



Title: INITIAL APPLICATION / APPOINTMENT TO PROFESSIONAL STAFF	Policy Number: CO 1.5
Regulation Reference: NCQA CR3; NCQA CR1.A; NCQA CR3.A; NCQA CR3.B; NCQA CR3.C	Effective Date: 04-01-2014 Last Annual Review Date: 11-21-2025 Last Revision Date: 08-28-2026 (Revision History on last page)

Policy Statement:

It is the policy of Paul L. Foster School of Medicine (PLFSOM) to obtain confirmation of the information supplied in the Professional Staff application from the primary source and to insure a high level of professional practitioners through review of their background, experience, training and demonstrated current competence in exercising the privileges requested.

NOTE: PLFSOM does not credential any providers for provisional status as outlined in Texas HB 1594 effective September 1, 2007. All applicants must submit the required documentation as listed in this policy. All verifications must be performed as listed in this policy unless they meet the criteria of hospital-based anesthesiologists, CRNAs and radiologists detailed below. Complete files must be reviewed by the PLFSOM Credentials Committee and approved by the Dean before any staff membership or privileges can be granted excepting the granting of temporary clinical privileges.

Procedure

Section 1: Required documents for credentialing application to Professional Staff

1. Credentialing must be performed to all Professional Staff as defined in the Texas Tech University Health Sciences Center El Paso, PLFSOM Professional Staff Bylaws. In the instance of anesthesiologists, CRNAs and radiologists working in the hospital setting, PLFSOM may accept the credentialing of the affiliated hospitals in lieu of credentialing performed by TTUHSC El Paso. All required items listed in 2, 3, and 4 below must be submitted to complete the enrollment with payers. PLFSOM, at the discretion of the Chairman of the Credentials Committee, may perform selected verifications of these elements.
2. Individuals requesting Professional Staff membership and PLFSOM Ambulatory Clinics privileges will be sent an initial credentialing application packet, either in paper form or through the online credentialing system. The initial credentialing packet will include the following items:
 - Welcome Letter and Instructions for Initial Application Process
 - Applicants Rights Regarding Information
 - Addendum to the Texas Standardized Credentialing Application

- Texas Standardized Credentialing Application*
- Faculty Appointment Addendum (if applicable)
- Federal Health Care Program Exclusion Attestation Form
- Professional Staff Bylaws, Credentialing Policies and Procedures, and Medical Practice Income Program Bylaws Acknowledgement Form
- Identity Verification Form
- Supervising Physician Agreement, if applicable
- Delineation of Privilege form specific to the department / service the applicant is requesting appointment (if applicable)

3. During the initial credentialing process, the applicant must supply the Credentialing Office with a complete application packet including all required licenses, certificates and other attachments as listed on the application checklist. All of the following items must be submitted, and reviewed and/or verified in order for an application to be considered complete (See Appendix A, for verification sources used):

- Complete Texas Standardized Credentialing Application including:
 - Original initials on page 11 and original signature on page 12, which are to be used as release of authorization from the applicant to TTUHSC to collect any information necessary to verify the information in the credentialing application
 - Whether the provider will accept new patients
 - Appropriate 24-hour coverage
 - Lack of present illegal drug use.
 - History of loss of license and felony convictions
 - History of loss or limitation of privileges or disciplinary activity
 - Reasons for any inability to perform the essential functions of the position, with or without accommodations
 - Attestation to the correctness and completeness of the application, signed and dated by the applicant within 90 days of final approval
- Signed and dated PLFSOM Faculty Appointment Addendum
- Completed, signed and dated Addendum to the Texas Standardized Credentialing Initial Application Form to include Provider's Race, Ethnicity and Language (response is optional)
- Current photograph for identification purposes (passport photo size).
- Signed and dated Federal Health Care Program Excluded Provider form
- Current curriculum vitae that includes a revision date within 3 months from the date the application consent statement was signed, and all beginning and ending dates for training programs, work history etc., should include both a month and year

NOTE: Any time gaps exceeding 6 months, beginning with the date of entrance into Medical School or Training Program as it pertains to his/her specialty to the date of submission of the application, should be clarified by the applicant in writing.
- Signed statement that applicant has received, read, and agrees to abide by the provisions of the Professional Staff and MPIP Bylaws*
- Signed and dated Hospital Coverage Letter*

