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West Virginia Medicaid Promoting Interoperability (PI) Program Frequently Asked Questions

WEST VIRGINIA Department of Health & Human Resources

BUREAU FOR MEDICAL SERVICES

Medicaid Promoting Interoperability (PI) Program Frequently Asked Questions

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The State of West Virginia has consolidated the following Frequently Asked Questions (FAQs) regarding the West Virginia Medicaid Promoting Interoperability (PI) Program, formerly called Medicaid Electronic Health Record (EHR) Incentie Program. The FAQs include all questions and responses (that are still valid with current program regulations) collected from the Center for Medicare and Medicaid Services (CMS) website, the CMS Health Information Technology for Economic and Clinical Health Act (HITECH) website, Community of Practice Calls, and State regulations that affect the program. If you have additional questions regarding the information contained in the FAQs, please contact Sam Stout at (304) 558-1700, or email at dhhrbms@wv.gov.

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ. The site however no longer houses all FAQs related to the EHR program after March 2, 2018.

1 General Questions

If I have questions regarding the letter and questionnaire, who should I contact?

Questions can be directed to dhhrehr@wv.gov. When contacting this email, please be sure to provide your case number, provider National Provider Identifier (NPI) number, and the provider name used in the attestation.

What are the requirements/guidelines for acceptable screenshots of documentation for the audit?

The screenshot should:

- Show that it is from the Certified Electronic Health Record Technology (CEHRT), such as a vendor logo and the provider/practice name.
- Provide the date of the screenshot, especially if the documentation is used to verify a function that occurred previously.
- Include the information related to what is being verified.

Is this audit going to be completed remotely or on-site?

A desk audit will be performed where supporting documentation is received and reviewed remotely. Based on these results, additional review may be required, which could include an on-site visit. Hospitals or providers will be notified in advance of any on-site audits.

If data is in the CEHRT, can a different system be used to generate reports to provide documentation for this audit?

The CEHRT must be able to record the numerator and denominator and generate a report. However, non-certified systems can be used to calculate numerators and denominators and to generate reports regarding the measures.

If an Eligible Professional (EP) sees a patient in a setting that does not have CEHRT but enters all of the patient's information into a CEHRT at another practice location, can the patient be counted in the numerators and denominators of MU measures for the Medicare and Medicaid EHR Incentive Programs?

Starting in 2013, an EP must have access to CEHRT at a location in order to include patients seen in locations in the determination of whether they meet the threshold of 50% of patient encounters at locations equipped with CEHRT to be eligible for the PI Program, formerly EHR Incentive Program. However, if the EP meets this threshold and also includes information on patient encounters at locations where they do not have access to CEHRT, information about those encounters can be included when calculating the numerators and denominators for the meaningful use measures.**How do I know if my EHR system is certified? How can I get my EHR system certified?**

The Medicare and Medicaid EHR Incentive Programs require the use of CEHRT, as established by a new set of standards and certification criteria. Existing EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) to meet these new

criteria in order to qualify for the incentive payments. The Certified Health IT Product List (CHPL) is available at https://chpl.healthit.gov/#/resources. [Note, this has to be used in Crome or another browser other than Internet Explorer]. This is a list of complete EHRs and EHR modules that have been certified for the purposed of this program.

Through the temporary certification program, new certification bodies have been established to test and certify EHR technology. Vendors can submit their EHR products to the certifying bodies to be tested and certified. Hospitals and practices who have developed their own EHR systems or products can also seek to have their existing systems or products tested and certified. Complete EHRs may be certified, as well as EHR modules that meet at least one of the certification criteria. Once a product is certified, the name of the product will be published on the ONC website: https://chpl.healthit.gov/#/resources.

2 Eligible Professionals

If I didn't contract with a third party to conduct a security risk assessment, do I still need to provide my results and documentation?

Yes, all providers attesting to the program need to undergo a security risk assessment and all findings and associated documentation must be provided regardless of the use of a third party.

How can a provider meet the Protect Electronic Protected Health Information core objective in the PI Programs?

