have complied with “CBP ready” medical staff bylaws and CMS and state documentation requirements. Obtaining further information will then become a matter of discussion/negotiation with the applicable DSH or DSTE (e.g., the need to ensure compliance and quality for the Originating Site and the workload and efficiencies involved for the distant site). If those discussions do not yield satisfactory results, the parties may choose not to work together – or at least choose not to effectuate or retain a CBP agreement.

- **How does the Originating Site enter practitioners into its credentialing software without having all of the practitioners’ credentialing information?**

Since the Originating Site is not required to obtain or track most standard credentialing information, facilities should consider what information should be entered into their credentialing database. Some databases will not let the Originating Site enter a practitioner without certain information, such as license expiration dates. To keep track of practitioners credentialed by proxy, Originating Sites may need to consider, for example, maintaining a binder or electronic file with the most updated practitioner roster, license verifications and privilege delineation, and a document that states the date of approval. It is suggested that the Originating Site include the executed telemedicine agreement in this file. Having the file in an accessible format simplifies the process for presenting to an accreditor, should surveyors ask about telemedicine credentialing during a survey.

- **Do all CBP processes look alike?**

Originating Site CBP processes may differ at different facilities. For example, some Originating Site hospitals may choose to include distant-site telemedicine practitioners as members of their medical staffs, while others may not. Originating Sites that do afford telemedicine practitioners medical staff membership may choose to create, and assign the practitioners to, a separate medical staff category that defines such practitioners’ obligations and prerogatives. Additionally, at some Originating Site hospitals, telemedicine practitioners may be allowed or required (remotely) to attend specified medical staff committee or department meetings (e.g., for quality improvement or peer review purposes). In short, there are many ways to implement CBP.



## TELEMEDICINE PROGRAM EXPECTATIONS

Facilities may wish to adopt a preamble or a mission statement for their policies and/or bylaws relating to telemedicine services and CBP. Such a preamble or mission statement can define telemedicine, describe its value to the facility, and briefly outline the CBP process and the value of that process. Sample language might look like the following:

Telemedicine involves the use of electronic equipment and communication systems to provide or support the delivery of clinical patient care from a distance and improve both patient care at the hospital and access to treatment and services for the hospital's patients. This <NAME OF DOCUMENT> describes why and how we plan to use telemedicine at <FACILITY NAME>. It also describes the processes and controls we plan to implement relating to the credentialing of telemedicine practitioners, the promotion of quality patient care, and how we will ensure the security and confidentiality of both credentialing and patient data.

Telemedicine services will be provided at this facility pursuant to written agreements between the facility and one or more distant site hospitals ("DSHs") or distant site telemedicine entities ("DSTEs"). The agreements will include provisions and satisfy requirements that are mandated by federal and state regulatory bodies and accreditation entities in order to promote the safe and efficient delivery of telemedicine services. Clinical services offered through these agreements will be provided consistent with legally required and commonly accepted quality, privacy, and security standards.

For telemedicine practitioners who are privileged at a DSH or DSTE with which this hospital contracts, the credentialing information and privileging decisions of that DSH or DSTE may be relied upon by our Medical Staff when it recommends to our governing body telemedicine privileges to be exercised at this hospital by those practitioners. The ultimate determination with respect to clinical privileges, if any, that will be exercised by these telemedicine practitioners at this hospital will, as is the case for all other practitioners regularly exercising privileges here, be made by this hospital's governing body.

This hospital, through the auspices of its Medical Staff and pursuant to its Medical Staff Bylaws and/or policies, will periodically perform internal reviews of the services performed by the practitioners who exercise telemedicine privileges for our patients, and will send evidence of those reviews (including complaints and concerns) to the DSHs and DSTEs with which we contract. Doing so will assist those entities to better assess those practitioners' care, treatment, and services and, if necessary, make adjustments to their privileges and/or require that the practitioners engage in performance improvement initiatives.

## CLINICAL SERVICES/DELIVERY OPTIONS

Telemedicine services provided at Originating Sites will often involve a distant-site practitioner communicating with a patient and/or an Originating Site practitioner, where the Originating Site practitioner retains responsibility for the patient. There are also telemedicine consultations in which

an Originating Site practitioner may not be present and the distant site practitioner will have total responsibility for the patient. There are also telemedicine consultations where the Originating Site practitioner is present and the distant site practitioner may have total or shared responsibility for the patient (provided that the distant-site practitioner is granted privileges to write orders and/or direct treatment and services, even though care is provided via telemedicine link). Some clinical services provided via telemedicine may be on a routine or regular basis, while others may be available on an ad-hoc basis.

All of these examples of service-delivery options are subject to applicable state and federal laws governing the delivery of services via telemedicine, and all require approval of requisite clinical privileges for the practitioners delivering the services.

## **OPERATIONAL BEST PRACTICE CONSIDERATIONS**

When a credentialing agreement is entered into to support the delivery of telemedicine services via CBP, it is recommended that the DSH or DSTE be required to provide at least the following to the Originating Site for each telemedicine practitioner who is covered by the agreement:

- Practitioner data elements required to complete NPDB queries.
- Privilege delineations for each practitioner covered by agreement.

The agreement should also require that any adverse events or patient complaints at the Originating Site about a practitioner covered by the agreement with the DSH or DSTE, and that any adverse events, patient complaints, corrective actions, or modification of privileges known to, or taken by the DSH or DSTE with respect to a practitioner covered by the agreement be shared with the Originating Site. In both cases, this information should be shared as soon reasonably practicable once it becomes apparent to the applicable entity (but within 30 days), except with respect to modifications or restrictions of privileges, which should generally be reported within 24 hours.

Note: The 24-hour time frames is considered best practice by NAMSS and ATA.

Distant-site practitioners covered by the agreement, including new practitioners who are added after the agreement is executed, should acknowledge their participation in the process covered by the agreement. They should also authorize the parties to the agreement to gather and share credentialing and privileging information to facilitate their participation in the CBP process. Some organizations may choose to request the practitioners to execute a release along the lines of the following:

“I give my permission for the Medical Staff Services office (or applicable office) and other facility and/or medical staff representatives of both <Originating Site Facility Name> and <Distant Site> to share credentialing documents, verifications, and data as needed or relevant to the evaluation of my professional performance, conduct, and request for telemedicine privileges at <Originating Site Facility Name> and <Distant Site>. I agree to let you know if/when I cease providing telemedicine services for either or both <Originating Site Facility Name> and <Distant Site>.”

At the time of renewal of privileges, the Originating Site is required to query the NPDB again for each covered telemedicine practitioner.

Practitioners providing telemedicine services pursuant to a CBP agreement should be required to:

- Maintain clinical privileges and credentialing for telemedicine at the DSH or DSTE for any privileges to be exercised at the Originating Site.
- Maintain licensure or other authorization to practice in the state in which the Originating Site is located.
- Exercise professional judgment consistent with standards of their profession when engaging in telemedicine.

DSHs and DSTEs should be required to:

- Notify the Originating Site immediately if there are changes in the list of practitioners providing services for the Originating Site and changes to the practitioners' privileges.

