MGMA DataDive Glossary

Please note: This 94-page document contains definitions for terms reported in MGMA DataDive for the last five years. These definitions are in alphabetical, and due to changing survey questions, metrics included in this document might not be available in each year of DataDive.

Please consider the environment before printing.

The icons below represent each data set reported in MGMA DataDive.

Provider Compensation and Production
Management and Staff
Cost and Revenue
Provider Placement Starting Salary
Academic Compensation
Medical Directorship Compensation
On-Call Compensation
% Billable clinical

Billable clinical percent can be calculated a variety of ways. In general, the calculations are all the same – the clinical effort divided by the total effort. Often, the difference between formulas equals the units of measurement, such as hours per day or sessions per week. Clinical effort and activities include direct patient care and consultation, individually or in a team-care setting, where a patient bill is generated or a fee-for-service equivalent charge is recorded.

% of TC included in collections and charges

- **Technical Component (TC):** Modifier-TC, when attached to an appropriate CPT code, represents the technical component of the procedure and includes the cost of equipment and supplies to perform that procedure. This modifier corresponds to the equipment/facility part of a given procedure.
- Collections for professional charges and gross charges for laboratory, radiology, medical diagnostic and surgical procedures may have two components: the physician’s professional charge such as interpretation and the technical charge for the operation and use of the equipment. If collections for professional charges and gross charges did not include the technical component, referred to as professional services only billing, select “0%.” If collections for professional charges and gross charges did include the technical component, referred to as global fee billing, indicate the approximate percentage of charges represented by the technical component by selecting either “1-10%” or “10%.” MGMA DataDive reports 0% TC and no NPP productivity for production metrics in the “Productivity” section. In the Pro Report Builder, you can choose what percent (%) TC you would like to benchmark your data by.

0 to 30 days

Amounts owed to the practice by patients, third-party payers, employer groups, and unions for fee-for-service activities before adjustments for anticipated payment reductions, allowances for adjustments, or bad debts. Amounts assigned to “Accounts receivable” are due to “Gross fee-for-service charges”. Assigning a charge into “Accounts receivable” initiates at the time a practice submits an invoice to the payer or patient for payment. For example, if an obstetrics practice establishes an open account for accumulation of charges when a patient is accepted into a prenatal program and the account will not be invoiced until after delivery, then “Accounts receivable” will not reflect these charges until the creation of an invoice. Deletion of charges from “Accounts receivable” is done when the practice receives payment, turns over debt to a collection agency, or writes off the account as bad debt. “Accounts payable to patients and payers” are subtracted from “Accounts receivable” before reporting “Accounts receivable”. This is the net amount owed after patient refunds.

**Not Included:**

1. Capitation payments owed to the practice by HMOs.

31 to 60 days in A/R

Amounts owed to the practice by patients, third-party payers, employer groups, and unions for fee-for-service activities before adjustments for anticipated payment reductions, allowances for adjustments, or bad debts. Amounts assigned to “Accounts receivable” are due to “Gross fee-for-service charges”. Assigning a charge into “Accounts receivable” initiates at the time a practice submits an invoice to the payer or patient for payment. For example, if an obstetrics practice establishes an open account for accumulation of charges when a patient is accepted into a prenatal program and the account will not be invoiced until after delivery, then “Accounts receivable” will not reflect these charges until the creation of an invoice. Deletion of charges from “Accounts receivable” is done when the practice receives payment, turns over debt to a collection agency, or writes off the account as bad debt. “Accounts payable to patients and payers” are subtracted from “Accounts receivable” before reporting “Accounts receivable”. This is the net amount owed after patient refunds.

**Not Included:**
1. Capitation payments owed to the practice by HMOs.

61 to 90 days in A/R
Amounts owed to the practice by patients, third-party payers, employer groups, and unions for fee-for-service activities before adjustments for anticipated payment reductions, allowances for adjustments, or bad debts. Amounts assigned to “Accounts receivable” are due to “Gross fee-for-service charges”. Assigning a charge into “Accounts receivable” initiates at the time a practice submits an invoice to the payer or patient for payment. For example, if an obstetrics practice establishes an open account for accumulation of charges when a patient is accepted into a prenatal program and the account will not be invoiced until after delivery, then “Accounts receivable” will not reflect these charges until the creation of an invoice. Deletion of charges from “Accounts receivable” is done when the practice receives payment, turns over debt to a collection agency, or writes off the account as bad debt. “Accounts payable to patients and payers” are subtracted from “Accounts receivable” before reporting “Accounts receivable”. This is the net amount owed after patient refunds.

Not Included:
1. Capitation payments owed to the practice by HMOs.

91 to 120 days in A/R
Amounts owed to the practice by patients, third-party payers, employer groups, and unions for fee-for-service activities before adjustments for anticipated payment reductions, allowances for adjustments, or bad debts. Amounts assigned to “Accounts receivable” are due to “Gross fee-for-service charges”. Assigning a charge into “Accounts receivable” initiates at the time a practice submits an invoice to the payer or patient for payment. For example, if an obstetrics practice establishes an open account for accumulation of charges when a patient is accepted into a prenatal program and the account will not be invoiced until after delivery, then “Accounts receivable” will not reflect these charges until the creation of an invoice. Deletion of charges from “Accounts receivable” is done when the practice receives payment, turns over debt to a collection agency, or writes off the account as bad debt. “Accounts payable to patients and payers” are subtracted from “Accounts receivable” before reporting “Accounts receivable”. This is the net amount owed after patient refunds.

Not Included:
1. Capitation payments owed to the practice by HMOs.

120+ days in A/R
Amounts owed to the practice by patients, third-party payers, employer groups, and unions for fee-for-service activities before adjustments for anticipated payment reductions, allowances for adjustments, or bad debts. Amounts assigned to “Accounts receivable” are due to “Gross fee-for-service charges”. Assigning a charge into “Accounts receivable” initiates at the time a practice submits an invoice to the payer or patient for payment. For example, if an obstetrics practice establishes an open account for accumulation of charges when a patient is accepted into a prenatal program and the account will not be invoiced until after delivery, then “Accounts receivable” will not reflect these charges until the creation of an invoice. Deletion of charges from “Accounts receivable” is done when the practice receives payment, turns over debt to a collection agency, or writes off the account as bad debt. “Accounts payable to patients and payers” are subtracted from “Accounts receivable” before reporting “Accounts receivable”. This is the net amount owed after patient refunds.