To meet the "Protect Electronic Health Information" core objective, eligible professionals (EP), eligible hospitals or critical access hospitals (CAH) must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process. In addition to meeting the same security risk analysis requirements as, EPs and hospitals will also need to address the encryption and security of data stored in the certified EHR technology (CEHRT). These steps may be completed outside of the EHR reporting period time frame but must take place no earlier than the start of the EHR reporting year and no later than the provider attestation date. For example, an EP who is reporting Meaningful Use for a 90-day EHR reporting period may complete the appropriate security risk analysis requirements outside of this 90-day period as long as it is completed no earlier than January 1st of the EHR reporting year and no later than the date the provider submits their attestation for that EHR reporting period. This meaningful use objective complements but does not impose new or expanded requirements on the HIPAA Security Rule. In accordance with the requirements under (45 CFR 164.308(a)(1)(ii)), providers are required to conduct an accurate and thorough analysis of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI). Once the risk analysis is completed, providers must take any additional "reasonable and appropriate" steps to reduce identified risks to reasonable and appropriate levels. Please note that a security risk analysis or review needs to be conducted during each EHR reporting of meaningful use to ensure the privacy and security of their patients' protected health information.

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2019ProgramRequirementsMedicaid

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SecurityRiskAnalysis_Tipsheet-.pdf

Security Risk Assessment Tool: http://www.healthit.gov/providers-professionals/ehr-privacy-security/10-step-plan

If patients are dually eligible for Medicare and Medicaid, can they be counted twice by hospitals in their calculations for incentive payment if they are applying for both Medicare and Medicaid EHR Incentive Programs?

For the purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Thus, in this respect, the inpatient bed-day of a dually eligible patient could not be counted in the Medicaid

share numerator. In other respects, however, the patient would count twice. For example, in both cases, the individual would count in the total discharges of the hospital.

For the Medicare and Medicaid EHR Incentive Programs, does an EH have to count patients admitted to both the inpatient and emergency departments in the denominator of MU measures, or can they count only emergency department patients?

For the hospital MU objectives, the denominator is all unique patients admitted to an inpatient (POS 21) or emergency department (POS 23), which means all patients admitted to an inpatient department (POS 21) and all patients admitted to an emergency department (POS 23). If the EH elects to use the alternate method for calculating emergency department patients, as detailed in FAQ #10126, the denominator is all unique patients admitted to an inpatient department (POS 21) and all patients that initially present to the emergency department and are treated in the emergency department's observation unit or otherwise receive observation services, which includes patients who receive observation services under both POS 22 and POS 23. Patients admitted to the inpatient department must be included in the denominator of all applicable measures.

When EPs work at more than one clinical site of practice, are they required to use data from all sites of practice to support their demonstration of MU and the minimum patient volume thresholds for the Medicaid EHR Incentive Program?

CMS considers these two separate but related issues.

MU: Any EP demonstrating MU must have at least 50% of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with CEHRT capable of meeting all of the MU objectives. Therefore, WV will collect information on meaningful users' practice locations in order to validate this requirement in an audit.

Patient volume: EPs may choose one (or more) clinical sites of practice in order to calculate their patient volume. This calculation does not need to be across all of an EP's practice sites. However, at least one of the locations where the EP is adopting or meaningfully using CEHRT should be included in the patient volume. In other words, if an EP practices in two locations, one with CERHT and one without, the EP should include the patient volume at least at the site that includes the CEHRT. When making an individual patient volume calculation (i.e., not using the group/clinic proxy option), a professional may calculate across all practice sites, or just at the one site.

If an EP in the Medicaid EHR Incentive Program wants to leverage a clinic or group practice's patient volume as a proxy for the individual EP, how should a clinic or group practice account for EPs practicing with them part-time and/or applying for the incentive through a different location (e.g., where an EP is practicing both inside and outside the clinic/group practice, such as part-time in two clinics)?

EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions:

1. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
2. There is an auditable data source to support the clinic's patient volume determination; and
3. So long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

In order to provide examples of this answer, please refer to Clinics A and B, and assume that these clinics are legally separate entities.

If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time EP from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy patient volume. However, such EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the EP could not use his or her patient encounters from Clinic A in calculating his or her individual patient volume.

The intent of the flexibility for the proxy volume (requiring all EPs in the group practice or clinic to use the same methodology for the payment year) was to ensure against EPs within the same clinic/group practice measuring patient volume from that same clinic/group practice in different ways. The intent of these conditions was to prevent high Medicaid volume EPs from applying using their individual patient volume, where the lower Medicaid patient volume EPs then use the clinic volume, which would of course be inflated for these lower-volume EPs.

CLINIC A (with a fictional EP and provider type)

- EP #1 (physician): individually had 40% Medicaid encounters (80/200 encounters)
- EP# 2 (nurse practitioner): individually had 50% Medicaid encounters (50/100 encounters)
- Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200)
- Practitioner at the clinic, but not an EP (pharmacist), individually had 80% Medicaid encounters (80/100)
- EP #3 (physician): individually had 10% Medicaid encounters (30/300)
- EP #4 (dentist): individually had 5% Medicaid encounters (5/100)

- EP #5 (dentist): individually had 10% Medicaid encounters (20/200)

In this scenario, there are 1200 encounters in the selected 90-day period for Clinic A. There are 415 encounters attributable to Medicaid, which is 35% of the clinic's volume. This means that five of the seven professionals would meet the Medicaid patient volume criteria under the rules for the EHR Incentive Program. (Two of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included.)

