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Health Law ADVISORY

Current legal insights for health care executives

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Julie A. Knutson, Editor

Teleradiology and Proxy Credentialing – Can You Use It?

Many hospitals are currently contracting with teleradiologists to provide remote interpretations of images generated at their facilities. Proper credentialing of teleradiologists frequently raises questions—particularly whether hospitals may engage in "proxy" credentialing. "Proxy" credentialing refers to the practice of relying on the credentialing and privileging process of the teleradiologists' remote practice site with no or only very limited credentialing by the local hospital. The authority for the answer depends on whether your hospital is an acute general hospital subject to the Hospital Conditions of Participation set out at 42 CFR §482 *et seq.* or a critical access hospital ("CAH") subject to the CAH Conditions of Participation set out at 42 CFR §485.601 *et seq.* In either case, proxy credentialing does not meet the standards of the Centers for Medicare and Medicaid (CMS).

Accredited Acute General Hospitals. The situation is particularly confusing for Joint Commission accredited general acute hospitals because Joint Commission standards permit proxy credentialing, while CMS does not. When a Joint Commission-standard conflicts with CMS rules, the CMS rule is controlling.

Joint Commission Standard MS.13.01.01 states that practitioners who "provide official readings of images, tracings, or specimens (interpretive services) through a telemedicine link" are to be credentialed and privileged as if they are providing contracted services under Standard LD.04.03.09. Joint Commission Standard LD.04.03.09 confirms that when "interpretive services" are provided through a "telemedical link" the usual Joint Commission medical staff credentialing and privileging standards and processes are inapplicable:

> "When using the services of licensed independent practitioners from a Joint Commission-accredited ambulatory care provider through a telemedical link for interpretive services, the hospital accepts the credentialing and privileging decisions of a Joint Commission-accredited ambulatory provider only after confirming that those decisions are made using the process described in MS.06.01.03 through MS.06.01.07, excluding

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MS.06.01.03, EP2."

This means that, under strictly the Joint Commission standard and limited to practitioners providing teleradiology services, the local hospital may accept the credentialing and privileging decisions of a remote provider if the provider is accredited by the Joint Commission and the local hospital confirms that the process used by the remote provider complies with Joint Commission credentialing and privileging standards.

In contrast, CMS rules do not exclude teleradiology from the usual credentialing procedures that require that a hospital's medical staff follow perform a credentialing evaluation separate and apart from that of the remote hospital. The CoPs for Hospitals state that the "medical staff must examine credentials of candidates for medical staff membership and make recommendations to the governing body on the appointment of the candidates."[1] CMS also issued a Survey and Certification Letter in 2004 that clarified this CoP as follows: "[a] privileging process that results in a practitioner being granted privileges based on other than the medical staff's assessment of that individual practitioner's qualifications and demonstrated competencies would not comply with CMS requirements."[2] This interpretation applies to "all practitioners who provide a medical level of care and/or conduct surgical procedures in the hospital."[3] This requirement would not be met by the proxy credentialing permitted by the Joint Commission standard governing teleradiologists because teleradiology services are considered "a medical level of care," requiring individual credentialing through the medical staff process of the local hospital.

But is it necessary to repeat the entire application and primary source verification process for each teleradiology applicant? CMS has opined that a hospital may rely on a current application from another facility, but advises that the local hospital conduct key verifications, e.g., licensure, DEA registration, NPDB query, professional liability coverage and then submit the application and verifications through the usual committee, Medical Staff and Board approvals. If the hospital has adopted an expedited approval process as permitted under Joint Commission standards, eligible applications may be approved under the expedited process. There are indications that state licensure and survey departments may vary from CMS on the point of primary source verifications. Some, such as Nebraska, permit reliance on the primary source verification conducted by a credentials verification organization for the remote site. Others may require some level of primary source verification by the credentialing hospital.

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Critical Access Hospitals. CAH CoPs (42 CFR 485.627(a) include the following standard pertinent to credentialing: "[t]he CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment."

The Interpretative Guidelines for this regulation (Tag # C-0241) direct surveyors to look for the following indicators:

- The governing body or responsible individual must determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.