- Any additional documentation required by requested privileges, i.e. life support certificates, additional training certificates, CME certificates, case logs, etc.*
- Completed, signed and dated Delineation of Clinical Privilege Form in appropriate department (if applicable)
Supervising physician signatures, if not a licensed independent practitioner
- All providers who provide direct patient care at any of the Texas Tech Physicians of El Paso clinics, must provide and maintain Basic or Higher Life Support certification.
- Current state license*
- Current DEA certificate, if applicable to practice*
- Malpractice liability coverage (face sheet) which provides effective and expiration date, coverage limit amounts and any restrictions (practice locations, procedures, etc.)*
- Malpractice claims history - applicants are to provide information about: Claims that have been settled and any litigation (pending, settled, mediated, arbitrated or litigated)*
- Board certification or Board verification from primary source including expiration date or, indicate lifetime verification which must also be verified, if applicable*
- Educational Commission for Foreign Medical Graduates Certificate (ECFMG), if applicable
- Copy of valid state or federal government issued picture identification*
- Copy of immunization record with the following requirements for providers that do patient care are as follows: Tuberculosis skin test (TST) within 12 months of start date or if there is a history of Positive TB skin test, documentation of negative chest x-ray within 12 months of start date; Hepatitis B series (3 doses) and positive Hepatitis B titer for proof of immunity; Measles (Rubeola) titer, Mumps titer, Rubella Titer and Varicella titers for proof of immunity; Tdap vaccine and Influenza vaccine (later in season generally Sept through March)

NOTE: Copies of the actual documents such as Lab Report(s), Immunization and/or health record(s) must be provided.

4. Background Check: All TTUHSCEP employees must undergo a background check as an employment requirement. Effective August 1, 2018, all non-TTUHSCEP employee professional staff applicants must provide the report of a recent background check at initial credentialing. The Credentialing Office will provide these applicants with the company to be contacted to request the background check report. This report must be submitted directly to the Credentialing Office by the company or applicant and at his/her expense. The Credentialing Office will use TTU guidelines in the interpretation of these reports.

Section 2: Verification Process - Credentialing Application to Professional Staff

1. The Credentialing Specialist processing the application will:

- Date stamp all application forms and supporting documentation received by the applicant on the upper right-hand corner upon receipt.
- Screen the application for completeness and anomalies (e.g., frequent relocation of practice, unexplained time gaps, and frequent change of professional liability carrier, etc.). Applicants should complete all blanks, all questions, and attach all supporting documents. The applicant must account for all time starting from the date they entered Medical school or Training Program as it pertains to his/her specialty to the time application is received.

NOTE: Any time gaps exceeding 6 months beginning with the date of entrance into Medical school or Training Program to the date of receipt of application should be reviewed and clarified in writing. And then reviewed by the committee.

- Add the practitioner's name to the credentialing database and complete all fields in the following sections: Profile, Addresses, Education, Insurance, etc.
- Complete a Credentialing Checklist and prepare a credential file bearing the practitioner's name and the department to which he/she is assigned.
- Verify and/or query the following:
{All verifications must be from a primary source or a Joint Commission acceptable equivalent, date stamped, initialed and placed into the credentials file.}

- Texas Medical License or applicable Texas Professional License*

NOTE: Licenses are verified during the practitioner's initial appointment, reappointment, and license renewal. In addition, the Credentialing Specialist reviews monthly press releases sent by the Texas Medical Board or other Texas licensing board. This process will allow ongoing monitoring of sanctions or limitations on licensure.

- Other licensing states including current, expired and inactive licenses*
- DEA Certificate* with local address.
- Professional or Specialty Board Certification*, if certified
- Medical School or applicable Graduate School
- ECFMG {Educational Commission for Foreign Medical Graduates} certificate, if applicable
- American Medical Association {AMA} Profile or American Osteopathic Information Association {AOIA} Profile, as applicable
- Institutions where training was completed: Internship/Residency/Fellowship, as applicable. If internship and residency were completed at same institution and in the same specialty; one (1) verification will suffice. The provider must have completed all aspects of the practicing specialty and/or sub-specialty training program. All education verifications must be obtained after the satisfactory

completion of the program.

