Credentialing Locum Tenens and Telemedicine Providers:

MYTHS, TRADITIONS, TRENDS AND OPTIONS

Prepared by Hugh Greeley | Supported by Verisys Corporation
Here to stay and seemingly welcome everywhere

V

arious referred to as traveling physicians, locums tenens, telemedicine providers, and remote docs, they are becoming an essential component of the nation’s health care system. Many hospitals could not function without them, entire communities would be without specialty coverage, operating suites would stand empty, ER/EDs could not function, and hospitalist programs would not be able to meet the demand. By some estimates, there may be up to 100,000 physicians interested in providing clinical services in locations far from their homes. An equivalent number will soon be augmenting primary care physicians through telemedicine programs. According to an article in the New England Journal of Medicine (NEJM), the nation may not be far from having telemedicine consults in the comfort of one’s own home. The virtual house call is not far off.

Consider that, on average, a patient must wait 20 days for an appointment with a physician, then spend roughly two hours getting to and from the appointment. A virtual house call may still have a wait time to get an appointment, but would take only 20 to 30 minutes from the convenient locale of the patient’s office or home.

What may reduce wait time for an appointment is the activation of professional locum tenens physicians that allow hospitals and other organizations to staff up when needed and reduce staff during times of low volume.

Yet with this profound change in the manner through which communities access needed health care professionals, our traditional method of “on boarding” them has roots in the early days of the medical staff. Back to circa 1950–2000, most physicians preferred to practice at one location, one community, and at most, three or four hospitals. In those bygone days, physicians made a decision to practice in a specific location, often drawn by family, friends or promise of a partnership. They moved into town, set up an office and rarely changed practice locations. “On boarding” was a simple application, appointment to the medical staff so that they could participate in self-governance, emergency calls and in exercising the precious medical staff vote. Over the decades, credentialing became increasingly complex, however in the single-hospital paradigm, it was an activity that needed rigorous attention only once. Reappointments were not terribly cumbersome or bureaucratic.

Nearly all credentialing practices were conceived and solidified into rules, bylaws and standards during that third quarter of the century.

The Centers for Medicare and Medicaid Services (CMS) as well as various accreditation agencies codified practices into standards, many of which are simply no longer called for and do not provide the health care system with the flexibility necessary to efficiently provide services to patients.
For example: It does make sense to verify that a physician has a license, completed medical school, finished residency, is able to prescribe medications, is certified, has a clean National Practitioner Database (NPDB) report, etc. But does it make sense to do this 40 times per year for traveling doctors, for those providing telemedicine services in dozens or even 100s of facilities, and for those serving large multi-hospital systems?

Historically it did make sense for each individual state to require that physicians be licensed in that state as a prerequisite to clinical practice. A century ago, standards for physician education and training were not standardized, board certification was not prevalent, and there was a case to be made that the state must carefully scrutinize each potential clinician.

During the last 50 years, it has become apparent that individual state licensure could easily be replaced with an alternative system which would adequately protect patients from charlatans, criminals, imposters, the untrained, and from those with poor track records.

Historically there was compelling evidence suggesting that individual hospitals and their medical staffs must independently verify the qualifications and competence of each doctor regardless of their prior clinical activities or affiliations.

Today there is no logic in requiring a hospital to duplicate the verification of a physician’s education, training, experience, licensure status, DEA, certification status and all other material information concerning qualification and competence if such information was available from another accredited hospital, credentials verification organization or governmental agency. This information package could easily be supplemented with up-to-date professional references.

Today it is entirely possible to create a single or multiple competing databases that would hold a physician’s complete and verified education, training, and relevant practice history, along with a complete and verified curriculum vitae. The so-called “cloud” could then be accessed by any entity given permission to do so by the “owner” of the file.

This is no longer a theory; it is possible today to near instantly access all information needed to make a decision concerning staff membership or clinical privileges.

The nation is slowly moving in this direction as is demonstrated by the rules and regulations concerning granting permission to practitioners to provide remote or telemedicine. Under current rules, hospital “A” may grant clinical privileges, solely on the basis of the fact that another fully accredited hospital has done just that. No independent verification is needed, no clinical references, just a simple but non value-added licensure check.

