

This spring has been full of wild weather, and our thoughts are still with AHRA member Nora Cannon, director of radiology at St. John's Regional Medical Center in Joplin, MO. A tornado hit Joplin on the night of Sunday, May 22 and made direct contact with Nora's hospital, which subsequently had to be abandoned. We got word that Nora is fine, but her facility has been

devastated. When I spoke to Nora a few days back, her facility was just opening for outpatient services—what an amazing comeback in such a short time. It is amazing how quickly strong communities can work together to rebuild so quickly in even the direst of circumstances. Please keep Nora, as well as her coworkers, family, and community in your thoughts as they will need our support in the coming months.

## Regulatory Review

# CMS Issues Final Rule on Credentialing and Privileging for Telemedicine

By Adrienne Dresevic, Esq. and Carey F. Kalmowitz, Esq.

The Centers for Medicare and Medicaid Services (CMS) issued its final rule for telemedicine credentialing and privileging for hospitals and critical access hospitals (CAHs) on May 5, 2011. The Final Rule is effective July 5, 2011 and amends the conditions of participation (CoPs) for hospitals and CAHs, creating a more streamlined process for credentialing and privileging of telemedicine physicians.

Prior to the Final Rule, regulations had required hospitals and CAHs to apply the credentialing and privileging requirements as if all practitioners were onsite. CMS finally recognized this as a "limited approach," which failed to "embrace new methods and technologies for service delivery that may improve patient access to high quality care." Now, under the Final Rule, a hospital that provides telemedicine services to its patients via an agreement with a "distant-site" hospital would be allowed to rely upon information furnished by the distant-site hospital (often a larger medical center) in making credentialing and privileging decisions for the distant-site hospital's physicians and practitioners providing telemedicine services. The rule will reduce the burden and duplicative nature of the traditional privileging process for Medicare-participating hospitals and CAHs engaged in telemedicine agreements, while still assuring accountability to the process.

Notably, in issuing the Final Rule, CMS recognized that including the medical staff of a distant-site telemedicine entity as part of the new optional and streamlined credentialing and privileging process would increase the overall effectiveness of the Final Rule. A distant-site telemedicine entity is defined as one that (1) provides telemedicine services; (2) is not a Medicare-participating hospital; and (3) provides contracted services in a manner that enables a hospital or CAH using its services to meet all applicable CoPs, particularly requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of a hospital or CAH. The governing body of the hospital or CAH using telemedicine services is responsible for ensuring that the distant-site hospital or entity meets CMS credentialing and privileging standards. One way of ensuring this is the Final Rule's clarification that an agreement for the provision of telemedicine services be in writing. These agreements must be provided, upon request, when a hospital or CAH is surveyed.

Thus, if a telemedicine agreement is entered into with a distant-site hospital, the governing body of the hospital or CAH must ensure, through its written agreement, that the following provisions are met in order to allow its medical staff to rely upon the credentialing and privileging decisions made by the distant-site hospital when recommending privileges for individual physicians and practitioners providing such services:

- The distant-site hospital is a Medicare-participating hospital;
- The individual distant-site physician/practitioner is privileged at the distant-site hospital providing the telemedicine services, and a current list of those privileges are provided;
- The individual holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located;

With respect to a distant-site physician/practitioner who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital has evidence of an internal review of the distant-site physician/practitioner's performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician/practitioner.

If a telemedicine agreement is entered into with a distant-site telemedicine entity (as opposed to a Medicare-participating hospital), the governing body of the hospital or CAH must ensure, through its written agreement, that the distant-site telemedicine entity, acting as a contractor of services, furnishes its services in a manner that enables the hospital or CAH to comply with all applicable CoPs and standards. The final three requirements are the same as with a Medicare-participating hospital.

Of particular significance under the written agreement is that hospitals or CAHs that rely on this new so-called proxy credentialing will need to share what is generally considered privileged peer review information with the distant-site hospital or distant site entity for those practitioners who exercise telemedicine privileges at the hospital or CAH. Thus, it is wise for the written agreements to include language that will assure ongoing protection of this peer review information.

The Final Rule does not require, but allows, the “providing” hospital to decide, in its own discretion, whether to rely on credentialing and privileging decisions of the distant-site telemedicine entity (or hospital) or follow its traditional procedures. Hospitals and CAHs that choose to use this new stream-

lined proxy credentialing approach should (1) take steps to ensure that their medical staff bylaws permit credentialing for telemedicine privileges consistent with the Final Rule and (2) have written agreements in place.

## Commentary

# What Would You Do?

By AHRA Staff

Every month, a hypothetical industry and management related situation is posted. You are encouraged to share your thoughts (in the comment box below) on how you would resolve the issue. Be sure to check out others’ responses and join the discussion.

Here is this month’s scenario:

## Commentary

# ACOs: How Do We Prepare?

By Jef Williams, MBA, PMP and Shawn McKenzie, MPA, CRA, RT, CRT

It is no secret that much ambiguity remains around the structure, reimbursement model, and reporting requirements of Accountable Care Organizations (ACOs). That ambiguity, however, has not slowed the momentum we see with most organizations moving to become certified. While many questions remain unanswered, there are several things we are sure of. ACOs will include and affect the following:

- Primary care providers (PCPs) who provide service aggregately to at least 5000 Medicare beneficiaries
- Contracted specialists and hospitals (affiliated or otherwise)
- Reporting requirements that measure quality of care and cost at patient and episode level
- Commitment to operate for a minimum of 3 years
- The ability to receive and distribute CMS payments (and potentially shared savings returns) to all participants of the ACO

Diagnostic imaging (DI), as a service provider along the entire continuum of care, stands to be impacted most significantly by the potentially drastic changes that will accompany participation in an ACO. The current operation, technical, and administrative (business) model adopted by nearly all DI departments will undergo major shifts. The challenge for directors and managers in this time of uncertainty is to prepare for the future in an environment where the specifics for that future are unclear. While this may prohibit your ability to establish a detailed imaging strategy for the next 5 years related to ACO participation, there are steps you can take to poise your organization for success.

### Operational Readiness

One of the foundational elements of the ACO model is shared risk. In the current fee-for-service model, your department and

What would you do if the majority of your outpatients informed you that they could no longer afford the co-pays and deductibles at your hospital based outpatient imaging department because the out-of-pocket expenses at other, non-hospital based outpatient facilities are much less?

the radiology staff are rewarded for volume and operational efficiency. Within an ACO, the payment structure, whether it be capitation or bundled payments, will drive the fiscal rewards directly tied to better outcomes, fewer studies, and collaborative decision making regarding most appropriate exam types.

In order to prepare your staff and radiology group for these changes, it is important that you begin discussions now to build trust and discuss the potential changes to workflow, the definition of efficiency, and roles and responsibilities both within the department as well as to the entire ACO organization.

### Technical Readiness

ACOs will be joined together by way of information technology (IT). Without the technological functions provided with well built and implemented clinical information systems, the ability to share, as well as report and track patient data, will be overwhelming to the point of impossible. Your service line systems, along with other business or clinical applications integrated or interfaced to your department, will need to provide the following minimal functionality:

- Image sharing across care providers (including those captured by disparate PACS)
- Patient reporting across entire ACO
- Decision support for CPOE
- Cost reporting at patient/episode level

The challenges of technical interoperability within an ACO developed within affiliated providers or an integrated delivery network (IDN) will be difficult. For those pursuing an ACO model with providers and organizations that are non-affiliated and using disparate systems, it is critical that technical discussions be ongoing from the beginning. While technical in