



## Check List

### Telehealth Credentialing and Privileging Sec. 482.12. Conditions of Participation – Governing Body

The Centers for Medicare and Medicaid Services' (CMS) final rule on credentialing and privileging requirements for telehealth practitioners is effective on July 5, 2011. This rule establishes a process for originating-site hospitals (location of the patient) to rely on the credentialing and privileging decisions of the distant site hospital (location of the specialist) for telehealth practitioners.

#### Definition of Terms

- Originating Hospital: location of the patient
- Distant-Site Hospital: location of the telemedicine practitioner

\* Please Note: Red = New Provisions Provided Through CMS Final Rule

#### Executive Summary Conditions of Participation – Governing Body [Sec. 482.12]

**Section 482.12** pertains to the appointment of a hospital's medical staff.

**Section 482.12 (8)** requires that when telemedicine services are furnished to a distant-site hospital (i.e. the location of the telemedicine practitioner) that a formal written agreement specifies that it is the responsibility to meet the requirements 1-7 of 482.12 (see below for requirements 1-7).

**Section 482.12 (9)** specifically applies to the written agreement between the originating-site hospital and the distant-site hospital, which requires that the distant-site hospital is a contractor of services to the originating-site hospital and furnishes services that is compliant with the Conditions of Participation.



## Conditions of Participation – Governing Body Section 482.12 (1-9)

For the purposes of credentialing and privileging telehealth practitioners, the originating hospital's governing body, or the persons responsible for the hospital conduct, must adhere to the following conditions in determining appointment to the hospital's medical staff:

- (1) Determine which categories of practitioners are eligible candidates for appointment to the medical staff (in accordance with state law).
  
- (2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.
  
- (3) Assure that the medical staff has bylaws.
  
- (4) Approve medical staff bylaws and other medical staff rules and regulations.
  
- (5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.
  
- (6) Ensure the criteria for selection are individual character, competence, training, experience, and judgment.
  
- (7) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society.
  
- (8) Ensure that, when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the agreement is written and



that it specifies that it is the responsibility of the governing body of the distant-site hospital to meet the requirements in 1-7 regarding the distant-site hospital's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital.

- (9) Ensure that when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the written agreement specifies that the distant-site telemedicine entity is:
  - a contractor of services to the hospital
  - furnishing the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including 1-7 above.

The governing body of the hospital whose patients are receiving the telemedicine services may grant privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital's medical staff recommendations.

Staff recommendations may rely on information provided by the distant-site telemedicine entity.

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## Check List

### Telehealth Credentialing and Privileging Sec. 482.22. Conditions of Participation – Medical Staff

The Centers for Medicare and Medicaid Services' (CMS) final rule on credentialing and privileging requirements for telehealth practitioners is effective on July 5, 2011. This rule establishes a process for originating site hospitals (location of the patient) to rely on the credentialing and privileging decisions of the distant site hospital (location of the specialist) for telehealth practitioners.

#### Definition of Terms

- Originating Hospital: location of the patient
- Distant-Site Hospital: location of the telemedicine practitioner

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#### Executive Summary Conditions of Participation – Medical Staff [Sec. 482.22]

Section 482.22 pertains to medical staff employed by the hospital.

**Section 482.22 (3)** gives the originating site hospital the choice to rely upon the credentialing and privileging decisions made by the distant site hospital. However, the originating site hospital must ensure, through its written agreement with the distant site hospital that the following occur: 1. the distant site hospital providing the telemedicine services is a Medicare-participating hospital; 2. the telemedicine practitioner is privileged at the distant-site hospital; 3. the telemedicine practitioner holds a license or is recognized by the State in which the originating site hospital is located; 4. the originating-site hospital has evidence of an internal review of the distant-site practitioner's performance of these privileges and sends the distant site performance for use in periodic appraisal of the distant-site practitioner.

**Section 482.22 (4)**. The originating-site hospital must ensure through its written agreement with the distant-site hospital that the following conditions are met: 1. the distant-site telemedicine entity's medical staff credentialing and privileging process; 2. the telemedicine practitioner is privileged at the distant-site; 3. the telemedicine provider holds a license or is recognized by the state where the originating-site hospital is located; 4. the originating-site hospital has evidence of an internal review of the distant-site practitioner's performance of these privileges and sends the distant site performance for use in periodic appraisal of the distant-site practitioner.