[1] 42 C.F.R. § 482.22(a)(2)
[2] *CMS Letter to State Survey Agency Directors*, S&C 05-04 (Nov. 12, 2004)
[3] *Id.*

- It is the responsibility of the governing body to appoint, with the advice of the medical staff, the individual practitioners to the medical staff. After considering medical staff recommendations, and in accordance with established CAH medical staff criteria and State and Federal laws and regulations, the governing body decides whether or not to appoint new medical staff members or to continue current members of the medical staff.

- Criteria for selection of both new medical staff members and selection of current medical staff members for continued membership must be based on:

  --Individual character
  --Individual competence
  --Individual training
  --Individual experience and
  --Individual judgment

Given that there is no exception permitting proxy credentialing of privileged practitioners by CAHs, the CAH Conditions of Participation and Interpretive Guidelines indicate that teleradiologists should be individually credentialed by the CAH if their interpretations are to be relied upon for treatment decisions.

Practice Pointer: Most hospitals have found it prudent to work with teleradiology contractors to define a regular pool of radiologists designated to provide services at their hospital. A limited pool reduces the burdens of credentialing for the hospital and permits the development of ongoing working relationships, generally with a positive impact on the quality of services.

Julie A. Knutson
Andrew D. Kloeckner

Sales Tax for Copying Medical Records

The Nebraska Department of Revenue recently confirmed that health care providers and suppliers must charge state and local sales taxes on all fees assessed for copying medical records, subject to an important exception.

Neb. Rev. Stat. §71-8403 *et seq.* continues to govern a patient's access to medical records and allows providers to charge a limited fee for providing copies of a medical record in many circumstances. The law limits the allowable charges for copies of records provided at a patient's request or pursuant to a subpoena to no more than $20 as a handling fee and no more than 50 cents per page.

When charging for copies of medical records, providers must collect appropriate state and local sales taxes. Importantly, however, the Nebraska legislature recently crafted an exemption from sales taxes for the reproduction of medical records under certain circumstances. Section §23 of LB 916, enacted in 2008, created a specific exemption from sales tax for the reproduction of medical records "provided to the patient or a person holding such patient's power of attorney for health care."

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Copies of medical records that are provided to patients or their "attorneys-in-fact" under a Healthcare Power of Attorney are not subject to sales tax. An "attorney-in-fact is the person designed by the individual in the Power of Attorney document to make

health care decisions on his or her behalf—usually a close relative. This term does not refer to an attorney engaged by the patient for legal representation. If a patient's attorney requests a copy of the patient's medical record on behalf of his or her client in relation to legal representation, and the provider charges for copies, the provider is required to calculate and include sales tax on the bill sent to the attorney because the request was not received directly from the patient.

Copies of medical records requested by governmental and tax-exempt entities are exempt from the sales tax. However, the provider should obtain a copy of the tax-exempt certificate from the tax-exempt entity to document the basis for not charging and collecting sales tax.

Finally, in any case in which no charge is made for the medical records, either due to statutory limitation or policy, sales tax need not be collected.

Hospitals and other providers and suppliers of health care must be diligent in determining which medical record charges are subject to Nebraska sales taxes when charging third parties for copies of medical records and assure that, unless the exemption is applicable, such tax is charged and collected.

Andrew D. Kloeckner

CMS Clarifies Position On Mobile Diagnostic Tests

Coverage for Physician Offices

Over the past two years CMS has established stringent performance standards for suppliers enrolled in Medicare as IDTFs. These rules are found in 42 C.F.R. § 410.33. In the *proposed* 2009 MPFS, CMS proposed to expand the coverage of selected IDTF rules to cover most diagnostic tests conducted in physician and non-physician practitioner ("NPP") offices. It planned to reach those providing *any* diagnostic tests (other than clinical laboratory tests), but also indicated it was considering whether to limit the impact of the rule change to more advanced testing, such as PET, MRI, and CT. The rule change would have subjected physician and NPP organizations to many costly standards that CMS believes are core quality standards for diagnostic testing.

In the final version CMS did *not* enact this general expansion of IDTF rule coverage. Its decision was driven in part by enactment of Section 135 of MIPPA, which requires CMS to establish an accreditation process for entities furnishing advanced diagnostic testing procedures, such as PET, MRI and CT, by January, 2012. Thus, the expansion of IDTF standards to cover physician and NPP organizations providing diagnostic tests is on hold, with the exception of an expansion of the rules applicable to mobile diagnostic testing entities.