The telemedicine agreement may address whether practitioners providing telemedicine services at the Originating Site will be required or allowed to do the following at that site:

- Pay applicable Medical Staff fees and/or dues.
- Attend medical staff, department, and/or medical staff committee meetings.
- Exercise voting rights at any of such meetings.
- Participate in required on-site orientations.
- Complete annual education requirements.
- Obtain membership on the Medical Staff, or a Faculty Appointment if applicable.

## **OTHER PROGRAM CONSIDERATIONS**

### **DEFINITIONS-CBP AGREEMENTS**

When developing a CBP agreement, the Originating Site and DSH or DSTE should clearly define key terms. Some key terms, with example definitions are:

- **Credentialing:** The obtaining, verification and evaluation of practitioners' qualifications and competence to exercise requested clinical privileges.
- **Distant Site:** The entity through which a distant site telemedicine practitioner is initially credentialed and privileged to provide telemedicine services.
- **Originating Site:** The site where patients are physically located when receiving Telemedicine Services.
- **Telemedicine Practitioner:** A healthcare professional who provides telemedicine services via electronic means from a distant site.
- **Telemedicine Services:** Clinical services provided from a distant site by telemedicine practitioners to patients, or between practitioners consulting on a patient's condition, located at an Originating Site via telemedicine technologies.

## **BYLAWS**

Before implementing CBP, the Originating Site's medical staff bylaws should be amended as necessary to include provisions that accommodate the CBP process. Generally, this will require the adoption of bylaw provisions that (i) allow CBP in instances in which the Originating Site has entered into a CBP credentialing agreement with a DSH or DSTE that satisfies CoPs and applicable accreditation standards relating to such agreements, (ii) allow the Originating Site medical staff (through its medical executive committee) to rely on the credentialing efforts and decisions of the DSH or DSTE when making recommendations to the Originating Site governing body regarding applicable telemedicine applicants' privileges; and (iii) allow the governing body to act on such recommendations.

## **PROFESSIONAL SERVICE AGREEMENTS**

CBP credentialing agreements must include, or attach (or cross-reference) as a separate professional services agreement, a description of the specific telemedicine services that will be provided by the distant- site telemedicine practitioners at the Originating Site. The DSH or DSTE should provide an initial roster of practitioners approved for the delivery of telemedicine services to patients of the Originating Site (including a roster for each specialty covered by the agreement). The DSH or DSTE should also be required to provide a practitioner profile and a list of DSTE-approved privileges for each practitioner included in each roster.

## **COMMUNICATING CREDENTIALING APPROVALS AND CHANGES**

The Originating Site's governing body must approve the privileges of any distant site telemedicine practitioner before that practitioner performs services at the Originating Site. Upon governing body approval, the Originating Site should promptly provide a written and dated confirmation to the DSH's or DSTE's MSA that the practitioner has been approved for the exercise of telemedicine privileges at the Originating Site, including a list of the specific privileges that were approved. In the event that a DSH or DSTE wishes to add or remove a telemedicine practitioner (or a practitioner's privileges) from the roster of those providing services at the Originating Site, the DSH or DSTE MSA shall provide timely notification to the Originating Site. Notice of any resulting changes in the rosters and/or privileges of distant site telemedicine practitioners providing services at the Originating Site, once implemented, will be sent to the DSH or DSTE MSA.

## C.4 | OVERCOMING HURDLES

### CHALLENGES WITH CREDENTIALING BY PROXY

While CBP can be an effective way to streamline hospital operations and efficiently expand access to care, there are some challenges with implementing a CBP process. Therefore, it is important to be cognizant of these challenges when deciding how to move forward with your facility.

- 1) Key Stakeholders: For an Originating Site, relying on another facility's credentialing decisions can be complicated and perhaps unnerving. It is essential to ensure that all the key stakeholders are educated and kept in the loop when implementing CBP. This may include members of your facility's staff who may not be a part of the traditional credentialing process, such as clinical specialty administrators and department enrollment specialists; and, it certainly includes medical staff leadership and the governing body.

Getting to know the DSH or DSTE your facility will be contracting with, and relying on, is also important. It is appropriate to ask questions to, and about the Distant Site, to gain an understanding about how its processes work, and hopefully to gain added comfort with the relationship.

Different Originating Sites will have different approaches. Therefore, performing a little due diligence on your contractors and keeping all relevant stakeholders on the same page as to why CBP is needed, how it works, and what it can achieve, will promote confidence and cut down on miscommunication and confusion within your team.

- 2) Tracking Data: Though the MSA will largely rely on the verification work of the DSH or DSTE when using CBP, that is not the end of its work. Telemedicine practitioners are still subject to ongoing evaluations of their performance (incidents, complaints, etc.), as well as the recredentialing and (as applicable) reappointment cycles. Their board approval and recredentialing dates must be tracked and entered into credentialing software like any other practitioner on staff (if they are, in fact, appointed to the medical staff. See more in C.3). Quality reports to the distant sites (based on the ongoing tracking of, e.g., incidents and complaints relating to the telemedicine practitioners) must also be prepared and conveyed.
- 3) Professional Practice Evaluation: One of the requirements for utilizing CBP (see C.2 and #2 just above) is to provide periodic reports from the Originating Site to the DSH or DSTE on the performance of telemedicine practitioners. It is important to develop and implement an internal Quality Improvement process at the Originating Site to conduct internal reviews of telemedicine physician performance and to outline the method of disseminating these reports.
- 4) Below are some hurdles you may incur in developing a CBP program and tips from our experts on how to overcome them.

## **INERTIA**

One big hurdle that Originating Sites may face in trying to implement CBP is simple inertia. Hospitals often tend to be resistant to change, even when the change is intended to expand services and/or make needed services more accessible or make processes more efficient. There may be concerns about complexity or cost, or a perception that telemedicine services will infringe on or threaten, rather than enhance, Originating Site services and processes. In addition, although the traditional way of credentialing brings challenges to Originating Site MSPs and others, it has offered comfort over the years that, when utilized, it ensured that credentials were reviewed in a thorough, consistent manner that promoted quality of care.

CBP represents a significant change in process and contemplates reliance in part on the work of others. Communication is often the key to address these concerns. A clear explanation of the benefits and simplicity of the CBP process, and what telemedicine services can offer the facility, its patients, and its practitioners will go a long way towards convincing doubters. Use this Guidebook to help decision makers and your staff understand CBP, and it may help you to garner consensus when adopting a CBP program.

## **COMMUNICATION WITH CREDENTIALS VERIFICATION ORGANIZATIONS**

If the Originating Site has an existing relationship with a CVO, questions may arise as to why the facility should use CBP rather than the CVO to credential telemedicine practitioners. In such an instance, it is important to make both Originating Site and CVO personnel aware that CBP is a different, more “complete” process than credentials verification. CBP allows Originating Sites’ medical staffs to rely on the credentialing evaluations and decisions of DSHs and DSTEs for telemedicine practitioners, in addition to the credentialing verification functions that are performed by those entities. CVOs’ functions are generally limited to credentials verification. That said, CVOs can be assured that CBP will not interfere with the types of credentialing functions that CVOs typically perform (e.g., delegated NPDB queries, including for telemedicine practitioners, and/or verifications of the credentials of local practitioners providing onsite services). CBP should not substantively change their relationship with Originating Sites.