## Conditions of Participation – Medical Staff Sec. 482.22

The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

(a) Standard: Composition of the medical staff. The medical staff must be composed of doctors of medicine or osteopathy and, in accordance with State law, may also be composed of other practitioners appointed by the governing body.

(1) The medical staff must periodically conduct appraisals of its members.

(2) 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.

(3) When telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the originating site's governing body may choose, instead of (1) and (2), to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site telemedicine practitioners.

The originating site's governing body must ensure, through its written agreement with the distant-site hospital, that:

(i) The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.

(ii) The individual distant-site practitioner is privileged at the distant-site hospital, which provides a current list of the distant-site practitioner's privileges at the distant-site hospital.



(iii) The individual distant-site practitioner holds a license issued or recognized by the State in which the originating site hospital is located.

(iv) The hospital has evidence of an internal review of the distant site 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 or practitioner. This information must include all adverse events that result from the telemedicine services provided by the distant-site practitioner to the hospital's patients and all complaints the hospital has received about the distant-site practitioner.

(4) When telemedicine services are furnished to the hospital's patients through an agreement between the originating site and the distant-site telemedicine entity:

(i) The originating site governing body may choose, in lieu of the requirements in paragraphs (1) and (2) above, to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site telemedicine entity when making recommendations on privileges for the individual distant-site practitioners providing such services.

(ii) The hospital's governing body must ensure, through its written agreement that the distant-site telemedicine entity furnishes services that permit the hospital to comply with all applicable conditions of participation for the contracted services.

(iii) The hospital's governing body must also ensure, through its written agreement that all of the following provisions are met:

(a) The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the Governing Body standards at §482.12(a)(1) through (a)(7) and the Medical Staff standards at §482.22(a)(1) through (a)(2).



(b) The individual distant-site practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides the hospital with a current list of the distant-site practitioner's privileges at the distant-site telemedicine entity.

(c) The distant-site practitioner holds a license issued or recognized by the State in which the originating site hospital is located.

(d) The hospital has evidence of an internal review of the distant site practitioner's performance of telemedicine privileges and sends the distant-site telemedicine entity this performance information for use in the periodic appraisal of the distant-site practitioner.

At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site practitioner to the hospital's patients, and all complaints the hospital has received about the distant-site practitioner.

(b) Standard: Medical staff organization and accountability. The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to patients.

(1) The medical staff must be organized in a manner approved by the governing body.

(2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.



(3) The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by

State law of the State in which the hospital is located, a doctor of dental surgery or dental medicine.

(c) Standard: Medical staff bylaws. The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must:

(1) Be approved by the governing body.

(2) Include a statement of the duties and privileges of each category of medical staff (e.g., active, courtesy, etc.)

(3) Describe the organization of the medical staff.

(4) Describe the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body.

(5) Include a requirement that--

(i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

(ii) An updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the





medical history and physical examination are completed within 30 days before admission or registration.

(6) Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.

For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the originating site hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to the requirements in A-8 and A-9 of the Governing Body COPs, and (a)(3) & (a)(4) of the Medical Staff COPs.

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## Check List

### Telehealth Credentialing and Privileging Sec. 485.616. Conditions of Participation –Agreements for Critical Access Hospitals

The Centers for Medicare and Medicaid Services' (CMS) final rule on credentialing and privileging requirements for telehealth practitioners is effective on July 5, 2011. This rule establishes a process for originating site hospitals (location of the patient) to rely on the credentialing and privileging decisions of the distant site hospital (location of the specialist) for telehealth practitioners.

#### Definition of Terms

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#### Executive Summary Conditions of Participation – Agreements for Critical Access Hospitals [Sec. 485.616]

Section 485.616 pertains to agreements for critical access hospitals.

**Section 485.616(1)** this section outlines the requirements of the written agreement between the distant –site and originating-site hospital.

**Section 485.616(2)** this section explains that Critical Access Hospitals (CAHs) can rely on the credentialing and privileging decisions of the distant-site hospital. The CAH must also ensure the following through its written agreement with the distant-site hospital: 1. the distant-site hospital providing the telemedicine services is a Medicare participating hospital; 2. the physician is privileged at the distant-site hospital; 3. the distant-site physician holds a license in the state where the CAH is located; where there is a formal review of the distant-site's physicians privileges.