In a similar vein, 19 state medical boards through the Interstate Medical Licensure Compact have moved to rationalize the licensure issue for physicians who practice in multiple states.

It certainly seems that many in the credentialing field will see the day when individual facility-specific primary source verification will no longer be the burden it now is.

The primary beneficiaries of this movement will be patients—always first and foremost—and next, traveling or remote physicians and the hospitals they work with.

Back to the present

While the future may be only a decade away, today’s pressing need for quicker on-boarding is colliding with the traditional, slow-to-change regulations. The resulting situation is one in which hospitals must do all that they possibly can to rationalize the credentialing of this new breed of clinician. Let’s begin by identifying the problems and opportunities hospitals are faced with.
1. **Increasing numbers of traveling and remote clinicians.**
   Not much anyone can do about this one. Predictions are that the number of locum doctors will continue to grow and that telemedicine is in its infancy with huge potential to revolutionize the practice of medicine.

2. **Availability of more background data concerning physicians in general thus creating a need to access it prior to making decisions.**
   If there is a data source that is easily accessible, useful in shaping a decision concerning compliance or competency, there will be unrelenting pressure to access that data source. It is likely that hospitals will not have the sophistication to easily and efficiently establish systems to do so. Reliance upon entities with greater access to technology will increasingly be necessary.

3. **Historical practices that serve to slow the process down.**
   These we can change if we have the will to do so, and changing will substantially aid in meeting the three objectives of credentialing. Patient protection, facilitation of practice, and assisting the organization in fulfilling its mission.

4. **Pressure to grant temporary privileges.**
   The increasing use of locums physicians has put enormous pressure on the granting of “temporary” privileges. Understandable management has contracted with a locums to fill an urgent or long-term need. Such needs are difficult to predict through normal long-range planning activities. Your single anesthesiologist or surgeon finds it necessary to leave unexpectedly, a hospitalist's slot must be filled, babies need to be delivered, etc. each of these situations might call for a locums—STAT.

5. **Antiquated medical staff bylaws provisions concerning credentialing.**

6. **Misunderstood standards and regulations.**

7. **Paradigm-bound physician leaders and board members.**
However, STAT for some might not be STAT for others. First an application must be completed, this is facilitated by the locums agency but still must occur.

Then the process of primary source verification must begin and of collecting other important information such as that pertaining to current clinical competence.

Licensure, the NPDB, Excluded provider lists, and a host of other “qualifications” must be accessed.

Of the above, perhaps the most time consuming involve clinical or professional references and verification of past experience.

Management and patient care needs cannot wait; we need this doctor now, let’s just grant temporary privileges. (That, in essence, completely destroys the rationale for careful and complete verification of credentials.)

The information required to grant temporary privileges may vary somewhat from one hospital to another but it usually encompasses:

- **Licensure verification in your state.**
- **Confirmation of completion of medical or osteopathic school and residency.**
- **Evidence of clinical competence in the form of references from peers either gathered via mail, phone or electronically.**
- **An NPDB check as well as a check with the excluded provider data base, and confirmation of a valid DEA permit.**

**Relevant accreditation reference:**

“For the new applicant, temporary privileges may be granted by the CEO upon recommendation of the president of the medical staff. Temporary privileges may only be granted for up to 120 days. Prior to granting privileges, there must be verification of current licensure, relevant training or experience, current competence, ability to perform the privileges requested, and any other criteria required by the organization’s medical staff bylaws. The National Practitioner Data Bank query results must have been obtained and evaluated. It is also required that the new applicant has a complete application with no current or previously successful challenge to licensure or registration, has not been subject to involuntary termination of medical staff appointment at another organization, and has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.”

In many situations temporary privileges are only considered after all information has been collected and verified but before file review by the credentials, medical executive committees, board or relevant department chair.

Important note about temporary privileges. Hospitals and their medical staffs must realize that privileges are privileges regardless what you call them. The issue for the staff to recognize is that all privileges are time limited, for most doctors the time period is 24 months, for some (particularly locums docs) it is for less than 24 months.

