



NAMSSTM
EDUCATION. ADVOCACY. PATIENT SAFETY.

NAMSS - ATA

CREDENTIALING BY PROXY

A GUIDEBOOK

EXECUTIVE SUMMARY

CREDENTIALING

National Association Medical Staff Services (NAMSS) NAMSS–American Telemedicine Association (ATA) Credentialing by Proxy (CBP) Guidebook provides an efficient and comprehensive pathway to credentialing 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 inquiries also increases as practitioners seek privileges at more hospitals.

BACKGROUND

Telemedicine encompasses a broad variety of technologies and tactics to deliver medical care, health, and education services. Four distinct telemedicine categories currently exist: live video (synchronous communication), store-and-forward (asynchronous communication), mobile health, and remote-patient monitoring (RPM).

The federal government and hospital accrediting bodies recognized this problem and established Credentialing by Proxy (CBP) as a pathway for streamlined credentialing for telemedicine practitioners. 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.

CREDENTIALING BY PROXY CRITERIA

An originating site can use CBP when the telemedicine practitioner is located at: 1) a Medicare-participating distant-site hospital; or 2) another entity providing telemedicine services (a Distant Site Telemedicine Entity or DSTE). To use CBP, the originating site must enter into a written agreement with the distant site hospital or telemedicine entity, reflecting and confirming the following requirements:

- 1) The distant site hospital or telemedicine entity 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 distant site hospital or telemedicine entity.
- 3) The distant site hospital or telemedicine entity 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 reports this information to the distant site hospital or telemedicine entity 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 distant site telemedicine entities only, the agreement must also state that the DSTE is a contractor of services to the originating site, which furnishes contracted telemedicine services in a manner that permits the originating site to comply with all applicable Conditions of Participation.

The NAMSS-ATA Credentialing By Proxy Guidebook includes information on state, hospital accrediting body, and the National Practitioner Data Bank regulations pertaining to CBP, as well specific CBP responsibilities for the originating and distant sites.

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

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

In December 2017, 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 further into the healthcare industry, it is important that medical staff and other healthcare professionals be familiar with the processes of telemedicine credentialing and the opportunities to streamline the credentialing system and increase access to care.

The Joint Task Force members included the following representatives from both organizations: Alan Einhorn, Alexis Frehse, Becky Findley, Beth Erwin, Christy Denton, Diane Meldi, Geneva Harris, Joe Nahra, Judy Lentz, Kathy Risch, Kathy Schwarting, Linda Waldorf, Lisa Jones, LouAnn Brindle, Nathaniel Lacktman, Susan Diaz, Susan DuBois, and Taylan Bozkurt.

It is important that medical staff and other healthcare professionals be familiar with the processes of telemedicine credentialing and the opportunities to streamline the credentialing system and 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 40 years to where we are today – a true profession that spans a wide range of employment settings and requires a specific knowledge base and professional competencies. The NAMSS membership includes more than 6,000 medical staff and credentialing services professionals from hospitals, medical group practices, managed care organizations, and Credentials Verification Organizations (CVO). Through our education, advocacy, and commitment to patient safety, NAMSS continues to support medical staff professionals (MSPs), our members, and the healthcare industry. Learn more at namss.org.

ATA is a nonprofit association based in Washington, DC with a membership network of more than 10,000 industry leaders and healthcare professionals. As the only organization completely focused on telehealth, the ATA is working to change the way the world thinks about telemedicine and virtual care. We are committed to ensuring that everyone has access to safe, affordable, and effective care when and where they need it, and that providers are able to do more good for more people. We represent a broad and inclusive member network of technology solution providers, healthcare delivery systems, and payers, as well as partner organizations and alliances. Together, we are working to enhance the visibility of telehealth, promote responsible policy, and provide education and resources to help integrate virtual care into emerging value-based delivery models. Learn more at americantelemed.org.

TABLE OF CONTENTS

6	INTRODUCTION
8	C.1 THE TRADITIONAL CREDENTIALING PROCESS
10	C.2 CREDENTIALING BY PROXY
19	C.3 SETTING UP A CREDENTIALING BY PROXY PROGRAM
27	C.4 OVERCOMING HURDLES
29	CONCLUSION
30	ACRONYMS
31	COMMON TERMS AND DEFINITIONS
51	EXHIBITS AND RESOURCES

INTRODUCTION

CREDENTIALING

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

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 tactics to deliver medical care, health, and education services. Currently, there are four distinct categories of telemedicine applications: live video (also referred to as synchronous communication), which involves real-time interaction between patients and practitioners using audiovisual telecommunications technology; store-and-forward (also known as asynchronous communication), in which health history is transmitted through a secure electronic communications system to a practitioner; mobile health, which involves healthcare and public health education supported by mobile communication devices (e.g., targeted text messages that promote healthy behavior, or wide-scale alerts about disease outbreaks); and remote patient monitoring (RPM), in which personal healthcare and medical data is collected 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.

¹ The term “telemedicine” is used when referring to traditional clinical diagnoses and monitoring that are delivered by technology. The term “telehealth” is now more commonly used, as it 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

As many will be aware, there are multiple benefits to telemedicine, including increased patient access; enhanced reach of healthcare services; improved continuity of care and case management; higher patient satisfaction; and reduction of risk. 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 once released to their home or 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), shared health professional staffing, reduced travel times, and fewer or 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) physician and a remote physician who is supported by tele-ICU software. The result is an enhanced level of care, wherein local physicians backed by targeted specialists can immediately recognize and respond to problems as they arise.

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.

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)

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, verification, and review of key information on 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 practitioners are seeking privileges) and the distant sites (where the telemedicine practitioners are actually located) are often held to the same 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.

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

In addition, many of the hospitals that can most benefit from telemedicine services are smaller facilities, with a limited number of MSPs who have competing priorities, creating another barrier to the expansion of telemedicine services and their efficient implementation—and also creating frustration for telemedicine applicants and their organizations. The verification process for a standard physician privilege request can take about fifteen to thirty days in a traditional credentialing context, depending on the time it takes for affiliations and references to return their verifications. Verification is a detailed, comprehensive process that delves into all aspects of a practitioner's professional life. For a hospital seeking to verify the credentials of unknown, remotely located telemedicine applicants, there is added pressure to take the time needed to be thorough and complete for the 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.

Once all initial verifications are received by the MSP, 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 here will lengthen the review process—and such delays are not uncommon, due in some cases to the failure of applicants, or their references, or others to respond timely, or to respond at all. When all required information has been received, the application is ready to proceed for Medical Staff review. As outlined in the current Joint Commission (TJC) standard MS.06.01.7, 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 the requested privilege.

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

This review process can take an additional thirty to sixty 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 in order to address concerns or clear up apparent inconsistencies). The ultimate credentialing decision is then made by the governing body.

This process, while important for evaluating practitioners to protect patient safety, can quickly become unmanageable at a facility using telemedicine practitioners. There is now a streamlined process available which can accelerate credentialing of telemedicine practitioners and provide efficiencies to the MSA, freeing up much-needed staff time for other matters. This process is called credentialing by proxy, and 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 those practitioners who provided services solely via telemedicine. Consequently, hospitals were required to utilize traditional credentialing and privileging processes for all practitioners, whether onsite or telemedicine-based. This meant the governing body of the hospital was required to make all privileging decisions based upon the recommendations of its medical staff, after the medical staff had thoroughly and separately verified and examined the credentials of each practitioner applying for privileges, and after the medical staff had applied its specific criteria to determine whether or not the individual practitioner applicant 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), which often lack the resources to fully carry out the traditional credentialing process for every telemedicine practitioner who would like to provide telemedicine services to their patients.

Responding to industry needs, the Center 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.