The purpose of these rules is to prevent duplication of encounters. For example, if the two highest-volume Medicaid EPs in this clinic (EPs #1 and #2) were to apply on their own (they have enough Medicaid patients to do that), the clinic's 35% Medicaid patient volume is no longer an appropriate proxy for the low-volume providers (e.g., EPs #4 and #5).

If EP #2 is practicing part-time at both Clinic A and Clinic B, and both Clinics are using the clinic-level proxy option, each such clinic would use the encounters associated with the respective clinics when developing a proxy value for the entire clinic. EP #2 could then apply for an incentive, using data from one clinic or the other.

Similarly, if EP #4 is practicing both at Clinic A, and has her own practice, EP #4 could choose to use the proxy-level Clinic A patient volume data, or the patient volume associated with her individual practice. She could not, however, include the Clinic A patient encounters in determining her individual practice's Medicaid patient volume. In addition, her Clinic A patient encounters would be included in determining such clinic's overall Medicaid patient volume.

Can providers participating in the Medicare or Medicaid EHR Incentive Programs update their information (for example, if an address was mistakenly entered?

Yes, providers who have registered for the Medicare or Medicaid EHR Incentive Programs may correct errors or update information through the registration module on the CMS registration website (https://ehrincentives.cms.gov/hitech/login.action). The updated registration information will be sent to the State.

3 Meaningful Use and Clinical Quality

Who can enter medication orders in order to meet the measure for the computerized provider order entry (CPOE) MU objective under the Medicare and Medicaid EHR Incentive Programs?

As mentioned in 80 FR 62798, a medical staff person who is a credentialed medical assistant or is credentialed and performs the duties equivalent to a credentialed medical assistant may enter orders. We maintain our position that medical staff must have at least a certain level of medical training in order to execute the related CDS for a CPOE order entry. We defer to the provider to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines we have proscribed. We believe that interns who have completed their medical training and are working toward appropriate licensure would fit within this definition. We maintain our position that, in general, scribes are not included as medical staff that may enter orders for purposes of the CPOE objective. However, we note that this policy is not specific to a job title but to the appropriate medical training, knowledge, and experience.

For the Medicare and Medicaid EHR Incentive Programs, how should an EP, EH, or CAH that sees patients in multiple practice locations equipped with CEHRT calculate numerators and denominators for the MU objectives and measures?

EPs, EHs, and CAHs can add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure.

For objectives that require an action to be taken on behalf of a percentage of "unique patients," EPs, EHs, and CAHs may also add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure. Previously CMS had advised providers to reconcile information so that they only reported unique patients. However, because it is not possible for providers to increase their overall percentage of actions taken by adding numerators and denominators from multiple systems, we now permit simple addition for all MU objectives.

Please keep in mind that patients whose records are not maintained in CEHRT will need to be added to denominators whenever applicable in order to provide accurate numbers.

To report clinical quality measures, EPs who practice in multiple locations that are equipped with CEHRT should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters at those locations. To report clinical quality measures, EHs and CAHs that have multiple systems should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters in the relevant departments of the EH or CAH (e.g., inpatient or emergency department [POS 21 or 23]).

If data is captured using CEHRT, can an EP or EH use a different system to generate reports used to demonstrate MU for the Medicare and Medicaid EHR Incentive Programs?

By definition, CEHRT must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for all percentage-based MU measures (specified in the certification criterion adopted at 45 CFR 170.302(n)). However, the MU measures do not specify that this capability must be used to calculate the numerators and denominators. EPs and EHs may use a separate, non-certified system to calculate numerators and denominators and to generate reports on the measures.

EPs and EHs will then enter this information in CMS' web-based Medicare and Medicaid EHR Incentive Program Registration and Attestation System. EPs and EHs will fill in numerators and denominators for MU objectives, indicate if they qualify for exclusions to specific objectives, report on clinical quality measures, and legally attest that they have successfully demonstrated MU.

For the Medicare and Medicaid EHR Incentive Programs, when a patient is only seen by a member of the EP's clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP's denominator?