Not Included:
1. Capitation payments owed to the practice by HMOs.
Academic-specific position titles

Billing/Coding Manager:
- Oversee coding, charge entry, and all other aspects of the billing process for the clinical science department;
- General tasks range from performing reimbursement analysis to educating physicians and billing staff in billing procedures as well as CPT/ICD-9 coding;
- May develop fee structures, negotiate fees, and is knowledgeable of third-party payer billing requirements; and
- Reports to the chief department administrator or the top financial position.

Chief Department Administrator (CDA):
- Top administrative officer of one or more clinical science departments;
- Oversees, plans, guides and evaluates the nonmedical activities of the department including full or partial direct responsibility for the operation of ambulatory services;
- Broad responsibilities within the department include development of the department budget and approval of department expenditures;
- Responsibilities may include full or partial management of hospital functions, supervising the department administrative staff, assists and reports to the department chair.

Clinical Practice Manager:
- Coordinates and prioritizes resources, including staff, space, and equipment;
- Manages all aspects of the facility such as an ambulatory clinic, including building operations;
- Develops and implements practice standards and oversees all tasks related to the financial performance of the practice, including strategic planning such as forecasting, developing projections, and providing recommendations and justifications; and
- May report to the CDA or to the top administrative position in charge of ambulatory services.

Compliance Manager:
- Oversees all aspects of professional billing compliance;
- Responsible for adhering to all regulatory, credentialing, and licensing requirements, and for developing compliance policies and standards, overseeing and monitoring compliance activities, and achieving and maintaining compliance;
- May also have responsibility for research grants and contracts compliance; and
- Usually reports to the CDA.

Contracts/Grants Department Administrator:
- Oversees the disbursement, financial reporting, and the use of all extramural funds associated with the department’s clinical and basic research programs;
- Coordinates the development and submission of grant and contract proposals to internal and external agencies; and
- Reports to the CDA.

Departmental Financial Officer:
- Top financial position, which develops financial policies and oversees their implementation;
- Prepares short range and long-term projections to ensure that the department’s financial obligations are met; and
- Develops growth plans for the department and reports to the CDA or the department chair.

Division/Section Administrator:
- Top administrative officer of one or more divisions or sections of a clinical science department;
- Manages the nonclinical activities of the division(s) or section(s) and typically supervises the division or section administrative staff; and
• Usually reports to the CDA and/or a division/section chair.

**IS Manager/Network Administrator:**
• Coordinates the activities of the IS department including determining data processing requirements, managing department networks, determining feasibility of data projects, and performing analysis of department production; and
• Maintains and upgrades hardware and software.

**Reimbursement/Collections Manager:**
• Oversees payment and collection services for the department including establishing and maintaining the department’s fee schedules and fees that relate to managed care activities;
• Conducts regular analyses of reimbursement rates;
• Negotiates out-of-network fees;
• May be responsible for the practice’s central billing office;
• Oversees coding activities; and
• Usually reports to the Managed Care Director, the CFO, or the senior administrative officer.

**Academic Status**
• **Academic:** Anyone whole organization majority owner is a university, or their organization type is a medical school or university hospital
• **Non-Academic:** Anyone whose organization majority owner is not a university, and their organization type is not a medical school or a university hospital

**Accountable Care Organization (ACO)**
• A group of coordinated health care providers who form a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for their population of patients. The ACO is accountable to patients and the third-party payer for the quality, appropriateness, and efficiency of the care provided.

**Accounts Receivable**
Information regarding the age of your practice's accounts receivable (to the nearest whole dollar). Not included are accounts that have been assigned to collection agencies.

**ACO affiliation**
• **Commercial Insurance Company:** A privately formed health insurance company whose objective is to make a profit.
• **State or Federal Government Insurance:** A State or Federal Government provided health insurance such as Medicare or Medicaid.
• **Both Government and Commercial**

**ACO payment model**
• **Fee-for-Service (FFS) Shared Savings:** A payment model where providers, hospitals, and suppliers will be rewarded for lowering growth in health care costs while meeting performance standards on quality of care and putting patients first. This model requires coordinated care for all services provided under Medicare Fee-for-Service.
• **FFS with a Global Cap:** A payment model where services are unbundled and paid for separately with a global cap or limit on overall Medicare spending, used to incentivize collaborative care and reducing costs and unnecessary procedures.
• **Professional Service Capitation:** A model where health care providers are paid a set amount for each enrolled patient assigned to them per a specified time period regardless of number of visits or procedures for professional services.

• **Full Capitation:** A model where health care providers are paid a set amount for each enrolled patient assigned to them per a specified time period regardless of whether or not they seek care, number of visits, or procedures.

**ACO primary leadership**

• **Physicians:** Any doctor of medicine (MD) or doctor of osteopathy (DO) who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

• **Hospital/IDS:** A Hospital is an inpatient facility that admits patients for overnight stays, incurs nursing care costs, and generates bed-day revenues. An Integrated delivery system (IDS) is a network of organizations that provide or coordinate and arrange for the provision of a continuum of health care services to consumers and is willing to be held clinically and fiscally responsible for the outcomes and the health status of the populations served. Generally consisting of hospitals, physician groups, health plans, home health agencies, hospices, skilled nursing facilities, or other provider entities, these networks may be built through “virtual” integration processes encompassing contractual arrangements and strategic alliances as well as through direct ownership.

• **Hybrid of Hospital/IDS and Physicians**

**Additional time off**

Based on whether or not the provider receives additional time off for taking call.

**Adjusted fee-for-service charges**

The difference between "Adjustments to fee-for-service charges" and "Gross fee-for-service charges."

**Adjustments to fee-for-service charges (value of services performed for which payment is not expected)**

The difference between “Gross fee-for-service charges” and the amount expected to be paid by or back to patients or third-party payers. This represents the value of services performed for which payment is not expected.