- Hospital affiliations {last 5 years}, are obtained via primary source verification letter directly from the hospital or facility approved/designated verification company website, email confirmation from the hospital, fax, or documented verbal verification*
- Academic affiliations {last 5 years)*
- Professional Practice/work history {last 5 years}, as related to healthcare profession *
- Military affiliation *

NOTE: A DD214 discharge certificate may stand as verification in place of a written response from the National Personnel Records Center

- Three professional peer references from the same field and/or specialty that are not relatives. All peer references should have firsthand knowledge of the applicant's abilities and competence. {Physicians should list physicians, dentists should list dentists, podiatrists should list podiatrists, etc.) {Include release consent statements {from application) and include a copy of the delineated clinical privileges requested)* For professional's completing or within one year post graduate training programs, one peer reference must be from the applicant's program director or associate program director.

NOTE: Professionals in training may not serve as a peer reference.

- National Practitioner Data Bank {NPDB)*

NOTE: Querying the NPDB meets the NCQA, URAC standard for Medicare and Medicaid sanction queries. It also provides information regarding history of liability claims, settlements, or judgments.

- Current malpractice liability insurance certificate and claims history.*

NOTE: "Malpractice Actions" means more than a notice of claim. Applicants are to provide information about: Claims that have been settled and any litigation {pending, settled, mediated, arbitrated or litigated).

- Malpractice liability insurance carriers which provided coverage during the 5 year period immediately prior to application.*
 - As applicable, current TTUHSC malpractice coverage in the amount of \$400,000/\$1,200,000 with an effective date to demonstrate insurability.*
 - All **Physician Extenders** need a protocol developed by the physician extender and a supervising physician(s). Protocol must be signed by the physician extender and applicable supervising physician(s) within 30 days of each other's signature. Protocols should outline the physician extender's specific duties, including ability to prescribe non-controlled medications and controlled substances, and should meet requirements for licensure, delegation, collaboration and supervision as appropriate.*
- * Verifications subject to change over time must be 120 days current before presenting to the Credentials Committee for approval of membership and privileges.

2. Monitor return of the letters by making notation on the application and by keying in the date of receipt into the credentialing database. Flag pertinent information relating to claims, settlements, professional problems, health status, etc., and prepare and adverse action review form for signature by the Department Chair.

Flag and discuss negative, questionable or unusual responses with the appropriate Department Chair and the Chairperson of the Credentials Committee. When reference letters make vague reference to professional problems or contain significant omissions, telephone calls should be initiated to peer references or previous/present hospital affiliations. The Credentialing Office Specialist and/or the Department Chairman or Credentials Committee Chairman should make these calls. Type a "Memo to File" summarizing content of the discussion but not including specific individual's names or other identifying terms and place in the applicant's file. In all cases, references who have given questionable verbal references should be encouraged to put the comments in writing. Information should be gathered to the degree that no one is uncomfortable recommending an applicant for privileges and membership.

3. Notify the practitioner if information gathered during the credentialing process varies substantially from what is provided in the application. The Credentialing Office is not required to allow an applicant to review references or recommendations, or other information that is peer-review protected. (Refer to the "Right to Notification and Correction of Information" policy.)

The applicant will be contacted in the following cases or as needed:

- a. to complete any missing information/documentation;
 - b. to clarify any time gaps in his or her career; and/or
 - c. to furnish a written statement of explanation for any questions answered in the affirmative
4. Perform a search on each practitioner through the following General Services Administration sites via the internet and complete the information on the Credentialing Checklist:
 - a. Office of Inspector General (OIG) - U.S. Department of Health & Human Services
 - b. Office of Inspector General (OIG)-Texas Health & Human Services Commission
 - c. System for Award Management (SAM)
 - d. Medicare Opt Out List Search
 - e. Department of Treasury's Office of Foreign Assets Control (OFAC) List
 - f. Sex Offender Registry-Texas Department of Public Safety, and National Sex Offender
 5. The pending file will be reviewed two weeks or sooner, as needed, from the time the initial verification letters were sent. If no response, re-send the letter stamped/typed "second request" and contact the source for status. Evaluate the reasons for the delay, find alternate methods for obtaining information. If no response is still obtained, re-send the letter stamped/typed "third request". Document all incoming and outgoing conversations/contacts on the back of the credentialing worksheet. If verification is not received after verbal contact, contact the applicant and ask him or her for assistance in obtaining the reference (he or she can

make a personal telephone call). The burden of proof is on the applicant.