There is no need to use the term temporary privileges as all are in fact “temporary”. Example: Your hospital contracts with a locums surgeon to fill in for an existing doctor who is not available or for any other reason. You have determined that the term of the contract will be 55 days because you know that the normal doctor will be back by then. Your staff and board should grant clinical privileges for the 55 (or for more if you want to be safe) days you know you will need that practitioner.

You do not have to call them temporary, they are simply clinical privileges granted for a specific time period.
1. **Q** I’m not sure how much you’ll get into the types of telehealth, but I would be curious to know more about the credentialing for “tele-rounding.” Thank you!

   **A** Rounding (or daily rounds) is simply another activity that is now performed remotely. Usually there is an RN present to respond to specific questions posed by the telehealth practitioner. Tele-rounding does not require any special activity on the part of the medical staff or medical staff professional. The regular “credentialing” activity usually applied to your telehealth practitioners will do the trick.

2. **Q** I am particularly interested in telehealth credentialing challenges.

   **A** The major credentialing challenges faced as a result of the advent of telehealth relate to MSP time, staff leadership availability, and the specific policy adopted by your board to permit remote practice of clinical medicine. I generally recommend that you, as the originating facility enter into an agreement with the distant hospital permitting you to piggyback off their privileging decisions. As long as the distant facility is appropriately accredited, you are permitted to rely upon their due diligence and assignment of privileges. Your obligation is to assure that you approve their procedures for credentialing, that you receive a copy of the specific privileges granted by the distant facility’s board, both parties must agree to share any pertinent quality findings with the other party, and the distant facility must inform the originating facility if there are any changes in a practitioner’s privileges or membership.

   Your board must play a role in the entire process.

   Alternatively, you are permitted to conduct the privileging process according to your existing medical staff bylaws, in other words, the entire process would proceed as if the practitioner were applying as a normal applicant. We do not recommend this as it is extremely time consuming and unnecessary.

   More recently, some facilities are reporting good results by entering into an agreement with a CVO selected jointly by both facilities that permits primary source verifications to be performed once, used by both facilities and any others linked into the telehealth program. Once all required information was received from the CVO, your medical staff would continue to process applications as directed in the bylaws.

   It is highly likely that, as the nation’s regulators become more comfortable with telehealth, much of the bureaucracy associated with telehealth credentialing will disappear.
3. **Q** We are considering making TELEMEDICINE a Staff Category in the Bylaws, allowing for specialty services (e.g. Tele-radiology, Tele-cardiology, Tele-pediatrics). Do you see any issue as far as The Joint Commission (TJC) and CMS are concerned?

**A** No issues relative to any accrediting agency or the CMS. This is because none of these organizations have any standards concerning staff categories other than the fact that you must have an Active category.

That being said, I do not see any benefit that would accrue to patients, physicians or your hospitals from establishing such categories. Telehealth practitioners do not want nor need staff membership. So why go through this process? Each telehealth practitioner must, however, have clinical privileges.

Please ask yourself and your staff leaders this question: What goal will we achieve by establishing such a category; how will patients benefit; how will physicians benefit; and, how will this improve the hospital’s ability to function?

I believe the answer is that there will be no benefit.

4. **Q** What orientation should locum tenens receive? The same as other medical staff or an abbreviated version? Some locum tenens may work for only two weeks. How would you conduct focused and ongoing professional practice evaluations for locum tenens who work only short duration of weeks?

**A** As soon as the locums hit the hospital, begin the process of gathering any information that is generated relating to his or her activities.

Complaints, complements, incident reports, sentinel events, charts sent to peer review for whatever reason, etc. Because this doctor or APRN may be leaving soon, there is no reason to worry about converting F to OPPE. Just collect the information and periodically make sure a staff leader is looking at it and documenting his or her opinion.

If a major problem occurs, handle it as you normally would.
5. If you are not billing for the physician's professional fees who provide locum coverage, does the 120 days CMS rule apply? Meaning, do you have to limit the number of days they practice?