## **SITE-SPECIFIC DOCUMENTATION**

Originating Sites may require that site-specific forms or other documents be included in their internal credentialing files, in addition to the documents that may be held or routinely produced by the DSH or DSTE. Managing these specifics is a challenge as the number of DSHs and DSTEs, as well as telemedicine practitioners, continue to increase. DSHs and DSTEs may feel particularly averse to additional document demands if they are providing telemedicine services to multiple Originating Sites with different or inconsistent document needs or demands.

Here again, communication is key. The Originating and distant sites should each be prepared to explain why additional documentation/forms are (or are not) necessary to them—which will hopefully lead to accommodation. If/Once accommodation is reached, the CBP agreement should outline the documents that will be required by the Originating Sites to ensure that both sides are on the same page.

## CONCLUSION

Both NAMSS and the ATA are proud to have presented this guidebook on CBP and hope that it helps increase the understanding and utilization of this process across healthcare facilities. We will continue to serve our members and others in the healthcare industry and will monitor further developments in the worlds of telemedicine and credentialing.

If you have questions about the Guidebook or either of the organizations involved in its development, please contact:

- [Info@NAMSS.org](mailto:Info@NAMSS.org)
- [Info@AmericanTelemed.org](mailto:Info@AmericanTelemed.org)

A special thanks to all the volunteers from NAMSS and the ATA who contributed their expertise to the development of our CBP Guidebook.



## ACRONYMS

Accreditation Commission for Healthcare (ACHC)  
American Telemedicine Association (ATA)  
Centers for Medicare and Medicaid Services (CMS)  
Conditions of Participation (CoPs)  
Credentialing by Proxy (CBP)  
Credentials Verification Organization (CVO)  
Critical Access Hospital (CAH)  
Distant Site (DS)  
Distant Site Telemedicine Entity (DSTE)  
Drug Enforcement Administration (DEA)  
Educational Commission for Foreign Medical Graduates (ECFMG)  
Focused Professional Practice Evaluation (FPPE)  
Medical Services Professionals (MSP)  
Medical Staff Administration (MSA)  
National Association Medical Staff Services (NAMSS)  
National Integrated Accreditation for Healthcare Organizations (NIAHO)  
National Practitioner Data Bank (NPDB)  
Originating Site (OS)  
Ongoing Professional Practice Evaluation (OPPE)  
Remote Patient Monitoring (RPM)  
The Joint Commission (TJC)

## COMMON TERMS AND DEFINITIONS

### A

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#### **Accreditation<sup>B</sup>**

Determination by an accrediting body (such as DNV-GL, ACHC, or the Joint Commission) that an eligible organization complies with applicable accreditation requirements.

#### **Accreditation Contract<sup>B</sup>**

The primary document that establishes the terms of the relationship between the organization and the accreditor.

#### **Accreditation Manual<sup>B</sup>**

An accreditor publication consisting of policies, procedures, and accreditation requirements relating to ambulatory care, behavioral health care, critical access hospital, home care, hospital, nursing care center, office-based surgery, and clinical laboratory and point-of-care testing. Organizations should use the manual that contains the set of accreditation requirements that is most appropriate to the primary focus or mission of the organization.

#### **Accreditation Process<sup>B</sup>**

A continuous process whereby organizations are required to demonstrate to the accreditor that they are providing safe, high-quality care, as determined by compliance with accreditor's standards and performance measurement requirements (as applicable). Key components of this process are an on-site evaluation of the organization by an accreditor surveyor(s) and, where applicable, submission of performance measurement data to the accreditor.

#### **Asynchronous<sup>A</sup>**

An exchange of information regarding a patient that does not occur in real time, including the secure collection and transmission of a patient's medical information, clinical data, clinical images, laboratory results, or a self-reported medical history.

### B

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### C

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#### **Centers for Medicare & Medicaid Services (CMS)<sup>A</sup>**

A federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and Health Insurance Portability and Accountability Act (HIPAA) standards.

**Clinical Privileges<sup>B</sup>**

Authorization granted by the appropriate authority (e.g., the governing body) to a practitioner to provide specific care, treatment, or services in the organization within well-defined limits, based on the following factors: license, education, training, experience, competence, health status, and judgment.

**Continuity of Care<sup>A</sup>**

A practitioner utilizing telehealth must provide the patient a reasonable mechanism to contact the practitioner, or a covering practitioner, for follow-up care related to the patient's telehealth encounter. All telehealth interactions and transactions must comply with applicable state and federal privacy and security requirements.

**Contract<sup>B</sup>**

A formal agreement for care, treatment, or services with an organization, agency, or individual that specifies the services, personnel, products, or space provided by, to, or on behalf of the organization and specifies the consideration to be expended in exchange.

**Contracted Services<sup>B</sup>**

Services provided through a written agreement with another organization, agency, or person. The agreement specifies the services or personnel to be provided on behalf of the applicant organization and the fees to provide these services or personnel.

**Contractual Agreement<sup>B</sup>**

An agreement with any organization, group, agency, or individual for services or personnel to be provided by, to, or on behalf of the organization. Such agreements are defined in written form, such as in a contract, letter of agreement, or memorandum of understanding.

**Credentialing<sup>B</sup>**

The process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a healthcare organization.

**Credentials<sup>B</sup>**

Documented evidence of licensure, education, training, experience, or other qualifications.

**Credentials Verification Organization (CVO)<sup>B</sup>**

Any organization that provides information on an individual's professional credentials. An organization that bases a decision in part on information obtained from a CVO should have confidence in the completeness, accuracy, and timeliness of information. To achieve this level of confidence, the organization should evaluate the agency providing the information initially and then periodically as appropriate. The ten principles that guide such an evaluation include the following:

- 1) The agency makes known to the user the data and information it can provide.
- 2) The agency provides documentation to the user describing how its data collection, information development, and verification process(es) are performed.

- 3) The user is given sufficient, clear information on database functions, including any limitations of information available from the agency (e.g., practitioners not included in the database), the time frame for agency responses to requests for information, and a summary overview of quality control processes related to data integrity, security, transmission accuracy, and technical specifications.
- 4) The user and agency agree on the format for transmitting credentials information about an individual from the CVO.
- 5) The user can easily discern what information transmitted by the CVO is from a primary source and what is not.
- 6) For information transmitted by the agency that can go out of date (e.g., licensure, board certification), the CVO provides the date the information was last updated from the primary source.
- 7) The CVO certifies that the information transmitted to the user accurately represents the information obtained by it.
- 8) The user can discern whether the information transmitted by the CVO from a primary source is all the primary source information in the CVO's possession pertinent to a given item or, if not, where additional information can be obtained.
- 9) The user can engage the CVO's quality control processes when necessary to resolve concerns about transmission errors, inconsistencies, or other data issues that may be identified from time to time.
- 10) The user has a formal arrangement with the CVO for communicating changes in credentialing information.