Responding to industry needs, the Center 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. These new regulations, which authorized the process of CBP, were intended to encourage innovative approaches to patient-service delivery and provide greater flexibility in hospital telemedicine arrangements (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 requires careful attention to the legal and regulatory considerations. To operate a successful CBP program, hospitals will have to abide by the CBP requirements in the CoPs, state regulations where the originating site is located, the standards required by their hospital accreditation program, and their own Medical Staff bylaws (see C.3). CBP is both permitted and feasible, but it is essential that hospitals understand and follow these requirements as they establish or modify their existing credentialing programs.

STREAMLINED CREDENTIALING FOR TELEMEDICINE PRACTITIONERS

The updated CMS regulations allow an originating site to use CBP when the telemedicine services are provided by a practitioner located at: 1) a Medicare-participating distant site hospital; or 2) another entity providing telemedicine services (a Distant Site Telemedicine Entity or DSTE).

A distant site telemedicine entity is an entity that: 1) provides telemedicine services; 2) is not a Medicare-participating distant site hospital and 3) provides contracted services in a manner that enables the originating site to meet all applicable CoPs, particularly those requirements related to the credentialing and privileging of telemedicine practitioners. A DSTE may be a physician group, a non-Medicare-participating hospital, or other non-hospital telemedicine practitioner. The DSTE rules are used when the practitioner of telemedicine services is not a hospital.

I. CREDENTIALING BY PROXY WRITTEN AGREEMENT

To utilize CBP, the originating site must enter into a written agreement with the distant site hospital or telemedicine entity, reflecting and confirming certain requirements. They are as follows:

- 1) The distant site hospital or telemedicine entity 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 distant site hospital or telemedicine entity
- 3) The distant site hospital or telemedicine entity 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 reports this information to the distant site hospital or telemedicine entity 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 distant site telemedicine entities only, the agreement must also state that the DSTE is a contractor of services to the originating site which 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 rooted in federal regulations, but hospitals should be cognizant of

state laws regarding peer review decisions, confidentiality, and practitioner disciplinary actions, and regarding professional review actions under the federal Health Care Quality Improvement Act. 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 distant site hospital or telemedicine entity 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. The originating site's medical staff bylaws should include provisions for CBP, and hospitals can consider using the opportunity to create a separate telemedicine medical staff category if desired (with accompanying limits on telemedicine staff responsibilities and rights).

As described below, CBP standards used by many of the major accreditation organizations closely mirror the Medicare CoPs (with the exception of TJC). Hospitals must also work within the requirements of state laws (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 improvements to your credentialing process as it relates to 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 will be able to offer telemedicine services sooner. CBP can cut down on long waiting periods for access to telemedicine practitioners offering specialty and/or augmented services, especially in medically underserved areas.
- 2) **Expanded Access to Practitioners:** Many small or rural facilities face issues with their roster of practitioners. Certain types of physicians or practitioners may be in limited supply, or the local population may not be large enough to support a specific clinical specialty. Using CBP can help hospitals promptly and efficiently secure needed medical expertise using telemedicine services when a practitioner cannot be physically present.
- 3) **Decreasing Costs:** In many cases, especially for small or rural hospitals or within facilities that are only able to offer limited specialty services due to staffing, facility or cost limitations, adding specialty expertise or back-up by traditional means may be 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 care delivery methods at these facilities.

- 4) **Improved Patient Experience:** Telemedicine services have been largely heralded as an avenue to improve patient care and patient satisfaction, enabling patients to access care in their home communities. Allowing expanded access to telemedicine may improve outcomes and the patient experience by allowing facilities to draw on expertise and clinical knowledge beyond their immediate area. CBP enables facilities to provide that access on a more expedited, efficient and cost-effective basis than does traditional credentialing.

Overall, CBP, if adopted at your facility, has the potential to dramatically increase the speed and efficiency with which your MSA can facilitate the credentialing and privileging of remote practitioners, saving both time and money and providing timelier, expanded care and services to patients. While there may be a learning curve to adoption of CBP, this guide will act as a roadmap to implement these processes and give you the knowledge needed to launch a successful CBP program at your facility.

Overall, CBP, if adopted at your facility, has the potential to dramatically increase the speed and efficiency with which your MSA can facilitate the credentialing and privileging of remote practitioners, saving both time and money and providing timelier, expanded care and services to patients.

HOSPITAL ACCREDITATION ORGANIZATIONS

Most hospital accreditation bodies have amended their standards to align with CMS's requirements, and we have outlined the standards of three of those accreditation organizations here.

HEALTHCARE FACILITIES ACCREDITATION PROGRAM (HFAP)

HFAP provides accreditation to hospitals, ambulatory care/surgical facilities, mental health facilities, rehabilitation facilities, clinical laboratories, CAHs, and primary stroke centers. HFAP covers telemedicine credentialing in its Governing Body and Medical Staff standards. The relevant standards can be found in the Exhibits and Resources (Hospital Accreditation Body Standards and Guidelines on Credentialing by Proxy).

HFAP 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, HFAP applies

Originating Site: Where the patient is receiving the services.

Distant Site: Where the practitioner is actually located.

standards 3.00.02 and 3.00.03, which cover distant site hospital and telemedicine entity agreements.

For distant site hospital agreements, HFAP allows the governing body of the hospital whose patients are receiving the telemedicine services to choose to have its medical staff rely on the credentialing and privileging decisions made by the distant site when making its recommendations for privileges at the hospital. They require: 1) the distant site to participate in Medicare; 2) the distant site to provide the originating site a list of all practitioners covered by the agreement and outline their privileges at the distant site; 3) the distant site to ensure that all covered practitioners hold a license in the state where the originating site is located; and 4) the originating site to periodically review the telemedicine services provided and share feedback for the distant site's use in its own appraisals of the practitioners (at a minimum including all information on adverse events and complaints relating to the telemedicine services). The same provisions are required to be met for distant site telemedicine entity agreements, with the additional requirement that the DSTE furnishes services that permit the 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 same requirements as HFAP.

For distant site hospital agreements, DNV-GL allows the governing body of the hospital whose patients are receiving the telemedicine services to choose to have its medical staff rely on the credentialing and privileging decisions made by the distant site when making its recommendations for privileges at the hospital. They require: 1) the distant site to participate in Medicare; 2) the distant site to provide the originating site a list of all practitioners covered by the agreement and outline their privileges at the distant site; 3) the distant site to ensure that all covered practitioners hold a license in the state where the originating site is located; and 4) the originating site to periodically review the telemedicine services provided and share feedback for the distant site's use in its own appraisals of the practitioners (at a minimum including all information on adverse events and complaints relating to the telemedicine services). As with HFAP, the same provisions are required to be met for distant site telemedicine entity agreements, with 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 requirements of the CoPs.

THE JOINT COMMISSION

TJC has recently proposed revisions to its hospital accreditation standards regarding credentialing for telemedicine services. The original telemedicine standards, which became effective in 2011, required both the originating site and distant site to be accredited with TJC in order for CBP to be allowed. This requirement is not contained in the CMS regulations, and was a limiting factor in the ability of TJC-accredited hospitals to utilize CBP.

TJC's proposed revisions, released in November 2017, would allow originating sites to use credentialing and privileging information provided by a distant site to grant their own hospital-specific privileges. In using this CBP information, the revised standards would require: 1) the originating site to obtain a current list of the licensed independent practitioner's privileges from the distant site; 2) the contract to document the method for credentialing and/or privileging at the distant site and that the process meets the general TJC requirements; 3) the contracted practitioner to have a license issued or recognized in the state where the patient receives the services; and 4) the originating site to send information to the distant site relating to the practitioner's quality of care, treatment, and services, including all adverse outcomes and substantiated complaints. The revisions would remove the requirement that the distant site or DSTE itself be TJC-accredited, as long as it followed the above requirements when doing its own credentialing and privileging.