The EP can include or not include those patients in their denominator at their discretion as long as the decision applies universally to all patients for the entire EHR reporting period and the EP is consistent across MU measures. In cases where a member of the EP's clinical staff is eligible for the Medicaid EHR incentive in their own right (nurse practitioners [NPs] and certain physician assistants [PAs]), patients seen by NPs or PAs under the EP's supervision can be counted by both the NP or PA and the supervising EP, as long as the policy is consistent for the entire EHR reporting period.

To meet the MU objective "use CPOE" for the Medicare and Medicaid EHR Incentive Programs, should EPs include hospital-based observation patients (billed under POS 22) whose records are maintained using the hospital's certified EHR system in the numerator and denominator calculation for this measure?

If the patient has records that are maintained in both the hospital's certified EHR system and the EP's certified EHR system, the EP should include those patients seen in locations billed under POS 22 in the numerator and denominator calculation for this measure. If the patient's records are maintained only in a hospital's certified EHR system, the EP does not need to include those patients in the numerator and denominator calculation to meet the measure of the "use computerized provider order entry (CPOE)" objective.

If an EP is unable to meet the measure of an MU objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective under the Medicare and Medicaid EHR Incentive Programs?

Some MU objectives provide exclusions and others do not. Exclusions are available only when our regulations specifically provide for an exclusion. EPs may be excluded from meeting an objective if they meet the circumstances of the exclusion. If an EP is unable to meet an MU

objective for which no exclusion is available, then that EP would not be able to successfully demonstrate MU and would not receive incentive payments under the Medicare and Medicaid EHR Incentive Programs.

For the MU objective, "Capability to submit electronic syndromic surveillance data to public health agencies," what is the definition of "syndromic surveillance"?

Syndromic surveillance uses individual and population health indicators that are available before confirmed diagnoses or laboratory confirmation to identify outbreaks or health events and monitor the health status of a community.

Do controlled substances qualify as "permissible prescriptions" for meeting the eRx MU objective under the Medicare and Medicaid EHR Incentive Programs?

The inclusion of controlled substances in the permissible prescriptions for the purposes of the eRx MU objective is an option for providers, but not be required.

As discussed in the Stage 3 Final Rule, many States have varying policies regarding controlled substances and may address different schedules, dosages, or types of prescriptions differently. Given these developments with states easing some of the prior restrictions on electronically prescribing controlled substances, we believe it is no longer necessary to categorically exclude controlled substances from the term “permissible prescriptions” (80 FR 62801).

Therefore, for the purposes of this objective, that prescriptions for controlled substances may be included in the definition of permissible prescriptions where the electronic prescription of a specific medication or schedule of medications is permissible under State and Federal law.

Can the drug-drug and drug-allergy interaction alerts of my EHR also be used to meet the MU objective for implementing one clinical decision support rule for the Medicare and Medicaid EHR Incentive Programs?

No. The drug-drug and drug-allergy checks and the implementation of clinical decision support interventions are separate measures. EPs and EHs must implement five clinical decision support interventions in addition to CDS drug-drug and drug-allergy interaction.

Under the Medicare and Medicaid EHR Incentive Program, who is responsible for demonstrating MU of CEHRT, the provider or the vendor?

To receive an EHR incentive payment, the provider (EP, EH, or CAH) is responsible for demonstrating MU of CEHRT under both the Medicare and Medicaid EHR incentive programs.

In a group practice, will each provider need to demonstrate MU in order to get Medicare and Medicaid EHR incentive payments or can MU be calculated or averaged at the group level?

The Medicare and Medicaid EHR Incentive Programs are based on individual EP performance and not by group practice. Each EP within a group practice will need to demonstrate the full requirements of MU in order to qualify for the EHR incentive payments or avoid a payment adjustment.

For the MU objective of "generate and transmit prescriptions electronically (eRx)" for the Medicare and Medicaid EHR Incentive Program, should electronic prescriptions fulfilled by an internal pharmacy be included in the numerator?

We define a permissible prescription as all drugs meeting the definition of prescription not listed as a controlled substance in Schedules II–V http://www.deadiversion.usdoj.gov/schedules/index.html. Although the Drug Enforcement Administration's (DEA) interim final rule on electronic prescriptions for controlled substances (75 FR 16236) removed the Federal prohibition to electronic prescribing of controlled substances, some challenges remain including more restrictive State law and widespread availability of products both for providers and pharmacies that include the functionalities required by the DEA's regulations. We continue to exclude over the counter (OTC) medicines from the definition of a prescription (77 FR 53989).

We continue to allow providers the option to include or exclude controlled substances in the denominator where such medications can be electronically prescribed. These prescriptions may be included in the definition of ''permissible prescriptions'' at the providers discretion where allowable by law (80 FR 62801).