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## D

### **Distant Site<sup>A</sup>**

Site at which the practitioner or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>). Other common names for this term include hub site, specialty site, provider/practitioner site and referral site. The site may also be referred to as the consulting site.

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## E

### **e-Prescribing<sup>A</sup>**

The electronic generation, transmission, and filling of a medical prescription, as opposed to traditional paper and faxed prescriptions. E-prescribing allows for qualified healthcare personnel to transmit a new prescription or renewal authorization to a community or mail-order pharmacy.

### **Element of Performance (EP)<sup>B</sup>**

Specific action(s), process(es), or structure(s) that must be implemented to achieve the goal of a standard. The scoring of EP compliance determines an organization's overall compliance with a standard.

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**F****Focused Professional Practice Evaluation<sup>B</sup>**

The time-limited evaluation of practitioner competence in performing a specific privilege. This process is implemented for all initially requested privileges and whenever a question arises regarding a practitioner's ability to provide safe, high-quality patient care.

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**G****Governance<sup>B</sup>**

The individual(s), group, or agency that has ultimate authority and responsibility for establishing policy; maintaining quality of care, treatment, or services; and providing for organization management and planning. Governance may be a separate entity, or it may fall within the medical advisory or executive committee. Other names for this group include the board, board of trustees, board of governors, board of commissioners, and partnership.

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**H****Hub Site<sup>A</sup>**

Location from which specialty or consultative services originate.

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**I****Informed Consent<sup>B</sup>**

Agreement or permission accompanied by full notice about the care, treatment, or service that is the subject of the consent. A patient must be apprised of the nature, risks, and alternatives of a medical procedure or treatment before the physician or other healthcare professional begins any such course. After receiving this information, the patient then either consents to or refuses such a procedure or treatment.

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**J**

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**K**

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**L****Licensed Independent Practitioner<sup>B</sup>**

An individual permitted by law and by the organization to provide care, treatment, and services without direction or supervision. A licensed independent practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges. When standards reference the term licensed independent practitioner, this language is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified healthcare personnel (e.g., physician assistants and advanced practice registered nurses) to the extent authorized by state law or a state's regulatory mechanism or federal guidelines and organizational policy.

## **Licensure<sup>A</sup>**

A legal right that is granted by a government agency in compliance with a statute governing an occupation (e.g., medicine, nursing, psychiatry, or clinical social work) or the operation of an activity in a healthcare occupancy (e.g., skilled nursing facility, residential treatment center, hospital).

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## **M**

### **Medical Staff<sup>B</sup>**

The group of all licensed independent practitioners and other practitioners privileged through the organized medical staff process that is subject to the medical staff bylaws. This group may include others, such as retired practitioners who no longer practice in the organization but who wish to continue their membership in the group, courtesy staff, scientific staff, and so forth.

### **Medical Staff Bylaws<sup>B</sup>**

A document or group of documents adopted by the voting members of the organized medical staff and approved by the governing body that defines the rights, responsibilities, and accountabilities of the medical staff and various officers, persons, and groups within the structure of the organized medical staff; the self-governance functions of the organized medical staff; and the working relationship with and accountability to the governing body of the organized medical staff.

### **Medical Staff Executive Committee<sup>B</sup>**

A group of individuals, the majority of whom are licensed practitioner members of the medical staff practicing in the organization, that is selected and/or elected and removed according to the process contained in the medical staff bylaws. This group is responsible for making specific recommendations directly to the organization's governing body for approval, as well as receiving and acting on reports and recommendations from medical staff committees, clinical departments, or services, and assigned activity groups. The medical staff executive committee also acts on the behalf of the medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff. The medical staff, as a whole, may serve as the executive committee.

### **Medical Staff - Organized<sup>B</sup>**

A self-governing entity accountable to the governing body that operates under a set of bylaws, rules and regulations, and policies developed and adopted by the voting members of the organized medical staff and approved by the governing body. The organized medical staff is comprised of doctors of medicine and osteopathy and, in accordance with the medical staff bylaws, may include other practitioners.

### **Medical Staff - Voting Members of the Organized<sup>B</sup>**

Those practitioners within the organized medical staff who have the right to vote on adopting and amending medical staff bylaws, rules and regulations, and policies.

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## N

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## O

### **Ongoing Professional Practice Evaluation<sup>B</sup>**

A document summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise, or revoke existing privilege(s) prior to or at the end of the two-year license and privilege renewal cycle.

### **Originating Site<sup>A</sup>**

Location of the patient at the time the service being furnished via a telecommunications system occurs. A telepresenter may be needed to facilitate the delivery of this service (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>). Other common names for this term include spoke site, patient site, remote site, and rural site.

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## P

### **Practitioner<sup>B</sup>**

Any individual who is licensed and qualified to practice a healthcare profession (e.g., physician, nurse, social worker, clinical psychologist, psychiatrist, respiratory therapist) and is engaged in the provision of care, treatment, or services.

### **Primary Source Verification<sup>B</sup>**

Verification of an individual practitioner's reported qualifications by the original source or an approved agent of that source. Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, secure electronic verification from the original qualification source, or reports from Credentials Verification Organizations (CVO) that meet accreditor requirements.

### **Privileging<sup>B</sup>**

The process whereby the specific scope and content of patient care services, clinical privileges, are authorized for a healthcare practitioner by a healthcare organization based on evaluation of the individual's credentials and performance.

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## Q

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## R

### **Remote Patient Monitoring<sup>A</sup>**

The remote monitoring of a patient's vital signs, biometric data, or other objective or subjective data by a device which transmits such data electronically to a healthcare practitioner.

## S

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### **Sentinel Event<sup>B</sup>**

A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel events are a subcategory of adverse events.

### **Spoke Site<sup>A</sup>**

Remote site where the patient is presented during telemedicine encounter or where the professional requesting consultation with a specialist is located.

### **Standard of Care<sup>A</sup>**

A practitioner utilizing telehealth shall be held to the same standards of professional practice as a practitioner practicing the same profession in an in-person setting, and nothing in this section is intended to create any new or different standards of care. However, it needs to be acknowledged that standards of care do vary based on site of care, time of day/night, location of the patient, and data available to the provider. It should be the responsibility of the provider to escalate to a higher level of care (or otherwise initiate appropriate recommendations) when medically indicated or necessary for patient safety.

### **Store and Forward (S&F)<sup>A</sup>**

Asynchronous transmission in a secure manner of clinical data from one site to another.

### **Suspension - Automatic<sup>B</sup>**

Suspensions that are automatically enacted whenever the defined indication occurs, and do not require discussion or investigation. Examples are loss of licensure or exceeding the allowed medical record delinquency rate. Privileges are automatically suspended until the license is renewed, or the records are completed, or the delinquency rate falls to an acceptable level.

### **Suspension - Summary<sup>B</sup>**

While enacted automatically whenever the defined indication occurs, summary suspensions also require a subsequent evaluation or investigation of the reason the indication occurred and a decision as to whether the suspension should be continued and for what length of time. Examples are the occurrence of a sentinel event that might be related to the licensed independent practitioner's performance, or a significant complaint against the licensed independent practitioner, such as misconduct or assault. The summary suspension is enacted while the incident is under investigation.