It is important to note that as of this publication, these proposed standards have not yet been adopted by the Joint Commission and are still within TJC's internal review process. NAMSS will be share any updates as soon as they are available.

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. If the originating site is granting privileges to a practitioner, no matter where the practitioner is physically located, the standard requirement to query the NPDB still stands. 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 hospitals' medical staff credentialing. It is essential that MSPs and their facilities are aware of any additional requirements or standards 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 the responsibilities of both parties. Suggestions for both:

Originating Site: Where the patient is receiving the services.

Distant Site: Where the practitioner is actually located.

DISTANT SITE RESPONSIBILITIES

COMPLIANCE WITH CONDITIONS OF PARTICIPATION

The originating site is a Medicare-participating hospital. The distant site should represent that its credentialing program has been reviewed and approved by its governing body and meets or exceeds all applicable CoPs related to credentialing and the telemedicine services, including but not limited to the requirements at 42 C.F.R. § 482.12(a)(1) through (a)(9) and 42 C.F.R. § 482.22(a)(1) through (a)(4). Specifically, the governing body of the distant site, through its Credentialing Program, shall:

- Determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff.
- Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.
- Assure 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 in the facility dependent solely upon certification, fellowship or membership in a specialty body or society.

If the distant site is a DSTE, the agreement should state that the DSTE is a contractor of services to the originating site which furnishes contracted telemedicine services in a manner that permits the originating site to comply with all applicable CoPs.

CREDENTIALING

The distant site shall evaluate and, if appropriate, approve applications for clinical privileges of practitioners at the distant site who seek to provide telemedicine services at the originating site.

- The distant site 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.
- Upon reasonable request and subject to State law limitations, the distant site shall 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).

CONTRACT RENEWAL - RECREDENTIALING

The distant site shall conduct recredentialing of the distant site telemedicine practitioners in accordance with its established policies and procedures, and as required for CBP by the CoPs and the originating site's accreditation body standards related to telemedicine credentialing, and will include in its re-credentialing process information provided to the distant site by the originating site.

CHANGES IN PRIVILEGES; DISCIPLINARY ACTION

The distant site shall notify 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 and shall notify the originating site if any action classified as disciplinary action has been taken against a distant site telemedicine practitioner or of any action taken by a state or federal authority which restricts or limits the practice or professional prerogatives of a distant site telemedicine practitioner.

RECOMMENDED AREAS OF SUPPORT TO THE ORIGINATING SITE

- Offer the originating site the opportunity to do a site visit at the distant site credentials office if the originating site is uncertain or needing clarification regarding distant site compliance with CMS- (or accreditation organization-) approved credentialing practices.
- Ensure that distant site is available to assist with responses to accreditor inquiries about the distant site's credentialing process and credentialing actions.
- Assist the originating site's MSA with bylaw revisions and acceptance of new privilege delineation concepts.
- Be accessible for regular communication with 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 have approved bylaws and/or policies that enable them to rely upon the distant site's telemedicine credentialing decisions when making their own credentialing and privileging decisions regarding distant site telemedicine practitioners. To that end, the originating site shall comply with applicable CoPs and accreditation requirements relating to the CBP process. The originating site shall ensure that each telemedicine practitioner who is granted privileges at the originating site holds a license issued or recognized by the state where the originating site is located. The originating site shall also ensure that the privileges it grants each telemedicine practitioner at the originating site do not exceed the privileges granted to that telemedicine practitioner by the distant site. The originating site should state that it is not required to use the CBP process to credential distant site telemedicine practitioners, and that it may conduct its own original-source credentialing for some or all of such practitioners.

In any event, the originating site agrees and acknowledges that it remains ultimately responsible for the credentialing and privileging decisions it makes regarding the telemedicine practitioners.

PERFORMANCE INFORMATION

The originating site shall maintain evidence of its internal reviews of each telemedicine practitioner's performance and quality at the originating site and shall provide such performance and quality information to the distant site for the distant site's periodic appraisals of the telemedicine practitioners, in accordance with 42 C.F.R. § 482.22(a)(3) (iv). At a minimum, this performance and quality information shall 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 (including but not limited to adverse outcomes related to sentinel events that are considered reviewable by CMS). The originating site shall notify the distant site as soon as reasonably practicable of any action taken against a telemedicine practitioner by the originating site which is classified as disciplinary under the originating site's credentialing policies.

STATE AND/OR FEDERAL DISCIPLINARY ACTION

The originating site shall notify the distant site as soon as reasonably practical of any action taken by a state or federal authority which 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 INTERNAL POLICIES)

- The Governing Body must approve and authorize use of telemedicine clinical services.
- The Medical Staff determines services appropriate for telemedicine.
- The Medical Staff Executive Committee and Governing Body periodically reaffirms services appropriate for telemedicine.
- Create one telemedicine credentials file with relevant (to the distant site) telemedicine practitioners per contract.
- Query National Practitioner Data Bank for all relevant practitioners prior to granting privileges.
- Take the agreement, list of practitioners (privilege delineation form), and National Practitioner Data Bank results to the Medical Staff Executive Committee and then to the Governing Body for approval.
- Review the agreement and practitioner files annually.

C.3 | SETTING UP A CREDENTIALING BY PROXY PROGRAM

The requirements and processes used to establish and implement a CBP program will differ across organizations. Contributing factors may include which clinical services will be incorporated into the scope of telemedicine services, state laws, and institutional bylaws, rules, and regulations. The terms of individual credentialing agreements between originating site's and distant site's will also differ depending on the parties involved. The following provides general guidance to assist in the development of your program.

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.

WHERE TELEMEDICINE MEETS CREDENTIALING

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. In order to care for patients at remote hospitals, however, telemedicine practitioners are obliged to obtain clinical privileges at those hospitals. In Sections C.1 and C.2, above, we have described some of the challenges associated with traditional credentialing processes when utilized to credential telemedicine applicants, and we have also discussed the benefits associated with CBP programs when credentialing such applicants. Below is further information comparing traditional credentialing and CBP, as well as practical information relating to the implementation and operation of CBP programs.

EFFICIENCIES	
TRADITIONAL CREDENTIALING	CREDENTIALING BY PROXY
2-Year 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	One List for All Contracted Practitioners
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	N/A
Dues/Fees	N/A
ED Call Coverage	N/A
Meeting Attendance - Annual	N/A
Meeting Attendance - Departmental	N/A
Parking	N/A
Vote MS Actions	N/A

*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 may not require telemedicine practitioners serve on medical staff committees, attend certain meetings (remotely), pay dues, etc. Each hospital can have its own process for appointing telemedicine practitioners, including creating a separate category of appointments with its own set of requirements.

FREQUENTLY ASKED QUESTIONS (FAQS)

CBP represents a change from the traditional process by which clinicians are privileged. Below are some FAQs for an originating site considering implementation of a CBP program:

- **How do we know the physician is competent and qualified?**

CBP allows the originating site medical staff to accept the privileging decision of the distant site when making its recommendations for privileging to the originating site’s governing body, without having to repeat credentialing efforts. If, for example, both the distant site and originating site are accredited by the Joint Commission, they are both held to the same rigorous standards for credentials verification and evaluation. Since 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 applies for distant site hospitals accredited by other accepted accreditation bodies.

Originating Site: Where the patient is receiving the services.

Distant Site: Where the practitioner is actually located.

- **What is the originating site responsible for tracking?**

The originating site should consider confirming that the physicians' medical licenses are up-to-date. The originating site should also complete its own NPDB queries, unless they make the distant site an authorized agent. All other credentials should be tracked and maintained by the distant site, although the originating site can choose to perform other tracking functions. Once the originating site approves privileges for telemedicine practitioners, it must periodically review the telemedicine services they provide and share feedback with the distant site (at a minimum including information on adverse events and complaints).

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

Each organization will likely be deemed responsible for negligence based on its own credentialing responsibilities.