  *Included:*

  1. Medicare/Medicaid charge restrictions (the difference between the practice’s full, undiscounted charge and the Medicare limiting charge);
  2. Third-party payer contractual adjustments (commercial insurance and/or managed care organization);
  3. Charitable, professional courtesy or employee adjustments; and
  4. The difference between a gross charge and the Federally Qualified Health Center (FQHC) payment. This could be a positive or negative adjustment.

**Administrative supplies and services**

Cost of printing, postage, books, subscriptions, administrative and medical forms, stationery, bank charges, bank processing fees, credit card fees, and other administrative supplies and services.

  *Include:*

  1. Purchased medical transcription services.
Ancillary service clinical laboratory revenue
For hospital/IDS practices only. The amount of the ancillary service revenue was posted for clinical laboratory services for the medical practice’s patients.

- **All**: Revenue for all services was posted to the medical practice.
- **Some**: Some revenue for services was posted to the IDS/hospital/MSO and some revenue was posted to the medical practice.
- **None**: Revenue for all services was posted to the IDS/hospital/MSO.

Ancillary/supplementary services
Such services are those that are provided as part of, or are wholly owned by the practice. Ancillary services are those services that supplement the routine (professional) services personally performed by the practice’s provider staff. Such services are billed under separate CPT codes and reimbursed separately, either by third-party payers and/or patients.

- **Advanced radiology**: Examples of such services include but are not limited to mammography, CT, MRI, nuclear medicine, ultrasound, bone densitometry, cardiac catheterization lab, ECP, MRA, EMG, and EEG.
- **Aesthetics and cosmetic services**: Examples of such services include but are not limited to Botox, laser hair removal, skin care, and vein removal.
- **Allergy/Asthma/Immunology**: Examples of such services include allergy injections, pulmonary function tests, and vaccinations.
- **Ambulatory surgery center**: An ambulatory surgery center (ASC) is specifically licensed to provide surgery services performed on a same-day outpatient basis, including endoscopy centers. Select if your practice or physicians owned or had financial interest in an ASC as part of, or wholly owned by the practice. ASC is not a separate legal entity.
- **Audiology/Hearing Aid(s)/Center**: Examples of such services include hearing aids and centers where audiology tests take place.
- **Clinical laboratory services**: (tests of high complexity under CLIA): Check if your practice provided lab tests of high complexity as determined under CLIA. Not Included: if your practice performed only tests of waived or moderate level complexity under CLIA. For further guidance on CLIA complexity categorization refer to the US FDA Website.
- **Clinical research/drug studies**: Select if your practice participated and provided services under a clinical/drug trial study or research program.
- **Complementary alternative medicine**: Examples of such services include but are not limited to massage therapy, acupuncture, and acupressure.
- **Drug administration**: Examples of such services include, but are not limited to, chemotherapy.
- **Durable Medical Equipment (DME)**: Examples of such products include but are not limited to hearing aids, orthotics, diabetic meters and supplies, aids to daily living, and orthopedic supplies.
- **General radiology**: Examples of such services include general and routine X-rays.
- **Health education/counseling services**: Select if your practice provided billable services for health education and guidance to patients related to diet, weight control, diabetes, physiological, and/or genetic counseling.
- **Optical shop**: If the participant’s practice or physicians owned or had financial interest in an optical service shop they are included here. If the optical shop is a separate legal entity.
- **PT/OT/Cardiac rehabilitation**: Examples of therapies and testing that pertain to these lines of services include biofeedback and phase II cardiac rehabilitation.
- **Radiation therapy**: Examples of such services include but are not limited to radiotherapy and X-ray therapy.
- **Sleeping lab/center**: Examples include sleep studies or polysomnogram.
ASA units
American Society of Anesthesiologists (ASA) units. The ASA units for a given procedure consist of three components:
1. Base unit;
2. Time in 15- minute increments; and
3. Risk factors.

Please note:
1. Adjustments should be made if provider supervises a CRNA that is not employed by the reporting practice; and
2. Do not duplicate units for split bills. Instead, report units on a per case basis.

Bad debts due to fee-for-service activity (accounts assigned to collection agencies)
The difference between “Adjusted fee-for-service charges” and the amount actually collected.
Included:
1. Losses on settlements for less than the billed amount;
2. Accounts written off as not collectible;
3. Accounts assigned to collection agencies; and
4. In the case of accrual accounting, the provision for bad debts.

Base compensation
The amount paid as routine or regular compensation, regardless of the faculty member's funding sources or productivity. This amount is guaranteed by the medical school, hospital, practice plan, or Veterans Administration to the faculty member.
Not Included:
Incentive payments, honoraria, bonuses, profit-sharing distributions, expense reimbursements, fringe benefits paid by the medical school or department such as life and health insurance, retirement plan contributions, automobile allowances, or any employer contributions to 401(k), 403(b), or Keogh Plan.

Beds in department
The number of beds in the department that the directorship serves.

Beds in organization
The number of beds in the organization that sponsors the directorship.

Billing and collections purchased services
When a medical practice decides to purchase billing and collections services from an outside organization as opposed to hiring and developing its own employed staff to conduct billing and collections activities, the cost for such purchased services should be considered "Billing and collections purchased services”.
Included:
1. Claims clearinghouse cost.

Bone densitometry - Staffing
For OB/GYN practices only.
FTE and cost for staff that perform bone densitometry procedures.
Included:
1. Registered technologists; and
2. Technicians that are not necessarily licensed but are trained and perform bone densitometry procedures such as LPNs, RNs, or MAs.

Bone densitometry (DEXA) – Expenses
For OB/GYN and orthopedic practices only.
Noninvasive technology that is used to measure bone mass using Dual Energy X-Ray Absorptiometry (DEXA).

Bonus/incentive amount
The total dollar amount of any bonus or incentive payments received by each individual. The amount listed as a bonus/incentive should be included in “Total Compensation”.

Building and occupancy
Cost of general operation of buildings and grounds.

Included:
1. Rental, operating lease, and leasehold improvements for buildings and grounds;
2. Interest paid on loans for real estate used in practice operations;
3. Cost of utilities such as water, electric power, space heating fuels, etc.;
4. Cost of supplies and materials used in housekeeping and maintenance; and
5. Other costs such as building repairs and security systems.

