1. Why it is important to check that the practitioner is not currently excluded, suspended, debarred, or ineligible to participate in Federal health care programs?
    a. A facility could lose its accreditation if it does not do so.
    b. It is required by Medicare Conditions of Participation.
    c. The facility won't get paid for treating patients unless service is provided by authorized provider.
    d. It would violate state licensure regulations.

2. Which of the following credentials must be tracked on an ongoing basis?
    a. Medical school completion
    b. Post graduate education completed
    c. Closed medical malpractice claims
    d. Licensure

3. According to NCQA standards, an organization that discovers sanction information, complaints, or adverse events regarding a practitioner must take what action?
    a. Determine if there is evidence of poor quality that could affect the health and safety of its members.
    b. Immediately take action to remove the provider from its panel.
    c. Initiate Ongoing Professional Practice Evaluation.
    d. Notify the practitioner that he/she is under investigation and initiate the hearing process.

4. What is the name of the entity that was established through the Health Care Quality Improvement Act of 1986 to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from state to state without disclosure or discovery of previous medical malpractice payment and adverse action history?
    a. Emergency Medical Treatment and Active Labor Act
    b. The National Practitioner Data Bank
    c. The Patient Safety and Quality Improvement Act
    d. Sherman Anti-trust Act

5. When developing clinical privileging criteria, which of the following is important to evaluate?
    a. How many providers are in that specialty.
    b. Established standards of practice such as, specialty board recommendations.
    c. Whether or not the quality department can support the FPPE process.
    d. The average cost to the patient.

6. What is the main reason for periodically assessing appropriateness of clinical privileges for each specialty?
    a. It's required by accreditation standards.
    b. It is required by the Medicare Conditions of Participation.
    c. To protect patient safety by ensuring current competency, relevance to the facility, and accepted standards of care.
    d. It's required by bylaws.

7. Which of the following specialists is most likely to perform a PTCA?
    a. General surgeon
    b. OB/GYN
    c. Urologist
    d. Interventional Cardiologist

8. The Joint Commission hospital standards require that clinical privileges are hospital specific and
    a. Based on the individual's demonstrated current competence and the procedures the hospital can support.
    b. Based on board certification.
    c. Based on the privileges the individual is currently approved to perform at other hospitals.
    d. Posted in a place that is accessible to all hospital employees.

9. Which of the following would be routinely performed by a cardiologist?
    a. Hysterectomy
    b. Transesophageal Echocardiography
    c. Urethral dilation
    d. Renal dialysis

10. Which NCQA-required committee makes recommendations regarding credentialing decisions?
    a. Medical Executive Committee
    b. Quality Care Committee
    c. Credentialing Committee
    d. Patient Care Committee

11. HFAP standards require three medical staff committees to be delineated in the medical staff structure. Two of them are the Medical Executive Committee and the Utilization of Osteopathic Methods & Concepts Committee (required for hospitals with ten or more DOs who admit patients and provide direct patient care). What is the other required medical staff committee?
    a. Credentials Committee
    b. Investigational Review Board
    c. Utilization Review Committee
    d. Medical Records Committee

12. If you needed to find out about what the Federal Government requires in regards to anti-trust issues, what law would you consult?
    a. Healthcare Quality Improvement Act
    b. Patient Safety and Quality Improvement Act
    c. Medicare Conditions of Participation
    d. Sherman Anti-trust Act

13. Peer references should be obtained from:
    a. Practitioners who have referred patients to the provider
    b. Family, friends and neighbors
    c. Former hospital administrators
    d.Practitioners in the same professional discipline as the applicant

14. Patrick v. Burgett is an important case because it:
    a. Showed that a hospital can assert that peer review is performed at the state's request.
    b. Illustrates that the governing body is the ultimate authority.
    c. Set aside the charitable immunity doctrine and held that the hospital was liable for negligent treatment of the patient.
    d. Illustrates the potential for antitrust liability arising out of peer review activities.

15. If a medical staff member has privileges and/or medical staff appointment revoked, he/she must be:
    a. Granted temporary privileges.
    b. Provided due process.
    c. Reported immediately to the national practitioner data bank.
    d. Offered a leave of absence from the medical staff.