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

No, but it is recommended to keep your distant sites informed about anticipated accreditation surveys so that they can assist with any questions. Per CMS regulations and accreditor standards, surveyors may ask to see the following:

- Telemedicine credentialing agreement
- Current physician rosters for all telemedicine services
- Credentialing body meeting minutes indicating approvals of current rosters
- Current medical licenses and distant site privilege lists for all telemedicine practitioners on the rosters
- Should additional documents be requested that require input or assistance from a distant site, the originating site should work with the applicable distant site.

- **How does an originating site track quality data or FPPE/OPPE on these practitioners?**

When CBP is utilized, both the originating site and the distant site have quality of care responsibilities. CMS and most accrediting organizations require the originating site to provide to the distant site 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 distant site in its ongoing peer review and credentialing and privileging activities relating to its telemedicine practitioners.

- **Will the originating site be notified if a physician is removed from a distant site’s roster for misconduct or quality issues?**

Practitioners at the distant site should be monitored carefully by the distant site for clinical performance, including by taking into consideration information provided by 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.

- **What does the originating site need to do to enable its facility 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 distant site(s) and amend its medical staff bylaws, to the extent necessary, to accommodate the CBP process.

- **Why can’t the distant site provide the originating site with more information on these practitioners?**

It can, but whether to request additional information is a balancing process. While some requests for additional information are entirely prudent and appropriate, it is noted that, with the rapid growth of telemedicine programs, it can quickly become burdensome for a distant site to provide extra information to an originating site. When extra information is requested, it may be in addition to the documentation that is required in the credentialing process and it may be unnecessary. Such requests can create more work for credentialing personnel in acquiring and evaluating these documents, without adding value--and could ultimately hinder the goal of making credentialing as efficient as possible and without unnecessary repetition of effort.

- **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 physician without certain information, such as license expiration dates. To keep track of physicians credentialed by proxy, originating sites may need to consider, for example, maintaining a binder or electronic file with the most updated physician roster, license verifications and privilege delineation, and a document which 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 makes things simpler and is easier to present 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. For those originating sites that do afford telemedicine practitioners medical staff membership, they 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).

TELEMEDICINE PROGRAM EXPECTATIONS

Facilities may wish to adopt a policy or a mission statement, or even preamble language for the adoption of CBP processes and bylaws, that defines telemedicine, describes its value to the facility(ies) and outlines the CBP process. Sample language may include:

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 statement describes the use of telemedicine at <FACILITY NAME>, including processes and controls relating to the credentialing of telemedicine practitioners, the promotion of quality patient care, and ensuring the security and confidentiality of both credentialing and patient data.

Telemedicine services will be provided pursuant to regulatory and accreditation compliant written agreements between this facility and one or more distant site hospitals or distant site telemedicine entities. Clinical services offered through these means will be provided consistent with commonly accepted quality, privacy, and security standards. This hospital, through the auspices of the Medical Staff and pursuant to the Medical Staff Bylaws and/or policies, will periodically perform internal reviews of the telemedicine practitioner's performance of privileges and send evidence of such to the distant site(s) for the purpose of ensuring ongoing assessment of the practitioner's care, treatment, and services for privileging and performance improvement.

For telemedicine practitioners who are privileged at the hospital's contracted distant sites for the services and procedures that will be provided at this hospital, the credentialing information and privileging decisions of such distant site may be relied upon by our Medical Staff when it recommends to this hospital's governing body telemedicine privileges to be exercised by the practitioners at this hospital. The ultimate determination with respect to clinical privileges, if any, that will be exercised by these telemedicine practitioners at this hospital will be made by this hospital's governing body.

CLINICAL SERVICES

Telemedicine services provided at originating sites will often consist of a distant site practitioner communicating with a patient and an originating site practitioner, where the originating site practitioner retains responsibility for the patient. There are telemedicine consultations where an originating site practitioner may not be present, and the distant site practitioner will have total responsibility for the patient, or where the originating site practitioner is present and the distant site practitioner may have total or shared responsibility for the patient (provided, in this latter case, 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 will be on a routine basis, while others are available for ad hoc consultations. All of these examples of service delivery options are subject to applicable state and federal laws governing the delivery of services via telemedicine, and the approval of requisite clinical privileges by the practitioners delivering the services.

OPERATIONAL BEST PRACTICE CONSIDERATIONS

When a credentialing agreement is entered into to facilitate the delivery of telemedicine services via CBP, it is recommended that the distant site 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 CBP.

The agreement should also require that any adverse events or patient complaints at the originating site about a practitioner covered by the agreement be shared by the originating site with the distant site, and that any adverse events, patient complaints, corrective actions, or modification of privileges known to, or taken by the distant site with respect to a practitioner covered by the agreement be shared by the distant site with the originating site. In both cases, this information should be shared as soon as it becomes apparent to either site (no more than 30 days after the site becomes aware of the issue), except with respect to modifications of privileges, which should be reported within 24 hours.

Note: The 30-day and 24-hour time frames are considered best practice by NAMSS and ATA, but the exact time frames should be specified in the credentialing agreement.

Distant site practitioners covered by the agreement, including new practitioners who are added from time to time, should acknowledge their participation in the agreement and be oriented to the CBP process when they agree to participate and provide telemedicine services. 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 and between <Originating Site Facility Name> and <Distant Site>. I agree to let you know when I am no longer providing telemedicine services.”

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 should be required to:

- Maintain clinical privileges and credentialing for telemedicine at the distant site for any privileges to be exercised at the originating site.
- Exercise professional judgment consistent with standards of their profession when engaging in telemedicine.

Distant sites should be required to:

- Notify the originating site MSA when program details (e.g., changes in practitioners providing
- services and practitioners’ privileges) have changed.

The telemedicine agreement may include consideration addressing whether practitioners providing telemedicine services should be required to do the following at the originating site:

- Pay applicable Medical Staff fees and/or dues.
- Participate in required on-site orientations.
- Complete annual education requirements.
- Provide verification of immunity status for health clearance.
- 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 distant site should clearly define key terms. Some key terms, with example definitions are:

- **Credentialing:** The verification and evaluation of the distant site telemedicine practitioners’ qualifications and competence to exercise requested telemedicine privileges.
- **Distant Site:** The entity through which the distant site telemedicine practitioners are credentialed and privileged to provide telemedicine services.
- **Originating Site:** The site where patients are physically located when receiving the Telemedicine Services, namely the originating site’s location.
- **Telemedicine Practitioner:** A duly qualified healthcare professional who is duly

credentialed and privileged by the distant site, holds a license issued or recognized by the State where the originating site is located.

- **Telemedicine Services:** The clinical services provided by the distant site's telemedicine practitioners to patients at the originating site via telemedicine technologies pursuant to a credentialing or professional services agreement.

BYLAWS

Before implementing CBP, the originating site's medical staff bylaws should be amended as necessary to include provisions that accommodate the CBP process.

PROFESSIONAL SERVICE AGREEMENTS

CBP credentialing agreements can 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 distant site 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 distant site should also be required to provide a practitioner profile and a list of distant site-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 distant site'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 distant site 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 distant site MSA shall provide timely notification to the originating site. Notice of any resulting changes in the rosters and/or privileges of distant site practitioners providing services at the originating site, once implemented, will be sent to the distant site 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, and it is important to be cognizant of these when deciding how to move forward with your facility.