Rules pertaining to restrictions on the number of days you may award temporary privileges do not change as a result of billing issues. It is entirely within your ability to eliminate the games you are forced to play with temporary privileges by quickly moving to an expedited approval system. Once this is in place, your board may then grant privileges for any designated time period. Since they are not temporary, the rules relating to temporary do not apply.

6. Can there be any differences to the credentialing process for locum tenens providers versus hired providers? I work in an ambulatory world without bylaws.

Not really. Any practitioner who will be providing patient care must be found both qualified to practice within the organization and competent to do so.

Qualified will depend upon your organization’s rules but at a minimum, they should include licensure, verification of professional education, residency, NPDB check, excluded provider check, review to assure recent relevant clinical practice.

Competence must be evaluated through references, review of malpractice history, disciplinary action history, ability to provide clinical service (health issues), gaps in practice history, and if available, any relevant quality data available from any source.

7. How often should temporary privileges be granted if all information for credentialing has not been received?

Never! As long as you have assured that the rules in place at your facility, call for necessary information only.
8. If your bylaws allow temporary privileges to only be granted for 60 days, is it acceptable to “re-issue” temp privileges for an additional 60 days if necessary?

Yes, but why not simply change the rule to 120 and be done with it? Older traditional bylaws required that temporary privileges be granted for no more that 60 days for reasons that are no longer applicable.

9. How can we change the attitudes of the up-and-coming who now have created “alarm fatigue,” which was created to alert any problems of the patient?

I do not perceive this question as pertaining to credentialing. It relates to training, supervision, and clinical management.

10. In replacing physical credentialing board meetings, is it even necessary to have a virtual meeting? Can you not just have the board review individually and sign off on the file?

Yes, this is an acceptable form of a virtual meeting. I suggest that you attempt to structure such an “open meeting” so as to first secure the recommendation of the relevant department chair. All other recommendations and decisions often hinge on this first review and opinion.

Also, such process does not eliminate the need for minutes reflecting the process and its outcome. Documentation on the application for privileges or a separate form is critical for a number of very real reasons such as future corporate negligence defense, and standards compliance.

11. What types of documents do patients need to sign to agree that he/she will be cared for by a locum clinician?

The normal hospital and consent for surgical or other procedure consent form is usually sufficient. The fact that the practitioner is a locum is irrelevant.
12. **How do you deal with a locum who comes and goes on a regular basis at your hospital?**

For instance, we use them to fill in for hospitalists, ED physicians, pediatric hospitalists, ortho surgery. We have some who have been coming to Hawaii for years covering for us.

**A**

Grant them privileges for two-year terms as you would if they lived on the island. Treat them as you would any other staff member to whom you have granted privileges. Remember, making them a member of the staff is discretionary. Granting of clinical privileges is the important issue.

Enroll in the NPDB's continuous monitoring process so that you would pick up any pertinent change in their qualifications.

Enroll in FACIS for historical as well as up-to-the-minute changes to a provider's licensure status. FACIS, by Verisys, makes available data on exclusions, debarments, disciplinary action, sanctions, press releases, and minutes from state medical board hearings as soon as it is published.

13. **What does it mean to grant privileges but not staff appointment?**

**A**

Membership and clinical privileges are two different issues. We frequently grant privileges (to PAs and APRNs) without staff membership, and we grant staff membership without privileges to those we wish to honor. The only barrier to granting physicians privileges without membership is tradition.

14. **I am contracted with a tele-radiology company for PSV and when they send me the file, their queries are a year or two old. They are TJC accredited. I'm not comfortable with relying on PSV done that long ago, so I re-verify everything. I'm not comfortable accepting PSV's that old and yet, they are unable to provide all of their clients with current PSVs.**

**A**

Some data need not be subject to re-verification due to the fact that it does not change. (Medical school and residency completion are good examples) however any data/information that could change such as board status, information in the NPDB, licensure status, malpractice history, recent relevant work history, professional references, etc. can and sometimes does change. This information must be updated to assure that it is current. Your CVO should know this and can probably accommodate your need for current data and information.
15. I have heard from surveyors that locums doctors must be given medical staff appointment so that they will be required to follow the medical staff bylaws. You seem to have said that we could give them privileges only with no membership?