### **Synchronous<sup>A</sup>**

Interactive exchange of information regarding a patient occurring in real time.



## T

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### **Teleconferencing<sup>A</sup>**

Interactive electronic communication between multiple users at two or more sites that facilitates voice, video, and/or data transmission systems: audio, graphics, computer and video systems.

### **Teleconsultation<sup>A</sup>**

Consultation between a provider and specialist at distance using either store and forward telemedicine or real time videoconferencing.

### **Telehealth Evaluation<sup>A</sup>**

Prior to diagnosing, providing treatment or making recommendations, including issuing a prescription, the practitioner must obtain an applicable history and physical evaluation of the patient adequate to establish diagnosis and identify underlying conditions and/or contraindications to any treatment or prescription recommended/provided. The history and clinical evaluation may be conducted via synchronous or asynchronous telehealth communication, provided the relevant standard of care is met.

### **Telehealth and Telemedicine<sup>A</sup>**

A mode of delivering healthcare services through the use of telecommunications technologies, including but not limited to asynchronous and synchronous technology, and remote patient monitoring technology, by a healthcare practitioner to a patient or a practitioner at a different physical location than the healthcare practitioner. Synchronous and asynchronous communication, videoconferencing, virtual clinician-patient encounters, transmission of still images, e-health including patient portals, remote monitoring of patient conditions, e-consultations, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth.

### **Telemetry<sup>A</sup>**

Remote acquisition, recording and transmission of patient data via a telecommunications system to a healthcare provider for analysis and decision making.

### **Telemonitoring<sup>A</sup>**

The process of using audio, video, and other telecommunications, and electronic information processing technologies to monitor the health status of a patient from a distance.

### **Telepresence<sup>A</sup>**

- a) The use of a set of technologies that allows individuals to feel as if they were present, to give the appearance of being present, or to have an effect at a place other than their true location. Telepresence generally means the use of audio/video.
- b) The method of using robotic and other instruments that permit a clinician to perform a procedure at a remote location by manipulating devices and receiving feedback or sensory information that contributes to a sense of being present at the remote site and allows a satisfactory degree of technical achievement.

**U** \_\_\_\_\_

**V** \_\_\_\_\_

**Virtual Visits<sup>A</sup>**

Live, synchronous, interactive encounters between a patient and a healthcare provider via video, telephone, or live chat.

**W** \_\_\_\_\_

**X** \_\_\_\_\_

**Y** \_\_\_\_\_

**Z** \_\_\_\_\_

**SOURCES**

- A) American Telemedicine Association, Telehealth – Defining 21st Century Care, 2020, [americantelemed.org/resource/why-telemedicine/](http://americantelemed.org/resource/why-telemedicine/)
- B) The Joint Commission, [www.jointcommission.org](http://www.jointcommission.org)
- C) CMS, Glossary, [cms.gov/apps/glossary/](https://www.cms.gov/apps/glossary/)

## EXHIBITS AND RESOURCES

### FEDERAL REGULATIONS AND GUIDELINES ON CREDENTIALING BY PROXY

- 42 C.F.R. § 482.12(a)
- 42 C.F.R. § 482.22(a)
- 42 C.F.R. § 485.616(c)
- 42 C.F.R. § 485.635
- Medicare State Operations Manual, App. A and W, CMS Pub. 100-07 (containing survey standards regarding credentialing by proxy)
- CMS Survey & Certification Letter No. 11-32-Hospital/CAH (July 15, 2011)
- 76 FR 25550 (May 5, 2011) (final rule on credentialing by proxy)
- 76 FR 29479 (May 26, 2010) (proposed rule on credentialing by proxy)

### HOSPITAL ACCREDITATION BODY STANDARDS AND GUIDELINES ON CREDENTIALING BY PROXY

- Joint Commission Proposed Revisions
- ACHC Standards
- DNV-GL Standards

### STATE REGULATIONS ON CREDENTIALING BY PROXY

#### Alabama

<http://www.alabamaadministrativecode.state.al.us/docs/hlth/420-5-7.pdf>  
Title 420 (Alabama State Board of Health), Section 5-7 (Hospitals)

#### Alaska

<https://www.akleg.gov/basis/aac.asp#2.05>  
Title 7 (Health and Social Services), Chapter 12 (Facilities and Local Units), Article 3 (General Acute Care, Rural Primary Care, Long-term Acute Care, and Critical Access Hospitals), and Article 12 (General Provisions)

#### Arizona

[http://apps.azsos.gov/public\\_services/Title\\_09/9-10.pdf](http://apps.azsos.gov/public_services/Title_09/9-10.pdf)  
Title 9 (Health Services), Chapter 10 (Department of Health Services – Health Care Institutions: Licensing), Article 2 (Hospitals)

#### Arkansas

<https://www.healthy.arkansas.gov/>

**California**

[https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=IAF61F2B05B6111EC9451000D3A7C4BC3&originationContext=documenttoc&transitionType=Default&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=IAF61F2B05B6111EC9451000D3A7C4BC3&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default))

Title 22 (Social Security), Division 5 (Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies), Chapter 1 (General Acute Care Hospitals)

**Colorado**

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Title 6, Division 1000 (Department of Public Health and Environment), Section 11 (Health Facilities and Emergency Medical Services Division), Chapter 4 (General Hospitals)

**Connecticut**

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Title 19-13 (Public Health Code), Chapter 4 (Hospitals, Child Day Care Centers and Other Institutions and Children's General Hospitals), Sections 3-4b (Short-term Hospitals, General and Special)

**Delaware**

<https://regulations.delaware.gov/register/july2021/emergency/25%20DE%20Reg%2029%2007-01-21.pdf>

Title 16 (Health and Safety), Division of Public Health, Health Systems Protection, Section 4407 (Hospital Standards)

District of Columbia <https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=22-B20&ChapterId=571>

Title 22 (Health), Subtitle 22-B (Public Health and Medicine), Chapter 20 (Hospitals)

**Florida**

<https://www.flrules.org/gateway/ChapterHome.asp?Chapter=59A-3>

Title 59 (Agency for Health Care Administration), Subtitle A (Health Facility and Agency Licensing), Chapter 3 (Hospital Licensure)

**Georgia**

<http://rules.sos.state.ga.us/gac/111-8-40>

Title 111 (Rules of Department of Community Health), Chapter 8 (Healthcare Facility Regulation), Section 40 (Rules and Regulations for Hospitals)

**Hawaii**

<http://health.hawaii.gov/opppd/files/2015/06/11-93.pdf>

Title 11 (Department of Health), Chapter 93 (Office of Health Care Assurance), Subchapter 1 (Broad Service Hospitals)

**Idaho**

<https://adminrules.idaho.gov/rules/current/16/160314.pdf>

Title 16 (Department of Health and Welfare), Chapter 3, Section 14 (Rules and Minimum Standards for Hospitals in Idaho)

**Illinois**

<http://www.ilga.gov/commission/jcar/admincode/077/07700250sections.html>

Title 77 (Public Health), Chapter 1 (Department of Public Health), Subchapter B (Hospitals and Ambulatory Care Facilities), Part 250 (Hospital Licensing Requirements)

