CMS Requirements for Credentialing by Proxy

For credentialing by proxy, the following conditions must be met:

- There must be a written agreement between the two parties
- The telehealth provider is privileged at the distant site hospital
- A current list of the telehealth provider’s privileges is given to the originating site hospital
- The distant hospital is a Medicare participating hospital or a telemedicine entity
- A “telemedicine entity” is defined as follows:
  - Providing telemedicine services;
  - Is not a Medicare-participating hospital; and
  - Provides its services in a manner that allows the originating site hospital or the CAH to comply with all applicable CoPs and standards
- The telehealth provider holds a license issued or is recognized by the state in which the originating site hospital is located
- The originating site hospital has an internal review of the telehealth provider’s performance and provides this information to the distant site hospital
- The originating site hospital must inform the distant site hospital of all adverse events and complaints regarding the services provided by the telehealth provider

Note: Credentialing by Proxy is Optional. Should a hospital wish to go through a full credentialing and privileging process with a telehealth provider, it is free to do so.

This information was obtained from the Center for Connected Health Policy’s website. For more detailed information on CMS and TJC regulations and standards regarding telehealth credentialing and privileging, visit: telehealthpolicy.us/credentialing-privileging
SAMPLE PRIVILEGING AND CREDENTIALING AGREEMENT

Provided courtesy of the University of California, Davis Health System

This Agreement is entered into by and between the (Distant Site Official Name), a constitutional corporation under Article IX of the Constitution of the State of California “(distant site name)” and (originating site name) (“FACILITY”).

RECITALS

WHEREAS, (distant site name) has established a telemedicine program (“Program”) that provides patients and health care professionals at outlying hospitals and clinics access to (distant site name) physicians and other providers practicing in a broad array of clinical specialties “(distant site name Providers)”;

WHEREAS, FACILITY has determined that its Medical Staff may rely on the privileging and credentialing decisions made by (distant site name) when granting privileges to (distant site name) Providers; and

WHEREAS, FACILITY desires to efficiently credential and privilege (distant site name) Providers who provide Program services for the benefit of its patients.

NOW, THEREFORE, (distant site name) and FACILITY agree as follows:

AGREEMENT

Section 1. (Distant site name)- ACKNOWLEDGEMENTS AND RESPONSIBILITIES

1.1 (Distant site name) confirms that its (facility/Medical Center) is a Medicare-participating hospital.

1.2 All (distant site name) Providers are members of the Medical Staff of the (distant site name), credentialed and privileged in their respective specialty areas.

1.3 (distant site name) maintains a list of privileges for each (distant site name) Provider and upon full execution of this Agreement, (distant site name) shall send FACILITY identifiable (distant site name) Provider information for FACILITY’s National Practitioner Databank query. As necessary, (distant site name) Provider information shall be updated by (distant site name) and provided to FACILITY.

1.4 All (distant site name) Providers are licensed in the State or otherwise legally permitted to practice in the State where FACILITY is located.

1.5 The (distant site name) Medical Staff credentialing process complies with all of the standards required under 42 C.F.R. § 482.12(a)(1)-(a)(7).

Section 2. FACILITY- ACKNOWLEDGEMENTS AND RESPONSIBILITIES

2.1 The governing body of FACILITY has chosen to have its Medical Staff rely on the credentialing and privileging decisions of (distant site name) in recommending a physician or other qualified licensed health care provider for Medical Staff privileges at FACILITY.

2.2 FACILITY complies with all governing body responsibilities as required under 42 C.F.R. § 482.22(a) [Hospitals] or 42 C.F.R. § 485.616(c) [Critical Access Hospitals].

2.3 FACILITY shall review the list of Program (distant site name) Providers who have privileges and are members of the Medical Staff at (distant site name) prior to granting privileges to a (distant site name) Provider at FACILITY.

2.4 FACILITY will perform a periodic internal review of the (distant site name) Provider’s performance at FACILITY and complete the Telemedicine Professional Practice
Evaluation ("Evaluation Form") attached hereto as Exhibit A. FACILITY shall also provide specific details regarding any complaints received about the (distant site name) Provider and/or any adverse events that occurred. The Evaluation Form and any additional information shall be sent to the (distant site name) Medical Staff office for use in its periodic appraisal of the (distant site name) provider.

Section 3. GENERAL TERMS

3.1 This Agreement shall be effective on the last date signed below and shall continue in effect unless terminated in accordance with Article 3.2

3.2 Either party may terminate this Agreement with thirty (30) days prior written notice to the other party.

This Agreement constitutes the entire understanding of the parties with respect to the subject matter hereof and supersedes any prior understanding between them, whether oral or written, respecting the same subject matter.

IN WITNESS WHEREOF, the parties have executed this Agreement.

(Distant site name)
By:__________________________________ By:__________________________________
Name:_______________________________
Title:________________________________
Date:_______________________________ Date:_______________________________
EXHIBIT A
Telemedicine Professional Practice Evaluation

Individual Proctored: _______________________________________________

Date of review: ________________________

Proctor: __________________________________________________________

Patient name: ______________________________________________________

Diagnosis: _________________________________________________________

Based on my review of the consultation proved in this case, I make the following evaluation:

1. **Patient Care**: is compassionate, appropriate and effective
   Acceptable ____ Marginal ____ Unacceptable ____ Unable to assess ____

2. **Medical/Clinical Knowledge**: Demonstrates knowledge of established and evolving sciences and applies it to patient care
   Acceptable ____ Marginal ____ Unacceptable ____ Unable to assess ____

3. **Practice-Based Learning and Improvement**: Uses scientific evidence and methods to investigate, evaluate, improve care
   Acceptable ____ Marginal ____ Unacceptable ____ Unable to assess ____

4. **Interpersonal and Communication Skills**: Establishes and maintains professional relations with patients, families
   Acceptable ____ Marginal ____ Unacceptable ____ Unable to assess ____

5. **Systems-Based Practice**: Understand the contexts and systems in which care is provided and applies this knowledge
   Acceptable ____ Marginal ____ Unacceptable ____ Unable to assess ____

6. **Professionalism**: Demonstrates a commitment to professional development, ethical practice, diversity and responsibility to patients, profession and society
   Acceptable ____ Marginal ____ Unacceptable ____ Unable to assess ____

**Overall Impression**:
Acceptable ____ Marginal ____ Unacceptable ____

Proctor’s Signature: ___________________________ Date: ________________

Proctor’s Printed Name: _______________________________
Exhibit B
Telemedicine Professional Practice Evaluation
Complaints and Adverse Events

Provider reviewed: _____________________________________

Date of review: ______________________________

Hospital or care setting: _________________________________

If the provider has been the subject of any complaints and/or adverse events, please report those events on this form.

Date of complaint or adverse event: ____________________________________

Details of complaint or adverse event: _______________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Overall Impression:
Acceptable ____ Marginal ____ Unacceptable _____

Reviewer’s signature: ___________________________ Date: ________________

Reviewer’s printed name: ______________________________________________

Forward to: (distant site name)
Medical Staff Administration, Credentials Unit
(Distant Site Mailing Address)