Answer: Asked previously and answered.

16. We have a contract for hospitalists and some members of the group do not live in our service area. Our bylaws call for members to live and work within 30 minutes of the hospitals so that they can provide continuous care to their patients. Our medical staff committee keeps making exceptions to this rule for them. Should we be worried?

Answer: Yes, be mildly worried because every time you make an exception, you weaken the rule and make it more subject to successful challenge if you do not make the exception when requested. Ideally you should not make exceptions to your rules. My recommendation is that you change the rule as it is no longer applicable to all staff members.

17. We have an ortho group who keeps bringing in locums to cover while one of them is on vacation. They get very angry when we are unable to process the application quickly enough “for them”. Often they go right to management and we are pressured to work overtime.

Answer: This is not a question, it is a factual statement and all too common a situation for medical staff service professionals. How about adding, “What should we do about this?”

Now it is a question. Figure out how to conduct PSV as rapidly as possible. (This may involve changing some of your procedures and eliminating work that adds no value such as verifying a physician's 35-year work history.)

Adopt an expedited review and approval system as described in this short document.
18. **Q** Our locums provider sends us a list of all hospitals at which a locums applicant has worked; must we verify each of these past practices? Can’t the locums agency do this for us. Some of the docs they send have been to 75 hospitals?

**A** No you need not verify the entire work history; there is no value in continuing this antiquated practice for locums doctors.

And yes you could put the burden on the locums agency for this activity, however you cannot shift the burden of securing professional references attesting to competence to the locums agency. This burden can only be shifted to an accredited/certified CVO or to another hospital in the case of telehealth providers.

19. **Q** We have heard from our corporate compliance officer that we cannot let a locums doctor begin to work if they were excluded in the past, but are no longer excluded.

**A** You may not permit a currently excluded provider to provide care if you participate in a federal entitlement program. If you determine that a provider was once excluded but is no longer, you have a decision to make once you have evaluated the reason he or she was excluded. You could either permit the practitioner to practice or send him/her packing.

20. **Q** You proposed setting up a system in which the MEC could meet in special session without meeting our MEC quorum requirements. Can we really do this?

**A** Yes!

21. **Q** Often our locums doctors are gone before our board can act on their application, would a special committee of the board eliminate the need to take the application to the full board?

**A** Yes!
22.

**Q**
We use a terrific telemedicine group supplied by a nationally recognized clinic. They have hundreds of doctors who might provide telemedicine services to us. We can’t credential all of them and don’t want them on our staff. We wave dues, meeting requirements, and residency requirements. There must be a better way…You have provided lots of suggestions, can we call you for further advice?

**A**
Yes, but this is an easy one. Rely upon the credentialing program at the distant hospital. Grant them clinical privileges without membership. That’s all they want and need.

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**Hugh Greeley —**

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Hugh Greeley began his health care career in 1973 while working with the National Blue Cross Association and then with the Joint Commission on Accreditation of Hospitals (now JCAHO) in Chicago, IL. Since that time, he has worked with Medical Societies, Hospital Associations, Universities, Foreign Governments, and others to advance the cause of patient care.

Mr. Greeley is widely regarded as an expert in matters pertaining to medical staff administration, hospital governance, credentialing, performance improvement, accreditation, anti-trust and corporate negligence. During his career, he visited approximately 1,000 hospitals and has spoken as a faculty member at over 3,500 conferences, institutes and seminars.

Mr. Greeley is the Chairperson of the Volunteers in Medicine Institute, an organization dedicated to assisting hospitals and their communities in establishing free clinics for the uninsured. He is also on the faculty of The Governance Institute, La Jolla, CA; a member of The Bureau of the Healthcare Facilities Accreditation Program, Chicago, IL, and a member of the Selection Committee for the Excellence In Medicine Awards of the Foundation of the American Medical Association.

Mr. Greeley is the author of numerous publications, articles and electronic letters. He is regularly requested to assist both medical and hospital organizations in his areas of expertise.
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