16. Access to credentials files should be:
    a. Available to all members of the organization's staff.
    b. Described fully in an access policy.
    c. Available to the organization's patients and potential patients.
    d. Available to any physician on the staff.

17. Which of the following bodies approves clinical privileges?
    a. Credentials Committee
    b. Peer Review Committee
    c. Medical Executive Committee
    d. Governing Body or Board

18. What primary source verification is required by NCQA prior to provisional credentialing?
    a. Current competence
    b. Licensure and 5 year malpractice history or NPDB
    c. Education and Training
    d. Ability to perform privileges requested

19. According to The Joint Commission standards, initial appointments to the medical staff are made for a period of:
    a. One year
    b. Two years
    c. Three years
    d. Not to exceed two years

20. According to The Joint Commission standards, temporary privileges may be granted by:
    a. The department chair
    b. The CEO
    c. The CEO on the recommendation of the medical staff president or authorized designee
    d. The department chair and the president of the medical staff

21. According to The Joint Commission Standards, which of the following items must be verified with a primary source?
    a. Medicare/Medicaid Sanctions
    b. Proof of professional liability insurance
    c. Licensure, training, experience, and competence
    d. Date of last hepatitis test

22. According to NCQA standards, a copy of which of the following is acceptable verification of the document?
    a. DEA certificate
    b. Licensure
    c. Board certification
    d. Medical school diploma

23. According to NCQA standards, which is an acceptable source for primary source verification of Medicare and Medicaid sanction activity against physicians?
    a. Federation of State Medical Boards
    b. American Board of Medical Specialties
    c. Education Commission on Foreign Medical Graduates Profile
    d. Letter from the State licensing agency

24. According to The Joint Commission standards, which of following is considered a designated equivalent source for verification of board certification?
    a. The American Board of Medical Specialties
    b. Education Commission on Foreign Medical Graduates Profile
    c. Federation of State Medical Boards
    d. Viewing of the original certificate issued by the certifying board

25. Which of the following organizations have been recognized by The Joint Commission and NCQA to provide primary source verification of medical school graduation and residency training for U.S. graduates?
    a. American Medical Association Masterfile
    b. National Practitioner Data Bank
    c. Federation of State Medical Boards
    d. Education Commission on Foreign Medical Graduates Profile

26. According to NCQA standards, the application attestation statement must affirm that the application:
    a. Is correct and complete.
    b. Was actually completed by the provider.
    c. Was signed in the presence of a notary public.
    d. Releases all parties from liability provided truthful statements are made regarding the applicant.

27. According to The Joint Commission standards, medical staff bylaws should define:
    a. The structure of the medical staff.
    b. Mechanism for appointment/reappointment of physician employed non-independent practitioners.
    c. A requirement that departments meet on at least a quarterly basis.
    d. The mechanism for emergency department call schedule.

28. According to The Joint Commission hospital standards, professional criteria for the granting of clinical privileges must include at least:
    a. Relevant training or experience, ability to perform privileges requested, current licensure, and competence.
    b. Verification of all current and prior malpractice suits filed and settlements made.
    c. Letters of reference from the Chief Executive Officer of all current and prior hospital affiliations.
    d. Participation in all managed care plans for which the hospital holds contracts.

29. The Joint Commission hospital standards require medical staff bylaws to include:
    a. A mechanism for selection and removal of officers.
    b. A requirement that all quality of care information be reviewed by the medical staff president.
    c. A mechanism for removal of the hospital's chief executive officer.
    d. A statement that medical staff members must attend at least 25% of medical staff meetings held.

30. According to NCQA standards, which of the following is an approved source for verification of board certification?
    a. National Practitioner Data Bank
    b. State licensing agency if state agency conducts primary verification of board status
    c. Viewing of the original board certificate
    d. Health Care Integrity Protection Data Bank

31. According to The Joint Commission hospital standards, which of the following is a required component of the reappointment process?
    a. Documentation of the applicant's health status
    b. Verification of residency training
    c. Medicare/Medicaid sanctions query
    d. Primary source verification of malpractice suits

32. According to URAC's health network standards, each applicant within the scope of the credentialing program submits an application that includes at least which of the following:
    a. State licensure information, including current license(s) and history of licensure in all jurisdictions
    b. A listing of all current and past hospital affiliations
    c. A NPDB self-query
    d. Copies of all current licensure

33. According to AAAHC, which must be monitored on an ongoing basis?
    a. Current licensure
    b. Medical malpractice liability coverage
    c. Health status
    d. Hospital and other healthcare facility affiliation

34. According to The Joint Commission, a nurse practitioner functioning independently and providing a medical level of care must:
    a. Have a job description.
    b. Be granted delineated clinical privileges.
    c. Be directly supervised by an active physician staff member.
    d. Participate in medical staff quality assessment activities.