**Indiana**

[https://www.in.gov/health/files/410\\_IAC\\_15-1.pdf](https://www.in.gov/health/files/410_IAC_15-1.pdf)

Title 410 (Indiana State Department of Health), Article 15 (Hospital Licensure Rules)

**Iowa**

<https://www.legis.iowa.gov/law/administrativeRules/rules?agency=481&chapter=51&pubDate=08-24-2022>

Title 481 (Inspections and Appeals Department), Chapter 51 (Hospitals)

**Kansas**

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Title 28 (Department of Health and Environment), Article 34 (Hospitals)

**Kentucky**

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Title 902 (Cabinet for Health and Family Services – Department for Public Health), Chapter 20 (Health Services and Facilities), Section 16 (Hospitals, Operations and Services)

**Louisiana**

[https://ldh.la.gov/assets/medicaid/hss/docs/HSS\\_Hospital/Regulations/Chapter\\_93\\_Hospitals.pdf](https://ldh.la.gov/assets/medicaid/hss/docs/HSS_Hospital/Regulations/Chapter_93_Hospitals.pdf)

Title 48 (Public Health – General), Part 1 (General Administration), Subpart 3 (Licensing and Certification), Chapter 93 (Hospitals)

**Maine**

<http://www.maine.gov/sos/cec/rules/10/chaps10.htm#144>

Title 10 (Department of Health and Human Services), Subtitle 144 (General), Chapter 112 (Regulations for the Licensing of Hospitals)

**Maryland**

[http://www.dsd.state.md.us/comar/subtitle\\_chapters/10\\_Chapters.aspx#Subtitle07](http://www.dsd.state.md.us/comar/subtitle_chapters/10_Chapters.aspx#Subtitle07)

Title 10 (Maryland Department of Health), Subtitle 7 (Hospitals), Chapter 1 (Acute General Hospitals and Special Hospitals)

**Massachusetts**

<https://www.mass.gov/doc/105-cmr-130-hospital-licensure/download> (Department of Public Health), Chapter 130 (Hospital Licensure)

**Michigan**

[http://dmbinternet.state.mi.us/DMB/ORRDocs/AdminCode/1775\\_2017-098LR\\_AdminCode.pdf](http://dmbinternet.state.mi.us/DMB/ORRDocs/AdminCode/1775_2017-098LR_AdminCode.pdf) Title 325 (Health and Human Services), Chapter 1001 (Minimum Standards for Hospitals)

**Minnesota**

<https://www.revisor.mn.gov/rules/4640/> Chapter 4640 (Hospital Licensing and Operation)

**Mississippi**

[http://www.msdh.state.ms.us/msdhsite/\\_static/resources/7419.pdf](http://www.msdh.state.ms.us/msdhsite/_static/resources/7419.pdf)

Title 15 (Mississippi State Department of Health), Part 16 (Health Facilities), Subpart 1 (Health Facilities Licensure and Certification)

**Missouri**

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Title 19 (Department of Health and Senior Services), Division 30 (Regulation and Licensure), Chapter 20 (Hospitals)

**Montana**

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Title 37 (Public Health and Human Services), Chapter 106 (Health Care Facilities), Subchapter 4 (Minimum Standards for a Hospital)

**Nebraska**

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Title 175 (Health Care Facilities and Services Licensure), Chapter 9 (Hospitals)

**Nevada**

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Chapter 449 (Medical Facilities and Other Related Entities), Hospitals 449.279

**New Hampshire**

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Title He-P 800 Residential Care and Health Facility Rules

**New Jersey**

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Title 8 (Health), Chapter 43G (Hospital Licensing Standards)

**New Mexico**

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Title 7 (Health), Chapter 7 (Hospitals), Part 2 (Requirements for Acute Care, Limited Services and Special Hospitals)

**New York**

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Title 10 (Health), Volume C, Article 2 (Hospitals), Part 405 (Hospitals – Minimum Standards)

**North Carolina**

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### **North Dakota**

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### **Ohio**

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Title 37 (Health – Safety – Morals), Chapter 3727 (Hospitals)

### **Oklahoma**

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### **Oregon**

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### **Pennsylvania**

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Title 28 (Health and Safety), Part 4 (Health Facilities), Subpart B (General and Special Hospitals)

### **Rhode Island**

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Title 23 (Health and Safety), Chapter 17 (Licensing of Health-Care Facilities)

### **South Carolina**

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Chapter 61 (Department of Health and Environmental Control), Section 16 (Minimum Standards for Licensing Hospitals and Institutional General Infirmaries)

### **South Dakota**

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### **Tennessee**

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### **Texas**

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**Utah**

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**Vermont**

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**Virginia**

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**Washington**

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**West Virginia**

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**Wisconsin**

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**Wyoming**

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### AMERICAN TELEMEDICINE ASSOCIATION

901 N GLEBE ROAD  
STE 850 ARLINGTON, VA 22203  
703-373-9600  
[INFO@AMERICANTELEMED.ORG](mailto:INFO@AMERICANTELEMED.ORG)



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202-367-1196  
[INFO@NAMSS.ORG](mailto:INFO@NAMSS.ORG)

**YOUR FACILITY**

# DISTANT-SITE STATEMENT OF INITIAL PRIMARY SOURCE CREDENTIALING ACTIVITY

Provider: \_\_\_\_\_ Date: \_\_\_\_\_

*Distant Site* verifies primary source credentialing has been processed for the above-named provider in accordance with Joint Commission and CMS Standards. Primary source verifications include the list below. This will be considered credentialing documentation per the Credentialing by Proxy agreement.

- Originating site state board medical licensure
- Medical state board licensure(s) in other states
- NPDB
- Originating site BNDD (if applicable)
- DEA (if applicable)
- Malpractice/professional liability history
- Medical staff affiliations and work history
- Verification of education and training from medical school forward
- Criminal background check
- Office of the Inspector General (OIG) exclusion check and SAM
- ABMS or AOA verification of current board certification
- Verification of current competency based on patient volume as determined on the DOP
- Verification of current competence via reference checks by individuals personally acquainted with the applicant's professional and clinical performance in this or other hospitals. The references contain informed opinions on each applicant's scope and level of performance and applicant's actual clinical performance in general terms, the satisfactory discharge of his/her professional obligation as a medical staff member and his/her ethical performance. Appraisal also includes applicant's clinical judgment and technical skills as well as outcomes of medical management.
- An attestation that the applicant has no health problems that could affect their ability to perform the privileges requested.
- Other information included in the credentialing process includes: previously successful or currently pending challenges to any licensure or registration or the voluntary or involuntary relinquishment of such licensure or registration; voluntary or involuntary termination of medical staff membership including pending action or voluntary or involuntary limitation, reduction or loss of clinical privileges including pending action at another healthcare organization; final judgments or settlements involving the applicant.

It has also been concluded that this provider possesses the necessary skills and expertise to justify granting clinical privileges and has no quality-of-care concerns related to their privileges which have been granted at *Distant Site*.