Not Included:
1. Interest paid on short-term loans, which is included in “Miscellaneous operating cost”;
2. Interest paid on loans for real estate not used in practice operations, such as nonmedical office space in practice-owned properties. Such interest is included in “Nonmedical cost”;
3. Cost of producing revenue from sources such as parking lots or leased office space from practice-owned properties. Such cost is included in “Nonmedical cost”;
4. Depreciation costs.

Building/occupancy depreciation
Depreciation cost for buildings and grounds.

Not Included:
1. Interest paid on short-term loans, which is included in "Miscellaneous operating cost";
2. Interest paid on loans for real estate not used in operations such as nonmedical office space in practice-owned properties;
3. Rental, operating lease, and leasehold improvements for buildings and grounds;
4. Interest paid on loans for real estate used in ASC operations;
5. Cost of utilities such as water, electric power, and space heating fuels;
6. Cost of supplies and materials used in housekeeping and maintenance; or
7. Other costs such as building repairs and security systems.

Centralized staff position
These individuals work in a centralized administrative department. A centralized administrative department would provide leadership and has the authority/responsibility for the operations of the various physician practices within the entity. This department would provide oversight and encompass many or all of the following types of activities: establishing policies, negotiating managed care agreements, strategic planning, physician contracting, approving expenditures, as well as affording any other resources required to manage the physician practices.

Certified in Position

• Not Certified: Individuals who are not certified in their reported position title.
• **Certified**: Individuals who are certified in their reported position title. For example, if you are submitting a Medical Assistant and that individual is a Certified Medical Assistant.

**Charged services and the average fee**

For primary care practices only.

• **Disability evaluation**: Appraisal or assessment by the practice for benefit claims.

• **Form completion (immunization, school)**: Examples of forms completed by the practice include but are not limited to immunization, camp, daycare, school, and athletic paperwork.

• **Online evaluation**: Non face-to-face contact.

• **Physician telephone care management**: Telephone-based care management services. Services may include addressing health care needs through patient symptoms and previous history. It may also be used to schedule appointments, recommend appropriate level of care, provide health education or resource referral.

**Charity care**

Fee-for-service gross charges, at the practice’s undiscounted rates, for all services provided to charity patients. Charity patients are patients not covered by either commercial insurance or federal, state, or local governmental health care programs and who do not have the resources to pay for services. Charity patients must be identified at the time that service is provided so that a bill for service is not prepared.

**Claims processed per biller**

For anesthesiology practices only.

To calculate, take the total number of claims processed by your group, divide by the total number of FTE who processed anesthesiology billing. For example, if your group processed 30,000 anesthesiology claims in 2013 and had 5.5 FTE working on anesthesia billing, you would enter 5454.54 (30,000/5.5) for “Number of claims processed per biller for anesthesia claims.”

**Clinical laboratory – Expenses**

Cost of clinical laboratory and pathology procedures defined by CPT codes 80047-89398, 36415, and 36416.

**Included:**

1. Rental and/or depreciation cost of major furniture and equipment subject to capitalization;
2. Repair and maintenance contract cost;
3. Cost of supplies and minor equipment not subject to capitalization;
4. Other costs unique to the clinical laboratory; and
5. Cost of purchased laboratory technical services for fee-for-service patients.

**Not Included**

1. Cost of purchased laboratory technical services for capitation patients. Such cost should be reported as “Purchased services for capitation patients.”

**Clinical laboratory – Staffing**

The clinical laboratory and pathology department conducts procedures for clinical laboratory and Pathology CPT codes 80047-89398, 36415, and 36416.

**Included:**

1. Cost/FTE of support staff such as nurses, secretaries and technicians; and
2. Cost/FTE of department director or manager.
Clinical service hours
Weekly hours during which a clinician is involved in direct patient care where a patient bill is generated and a fee-for-service equivalent charge is created for the practice. Clinical service hours include seeing patients in the office, outpatient clinic, emergency room, nursing home, operating room, labor and delivery, and time spent on hospital rounds.

**Included:**
1. Capitated (HMO) contracts;
2. Indigent and professional courtesy care;
3. Clinical or ancillary services;
4. Dictation and chart documentation; and
5. Clinical services delivered at VA facilities where a patient bill is generated.

**Not included:**
1. On-call time regardless of whether physician is on- or off-site;
2. Non-billable clinical activities where a patient bill is not generated nor a fee-for-service equivalent charge recorded such as pro bono clinical activities performed at VA facilities;
3. Telephone conversations with patients, consultations with providers, interpretation of diagnostic tests, and chart reviews;
4. Research activities including specific research, training, and other projects that are separately budgeted and accounted for by the medical practice;
5. Performing administrative activities or support activities in a medical practice; or
6. Case conferences.

Collections for professional charges
Amount of collections attributed to a physician for all professional services.

**Included:**
1. Fee-for-service collections;
2. Allocated capitation payments;
3. Administration of chemotherapy drugs; and
4. Administration of immunizations.

**Not included:**
1. Collections on drug charges, including vaccinations, allergy injections, and immunizations, as well as chemotherapy and antinauseant drugs;
2. The technical component associated with any laboratory, radiology, medical diagnostic or surgical procedure collections. If your practice cannot break this out, report collections and answer the appropriate response to the question regarding technical component. If you can report collections without technical component, answer 0% for the technical component question;
3. Collections attributed to nonphysician providers
4. Infusion-related collections;
5. Facility fees;
6. Supplies; or
7. Revenue associated with the sale of hearing aids, eyeglasses, contact lenses, etc.

Colonoscopies
For gastroenterology practices only.
Included are the number of minutes scheduled for, number of procedures, charges and revenue for colonoscopies conducted by your practice. Including procedure codes 45355-45392.

Commercial
Include all fee-for-service, managed care fee-for-service and capitated charges for all services provided patients under a commercial capitated contact.
• **Commercial: fee-for-service:** Fee-for-service gross charges, at the practice’s undiscounted rates, for all services provided to fee-for-service patients who were covered by commercial contracts that do not include a withhold but may or may not include a performance-based incentive. A commercial contract is any contract that is not Medicare, Medicaid, or workers’ compensation.