**Sec. 485.616 Condition of participation: Critical Access Hospitals (CAHs).  
Agreements.**

(a) Standard: Agreements with network hospitals. In the case of a CAH that is a member of a rural health network as defined in Sec. 485.603 of this chapter, the CAH has in effect an agreement with at least one hospital that is a member of the network for—

(1) Patient referral and transfer;

(2) The development and use of communications systems of the network, including the network's system for the electronic sharing of patient data, and telemetry and medical records, if the network has in operation such a system; and

(3) The provision of emergency and nonemergency transportation between the facility and the hospital.

(b) Standard: Agreements for credentialing and quality assurance. Each CAH that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least:

(1) One hospital that is a member of the network;

(2) One QIO or equivalent entity; or

(3) One other appropriate and qualified entity identified in the State rural health care plan.

(c) Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners.



- (1) The governing body of the CAH must ensure that, when telemedicine services are furnished to the CAH's patients through an agreement with a distant-site hospital, the agreement is written and specifies that it is the responsibility of the governing body of the distant-site hospital to meet the following requirements with regard to its telemedicine practitioners:
  - (i) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.
  - (ii) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.
  - (iii) Assure that the medical staff has bylaws.
  - (iv) Approve medical staff bylaws and other medical staff rules and regulations.
  - (v) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.
  - (vi) Ensure the criteria for selection are individual character, competence, training, experience, and judgment.
  - (vii) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society.
- (2) When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site hospital, the CAH's governing body or responsible



individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site hospital regarding individual distant-site physicians or practitioners. The CAH's governing body or responsible individual must ensure, through its written agreement with the distant-site hospital, that the following provisions are met:

- (i) The distant-site hospital providing telemedicine services is a Medicare-participating hospital.
  
- (ii) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site practitioner's privileges at the distant-site hospital;
  
- (iii) The individual distant-site practitioner holds a license issued or recognized by the State in which the CAH is located; and
  
- (iv) With respect to a distant-site practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site practitioner's performance of these privileges and sends the distant-site hospital such information for use in the periodic appraisal of the individual distant-site practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH's patients and all complaints the CAH has received about the distant-site physician or practitioner.
  
- (3) The governing body of the CAH must ensure that when telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the agreement is written and specifies that the distant-site telemedicine entity is a contractor of services to the CAH and as such, in accordance with §485.635(c)(4)(ii), furnishes the contracted services in a manner that enables the



CAH to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in this section with regard to its practitioners providing telemedicine services.

(4) When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the CAH's governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site telemedicine entity regarding individual distant site practitioners. The CAH's governing body or responsible individual must ensure, through its written agreement with the distant-site telemedicine entity, that the following provisions are met:

(i) The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at paragraphs (c)(1)(i) through (c)(1)(vii) of this section.

(ii) The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides a current list to the CAH of the distant-site physician's or practitioner's privileges at the distant-site telemedicine entity.

(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH whose patients are receiving the telemedicine services is located.

(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site practitioner's performance of these privileges and sends the distant-site telemedicine entity such information for use in the periodic appraisal of the distant-site practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-



site practitioner to the CAH's patients and all complaints the CAH has received about the distant-site practitioner.

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## Check List

### **Telehealth Credentialing and Privileging Sec. 485.635. Condition of participation: Critical Access Hospitals (CAHs). Provision of Services.**

The Centers for Medicare and Medicaid Services' (CMS) final rule on credentialing and privileging requirements for telehealth practitioners is effective on July 5, 2011. This rule establishes a process for originating site hospitals (location of the patient) to rely on the credentialing and privileging decisions of the distant site hospital (location of the specialist) for telehealth practitioners.

#### **Definition of Terms**

- Originating Hospital: location of the patient
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#### **Executive Summary Conditions of Participation – Critical Access Hospitals (CAHs). Provision of Services.**

**Section 485.635** in the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier.





**Sec. 485.635 Condition of participation: Critical Access Hospitals (CAHs). Provision of Services.**

- (a) Standard: Patient care policies.
  - (1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.
  - (2) The policies are developed with the advice of a group of professional personnel that includes one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of Sec. 485.631(a)(1); at least one member is not a member of the CAH staff.
  - (3) The policies include the following:
    - (i) A description of the services the CAH furnishes directly and those furnished through agreement or arrangement.
    - (ii) Policies and procedures for emergency medical services.
    - (iii) Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.
    - (iv) Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all



scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.