35. According to The Joint Commission, which of the following is an acceptable source for verification for medical education of an international graduate?
    a. Board certification
    b. Federation of State Medical Boards
    c. Education Commission for Foreign Medical Graduates
    d. National Practitioner Data Bank

36. When evaluating compliance with the required time-frame for recredentialing, NCQA counts the recredentialing period to the:
    a. Day
    b. Week
    c. Month
    d. Year

37. NCQA standards require the organization to verify board certification at recredentialing:
    a. If a practitioner has received Medicare/Medicaid sanctions.
    b. If a practitioner is requesting a change in status.
    c. In all cases.
    d. If a practitioner has acquired additional board certification since last credentialed.

38. To whom does the AAAHC give the responsibility for approving and ensuring compliance with policies and procedures related to credentialing, quality improvement, and risk management?
    a. Medical staff
    b. Credentials committee
    c. Governing body
    d. Medical director

39. In order for a healthcare facility to participate in the Medicare and Medicaid programs it must comply with the:
    a. Medicare Conditions of Participation
    b. The Joint Commission of Accreditation of Healthcare Organizations standards
    c. National Committee for Quality Assurance (NCQA) standards
    d. American Accreditation HealthCare Commission/Utilization Review Accreditation Commission (AAHC/URAC) standards

40. According to The Joint Commission hospital standards, which of the following is an element of a self-governing medical staff?
    a. The medical staff determines the mechanism for establishing and enforcing criteria for assigning oversight responsibilities to practitioners with independent privileges.
    b. There can be any number of organized medical staffs as long as they are approved by the governing body.
    c. The hospital's board of directors determines the criteria for granting medical staff privileges.
    d. The medical staff is self-governing, and as such, its organization does not have to be approved by the governing body.

41. Robert's Rule of order is an example of
    a. Executive privilege
    b. Parliamentary procedure
    c. A code of conduct
    d. Bylaws

42. The medical staff application should provide a chronological history of:
    a. The applicant's education, training, and work history.
    b. CME activities and completion of residency.
    c. Marriages since medical school.
    d. Leadership positions held.

43. In order to participate in a managed care plan, a provider must be accepted to the plan's:
    a. Provider panel
    b. Medical staff
    c. Medical team
    d. Point of service plan

44. In order for a physician to practice medicine in any state in the United States, he/she must possess:
    a. Malpractice insurance with limits of at least $1 million per occurrence and $3 million annual aggregate.
    b. Appropriate board certification.
    c. Membership on the provider panel of the majority of the state's major managed care plans.
    d. Current state licensure.

45. Which of the following is considered post-graduate education?
    a. Medical school
    b. College
    c. Board Certification
    d. Residency training

46. Which of the following elements may not be used to evaluate credentials of applicants?
    a. Gender
    b. Licensure
    c. Post-graduate training
    d. Board certification

47. The release of liability statement signed by the applicant for medical staff appointment should include:
    a. The name of the department chairman for all past hospital appointments.
    b. A statement providing immunity to those who respond in good faith to requests for information.
    c. A statement of the correctness of the information provided.
    d. Primary source verification.

48. Primary source verification is:
    a. Receiving information directly from the issuing source.
    b. Required by the health care quality improvement act.
    c. Considered economic credentialing.
    d. Delegated credentialing.

49. Unexplained delays between graduation and medical school, incomplete training, and unexplained lapses in professional practice are examples of:
    a. Red flags.
    b. Medicare sanctions.
    c. Events reportable to the National Practitioner Data Bank.
    d. Professional liability actions.

