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The Law of Telemedicine Responding to Real World Practice

The practice of treating patients remotely, whether by telephone or over the internet, is becoming increasingly common, even in small and rural hospitals. This article sets forth the regulatory background authorizing telemedicine in Illinois and the credentialing and privileging requirements placed on both the hospital and the remote practitioners. It also provides some guidelines to assist counsel in ensuring their clients maintain ongoing compliance with those requirements.

The Illinois Medical Practice Act

The Illinois Medical Practice Act (225 ILCS 60/1, *et seq.*) authorizes the practice of telemedicine and declares it a public good. 225 ILCS 60/49.5. For the purposes of the Illinois Medical Practice Act, "telemedicine" means practicing medicine, including "rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois by a person located outside the State of Illinois as a result of transmission of individual patient data by telephonic, electronic, or other means of communication from within this State." 225 ILCS 60/49.5(c). With certain exceptions, all persons who treat patients located in Illinois via a telemedicine link must be licensed to practice medicine in Illinois. 225 ILCS 60/49.5(b). The statute expressly excludes certain minor activities from the definition of telemedicine, indicating the practitioner need not be licensed in Illinois in those limited instances. The language provides that "telemedicine" does *not* include periodic consultations between a person licensed in Illinois and a person outside of the state of Illinois, a second opinion provided to a person licensed in Illinois, or "diagnosis or treatment services provided to a patient in Illinois following care or treatment originally provided to the patient in the state in which the provider is licensed to practice medicine." 225 ILCS 60/49.5(c)(3).

Joint Commission Standards for Telemedicine

The Joint Commission defines "telemedicine" as "the use of medical information exchanged from one site to another via electronic communications to improve patient's health status." (*See* MS.13.01.01, Introduction, MS32). Significantly, the standard allows for "credentialing and privileging by proxy." *Id*. The theory of the credentialing-by-proxy approach is to respond to real-world needs by reducing the credentialing and privileging burden for the facility where the patient is physically located (i.e., the "originating site"), especially where there are large numbers of licensed independent practitioners who might provide telemedicine services. The standard recognizes that the remote provider (the "distant site") has more information that is relevant and more competent experience upon which to base its credentialing and privileging.

While acknowledging the realities of the modern practice of medicine and allowing privileging by proxy, the language of MS.13.01.01 is structured to clarify that the originating site retains the ultimate responsibility for patient care. The standard reads as follows:

> **For originating sites only:** Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

MS.13.01.01. In other words, the originating site "retains responsibility for overseeing the safety and quality of services offered to its patients." *Id*. This credentialing and privileging may be accomplished at the originating site by reliance on the distant site's procedures, provided the following conditions are met:

1. The distant site is a Joint Commission-accredited hospital or ambulatory care organization.
2. The practitioner is privileged at the distant site for those services to be provided at the originating site.
3. The distant site provides the originating site with a current list of licensed independent practitioners' privileges.
4. The originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. …

Id., Element of Performance A, MS33. The standard specifies what information must be sent to the originating site regarding performance. It must include, "[a]t a minimum,… all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site." *Id*.

The Joint Commission standards further clarify that the medical staffs of both the originating and distant sites are to remain involved in telemedicine services provided on an ongoing basis:

> **For originating and distant sites:** The medical staffs at both the originating and distant sites recommend the clinical services to be provided by licensed independent practitioners through a telemedicine link at their respective sites.

MS.13.01.01. In other words, the medical staffs make recommendations to the governing bodies of their respective organizations as to which telemedicine services they feel are warranted.

Medicare Conditions of Participation

On July 1, 2011, Medicare's Conditions of Participation (COPs) were updated to align themselves with the Joint Commission's privilege-by-proxy approach. Prior to this change, hospitals (and Critical Access Hospitals) had to undertake the burdensome credentialing procedure for each physician seeking to treat patients via remote electronic means. Thus, CMS revised 42 C.F.R. §§ 482 and 485 to allow privileging-by-proxy. The COPs, however, set forth a series of conditions that must be met before telemedicine may be practiced. These conditions generally attempt to ensure the distant-site entity can be held accountable to the originating-site hospital for meeting CMS credentialing and privileging standards.

Specifically, where telemedicine services are provided, there must be a *written agreement* with the distant site's governing body that requires the distant site to meet the traditional requirements of sections (a)(1) through (a)(7) of the COPs. 42 C.F.R. § 482.12(a)(8). Those traditional requirements mandate that governing bodies oversee the medical staff and its structure, such as requiring the medical staff have bylaws, that those bylaws be approved by the governing body, and ensuring the criteria for medical staff appointment. 42 C.F.R. § 482.12(a)(1)-(7).

Therefore, in each telemedicine agreement, those seven requirements in 42 C.F.R. § 482.12(a)(1)-(7) should be listed verbatim and remain binding on the distant site's governing body. The written agreement must further specify that "the distant-site telemedicine entity is a contractor of services to the hospital and … furnishes the contracted services in a manner that permits the hospital to comply with all applicable [COPs]…" 42 C.F.R. § 482.12(a)(9). If such a written agreement is in place, then the COPs allow the hospital's medical staff to "rely on information provided by the distant-site telemedicine entity." *Id*.

In addition to the written agreement, all of the following conditions must be met: (i) the distant-site hospital is a Medicare-participating hospital; (ii) the individual distant-site physician or practitioner is privileged at the distant-site hospital, which provides a current list of the distant-site physician's or practitioner's privileges; (iii) the individual distant-site physician or practitioner is licensed in the state where the patient is physically located; and (iv) the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. 42 C.F.R. § 482.22(a)(3). As with the Joint Commission standards, this information must include all adverse events and all complaints the hospital has received about the distant-site physician or practitioner. *Id.*

The above analysis shows state and federal law, as well as the Joint Commission, have expressly authorized the practice of medicine remotely via electronic means. It is significant that the modern realities of the practice of medicine, such as sending x-ray films to a radiologist in another state over the internet for diagnosis, is recognized under the law. Further, the facilities at which the patients are located need not undertake the burdensome procedure for credentialing and privileging each practitioner, who may only provide a single service for that facility. In each case where telemedicine services are provided, all of the above safeguards should be met. The hospital must have a written agreement with the telemedicine entity's governing body that contains a series of specific provisions. Further, it is critical that the telemedicine practitioners do not exceed the scope of the specific agreement and privileges granted to them. With these requirements and safeguards in place, hospitals can make competent use of physicians located off-premises for diagnosis and treatment, thereby improving the quality of patient care.

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