*Not Included:*
1. Charges for Medicare patients;
2. Charges for Medicaid patients;
3. Charges for capitation patients;
4. Charges for patients covered by a managed care plan;
5. Charges for workers’ compensation patients;
6. Charges for charity or professional courtesy patients; or
7. Charges for self-pay patients.

• **Commercial: managed care fee-for-service:** Fee-for-service gross charges, at the practice’s undiscounted rates, for all services provided to patients who were covered by managed care contracts that do include a withhold and may or may not include a performance based incentive. A commercial contract is any contract that is not Medicare, Medicaid, or workers’ compensation.

*Included:*
1. Charges for patients covered under discounted fee-for-service contract arrangements.

*Not Included:*
1. Charges for Medicare patients;
2. Charges for Medicaid patients;
3. Charges for capitation patients;
4. Charges for workers’ compensation patients;
5. Charges for charity or professional courtesy patients; or

• **Commercial: capitation:** Fee-for-service equivalent gross charges, at the practice’s undiscounted rates, for all services provided to patients under a commercial capitated contract.

*Not Included:*
1. Charges for fee-for-service patients; or
2. Charges for patients covered under discounted fee-for-service contract arrangements.

**Commission compensation**
The individual's annual commission compensation accrual.

**Compensation method**
The financial funds flow models that best represent the compensation plan for the reported management and staff.

- **Hourly rate**
- **Straight salary only (no bonus)**
- **Base salary PLUS discretionary bonus** (e.g., end-of-year bonus)
- **Bonus salary PLUS percentage of practice productivity and/or physician income** (formula bonus)
- **Base salary PLUS percentage of practices net profit** (formula bonus)
• **Base salary PLUS other formula bonus** (e.g., number of patient visits, patient satisfaction, etc.)
• **Base salary PLUS deferred compensation** (e.g., trusts, stock options, etc.)
• **Base salary PLUS combination of discretionary and formula bonuses PLUS deferred compensation**

**Compensation method**

- **Hourly Rate**: The provider is paid a defined amount for each hour that is spent performing medical directorship duties.
- **Daily Stipend**: The provider is paid a defined amount for each day that is spent performing medical directorship duties.
- **Weekly Stipend**: The provider is paid a defined amount for each week that is spent performing medical directorship duties.
- **Monthly Stipend**: The provider is paid a defined amount for each month that is spent performing medical directorship duties.
- **Quarterly Stipend**: The provider is paid a defined amount for each quarter that is spent performing medical directorship duties.
- **Annual Stipend**: The provider is paid a defined amount for the entire year for all time spent performing medical directorship duties.
- **Deferred Compensation**: The provider receives some type of deferred compensation, which is paid after the regular pay period, such as an annuity or pension plan, for time spent performing medical directorship duties.

**Compensation methods**

- **Straight/Base Salary %**: Compensation is a fixed, guaranteed salary.
- **Equal Share of Compensation Pool %**: A “compensation pool” is equal to the total practice revenues net of practice overhead expenses. Such plans generally treat practice overhead as a cost of doing business that is borne by the group as a whole and not allocated to individual physicians (with the potential exception of physician-specific direct expenses). Such plans may be referred to as “team” or “group-oriented” compensation methods.
- **Incentive %**: An incentive component is “at risk” or must be earned, and may be awarded based on one or more criteria including unit/department and/or organization performance, patient satisfaction, quality metrics, citizenship, and other factors.
- **Production %**: The production metric is measured on the individual physician's output level.
- **Other Compensation Method %**: A compensation plan metric that is not listed here.

**Consulting fees**

Fees for professional consulting services performed on a one-time or sporadic basis.

**Included:**
1. Fees for management, financial, and other outside consulting services.

**Cost allocated to medical practice from parent organization**

- When a medical practice is owned by a hospital, integrated delivery system, or other entity, the parent organization often allocates indirect costs to the medical practice. These indirect costs may have different names depending on the situation. Examples of alternative names are “shared services costs” or “uncontrollable costs.” These costs may be arbitrarily assigned to the medical practice, may be the result of negotiations between the practice and the parent organization, or the result of some sort of cost accounting system. Often, these indirect costs include a portion of the salaries of the senior management team of the parent
organization, a portion of corporate human resources costs, or a portion of corporate marketing costs.

- Depending on the type of cost, the cost may be allocated to the medical practice as a function of the ratio of medical practice FTE to total system FTE, the ratio of medical practice square footage to total system square footage, or the ratio of medical practice gross charges to total system gross charges. Depending on the culture of the integrated system, these indirect costs may or may not even show up on the financial statements of the medical practice.

- Regardless of the cost’s name, the reporting culture or the cost allocation method, please try to identify these costs and report them.

**Not Included:**
1. Cash loans made to subsidiaries. Cash for loans does not appear anywhere on this survey.

Cost allocation
In a prospective pay and managed care environment, identifying and controlling costs per covered life is crucial for medical practices. To control costs per covered life, a practice management professional must understand the costs of its healthcare services.

- **Outputs:** Understanding what activities a practice performs.
  - Example: surgical and radiology procedures
- **Inputs:** Understanding what resources go into performing these activities. They can allocate to one or more activities to determine cost per activity or procedure.
  - Example: support staff labor, physician labor, supplies, rent and insurance

The model calculates operating cost, provider cost, and total cost per procedure. Data is reported for outputs, procedures and charges. The cost allocated to each procedure type depends on the gross charges generated by each procedure compared to total gross charges for all procedures.

Cost of sales and/or cost of other medical activities
Cost of activities that generate revenue included in “Revenue from the sale of medical goods and services”, as long as this cost is not also included in “Total operating cost” or “Nonmedical cost.”

**Included:**
1. Cost of pharmaceuticals, medical supplies and equipment sold to patients primarily for use outside the practice. Examples include prescription drugs, hearing aids, optical goods, and orthopedic supplies.
2. Any provider consultant cost(s) within this question total.

**Not Included:**
1. Cost of drugs used in providing services including vaccinations, allergy injections, immunizations, chemotherapy, and anti-nausea drugs. Such cost is included in “Drug supply”; or
2. Cost of medical/surgical supplies and instruments used in providing medical/surgical services. Such cost is included in “Medical and surgical supply.”

Critical Care services (CPT codes 99291, 99292)
For anesthesiology practices only.