- 1) **Key Stakeholders:** Relying on another facility's credentialing decisions can be complicated. 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 specialty administrators and department enrollment specialists; and it certainly includes medical staff leadership and the governing body. The processes at different facilities will vary, but keeping all relevant stakeholders on the same page as to what the CBP system achieves, why it is needed, and how it works will cut down on miscommunication and confusion within your team.
- 2) **Tracking Data:** Though the MSA will largely be relying on the verification work done by the distant site when using CBP, that is not the end of its work. Telemedicine practitioners are still subject to the recredentialing and (as applicable) reappointment cycles, and 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). Ongoing tracking of practitioners (including quality reporting described herein) must be done for telemedicine practitioners as well.
- 3) **Professional Practice Evaluation:** One of the requirements for utilizing CBP (see C.2) is to provide periodic reports from the originating site to the distant site 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 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

The biggest hurdle that a facility may face is simple inertia. Hospitals often tend to be resistant to change, and even a shift to make processes more efficient may be met with some hesitation. Communication is key to address this – it may require a bit of engagement and thought to adopt a significant change like CBP, but clearly explaining its benefits and the simplicity of the process will go a long way towards convincing doubters. Use this guidebook as a way to help decision makers and your staff understand CBP and how it will help them, and it may help you to garner consensus when adopting a CBP program.

COMMUNICATION WITH THE CREDENTIALS VERIFICATION ORGANIZATION

If your facility has an existing relationship with a CVO, questions may arise as to the use of CBP rather than using the CVO's services to credential these telemedicine practitioners. It is advisable to communicate with your CVO and explain why CBP is better suited for credentialing distant site telemedicine applicants for your facility. CBP will not interfere with the types of credentialing 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) and CBP should not substantively change your relationship with your CVO.

SITE SPECIFIC DOCUMENTATION

Originating sites may require site-specific forms or other documents in addition to the documents held by the distant site. Managing these specifics is a challenge as the number of distant sites and participating physicians continues to increase. Your CBP agreement should outline the documents required by both sites, and will ensure that both sites are on the same page. With a little planning, coordination, and communication, obtaining and sharing documentation should be easy.

Originating sites, especially those that are new to telemedicine services, may have specific forms and documents required for granting privileges to practitioners. This becomes difficult to manage for an organization which is providing telemedicine programs to multiple originating sites. A CBP agreement usually indicates that the distant site will maintain a credentialing file for each physician and that the originating site will be notified if there are any changes to the roster of practitioners (or to their associated privileges) for those exercising telemedicine privileges at the originating site. The originating site should not need many new forms completed in this case. Process or policy changes, and possibly bylaw revisions, can decrease the amount of paperwork and increase the speed of obtaining privileges, making life easier for everyone.

CONTROL ISSUES

It is hard to relinquish control. 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 ensures that credentials are reviewed in a thorough, consistent manner, that promotes quality of care. Since CBP represents a significant change in process, and reliance in part on the work of others, it will help if both originating sites and distant sites work to adopt credentialing agreements (and associated processes) that are designed to maximize mutual distant site/originating site understanding and comfort with each other's actions and decisions.

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
- 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

American Telemedicine Association (ATA)
Center 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)
Healthcare Facilities Accreditation Program (HFAP)
Intensive Care Unit (ICU)
Joint Commission (TJC)
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)

COMMON TERMS AND DEFINITIONS

A

Accreditation^B

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

Accreditation Contract^B

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

Accreditation Manual^B

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^B

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, quarterly submission of performance measurement data to the accreditor.

Asynchronous^A

Term describing store and forward transmission of medical images and/or data because the data transfer takes place over a period of time, and typically in separate time frames. The transmission typically does not take place simultaneously. This is the opposite of synchronous.

Authentication^A

A method of verifying the identity of a person sending or receiving information using passwords, keys and other automated identifiers.

B

Best Practices^B

Clinical, scientific, or professional practices that are recognized by a majority of professionals in a particular field as being exemplary. These practices are typically evidence based and consensus driven.

C

Care Coordination^B

The process of coordinating care, treatment, or services provided by a healthcare organization, including referral to appropriate community resources and liaison with others (e.g. the individual's physician, other healthcare organizations, or community services involved in care or services) to meet the ongoing identified needs of individuals, to ensure implementation of the plan of care, and to avoid unnecessary duplication of services.

Care Plan^B

A written plan based on data gathered during assessment that identifies care needs and treatment goals, describes the strategy for meeting those needs and goals, outlines the criteria for terminating any interventions, and documents progress toward meeting the plan's objectives. The plan may include care, treatment, and services; habilitation; and rehabilitation.

Caregiver^B

A family member, a significant other, a friend, a volunteer, or an individual employed by the patient or resident to provide services in the home.

Certification Commission for Health Information Technology (CCHIT)^A

Founded in 2004 with the public mission of accelerating the adoption of health IT, it certifies electronic health records (EHRs) using comprehensive, practical definitions of what capabilities were needed in these systems. (<http://www.cchit.org/>)

Centers for Medicare & Medicaid Services (CMS)^A

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 (CHIP), and Health Insurance Portability and Accountability Act (HIPAA) standards.

Clinical Decision Support System (CDSS)^A

Systems (usually electronically based and interactive) that provide clinicians, staff, patients, and other individuals with knowledge and person-specific information, intelligently filtered and presented at appropriate times, to enhance health and health care.

Clinical Information System^A

Hospital-based information system designed to collect and organize data relating exclusively to information regarding the care of a patient rather than administrative data.

Clinical Practice Guidelines^B

Tools that describe a specific procedure or processes found, through clinical trials or consensus opinion of experts, to be the most effective in evaluating and/or treating a mother and/or newborn, patient, resident, or individual served who has a specific symptom, condition, or diagnosis. Synonyms include practice parameter, protocol, clinical practice recommendation, preferred practice pattern, and guideline.

Clinical Privileges^B

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.

Confidentiality^B

Protection of data or information from being made available or disclosed to any unauthorized person(s) or process(es).

Consultation^B

- a) Provision of professional advice or services.
- b) A review of an individual's problem by a second practitioner and the rendering of an opinion and advice to the referring practitioner. In most instances, the review involves the independent examination of the individual by the consultant.
- c) For purposes of Joint Commission accreditation, advice that is given to staff members of surveyed organizations relating to compliance with standards and requirements that are the subject of the survey.

Consultation Report^B

- a) A written opinion by a consultant that reflects, when appropriate, an examination of the individual and the individual's medical record(s).
- b) Information given verbally by a consulting practitioner to a care provider that reflects, when appropriate, an examination of the individual. The individual's care provider usually documents those opinions in the medical record.

Continuity^B

The degree to which the care of individuals is coordinated among healthcare professionals, among organizations, and over time.

Contract^B

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^B

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^B

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^B

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

Credentials^B

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

Credentials Verification Organization (CVO)^B

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.

D

Departments of the Medical Staff ^B

Any structural unit of the medical staff (whether it is called a department, a service, a unit, a section, or something similar) in which the director is responsible for recommending privileges for individuals in the unit to the medical staff executive committee.

Designated Equivalent Source ^B

Selected agencies that have been determined to maintain a specific item(s) of credential(s) information that is identical to the information at the primary source. Designated equivalent sources include but are not limited to the following:

- The American Medical Association (AMA) Physician Masterfile for verification of a physician's United States and Puerto Rican medical school graduation and postgraduate education completion.
- The American Board of Medical Specialties (ABMS) for verification of a physician's board certification.
- The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a physician's graduation from a foreign medical school.
- The American Osteopathic Association (AOA) Physician Database for pre-doctoral education accredited by the AOA Bureau of Professional Education; postdoctoral education approved by the AOA Council on Postdoctoral Training; postdoctoral education approved by the Accreditation Council for Graduate Medical Education (ACGME); and Osteopathic Specialty Board Certification.
- The Federation of State Medical Boards (FSMB) for all actions against a physician's medical license.
- The American Academy of Physician Assistants (AAPA) Profile for physician assistant education, provided through the AMA Physician Profile Service (<https://profiles.ama-assn.org/amaprofiles/>).

Diagnostic Equipment (Scopes, Cameras and Other Peripheral Devices) ^A

A piece of hardware or device not part of the central computer (e.g., digitizers, stethoscope, or camera) that can provide medical data input to or accept output from the computer.