\_\_\_\_\_  
Distant Site

# TELEMEDICINE CLINICAL PRIVILEGES - NEUROLOGY

## **APPLICANT**

Check off the “Requested” box for each privilege requested. Applicants have the burden of producing information deemed adequate by Your Facility for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

## **OTHER REQUIREMENTS**

Note that privileges granted may only be exercised at the site(s) and/or setting(s) that have sufficient space, equipment, and other resources required to support the privilege and have approved the applicant to exercise privileges at such site(s) and/or setting(s).

This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the applicant is obligated to meet at any site(s) and/or setting(s) at which the applicant is approved to exercise such privileges.

## **QUALIFICATIONS FOR ADULT NEUROLOGY**

### **Initial Applicants**

To be eligible to apply for privileges in Adult Neurology, the applicant must meet the following criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in Neurology, and
- Current certification or board eligibility with achievement of certification within five years leading to certification in neurology by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, and
- Current demonstrated competence, and
- Evidence of current physical and mental ability to perform privileges requested, and
- Provision of care for at least 50 Neurological patients, reflective of the scope of privileges requested, in the past 12 months or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

### **Renewal of Privileges**

To be eligible to renew privileges in Adult Neurology, the applicant must meet the following criteria:

- Current demonstrated competence and an adequate volume of experience with at least 100 patients with acceptable results reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges, and
- Maintenance of Certification or evidence of comparable CME is required.

## ADULT NEUROLOGY CORE PRIVILEGES

### Requested:

Evaluate, diagnose, treat and provide consultation to patients 18 years of age and older with diseases, disorders or impaired function of the brain, spinal cord, peripheral nerves, muscles, autonomic nervous system, and the blood vessels that relate to these structures. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with Your Facility policies regarding emergency and consultative call services. The core privileges in this specialty include the procedures below and such other procedures that are extensions of the same techniques and skills.

- Conducting a thorough and timely neurological examination via two-way audio and two-way video conferencing technology
- Interpretation of electroencephalogram (EEG) if within scope of Professional Service Agreement
- Obtaining an orderly and detailed history from the patient, family and staff
- Performing preliminary interpretations of relevant brain imaging studies
- Reviewing and correlating the results of other relevant diagnostic tests with the patient's clinical history and examination to formulate diagnosis and to recommend an evaluation and management plan.
- Other: \_\_\_\_\_

## QUALIFICATIONS FOR ACUTE STROKE NEUROLOGY

### Initial Applicants

To be eligible to apply for privileges in Acute Stroke Neurology, the applicant must meet the following criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in Neurology or Child Neurology, and
- Current certification or board eligible with achievement of certification within five years leading to certification in Neurology by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, and
- Current NIHSS certification, and
- Current demonstrated competence, and
- Evidence of current physical and mental ability to perform privileges requested, and
- Current certification or board eligible with achievement of certification within five years leading to subspecialty certification in Vascular Neurology by the American Board of Psychiatry and Neurology.

### Or

- Provision of care for at least 25 Acute Stroke Neurological patients, reflective of the scope of privileges requested, in the past 12 months or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

## Renewal of Privileges

To be eligible to renew privileges in Acute Stroke Neurology, the applicant must meet the following criteria:

- Current demonstrated competence and an adequate volume of experience with at least 50 stroke patients (including evaluation and diagnoses) with acceptable results reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges, and
- Current NIHSS certification, and
- Maintenance of Certification or evidence of comparable CME is required.

## ACUTE STROKE NEUROLOGY CORE PRIVILEGES

### Requested:

Evaluate, diagnose, treat, and provide consultation to patients with vascular diseases of the nervous system, including vascular events of arterial or venous origin from many causes that affect the brain or spinal cord. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with Your Facility policies regarding emergency and consultative call services. The core privileges in this specialty include the privileges below and such other privileges that are extensions of the same skills.

- Conducting an appropriate and timely examination via two-way audio and two-way video conferencing technology
- Obtaining an orderly and detailed history from the patient, family, and staff
- Emergency treatment of acute stroke, including thrombolytic therapy
- Interpretation of cranial MRI and CT
- Use of medical therapies for stroke prevention
- Reviewing and correlating the results of other relevant diagnostic tests with the patient's clinical history and examination to formulate diagnosis and to recommend an evaluation and management plan
- Other: \_\_\_\_\_

## QUALIFICATIONS FOR CHILD NEUROLOGY

### Initial Applicants

To be eligible to apply for privileges in Child Neurology, the applicant must meet the following criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in Child/Adolescent Neurology, and
- Current certification in Child Neurology or board eligibility with achievement of certification within five years leading to certification in Child Neurology by the American Board of Psychiatry and Neurology or a possession of a certificate of special qualification from the American Osteopathic Board of Neurology and Psychiatry, and

- Current demonstrated competence, and
- Evidence of current physical and mental ability to perform privileges requested, and
- Provision of care for at least 50 Child Neurological patients, reflective of the scope of privileges requested, in the past 12 months or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

### **Renewal of Privileges**

To be eligible to renew privileges in Child Neurology, the applicant must meet the following criteria:

- Current demonstrated competence and an adequate volume of experience with at least 100 inpatients or outpatients with acceptable results reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges, and
- Maintenance of Certification or evidence of comparable CME is required.

## **CHILD NEUROLOGY CORE PRIVILEGES**

### **□ Requested:**

Evaluate, diagnose, treat and provide consultation to neonates, infants, children and adolescents with all types of disease or disorders or impaired function, both acquired and congenital, of the brain, spinal cord, peripheral nerves, muscles, autonomic nervous system, and the blood vessels that relate to these structures. May provide care to patients in the intensive care setting in conformance with Your Facility policies. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with Your Facility policies regarding emergency and consultative call services. The core privileges in this specialty include the privileges below and such other privileges that are extensions of the same skills.

- Conducting an appropriate and timely examination via two-way audio and two-way video conferencing technology
- Interpretation of electroencephalogram (EEG)
- Obtaining an orderly and detailed history from the patient, family, and staff
- Reviewing and personally interpreting relevant imaging studies
- Reviewing and correlating the results of other relevant diagnostic tests with the patient's clinical history and examination to formulate diagnosis and to recommend an evaluation and management plan

## **QUALIFICATIONS FOR EEG**

### **Initial Applicants**

To be eligible to apply for EEG privileges, the applicant must meet the following criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in Neurology, and

- Current certification or board eligibility with achievement of certification within five years leading to certification in neurology by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, and
- Current demonstrated competence, and
- Evidence of current physical and mental ability to perform privileges requested, and
- Provision of care for at least 25 Neurological patients, reflective of the scope of privileges requested, in the past 12 months or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

### **Renewal of Privileges**

To be eligible to renew EEG privileges, the applicant must meet the following criteria:

- Current demonstrated competence and an adequate volume of experience with at least 50 patients with acceptable results reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges, and
- Maintenance of Certification or evidence of comparable CME is required.

### **EEG CORE PRIVILEGES**

**Requested:**

Interpretation of electroencephalogram (EEG) to include routine studies, STAT studies, and continuous EEG studies if within the scope of Professional Service Agreement.