**Included:**
1. Central venous lines (36555-36558, 36568-36569), arterial lines (36620), and Swan Ganz catheters (93503) placed by members of your group;
2. TEEs (93312-93318) that are performed and/or monitored by your group. Each separate CPT code billed is counted as one service;
3. Intubations (31500) that are not associated with anesthetic cases;
4. Other acute pain services and other flat fees; and
5. Other flat fee procedures that are not applicable to any other category. For example, if an E&M visit has been included under critical care, acute or chronic pain, do not double count here.

C-Sections (CPT codes 59514, 01968)
For anesthesiology practices only.

**Included:**
1. Labor epidurals (59409 or 01967) and C-sections (59514 or 01968). If a labor epidural is started and then a C-section is performed, count as one of each.

Data cuts

- **Per FTE physician =** 
  \[
  \frac{\text{performance measure}}{\text{Total physician FTE}}
  \]
- **Per total RVU =** 
  \[
  \frac{\text{performance measure}}{\text{Total RVUs}}
  \]
- **As a percentage of total medical revenue =** 
  \[
  \frac{\text{performance measure}}{\text{Total medical revenue}}
  \]
- **Per work RVU =** 
  \[
  \frac{\text{performance measure}}{\text{Physician work RVUs}}
  \]
- **Per FTE provider =** 
  \[
  \frac{\text{performance measure}}{\text{Total provider FTE, including physician and nonphysician provider FTE}}
  \]
- **Per patient =** 
  \[
  \frac{\text{performance measure}}{\text{Number of patients}}
  \]
- **Per square foot =** 
  \[
  \frac{\text{performance measure}}{\text{Square feet}}
  \]

Dedicated staffing model
For cardiology and primary care practices only.
An example of a medical practice with a dedicated staffing model is one in which each physician has an individual nurse that he/she works with on a daily basis.

Delivery Procedures
For OB/GYN practices only.
For the CPT codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622, and the total, for physicians and Certified Nurse Midwives (CNM) performed as well as the revenue for physicians and CNMs for the fiscal year reported in this questionnaire.

Demographic classification
- **Nonmetropolitan (49,999 or fewer):** The community in which the practice is located is generally referred to as “rural.” It is located outside of a “metropolitan statistical area” (MSA), as defined by the United States Office of Management and Budget, and has a population 49,999 or fewer.
- **Metropolitan (50,000 to 250,000):** The community in which the practice is located is an MSA or Census Bureau defined urbanized area with a population of 50,000 to 250,000.
• **Metropolitan (250,001 to 1,000,000)**: The community in which the practice is located is an MSA or Census Bureau defined urbanized area with a population of 250,001 to 1,000,000.

• **Metropolitan (1,000,001 or more)**: The community in which the practice is located is a “primary metropolitan statistical area” (PMSA) with a population of 1,000,001 or more.

**Diagnostic radiology (X-ray, Film, Digital CR, Digital DR, and C-arm)**
For orthopedic practices only.
Noninvasive technology that is used to measure Diagnostic radiology for X-ray.

**Direct operating cost in ASC**
For orthopedic practices only.
The amount of direct operating costs incurred from the services provided in the ASC.

**Double procedures**
For gastroenterology practices only.
Included are the number of minutes scheduled for, number of procedures, charges and revenue for double procedures conducted by your practice. Double may include combination of procedures performed on the same day of service. For example, an EGD and a Colonoscopy or an EGD and a Flex Sig.

**Drug supply**
Cost of drugs purchased for general practice use.

**Included:**
1. Cost of chemotherapy drugs, allergy drugs, and vaccines used in providing medical/surgical services.

**Not Included:**
1. Cost of specialized supplies dedicated for exclusive use in the departments of clinical laboratory, radiology, and imaging, or other ancillary services departments. Such cost is included in “Clinical laboratory”, “Radiology and imaging”, and “Other ancillary services”; or
2. Cost of pharmaceuticals sold to patients primarily for use outside the practice and not used in providing medical/surgical services. Examples include prescription drugs. Such cost is included in “Cost of sales and/or cost of other medical activities.”

**EGDs**
For gastroenterology practices only.
Included are the number of minutes scheduled for, number of procedures, charges and revenue for EGDs conducted by your practice. Including procedure codes 43200-43259.

**Electromyography**
For orthopedic practices only.
A test that measures the response of muscle fibers to electrical activity.

**Employed vs. contracted**
• Anyone who is employed by the participating group is included in the non-faculty category (whether or not they are an owner). If the person is a W-2 employee of your group, they should be listed as “non-faculty” and “group paid”. If an individual is a 1099 employee paid by your group, that person is included in “contracted” and “group paid”. If you work with CRNA’s or physicians who are employed by the facility or some other entity, those
individuals are included in “employed” and “nongroup paid.” Locums who are paid by the facility are included in “contracted” and “nongroup paid”.

- In the “Total Group Cost”, the total cost for those individuals by category if you pay for CRNA’s and/or physicians (whether they are employed or contracted) is included. Total cost would include salary, overtime, call pay, bonuses, fringe benefits and payroll taxes. If you pay for a group of employees (for example CRNA’s or residents) but receive a subsidy from the hospital or medical school to do so, only list what your medical group paid them. Net subsidy (money received from the facility less revenue paid back) you receive to assist with these costs are in the Financial Remuneration section of this survey.

Epidurals (CPT codes 62318, 62319)
For anesthesiology practices only.

**Included:**
1. The epidural (62318, 62319) for the day that the procedure was performed and count each day of subsequent follow-up as one follow-up visit (01996). For example, if patient A has an epidural placed for post-op pain on 12/1 and you visit him/her on 12/2, 3, 4, you would list one epidural and three days of follow-up visits.

Extramurally funded research projects
The number of extramurally funded research projects to which faculty devoted any amount of effort during any part of the fiscal year reported. Extramural is defined as dollars from outside resources used by your institution.

**Included:**
No-cost extension funding.

Extraordinary nonmedical cost
Cost that is unusual in nature and infrequent in occurrence.

**Included:**
1. Legal settlement cost; and
2. Environmental disaster recovery cost.

**Not Included:**
1. Cost included in “Nonmedical cost.”

Extraordinary nonmedical revenue
Revenue that is unusual in nature and infrequent in occurrence.

