



TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
Paul L. Foster School of Medicine

Credentialing Office Policy and Procedure

Title: REAPPOINTMENT / RE-CREDENTIALING APPLICATION TO PROFESSIONAL STAFF	Policy Number: CO 1.6
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 monitor each practitioner and to evaluate the practitioner's professional competence, character, and clinical judgment in the treatment of patients, his or her ethics and conduct, and maintenance of qualifications of membership as stated in the PLFSOM Ambulatory Clinical Bylaws.

In accordance to the PLFSOM Professional Staff the reappointment shall be for a period not to exceed three (3) years (36 months from the previous credentialing committee decision date).

Procedure:

Section 1: Required documents for re-credentialing application to Professional Staff

1. Re-credentialing must be performed to all Professional Staff as defined in the Texas Tech University Health Sciences Center El Paso, PLFSOM Professional Staff Bylaws.
2. A list of providers, whose Professional Staff membership and/or privileges will expire 4 months out, will be compiled on a monthly basis by a Credentialing Office staff member. Providers who appear on this list will be sent a re-credentialing packet, either in paper form or through the online credentialing system, at least 90 days prior to their membership and/or privilege expiration date and at least 60 days prior to the Credentials Committee meeting date at which their re-credentialing application will be reviewed.

The re-credentialing packet will include the following items:

- Instruction cover letter
- Provider re-credentialing checklist
- Applicant Rights Regarding Information
- Addendum to Texas Standardized Credentialing Application
- Texas Standardized Credentialing application
- Federal Health Care Program Exclusion Attestation Form
- Continuing Medical Education (CME) Attestation Statement / Continuing Education (CE)

Credentialing Office Policy and Procedure

Attestation

- Supervising Physician Agreement, if applicable
- Delineation of privilege form specific to the department /service to which the applicant is requesting reappointment

An application deadline, typically 3 weeks from the date the packet is sent, will be included in the cover letter. If a reappointment application is not received 7 days before the application deadline, Credentialing Office shall make a verbal and/or email contact with the Department Administrator and the practitioner reminding the practitioner of the deadline and potential inactivation. If application is not received within 7 days of this contact, the practitioner will be inactivated as a Voluntary Relinquishment of membership and privileges and this shall not be reportable to the National Practitioner Data Bank.

3. During the re-credentialing process, the applicant should 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 TTUHSCEP 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 Federal Health Care Program Excluded Provider attestation
 - Completed, signed and dated Addendum to the Texas Standardized Credentialing Reappointment Application to include Provider's Race, Ethnicity and Language (response is optional)
 - 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
 - Completed, signed and dated Delineation of Clinical Privilege Form in appropriate department (if applicable)
 - 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.
 - Any additional documentation required by requested privileges, ie life support certificates, additional training certificates, CME certificates, CE certificates, case logs, etc.
 - Current state license
 - Current DEA certificate, if applicable to practice

Credentialing Office Policy and Procedure

- 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 status
- Copy of valid state or federal government issued picture identification
- 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.

A Credentialing Specialist shall date stamp the re-credentialing application as each is received in the Credentialing Office along with other reappointment forms as they are received.

Section 2: Verification Process – Re-credentialing Application to Professional Staff

1. The Credentialing Specialist processing the application will:

- Forward a list of providers 90 days prior to expiration to the PLFSOM QI Director so Performance and Quality Improvement Provider Activity Profiles may be prepared. Quality/Performance report shall be reviewed and signed by the Department chair and included in the providers file, excluding hospital based only providers.
- Check application forms for completeness, screen the application for significant anomalies (e.g., frequent relocation of practice, unexplained time gaps, and frequent change of professional liability carrier, etc.) and request any missing information.
- Update, as necessary, any provider information in the credentialing database and complete all fields in the following sections: Profile, Addresses, Education, Insurance, etc.
- Complete a Re-credentialing Worksheet.
- 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 or another professional License*
NOTE: Licenses are verified during the practitioner's initial appointment, reappointment, and license renewal. In addition, the Credentialing Manager reviews monthly press releases sent by the Texas Medical Board. This process will allow ongoing monitoring of sanctions or limitations on licensure. All findings found during ongoing monitoring will be reviewed by the Credentials Committee.
 - Other states in which the provider holds an active license or any state license which was active at the time the provider was previously credentialed or re-credentialed
 - DEA Certificate*, if applicable to practice
 - Specialty Board Certification*, if certified, (lifetime verification must also be verified)
 - Current Hospital affiliations and affiliations which were active at the time the provider was previously credentialed or re-credentialed, are obtained via primary source verification letter directly with the hospital or facility approved/designated verification