50. When documenting a telephone conversation regarding primary source verification what should be documented?
    a. The date and time of the call only.
    b. Who answered the call.
    c. Name of person and organization contacted, date of call, what was discussed and who conducted the interview.
    d. The reason for the call.

51. According to HFAP standards, when confirming malpractice coverage the organization must:
    a. Query the NPDB
    b. Obtain the claim history with each carrier over the last five years
    c. Have evidence of professional liability insurance, which includes certificate showing amounts of coverage
    d. Require the applicant to attest that he/she has never been sued

52. Which of the following providers is considered a primary care physician (PCP)?
    a. General surgeon
    b. Gastroenterologist
    c. Family medicine practitioner
    d. Orthopedic surgeon

53. Which body has the obligation to the community to assure that only appropriately educated, trained and currently competent practitioners are granted medical staff membership and clinical privileges?
    a. Medical Staff
    b. Governing Body
    c. The Joint Commission on Accreditation of Healthcare Organizations
    d. State licensing Board

54. When credentialing and privileging practitioners it is appropriate to:
    a. Handle each applicant on a case-by-case basis.
    b. Follow a routine process for each applicant.
    c. Give preferential treatment to those providers whose specialty is primary care.
    d. Process all applications within one week of receipt.

55. Medical liability insurance should be held in what limits?
    a. $200,000 per occurrence and $500,000 annual aggregate
    b. $500,000 per occurrence and $1,000,000 annual aggregate
    c. $1,000,000 per occurrence and $3,000,000 annual aggregate
    d. As specified by the medical staff and board of directors

56. Which of the following would be an appropriate question to ask an applicant for medical staff?
    a. How many children to you have?
    b. Are you married?
    c. Do you have any medical conditions, treated or untreated, that would negatively affect your ability to provide the services or perform the privileges you are requesting?
    d. Have you been diagnosed with AIDS or a sexually transmitted disease?

57. The governing body delegates the responsibility of credentialing, recredentialing, and privileging to
    a. The hospital administrator
    b. The medical staff office
    c. The medical staff
    d. The credentials committee

58. Who should have access to medical staff meeting minutes?
    a. Medical Staff President
    b. Governing Body members
    c. Personnel as documented in a records access policy and procedure
    d. Hospital President

59. In addition to conclusions, recommendations made, and actions taken, which of the following should always be documented in meeting minutes:
    a. Names and professional titles of all in attendance
    b. Date and location of next scheduled meeting
    c. Any required follow-up to occur.
    d. Complete transcription of all discussion that occurred

60. Active, Associate, Courtesy, Honorary, Consulting are all examples of:
    a. Committees
    b. Medical staff officers
    c. Membership categories
    d. Privileges

61. Changes in medical staff bylaws are not final until formally approved by the:
    a. Medical staff
    b. Medical staff president
    c. Governing body
    d. Hospital CEO

62. What is the only hospital medical staff committee required by The Joint Commission hospital standards?
    a. Credentials committee
    b. Medical executive committee
    c. Pharmacy and therapeutics committee
    d. Utilization review committee

63. The Healthcare Quality Improvement Act:
    a. Provides immunity for health care entities that do not report information to the National Practitioner Data Bank.
    b. Keeps hospitals and physicians who perform peer review from being sued.
    c. Provides qualified immunity from antitrust liability arising out of peer review activities that are conducted in good faith.
    d. Creates an exception to the Doctrine of Ostensible Agency.

64. If you have a question regarding whether or not information regarding a practitioner should be released to a third party, which of the following would be the best person to ask?
    a. Director of Medical Records
    b. Chief of Staff
    c. Information Systems Director
    d. Organization's attorney

65. Prior to releasing information to a third party regarding a practitioner, the organization should acquire:
    a. A picture ID of the provider
    b. A signed consent and release form
    c. Approval from the organization's attorney
    d. Informed consent

66. You are working at an AAAHC accredited facility and you want to introduce the concept of utilizing a credentials verification organization. If the CVO is not accredited by a nationally recognized organization you must:
    a. Perform an initial on-site visit of the CVO to assess their capabilities and quality of work
    b. Perform an assessment of the capability and quality of the CVO's work
    c. Perform an assessment of their turn-around times
    d. Perform an assessment of all CVO policies and procedures