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Practitioner Signature

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Practitioner Printed Name

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Date

**YOUR FACILITY**

# DISTANT-SITE STATEMENT OF PRIMARY SOURCE CREDENTIALING ACTIVITY AT RENEWAL OF PRIVILEGES

Provider: \_\_\_\_\_ Date: \_\_\_\_\_

*Distant Site* verifies primary source credentialing has been processed for the above-named provider in accordance with Joint Commission and CMS Standards. Primary source verifications include the list below. This will be considered credentialing documentation per the Credentialing by Proxy agreement.

- Active originating site state board medical licensure
- Active state board medical licensure(s) in all states
- NPDB (National Practitioner Data Bank)
- Active originating site BNDD (if applicable)
- Active DEA (if applicable)
- Active professional liability coverage
- Active medical staff affiliations
- ABMS or AOA verification of current board certification (if applicable)
- Verification of current competence via focused professional practice evaluation (FPPE) and/or ongoing professional practice evaluation (OPPE).
- Verification of current competency based on patient volume as determined on the DOP. In the case of low/no volume, Your Name will adhere to policy.
- Verification of current competence via reference checks by an individual personally acquainted with the applicant's professional and clinical performance in this or other hospitals. The references contain informed opinions on each applicant's scope and level of performance and applicants' actual clinical performance in general terms, the satisfactory discharge of his/her professional obligation as a medical staff member and his/her ethical performance. Appraisal also includes applicant's clinical judgment and technical skills as well as outcomes of medical management.
- An attestation that the applicant has no health problems that could affect their ability to perform the privileges requested.
- Continuing medical education credits earned
- Other information included in the credentialing process includes: previously successful or currently pending challenges to any licensure or registration or the voluntary or involuntary relinquishment of such licensure or registration; voluntary or involuntary termination of medical staff membership including pending action or voluntary or involuntary limitation, reduction or loss of clinical privileges including pending action at another healthcare organization; final judgments or settlements involving the applicant.

It has been concluded that this provider possesses the necessary skills and expertise to justify granting clinical privileges and has no quality-of-care concerns related to their privileges which have been granted at *Distant Site*.

\_\_\_\_\_  
Distant Site



# TELEMEDICINE CLINICAL PRIVILEGES - CRITICAL CARE

## **APPLICANT**

Check off the “Requested” box for each privilege requested. Applicants have the burden of producing information deemed adequate by Your Facility for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

## **OTHER REQUIREMENTS**

Note that privileges granted may only be exercised at the site(s) and/or setting(s) that have sufficient space, equipment, and other resources required to support the privilege and have approved the applicant to exercise privileges at such site(s) and/or setting(s).

This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the applicant is obligated to meet at any site(s) and/or setting(s) at which the applicant is approved to exercise such privileges.

## **QUALIFICATION FOR CRITICAL CARE MEDICINE**

### **Initial Applicants**

To be eligible to apply for privileges in Critical Care Medicine, the applicant must meet the following criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in Anesthesiology, Emergency Medicine, Internal Medicine, Surgery, or OB/GYN and successful completion of an accredited fellowship in Critical Care, and
- Current subspecialty certification or board eligibility with achievement of certification within five years leading to subspecialty certification in critical care medicine by the American Board of Medical Specialties or the American Osteopathic Board, and
- Current ACLS Certification within 60 days of Board approval, and
- Current demonstrated competence, and
- Evidence of current physical and mental ability to perform privileges requested, and
- Provision of care for at least 50 patients, reflective of the scope of privileges requested, in the past 12 months or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

### **Renewal of Privileges**

To be eligible to renew privileges in Critical Care Medicine, the applicant must meet the following criteria:

- Current demonstrated competence and an adequate volume of experience with at least 100 patients with acceptable results, reflective of the scope of privileges requested, for the past 24 months, based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges. Maintenance of ACLS certification is required, and
- Maintenance of Certification or evidence of comparable CME is required.

## **CRITICAL CARE MEDICINE CORE PRIVILEGES**

### **□ Requested:**

Evaluate, diagnose, and provide treatment or consultative services for patients 18 years or older with life-threatening disorders, including but not limited to shock, sepsis, coma, heart failure, trauma, respiratory failure, drug overdoses, massive bleeding, diabetic acidosis, kidney failure and multiple organ dysfunction. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with Your Facility policies regarding emergency and consultative call services. The core privileges in this specialty include the following:

- Conducting an appropriate and timely examination via two-way audio and two-way video conferencing technology
- Obtaining an orderly and detailed history from the patient, family, and staff
- Preliminary Echocardiography and electrocardiography interpretation
- Management of anaphylaxis and acute allergic reactions
- Management of critical illness in pregnancy
- Management of massive transfusions
- Management of the immunosuppressed patient
- Management of post-operative complications
- Management of acute neurologic injury
- Management of mechanical ventilator support
- Management of central venous catheters, PA catheters, transvenous pacemakers
- Monitoring and assessment of metabolism and nutrition
- Preliminary interpretation of imaging studies

## **QUALIFICATIONS FOR CRITICAL CARE MEDICINE FELLOWS**

### **Initial Applicants**

To be eligible to apply for privileges in Critical Care Medicine Fellows, the applicant must meet the following criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in Anesthesiology, Emergency Medicine, Internal Medicine, Surgery, or OB/GYN, and
- Current Critical Care Medicine Fellow, and
- Current certification or active participation in the examination process with achievement of certification within five years leading to certification in Anesthesiology, Emergency Medicine, Internal Medicine, Surgery, or OB/GYN by ABMS or the AOA, and
- Current ACLS Certification within 60 days of Board approval, and
- Provision of care to at least 50 patients, reflective of the scope of privileges requested, in the past 12 months or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

## Renewal of Privileges

To be eligible to renew privileges in Critical Care Medicine Fellows, the applicant must meet the following criteria:

- Continued Critical Care Medicine Fellow currently in good standing. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges. Maintenance of ACLS certification is required, and
- Maintenance of Certification or evidence of comparable CME is required.

## CRITICAL CARE MEDICINE FELLOW TELEMEDICINE CORE PRIVILEGES

### Requested:

Evaluate, diagnose, and provide treatment or consultative services for patients 18 years or older with life-threatening disorders, including but not limited to shock, sepsis, coma, heart failure, trauma, respiratory failure, drug overdoses, massive bleeding, diabetic acidosis, kidney failure and multiple organ dysfunction. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with Hospital policies regarding emergency and consultative call services. The core privileges in this specialty include the following:

- Conducting an appropriate and timely examination via two-way audio and two-way video conferencing technology
- Obtaining an orderly and detailed history from the patient, family, and staff
- Management of anaphylaxis and acute allergic reactions
- Management of critical illness in pregnancy
- Management of massive transfusions
- Management of the immunosuppressed patient
- Management of post-operative complications
- Management of acute neurologic injury
- Management of mechanical ventilator support
- Monitoring and assessment of metabolism and nutrition
- Preliminary interpretation of imaging studies

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Practitioner Signature

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Practitioner Printed Name

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Date