Digital ^A

Data technology using discrete values as opposed to continuous or analog signals.

Digital Camera (still images) ^A

A camera that stores images digitally rather than recording them on film allowing data to be downloaded to a computer system, manipulated with a graphics program and printed or transmitted electronically. It is typically used to take still images of a patient for dermatology, ophthalmology, and wound care.

Digital Imaging and Communication in Medicine (DICOM) ^A

The international standard for medical images and related information (ISO 12052). DICOM consists of a set of protocols describing how images are identified, formatted, transmitted and displayed that is vendor-independent. It was developed by the American College of Radiology and the National Electronic Manufacturers Association (<http://medical.nema.org/>).

Digital Signature ^A

Mathematical scheme for authenticating digital messages or documents. Valid signatures give the recipient evidence that the message was created by a known sender and not altered in transit.

Distance Learning ^A

The incorporation of video and audio technologies, allowing students to “attend” classes and training sessions that are being presented at a remote location. Distance learning systems are usually interactive and are a tool in the delivery of training and education to widely dispersed students, or in instances in which the instructor cannot travel to the student’s site.

Distant Site ^A

Site at which the physician 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/physician site and referral site. The site may also be referred to as the consulting site.

E**e-App ^B**

An electronic form used for collecting information pertaining to the applicant organization. Information collected on this form will be used to determine the accreditation requirements applicable to the organization, the types of surveyors needed, the length of survey, and the survey fee.

e-Health ^A

Healthcare practice supported by electronic processes and communication.

e-Pharmacy ^A

The use of electronic information and communication technology to provide and support comprehensive pharmacy services when distance separates the participants.

e-Prescribing ^A

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.

Electronic Data Interchange (EDI) ^A

The sending and receiving of data directly between trading partners without paper or human intervention.

Electronic Health Record (EHR) ^A

A systematic collection of electronic health information about individual patients or populations that is recorded in digital format and capable of being shared across healthcare settings via network-connected enterprise-wide information systems and other information networks or exchanges. EHRs generally include patient demographics, medical history, medication, allergies, immunization status, laboratory test results, radiology and other medical images, vital signs, and billing information.

Electronic Medical Record (EMR) ^A

A computerized medical record generated in an organization that delivers healthcare. EMRs are often part of a local stand-alone health information system that allow storage, retrieval and modification of records.

Electronic Patient Record (EPR) ^A

An electronic form of individual patient information that is designed to provide access to complete and accurate patient data, alerts, reminders, clinical decision support systems, links to medical knowledge, and other aids.

Element of Performance (EP) ^B

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.

Encryption ^A

A system of encoding electronic data where the information can only be retrieved and decoded by the person or computer system authorized to access it.

Evidence-based Guidelines ^B

Guidelines that have been scientifically developed based on recent literature review and are consensus driven.

F**Firewall ^A**

Computer hardware and software that block unauthorized communications between an institution's computer network and external networks.

Focused Professional Practice Evaluation ^B

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.

Full-motion Video^A

A standard video signal that allows video to be shown at the distant end in smooth, uninterrupted images.

G

Governance^B

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.

Guardian^B

A parent, a trustee, a conservator, a committee, or another individual or agency empowered by law to act on behalf of or be responsible for the patient, resident, or individual served.

H

Health Information^B

Any information, oral or recorded, in any form or medium, that is created by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse that relates to past, present, or future physical or mental health or condition; the provision of healthcare; or payment for the provision of healthcare to an individual.

Health Information Exchange (HIE)^A

The mobilization of healthcare information electronically across organizations within a region, community or hospital system.

HIPAA^A

Acronym for Health Information Portability and Accountability Act. The HIPAA Privacy Rule protects the privacy of individually identifiable health information, the HIPAA Security Rule sets national standards for the security of electronic protected health information, and the confidentiality provisions of the Patient Safety Rule protect identifiable information being used to analyze patient safety events and improve patient safety. (<http://www.hhs.gov/ocr/privacy/index.html>)

Hub Site^A

Location from which specialty or consultative services originate.

I

Informatics^A

The use of computer science and information technologies for the management and processing of data, information and knowledge. The field encompasses human-computer interaction, information science, information technology, algorithms, areas of mathematics, and social sciences.

Informed Consent^B

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.

Interactive Video/Television^A

Video conferencing technologies that allow for two-way, synchronous, interactive video and audio signals for the purpose of delivering telehealth, telemedicine or distant education services. It is often referred to by the acronyms ITV, IATV or VTC (video teleconference).

Interdisciplinary^B

An approach to care that involves two or more disciplines or professions (e.g. social services, specialist consultation, nursing, medicine, therapies, spiritual support) collaborating to plan, treat, or provide care or services to a mother and/or newborn, patient, resident, or individual served and/or that person's family.

J

K

L

Licensed Independent Practitioner^B

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^A

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).

M**m-Health**^A

Practice of medicine and public health supported by mobile communication devices, such as mobile phones, tablet computers and PDAs for health services and information.

Meaningful Use^A

The set of standards defined by the Centers for Medicare & Medicaid Services (CMS) Incentive Programs that governs the use of electronic health records and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria.

Medical Staff^B

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^B

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^B

A group of individuals, the majority of whom are licensed physician 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^B

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^B

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.

Medication Reconciliation^B

The process of identifying the medications currently being taken by an individual. These medications are compared to newly ordered medications and discrepancies are identified and resolved.

Multi-point Teleconferencing^A

Interactive electronic communication between multiple users at two or more sites which facilitates voice, video, and/or data transmission systems: audio, graphics, computer and video systems. Multi-point teleconferencing requires a MCU or bridging device to link multiple sites into a single videoconference.

N

Non-simultaneously^C

While the telemedicine physician or practitioner still provides clinical services to the patient upon a formal request from the patient’s attending physician, such services may involve after-the-fact interpretation of diagnostic test to provide an assessment of the patient’s condition and do not necessarily require the telemedicine practitioner to directly assess the patient in “real time”. This would be similar to the services provided by an on-site radiologist who interprets a patient’s x-ray or CT scan and then communicates his or her assessment to the patient’s attending physician who then bases his or her diagnosis and treatment plan on these findings.

O

Ongoing Professional Practice Evaluation^B

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: Where the patient is receiving the services.

Distant Site: Where the practitioner is actually located.

Originating Site^A

Location of the Medicaid 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.

P**Patient Exam Camera (video)**^A

Digital or analog camera used to examine patients during a real-time teleconsult or acquire images for a store-forward teleconsult. Types of cameras include those embedded with set-top videoconferencing units, handheld video cameras, gooseneck cameras, camcorders, etc.

Peer Recommendation^B

Information submitted by a practitioner(s) in the same professional discipline as an applicant, reflecting his or her perception of the applicant's clinical practice, ability to work as part of a team, and ethical behavior; or the documented peer evaluation of practitioner-specific data collected from various sources for evaluating current competence.

Performance Improvement^B

The systematic process of detecting and analyzing performance problems, designing and developing interventions to address the problems, implementing the interventions, evaluating the results, and sustaining improvement.

Peripheral Devices^A

Any device attached externally to a computer (e.g., scanners, mouse pointers, printers, keyboards, and clinical monitors such as pulse oximeters, weight scales)

Personal Health Record (PHR)^A

Health record maintained by the patient to provide a complete and accurate summary of an individual's medical history accessible online.

Physician ^B

As defined by the Centers for Medicare & Medicaid Services in Sec. 1861.[42 U.S.C.1395x] of the Social Security Act, the term “physician,” when used in connection with the performance of any function or action, means:

- a) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)),
- b) A doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions,
- c) A doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them,
- d) A doctor of optometry, but only for purposes of subsection (p)(1) with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or
- e) A chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Physician Assistant ^B

An individual who practices medicine with supervision by licensed physicians, providing services ranging from primary medicine to specialized surgical care. The scope of practice is determined by state law, the supervising physician’s delegation of responsibilities, the individual’s education and experience, and the specialty and setting in which the individual works. 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.