6. If a response from an institution or agency is missing after 3 requests were submitted within a period of 6 weeks from initial request, present the file to the Credentials Committee Chairperson to decide whether to forgo the verification from the non-responsive institution after those multiple attempts. For professional education, verification from the Texas Medical Board website will suffice as verification of education.

According to that decision, notify the applicant via email or certified mail that the application is still incomplete and may be regarded as an involuntary withdrawal from the application process.

7. The lack of response from the applicant to verbal or written communication or his/her failure to submit requested documents or explanations during the application for a period of 28 consecutive days, will constitute voluntary withdrawal of the application. The applicant and the sponsoring department will then be notified in writing.
8. The application is considered "complete" when all required information, including verification letters have been received. Sequentially the Department Chairperson, and the Credentials Committee will review and approve the file and forward their recommendation to the Dean for final decision. Applications from a Clinical Department Chairperson will be reviewed and recommended by the Chairperson of the Credentials Committee.
9. Department Chairperson - Qualifications, Appointment and Removal, and Functions (Bylaws Article X, Section B., 1- 4)
 1. Qualifications, Appointment and Removal: Each Chairperson shall be a member of the Active Staff and shall be appointed by the Dean. A Chairperson may be removed by action of the Dean on behalf of the Governing Body.
 2. Functions: Each Chairperson shall (all other functions listed in Bylaws):
 - a. Review the professional performance of all individuals with clinical privileges in the Department and report and recommend to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;
 - b. Make recommendations to the Credentials Committee concerning the appointment, category, reappointment, and the delineation of clinical privileges for all Practitioners in the Department;
 - c. Be responsible for the overall implementation and participation in the quality assessment and improvement program within the Department;
10. At the time of Committee review, the application shall not be more than 90 days old from the date it was deemed complete by the Credentialing Director, Manager, or Chair, that includes the attestation, verification information, and NPDB response. The credentials files must be complete with current documentation before the Credentials Committee approves and recommends approval by the Dean to grant staff membership or clinical privileges. On occasion, the Credentials Committee may recommend approval of an incomplete application contingent on the receipt of a

missing document, with content fully satisfactory to the Credentialing Office.

11. All initial appointments to the Professional Staff shall be for a period not to exceed three (3) years (36 months from the initial credentialing committee decision date).
12. The applicant may be informed of the status of his/her credentialing application. If an application is determined to be incomplete, the applicant will be notified in writing within five (5) working days of receipt of application.
13. Applications for privileges that are new to a Clinical Department or Clinic will not be considered by the Committees until the addition of such privilege to the respective Delineation of Privileges form has been approved by the Credentials Committee (including the Director of the Quality Improvement Office), and the Dean at a prior regular series of meetings. Exceptions will be considered only for Special Temporary Privileges.
14. Acceptable Digital or Electronic Signature.
 - A handwritten signature on a document is valid, including when the entire document is scanned and emailed, or faxed to the credentialing office.
 - A graphic image of a signature placed on a document using secure software that verifies the identity of the user on the other end (*e.g.* Adobe Sign or DocuSign) is valid.
 - A graphic image of a signature placed on a document, or a typewritten name, regardless of font and not verified by secure software is generally discouraged, and will not be accepted **unless** accompanied by an email indicating the request to accept the digital or electronic signature in lieu of a handwritten one.

Policy Number:	CO 1.5	Version Number: 1.0
Signatory approval on file by:	Approved:	Adam H. Adler, M.D., Chair, TTUHSCEP PLFSOM Credentials Committee

Revision History		
	Credentials Committee	Dean Approval
Effective Date:	04-01-14	04-01-14
Annual Review Date:	03-25-19, 02-25-20, 02-23-21, 02-23-22, 09-27-23, 10-30-24, 11-19-25	03-26-19, 02-27-20, 02-25-21, 02-25-22, 09-29-23, 11-04-24, 11-21-25
Revision Date:	05-21-14, 09-22-15, 03-29-16, 02-27-18, 05-24-18, 07-24-18, 05-26-20, 08-25-20, 10-27-20, 02-23-21, 07-13-21, 11-16-21, 07-26-23, 01-24-24, 05-22-24, 03-26-25, 08-26-2026	05-23-14, 09-23-15, 03-31-16, 02-28-18, 05-24-18, 07-26-18, 05-28-20, 08-27-20, 10-28-20, 02-23-21, 07-15-21, 12-16-21, 07-28-23, 01-29-24, 05-24-24, 03-28-25, 08-28-2026