(v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.

(vi) A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.

(vii) If the CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of Sec. 483.25(i) is met with respect to inpatients receiving post-hospital SNF care.

(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.

(b) Standard: Direct services--(1) General. The CAH staff furnishes, as direct services, those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department. These direct services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.

(2) Laboratory services. The CAH provides, as direct services, basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 236a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include:



- (i) Chemical examination of urine by stick or tablet method or both (including urine ketones);
  - (ii) Hemoglobin or hematocrit;
  - (iii) Blood glucose;
  - (iv) Examination of stool specimens for occult blood;
  - (v) Pregnancy tests; and
  - (vi) Primary culturing for transmittal to a certified laboratory.
- (3) Radiology services. Radiology services furnished at the CAH are provided as direct services by staff qualified under State law, and do not expose CAH patients or staff to radiation hazards.
- (4) Emergency procedures. In accordance with the requirements of Sec. 485.618, the CAH provides as direct services medical emergency procedures as a first response to common life-threatening injuries and acute illness.
- (c) Standard: Services provided through agreements or arrangements.
- (1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including:



- (i) Inpatient hospital care;
  - (ii) Services of doctors of medicine or osteopathy; and
  - (iii) Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH.
  - (iv) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.
- (2) If the agreements or arrangements are not in writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated.
- (3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided.
- (4) The person principally responsible for the operation of the CAH under Sec. 485.627(b)(2) of this chapter is also responsible for the following:
- (i) Services furnished in the CAH whether or not they are furnished under arrangements or agreements.
  - (ii) Ensuring that a contractor of services (including one for shared services and joint ventures) furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.



(5) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier.

(d) Standard: Nursing services. Nursing services must meet the needs of patients.

(1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available.

(2) A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.

(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.

(4) A nursing care plan must be developed and kept current for each inpatient.

(e) Standard: Rehabilitation Therapy Services. Physical therapy, occupational therapy, and speech-language pathology services furnished at the CAH, if provided, are provided by staff qualified under State law, and consistent with the requirements for therapy services in Sec. 409.17 of this subpart.



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## Check List

### **Telehealth Credentialing and Privileging Sec. 485.641. Condition of Participation: Periodic Evaluation and Quality Assurance Review.**

The Centers for Medicare and Medicaid Services' (CMS) final rule on credentialing and privileging requirements for telehealth practitioners is effective on July 5, 2011. This rule establishes a process for originating site hospitals (location of the patient) to rely on the credentialing and privileging decisions of the distant site hospital (location of the specialist) for telehealth practitioners.

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#### **Executive Summary Conditions of Participation – Periodic Evaluation and Quality Assurance Review.**

**Section 485.641** the quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated.



**Sec. 485.641 Condition of Participation: Periodic Evaluation and Quality Assurance Review.**

- (a) Standard: Periodic evaluation—
  - (1) The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year and includes review of--
    - (i) The utilization of CAH services, including at least the number of patients served and the volume of services;
    - (ii) A representative sample of both active and closed clinical records; and
    - (iii) The CAH's health care policies.
  - (2) The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed.
- (b) Standard: Quality assurance. The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that--
  - (1) All patient care services and other services affecting patient health and safety, are evaluated;
  - (2) Nosocomial infections and medication therapy are evaluated;
  - (3) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants at the CAH are





evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH;

(4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by:

(i) One hospital that is a member of the network, when applicable;

(ii) One QIO or equivalent entity;

(iii) One other appropriate and qualified entity identified in the State rural health care plan;

(iv) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site hospital, the distant-site hospital; or

(v) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, one of the entities listed in paragraphs (b)(4)(i) through (iii) of this section; and

(5)(i) The CAH staff considers the findings of the evaluations, including any findings or recommendations of the QIO, and takes corrective action if necessary.

(ii) The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.

(iii) The CAH documents the outcome of all remedial action.



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