Originating Site: Where the patient is receiving the services.

Distant Site: Where the practitioner is actually located.

Picture Archiving and Communications System (PACS) ^A

Combination of hardware and software dedicated to short and long-term storage, retrieval, management, distribution and presentation of digital medical images.

Policy ^B

A principle or method that is developed for the purpose of guiding decisions and activities related to governance, management, care, treatment, and services. A policy is developed by organization leadership, approved by the governing body of the organization, and maintained in writing.

POTS ^A

Acronym for Plain Old Telephone Service.

Practitioner ^B

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.

Presenter (Patient Presenter) ^A

An individual with a clinical background trained in the use of telehealth equipment who must be available at the originating site to “present” the patient, manage the cameras and perform any “hands-on” activities to complete the tele-exam successfully. In certain cases, a licensed practitioner might not be necessary, and a non-licensed provider may provide tele-presenting functions. Legal requirements for presenter qualifications differ by location and should be followed.

Preventive Care ^B

The provision of healthcare that focuses on disease prevention and health maintenance. It includes early diagnosis of disease as well as discovery and identification of individuals at risk for the development of specific health problems or in need of counseling or other necessary interventions to avert a health problem. Screening tests, health education, and immunization programs are common examples of preventive care.

Primary Source ^B

The original source or an approved agent of that source of a specific credential that can verify the accuracy of a qualification reported by an individual practitioner. Examples include medical schools, nursing schools, graduate education, state medical boards, federal and state licensing boards, universities, colleges, and community colleges.

Primary Source Verification ^B

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^B

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.

Protected Health Information (PHI)^A

Part of the HIPAA Privacy Rule that protects all “individually identifiable health information” held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information “protected health information (PHI).” Individually identifiable health information” is information, including demographic data, that relates to the individual's past, present or future physical or mental health or condition, the provision of healthcare to the individual, or the past, present, or future payment for the provision of healthcare to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number). The Privacy Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

Q

Qualifications^B

Knowledge, education, training, experience, competency, licensure, registration, or certification related to specific responsibilities.

Quality Control^B

A set of activities or techniques whose purpose is to ensure that all quality requirements are being met. The organization monitors processes and solves performance problems to achieve this purpose.

Quality of Care, Treatment, or Services^B

The degree to which care, treatment, or services for individuals and populations increases the likelihood of desired health or behavioral health outcomes. Considerations include the appropriateness, efficacy, efficiency, timeliness, accessibility, and continuity of care; the safety of the care environment; and the individual's personal values, practices, and beliefs.

R

Record^B

- a) An account compiled by physicians and other healthcare professionals of a variety of health information, (e.g. assessment findings, treatment details, and progress notes).
- b) Data obtained from the records or documentation maintained on a patient or resident in any healthcare setting (e.g. hospital, home care, nursing care center, practitioner office). The record includes automated and paper medical record systems.

Remote Monitoring^A

Type of ambulatory healthcare where patients use mobile medical devices to perform a routine test and send the test data to a healthcare professional in real-time. Remote monitoring includes devices, such as glucose meters for patients with diabetes and heart or blood pressure monitors for patients receiving cardiac care.

RHIO^A

The terms Regional Health Information Organization (RHIO) and Health Information Exchange (HIE) are often used interchangeably. RHIO is a group of organizations with a business stake in improving the quality, safety, and efficiency of healthcare delivery. RHIOs are the building blocks of the proposed National Health Information Network (NHIN) initiative at the Office of the National Coordinator for Health Information Technology (ONC).

Rules, Regulations and Policies of the Medical Staff

As used in these standards, documents other than medical staff bylaws. When adopted by the organized medical staff and approved by the governing body, pursuant to the provisions of Standard MS.01.01.01, these documents have the force and effect of medical staff bylaws.

S

Safety^B

The degree to which the risk of an intervention (e.g. use of a drug, or a procedure) and risk in the care environment are reduced for a patient and other persons, including healthcare practitioners. Safety risks may arise from the performance of tasks, from the structure of the physical environment, or from situations beyond the organization's control, such as weather.

Safety Management^B

Activities selected and implemented by the organization to assess and control the impact of environmental risk, and to improve general environmental safety.

Scope of Services^B

The activities performed by governance, managerial, clinical, or support staff.

Security, Information^B

Administrative, physical, and technical safeguards to prevent unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Sentinel Event^B

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.

Simulation^B

Computer hardware and software allowing realistic interactions and interventions to occur in programmed scenarios to evaluate clinical practitioner competence.

Simultaneously^C

Clinical services are provided to the patient in "real time" by the telemedicine physician or practitioner, similar to the actions of an on-site physician or practitioner.

Spoke Site^A

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

Staff^B

As appropriate to their roles and responsibilities, all people who provide care, treatment, or services in the organization, including those receiving pay (e.g. permanent, temporary, part-time personnel, as well as contract employees), volunteers and health profession students. The definition of staff does not include licensed independent practitioners who are not paid staff or who are not contract employees.

Standard^B

A principle of patient safety and quality of care that a well-run organization meets. A standard defines the performance expectations, structures, or processes that must be substantially in place in an organization to enhance the quality of care, treatment, or services.

Store and Forward (S&F)^A

Type of telehealth encounter or consult that uses still digital images of patient data for rendering a medical opinion or diagnosis. Common services include radiology, pathology, dermatology, ophthalmology, and wound care. Store and forward includes the asynchronous transmission of clinical data from one site to another.

Suspension - Automatic^B

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 ^B

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 ^A

Interactive video connections that transmit information in both directions during the same time.

T**Telecommunications Providers (Telco) ^A**

An entity (the Federal Communications Commission in the US licenses Telcos) that provides telecommunications services to individuals or institutions.

Teleconferencing ^A

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 ^A

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

Telehealth and Telemedicine ^A

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Closely associated with telemedicine is the term "telehealth," which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth. Telemedicine is not a separate medical specialty. Products and services related to telemedicine are often part of a larger investment by healthcare institutions in either information technology or the delivery of clinical care. Even in the reimbursement fee structure, there is usually no distinction made between services provided on site and those provided through telemedicine and often no separate coding required for billing of remote services. Telemedicine encompasses different types of programs and services provided for the patient. Each component involves different providers and consumers.

Telematics ^A

The use of information processing based on a computer in telecommunications and the use of telecommunications to permit computers to transfer programs and data to one another.

Telementoring ^A

The use of audio, video, and other telecommunications and electronic information processing technologies to provide individual guidance or direction.

Telemetry ^A

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

Telemonitoring ^A

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 ^A

- 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 means HD quality audio/video. In some cases, the user's position, movements, actions, voice, etc. may be transmitted and duplicated in the remote location to enhance the effect. Information often travels in both directions between the user and the remote location (i.e. feedback of some sort is provided). Telepresence via video generally uses greater technical sophistication and higher audio/video fidelity than traditional videoconferencing.
- 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. This term could be applied to a surgeon using lasers or dental hand pieces and receiving pressure similar to that created by touching a patient so that it seems as though s/he is actually present, permitting a satisfactory degree of dexterity.

Teleradiology and Picture Archiving and Communications Systems (PACs) ^A

The electronic transmission of radiological images, such as x-rays, CTs, and MRIs, for interpretation and/or consultation.

The Joint Commission ^B

An independent, not-for-profit organization dedicated to improving the safety and quality of healthcare through standards development, public policy initiatives, accreditation, and certification. The Joint Commission accredits and certifies more than 20,000 healthcare organizations and programs in the US.