Credentialing Office Policy and Procedure

company website, email confirmation from the hospital, fax, or documented verbal verification *

- Additions to professional Practice/work history, as related to medical profession, since the time the provider was previously credentialed or re-credentialed*
- Additional institutions where training was completed, since the time the provider was previously credentialed or re-credentialed: Internship/Residency/Fellowship, as applicable.*
- Two professional peer references from the same field and/or specialty, that are not relatives, and who have firsthand knowledge of your 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)* Non physician providers shall include at least one peer reference from a supervising physician
- 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 period immediately prior*
- As applicable, current TTUHSC malpractice coverage in the amount of \$400,000/\$1,200,000 with an effective date to demonstrate insurability. *

*Verifications subject to change over time must be 120 days current before presenting to the Credentials Committee for approval of membership and privileges.

2. If additional privileges are requested, the practitioner should provide documentation of training and/or experience as required by the privilege document. If by training such as fellowship, primary source verification will be obtained from the institution where training was received.
3. Flag information relating to claims, settlements, professional problems, health status, etc. and prepare and adverse action review form for signature by the Department Chair.
4. Monitor return of the letters by making notation on the application and by keying in the date of receipt into credentialing software.

Flag and discuss negative, questionable or unusual responses with the appropriate Department Chair. 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 Specialist and/or the Department Chairman or Credentials Committee Chairman should make these calls. A “Memo to File” summarizing content of the discussion, but not including specific individual’s names or other identifying terms, will be placed in the applicant’s file. In all cases, references that 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

Credentialing Office Policy and Procedure

uncomfortable recommending an applicant for privileges and membership.

5. Notify the practitioner if information gathered during the reappointment credentialing process varies substantially from what is provided in the TDI 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.
6. 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 (run monthly by Director of Medical Staff or designee)
 - 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
7. Query the General Services Administration Sites. If practitioner's name appears on the websites searched, Credentialing personnel will verify whether or not it is the applicant. If practitioner has been debarred from any Federal health program, the Associate Dean of Clinical Affairs will be notified.
8. The pending file will be reviewed as needed from the time the initial verification letters were sent. If no response is received within two weeks, re-send the letter stamped/typed "second request" or contact the source for status. Document all incoming and outgoing conversations/contacts on the credentialing worksheet.

If there is no response to the second request(s), notify 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. If no response is still obtained, re-send the letter stamped/typed "third request".
9. 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.
10. 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.
11. The application is considered "complete" when all required information, including verification letters, have been received. The practitioner's credentials file containing the above information will

Credentialing Office Policy and Procedure

be forwarded to the appropriate Department Chair for review and recommendation to the Credentials Committee that meets monthly. The duties of the Department Chairperson regarding this process of review are detailed in CO Policy 1.5, Initial Application/Appointment to Professional Staff. Applications from a Clinical Department Chairperson will be reviewed and recommended by the Chairperson of the Credentials Committee.

12. The application when deemed complete by the Credentialing Director, Manager or Chair, that includes the attestation, verification information, and NPDB response, shall not be more than 90 days old at the time of Committee review. The credentials files must be complete with current documentation before presenting to the Credentials Committee for review and approval.
13. 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.
14. 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.
15. 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.

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Signatory approval on file by:	Approved:	Adam H. Adler, M.D., Chair, TTUHSCEP PLFSOM Credentials Committee

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