The denominator for this objective is "Number of permissible prescriptions written during the EHR reporting period for drugs requiring a prescription in order to be dispensed" for EPs" and ''Number of permissible new, changed, or refill prescriptions written for drugs requiring a prescription in order to be dispensed for patients discharged during the EHR reporting period'' for EHs and CAHs. The revised definition of permissible prescriptions allows providers the option of including or excluding prescriptions for controlled substances where the electronic prescription of controlled substances is permissible under State and Federal law. Prescriptions from internal pharmacies and drugs dispensed on site may be excluded from the denominator.

The numerator for this objective is a query of a drug formulary for EPs, EHs, and CAHs. The provider may still count a patient in the numerator where no formulary exists to conduct a query and limit their effort to query a formulary to simply using the function available to them in their CEHRT with no further action required.

The provider would include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective. We further clarify that for purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur simultaneously if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.

How should patients in swing beds be counted in the denominators of MU measures for EHs and CAHs for the Medicare and Medicaid EHR Incentive Programs?

A number of the MU measures for EHs and CAHs require the denominator to be based on the number of unique patients admitted to the inpatient or emergency department during the EHR reporting period. Unique swing bed patients who receive inpatient care should be included in the denominators of MU measures. However, if the EH or CAH's CEHRT cannot readily identify and

include unique swing bed patients who have received inpatient care, those patients may be excluded from the calculations for the denominators of MU measures.

How should nursery day patients be counted in the denominators of MU measures for EHs and CAHs for the Medicare and Medicaid EHR Incentive Programs?

Nursery days are excluded from the calculation of hospital incentives because they are not considered inpatient bed-days based on the level of care provided during a normal nursery stay. In addition, nursery day patients should not be included in the denominators of MU measures. However, if the EH's or CAH's CEHRT cannot readily identify and exclude nursery day patients, those patients may be included in the calculations for the denominators of MU measures.

Does a provider have to record all clinical data in their CEHRT in order to accurately report complete clinical quality measure data for the Medicare and Medicaid EHR Incentive Programs?

Providers are continuing to implement new workflow processes to accurately capture clinical data in their CEHRT, but many providers are not able to capture all data at this time. Although providers are encouraged to capture complete clinical data in order to provide the best care possible for their patients, for the purpose of reporting clinical quality measure data, CMS does not require providers to record all clinical data in their CEHRT at this time. CMS recognizes that this may yield numerator, denominator, and exclusion values for clinical quality measures in the CEHRT that are not identical to the values generated from other methods (such as record extraction). However, at this time, CMS requires providers to report the clinical quality measure data exactly as it is generated as output from the CEHRT in order to successfully demonstrate MU. CMS will continue to collaborate with our partners in the ONC and with industry stakeholders to make further headways in system interoperability, standards for EHR data, as well as certification of vendor products.

Can the drug-drug and drug-allergy interaction alerts of my electronic health record (EHR) also be used to meet the meaningful use objective for implementing one clinical decision support rule for the Medicare and Medicaid EHR Incentive Programs?

No. The drug-drug and drug-allergy checks and the implementation of clinical decision support interventions are separate measures. EPs and eligible hospitals must implement five clinical decision support interventions in addition to CDS drug-drug and drug-allergy interaction.

4 Glossary of Terms

AIU	Adopt, Implement, Upgrade
CAH	Critical Access Hospital
CEHRT	Certified Electronic Health Record Technology
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHPL	Certified Health IT Product List
CMS	Center for Medicare and Medicaid Services
CPOE	Computerized Provider Order Entry
CPT	Current Procedure Terminology
CQM	Clinical Quality Measure
DHS	Designated Health Services
DOJ	Department of Justice
EH	Eligible Hospital
EHR	Electronic Health Record
EP	Eligible Professional
eRx	Electronic Prescriptions
FQHC	Federally Qualified Health Center
HIT	Health Information Technology
HITECH	The Health Information Technology for Economic and Clinical Health Act
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
MU	Meaningful Use
NCPDP	National Council for Prescription Drug Programs
NP	Nurse Practitioner
NPI	The National Provider Identifier
ONC	Office of the National Coordinator for Health Information
ONC-ATCB	Office of the National Coordinator for Health Information Authorized Testing and Certification Body

PIP	Provider Incentive Payment
PA	Physicians Assistant
PFS	Physician Fee Schedule
POS	Place of Service
REC	Regional Extension Center
Recovery Act	American Recovery and Reinvestment Act of 2009
RHC	Rural Health Center
SDE	State Designated Entities
SNF	Skilled Nursing Facility