**Include:**
1. Legal settlement receipts; and
2. Environmental disaster recovery funds.

**Not Included:**
1. Revenues included in “Nonmedical revenue”.

Faculty anesthesiologists
For anesthesiology practices only.
The cost and FTE of all department faculty with an MD degree (or equivalent) and a minimum rank of instructor. Include all clinical activities performed in a department, faculty practice plan, medical school, hospital, or Veteran’s Administration setting. The minimum number of weekly work hours for 1.0 FTE is the number of hours that your department considers being a normal workweek. The normal workweek could be 37.5, 40, or 50 hours per week, depending on your department. Regardless of the number of hours worked, a faculty member cannot be counted as more than 1.0 FTE.
Faculty Rank
The highest academic rank held by the faculty physician.

Included:
• Instructor
• Assistant Professor
• Associate Professor
• Professor
• Division Chair/Chief
• Non-Faculty

Not included:
1. Itinerary volunteers or commissioned physicians who teach;
2. Fellows.

Fellowship
A physician who has completed training as a resident and has been granted a position allowing him or her to do further study or research in a specialty.

Financial support for operating costs (from parent organization)
Medical practices may receive operational support from a parent organization such as a hospital, IDS, or other entity.

Include:
1. Operating subsidies received from a parent organization such as a hospital, health system, PPMC, or MSO.

First-year guaranteed compensation
The first year guaranteed contract dollar amount, excluding:
• The dollar value of a signing bonus and other dollar amounts received through a bonus system such as production-based bonuses.
• The dollar value of expense reimbursements, fringe benefits paid by the medical practice such as retirement plan contributions, life and health insurance or automobile allowances or any employer contributions to a 401(k), 403(b) or Keogh Plan.

Flex Sigs
For gastroenterology practices only.
Included are the number of minutes scheduled for, number of procedures, charges and revenue for Flex Sigs conducted by your practice. Including procedure codes 45330-45345.

Follow-up visits (CPT codes 01996, 99231-99233)
For anesthesiology practices only.

Included:
1. The epidural (62318, 62319) for the day that the procedure was performed and count each day of subsequent follow-up as one follow-up visit (01996). For example, if patient A has an epidural placed for post-op pain on 12/1 and you visit him/her on 12/2, 3, 4, you would list one epidural and three days of follow-up visits.

Full-time equivalent
The full-time equivalent (FTE) a physician is considered to be employed by the practice. An FTE physician works whatever number of hours the practice considers to be the minimum for a normal workweek, which could be 37.5, 40, 50 hours, or some other standard. To compute FTE of a part-time physician, divide the total hours worked by the physician by the total number of hours that your medical
practice considers to be a normal workweek. For example, a physician working in a clinic or hospital on behalf of the practice for 30 hours compared to a normal workweek of 40 hours would be 0.75 FTE (30 divided by 40 hours).

**Included:**
1. Practice physicians such as shareholders/partners, salaried associates, employed and contracted physicians, and locum tenens;
2. Residents and fellows working at the practice; and

**Not Included:**
1. Full-time physician administrators or the time that a physician devotes to medical director activities.

**Furniture and equipment**
Cost of furniture and equipment in general use in the practice.

**Included:**
1. Rental cost of furniture and equipment used in reception areas, patient treatment/exam rooms, physician offices, and administrative areas; and
2. Other costs related to clinic furniture and equipment, such as maintenance cost.

**Not Include:**
1. Cost of specialized furniture and equipment dedicated for exclusive use in the information technology, clinical laboratory, radiology and imaging, or other ancillary services departments. Such cost is reported as a subset in “Information technology”, “Clinical laboratory”, “Radiology and imaging”, and “Other ancillary services”; or
2. Depreciation cost.

**Furniture/equipment depreciation**
Depreciation cost of furniture and equipment in general use in the practice.

**Included:**
1. Depreciation cost of furniture and equipment used in reception areas, patient treatment/exam rooms, physician offices, and administrative areas.

**Not Included:**
1. Cost of specialized furniture and equipment dedicated for exclusive use in the information technology, clinical laboratory, radiology and imaging, or other ancillary services departments. Such cost is included in “Information technology”, “Clinical laboratory”, “Radiology and imaging”, and “Other ancillary services”; or
2. Other costs related to clinic furniture and equipment such as maintenance cost.

**General accounting**
Cost and FTE of general accounting office staff, such as department supervisor, controller, financial accounting manager, accounts payable, payroll, bookkeeping, and financial accounting input staff.

**General administrative**
FTE of general administrative and practice management staff, supporting secretaries, and administrative assistants.

**Included:**
1. FTE of executive staff such as administrator, assistant administrator, chief financial officer, medical director, site/branch/office managers, human resources, marketing, credentialing, and purchasing department staff.

**Not Included:**
1. FTE of directors of departments listed separately on this survey. Examples include information technology director, medical records director, laboratory director, and
radiology director. Such FTE should be reported in “Information technology”, “Medical records”, “Clinical laboratory”, or “Radiology and imaging”, as appropriate; or
2. Credentialing staff as they pertain to managed care departments, such FTE should be reported in “Managed care administrative.”

General administrative
Cost of general administrative and practice management staff, supporting secretaries, and administrative assistants.

**Included:**
1. Cost of executive staff such as administrator, assistant administrator, chief financial officer, medical director, site/branch/office managers, human resources, marketing, credentialing, and purchasing department staff.

**Not Included:**
1. Cost of directors of departments listed separately on this survey. Examples include information technology director, medical records director, laboratory director, and radiology director. Such FTE and cost should be reported in “Information technology”, “Medical records”, “Clinical laboratory”, or “Radiology and imaging”, as appropriate; or
2. Credentialing staff as they pertain to managed care departments, such cost should be reported in “Managed care administrative.”

Geographic Section

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Goodwill amortization

When an IDS, hospital, or PPMC purchases a medical practice, the purchase price can be thought of as having two components - the value of the tangible assets and the value of the goodwill. Goodwill is the premium paid in excess of the value of the tangible and identifiable intangible assets. If financial statements are maintained in accordance with the income tax basis of accounting, goodwill may be amortized over a period of time. If financial statements are reported in accordance with generally accepted accounting principles, goodwill is periodically reviewed for impairment. The tangible and identifiable intangible assets are typically depreciated / amortized over a period of time. For this question, report the annual amortization or impairment cost of goodwill.