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Mobile Entities

While shelving the rule change for physician and NPP offices, CMS did expand IDTF coverage to mobile diagnostic testing entities. Specifically, it added to the IDTF standards new Section 410.33(g)(16) intended to require entities furnishing mobile diagnostic *services* to enroll in Medicare as IDTFs, regardless of where they furnish the services, and then to bill directly for those services. This change is very significant for both physician and NPP offices performing tests using outside or leased equipment or staff and to those who furnish equipment or staff but do not view themselves as "mobile diagnostic testing entities."

CMS may have been targeting those entities that are already enrolled as mobile providers and that conduct business along two lines — they may bill directly for some services they render as mobile suppliers, but they may also furnish equipment and personnel directly to physician and NPP offices in order to allow them to perform and bill for tests as tests performed by them. However, the comments to the final rule went further.

> "*Comment:* One commenter urges CMS to exclude from the definition of entities furnishing mobile diagnostic testing services those entities that do the following: lease equipment and provide technicians who conduct diagnostic tests in the office of the billing physician or physician organization; and furnish testing under the supervision of the physician who shares an office with the billing physician or physician organization.
>
> *Response:* We disagree with the commenter. We maintain that a mobile entity providing diagnostic testing services must enroll for any diagnostic imaging services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location so that CMS knows which entity is providing these diagnostic testing services."[1]

This comment seemed to eliminate the distinction between mobile diagnostic testing entities, which are in the business of furnishing tests and directly bill their services, from entities that merely lease equipment or staff to physician and NPP offices to enable *them* to perform tests. The comment fueled the debate as to what inputs a physician office can acquire from outside in order to conduct diagnostic tests as part of its practice. CMS seemed to be saying that the combination of equipment plus staff made the outside organization the provider of the diagnostic service and would subject it to the IDTF enrollment and direct billing standard. Among other things, this would have mooted much of the anti-markup rule's application to these tests by preventing physician and NPP organizations that use leased equipment and staff *from billing at all*.

This approach has turned out to be overbroad and CMS has now clarified (some would say changed) its position. In an act reminiscent of "slipping the check under the door," CMS used a FAQ it published on December 16 to acknowledge it is not yet sure how to approach this issue:

> "My company leases/contracts diagnostic testing equipment and/or non-physician personnel described in 42 C.F.R. 410.33 to an enrolled Medicare provider/supplier (e.g., medical group practice). Do I need to enroll as an Independent Diagnostic Testing Facility (IDTF)?
>
> Companies that lease or contract with a

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[1] 73 Fed. Reg. 69764 (November 19, 2008).

Medicare enrolled provider or supplier to provide: a) diagnostic testing equipment; b) non-physician personnel described in 42 C.F.R. 410.33(c); or c) diagnostic testing equipment and non-physician personnel described in 42 C.F.R. 410.33(c) are not required to enroll as an IDTF.

Medicare continues to evaluate arrangements where both diagnostic testing equipment and non-physician personnel are contracted to a Medicare enrolled provider or supplier and where the Medicare enrolled provider or supplier is billing for the diagnostic service."

Effect?

Coupled with the substantial relaxation of the anti-markup rule, this clarification suggests that an entity that is not enrolled as a mobile supplier of diagnostic tests can furnish the equipment and staff to perform or help perform a diagnostic test under the supervision of a member of the ordering group in the group's offices, and the group can bill for the diagnostic test without being subject to anti-markup restrictions as well. If this is the effect, it is likely to be temporary.

First, rules to implement Section 135 of MIPPA are likely to impose IDTF standards on physician and NPP organizations that provide advanced diagnostic testing by January of 2012.

Second, there is no bright line, and there is not likely to be a bright line, defining when a combination of inputs provided by a third party constitutes the performance of the test itself. CMS is likely to return to this issue, probably in the 2010 Medicare Physician Fee Schedule.

Alex M. (Kelly) Clarke

Vickie Brady Ahlers Named One of Ten Outstanding Young Omahans

Congratulations to Vickie Brady Ahlers on being selected as one of Ten Outstanding Young Omahans (TOYO). Since 1933, the Omaha Jaycees have been honoring ten men and women between the ages of 21 and 40 each year who strive for excellence and have a strong commitment to both community service and personal and professional development. Vickie was honored at the 76th Annual TOYO Awards dinner on January 28 at the Qwest Center Omaha.

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