U

V

Videoconferencing^A

Real-time transmission of digital video images between multiple locations.

W

X

Y

Z

SOURCES

A) American Telemedicine Association, Telemedicine Glossary, 2018, <https://thesource.americantelemed.org/resources/telemedicine-glossary>

B) The Joint Commission, <https://www.jointcommission.org>

C) CMS, 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
- HFAP Standards
- DNV-GL Standards

STATE REGULATIONS ON CREDENTIALING BY PROXY

Alabama

<http://www.alabamaadministrativecode.state.al.us/alabama.html>

Title 420 (Alabama State Board of Health), Section 5-7 (Hospitals)

Alaska

[http://www.legis.state.ak.us/basis/folioiproxy.asp?url=http://wwwjnu01.legis.state.ak.us/cgi-bin/folioisa.dll/aac/query=\[JUMP:%27Title7Chap12%27\]/doc/{@1}?firsthit](http://www.legis.state.ak.us/basis/folioiproxy.asp?url=http://wwwjnu01.legis.state.ak.us/cgi-bin/folioisa.dll/aac/query=[JUMP:%27Title7Chap12%27]/doc/{@1}?firsthit)

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

Title 9 (Health Services), Chapter 10 (Department of Health Services – Health Care Institutions: Licensing), Article 2 (Hospitals)

Arkansas

<https://www.healthy.arkansas.gov/images/uploads/rules/Hospitals.pdf>

California

[https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&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

<http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=5698>

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

Connecticut

<http://www.portal.ct.gov/DPH/Public-Health-Code/Quick-Browse--Public-Health-Code-by-Section>

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

[http://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Public%20Health/Health%20Systems%20Protection%20\(HSP\)/4407.pdf](http://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Public%20Health/Health%20Systems%20Protection%20(HSP)/4407.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

<http://www.in.gov/legislative/iac/TO4100/A00150.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=05-23-2018>

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

Kansas

http://www.kssos.org/Pubs/pubs_kar.aspx

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

Kentucky

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

<http://www.lrc.state.ky.us/kar/902/020/016.htm>

Louisiana

http://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

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

Massachusetts

<https://www.mass.gov/regulations/105-CMR-13000-hospital-licensure>

Title 105 (Department of Public Health), Chapter 130 (Hospital Licensure)

Michigan

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/?id=4640>
Chapter 4640 (Hospital Licensing and Operation)

Mississippi

https://msdh.ms.gov/msdhsite/_static/resources/7419.pdf
Title 15 (Mississippi State Department of Health), Part 16 (Health Facilities), Subpart 1 (Health Facilities Licensure and Certification)

Missouri

<https://s1.sos.mo.gov/cmsimages/adrules/csr/current/19csr/19c30-20.pdf>
Title 19 (Department of Health and Senior Services), Division 30 (Regulation and Licensure), Chapter 20 (Hospitals)

Montana

<http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37%2E106.4>
Title 37 (Public Health and Human Services), Chapter 106 (Health Care Facilities), Subchapter 4 (Minimum Standards for a Hospital)

Nebraska

http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-175/Chapter-09.pdf
Title 175 (Health Care Facilities and Services Licensure), Chapter 9 (Hospitals)

Nevada

<https://www.leg.state.nv.us/NAC/NAC-449.html>
Title 449 (Medical and Other Related Facilities), Chapter 279 (Hospitals)

New Hampshire

http://www.gencourt.state.nh.us/rules/state_agencies/he-p800.html
Title He-P (Former Division of Public Health Services), Chapter 802 (Rules for Hospitals)

New Jersey

<http://www.lexisnexis.com/hottopics/njcode>
Title 8 (Health), Chapter 43G (Hospital Licensing Standards)

New Mexico

<http://164.64.110.239/nmac/parts/title07/07.007.0002.pdf>
Title 7 (Health), Chapter 7 (Hospitals), Part 2 (Requirements for Acute Care, Limited Services and Special Hospitals)

New York

<https://regs.health.ny.gov/volume-c-title-10/1944055838/part-405-hospitals-minimum-standards>
Title 10 (Health), Volume C, Article 2 (Hospitals), Part 405 (Hospitals – Minimum Standards)

North Carolina

<http://reports.oah.state.nc.us/ncac.asp>

Title 10A (Health and Human Services), Chapter 13 (North Carolina Medical Care Commission), Subchapter B (Licensing of Hospitals)

North Dakota

<http://www.legis.nd.gov/cencode/t23c16.pdf>

Title 23 (Health and Safety), Chapter 16 (Licensing Medical Hospitals)

Ohio

<http://codes.ohio.gov/orc/3727>

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

Oklahoma

<http://www.oar.state.ok.us/>

Title 310 (Oklahoma State Department of Health), Chapter 667 (Hospital Standards)

Oregon

<https://secure.sos.state.or.us/oard/displayChapterRules.action>

Chapter 333 (Oregon Health Authority: Public Health Division), Division 500 (Hospitals, Generally)

Pennsylvania

<https://www.pacode.com/secure/data/028/subpartIVBtoc.html>

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

Rhode Island

<http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7022.pdf>

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

South Carolina

<http://www.scdhec.gov/Agency/docs/health-regs/61-16.pdf>

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

South Dakota

http://sdlegislature.gov/Statutes/Codified_Laws/DisplayStatute.aspx?Type=Statute&Statute=34-12

Title 34 (Public Health and Safety), Chapter 12 (Regulation of Hospitals and Related Institutions)

Tennessee

<http://publications.tnsosfiles.com/rules/1200/1200-08/1200-08-01.20170509.pdf>

Title 1200 (Health, Environment and Conservation), Chapter 8 (Bureau of Health Licensure and Regulation), Subchapter 1 (Standards for Hospitals)

Texas

[http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=133](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=133)

Title 25 (Health Services), Part 1 (Department of State Health Services), Chapter 133 (Hospital Licensing)

Utah

<https://rules.utah.gov/publicat/code/r432/r432-100.htm>

Title R432 (Health, Family Health and Preparedness, Licensing), Section 100 (General Hospital Standards)

Vermont

http://www.healthvermont.gov/sites/default/files/documents/pdf/REG_hospital-licensing.pdf

Hospital Licensing, Chapter 2 (Hospital and Medication Rules), Subchapter 1 (Hospital Licensing Rule)

Virginia

<https://law.lis.virginia.gov/admincode/title12/agency5/chapter410/>

Title 12 (Health), Agency 5 (Department of Health), Chapter 410 (Regulations for the Licensure of Hospitals in Virginia)

Washington

<http://apps.leg.wa.gov/WAC/default.aspx?cite=246-320>

Title 246 (Department of Health), Chapter 320 (Hospital Licensing Regulations)

West Virginia

<http://apps.sos.wv.gov/adlaw/csr/readfile.aspx?DocId=8233&Format=PDF>

Title 64 (West Virginia Division of Health), Series 12 (Hospital Licensure)

Wisconsin

http://docs.legis.wisconsin.gov/code/admin_code/dhs/110/124

Department of Health Services, Chapter 124 (Hospitals)

Wyoming

<https://health.wyo.gov/wp-content/uploads/2016/11/HLS-Rule-Ch-12-Hospitals.pdf>

Title 48 (Department of Health), Program 61 (Healthcare Licensing and Surveys), Chapter 12 (Rules and Regulations for the Licensure of Hospitals)



NAMSS™

EDUCATION. ADVOCACY. PATIENT SAFETY.

AMERICAN TELEMEDICINE ASSOCIATION

901 N GLEBE ROAD | STE 850
ARLINGTON, VA 22203
703-373-9600
INFO@AMERICANTELEMED.ORG

NATIONAL ASSOCIATION MEDICAL STAFF SERVICES

2025 M STREET NW | STE 800
WASHINGTON, D.C., 20036
202-367-1196
INFO@NAMSS.ORG