Not Included:
1. Depreciation of tangible or identifiable intangible assets such as the building or equipment. These depreciation costs are reported as a component of “Information technology” cost, “Building depreciation” cost, “Furniture and equipment depreciation” cost, “Clinical laboratory” cost, “Radiology and imaging” cost, and “Other ancillary services” cost.

Gross capitation revenue (per member per month capitation payments, capitation patient copayments)

Revenue received in a fixed per member payment, usually on a prospective and monthly basis, to pay for all covered goods and services due to capitation patients.

Included:
1. Per member per month capitation payments including those received from an HMO, Medicare AAPCC (average annual per capita cost) payments, state capitation payments for Medicaid beneficiaries, and capitation payments from other medical groups;
2. Portions of the capitation withholds returned to a practice as part of a risk-sharing arrangement;
3. Bonuses and incentive payments paid to a practice for good capitation contract performance;
4. Patient copayments or other direct payments made by capitation patients;
5. Payments received due to a coordination of benefits and/or reinsurance recovery situation for capitation patients; and
6. Payments made by other payers for care provided to capitation patients.

Not Included:
1. Payments paid to a practice by an HMO under the terms of a discounted fee-for-service managed care contract. Such payments are included in “Total net fee-for-service collections/revenue.”

**Gross charges for patients covered by capitation contracts**

Also known as fee-for-service equivalent gross charges. The full value, at a practice’s undiscounted rates, of all covered services provided to patients covered by all capitation contracts, regardless of payer.

**Included:**

Fee-for-service equivalent gross charges for all services covered under the terms of the practice’s capitation contracts, such as:

1. Professional services provided by physicians, nonphysician providers, and other physician extenders such as Nurses and Medical Assistants;
2. Both the professional and technical components (TC) of laboratory, radiology, medical diagnostic, and surgical procedures;
3. Drug charges, including vaccinations, allergy injections, immunizations, and chemotherapy and anti-nausea drugs;
4. Charges for supplies consumed during a patient encounter inside the practice’s facilities. Charges for supplies sold to patients for consumption outside the practice’s facilities are reported as a subset of “Revenue from the sale of medical goods and services”; and
5. Facility fees. Examples of facility fees include fees for the operation of an ambulatory surgery unit or fees for the operation of a medical practice owned by a hospital where split billing for professional and facility services is utilized.

**Not Included:**

1. Pharmaceuticals, medical supplies, and equipment sold to patients primarily for use outside the practice. Examples include prescription drugs, hearing aids, optical goods, orthopedic supplies, etc. If such goods are not covered under the capitation contract, the revenue from these charges is included in “Revenue from the sale of medical goods and services”;
2. The value of purchased services from external providers and facilities on behalf of the practice’s capitation patients. The cost of these purchased services is included in “Purchased services for capitation patients”;
3. Charges for fee-for-service activity allowed under the terms of capitation contracts. Such charges are reported as “Gross fee-for-service charges”; or
4. Capitation revenue. If capitation charges are not tracked, leave space blank.

**Gross fee-for-service charges (capitation contracts not included)**

The full value, at the practice’s undiscounted rates, of all services provided to fee-for-service, discounted fee-for-service, and noncapitated patients for all payers.

**Included:**

1. Professional services provided by physicians, nonphysician providers, and other physician extenders such as Nurses and Medical Assistants;
2. Both the professional and technical components (TC) of laboratory, radiology, medical diagnostic, and surgical procedures;
3. Drug charges, including vaccinations, allergy injections, immunizations, and chemotherapy and anti-nausea drugs;
4. Charges for supplies consumed during a patient encounter inside the practice’s facilities. Charges for supplies sold to patients for consumption outside the practice’s facilities are reported as a subset of “Revenue from the sale of medical goods and services”;
5. Facility fees. Examples of facility fees include fees for the operation of an ambulatory surgery unit or fees for the operation of a medical practice owned by a hospital where split billing for professional and facility services is utilized;
6. Charges for fee-for-service services allowed under the terms of capitation contracts;
7. Charges for professional services provided on a case-rate reimbursement basis; and
8. Charges for purchased services for fee-for-service patients. Purchased services for fee-for-service patients are defined as services that are purchased by the practice from external providers and facilities on behalf of the practice’s fee-for-service patients.

For purchased services, note the following:

a. The revenue for such services should be included in “Total net fee-for-service collections/revenue”;

b. The cost for such services should be included, as appropriate, in “Clinical laboratory”, “Radiology and imaging”, “Other ancillary services”; and

c. The count of the number of purchased procedures for fee-for-service patients should be included in "Output Measures", Number of Procedures column.

**Not Included:**

1. Charges for services provided to capitation patients. Such charges are included in “Gross charges for patients covered by capitation contracts”;
2. Charges for pharmaceuticals, medical supplies and equipment sold to patients primarily for use outside the practice. Examples include prescription drugs, hearing aids, optical goods, orthopedic supplies, etc. The revenue generated by such charges is included in “Revenue from the sale of medical goods and services”; or
3. Charges for any other activities that generate the revenue reported in “Revenue from the sale of medical goods and services.”

**Gross revenue from other medical activities**

Add “Other medical revenue”, "Revenue from hospital" and “Revenue from the sale of medical goods and services.”

**Not Included:**

1. Interest income, which is reported as “Nonmedical revenue”;
2. Income from practice nonmedical property such as parking areas or commercial real estate, which is reported as "Nonmedical revenue";
3. Income from business ventures such as a billing service or parking lot, which is reported as "Nonmedical revenue";
4. One-time gains from the sale of equipment or property, which is reported as “Nonmedical revenue”; and
5. Cash received from loans, which is not reported anywhere in this survey.
### Health and Human Services (HHS) Regions

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### Holiday On-Call Compensation
The amount compensated per day for holiday on-call coverage.

### Hospital beds in primary location area
The number of hospital beds in the primary location area, which is the area the practice currently serves or could serve for on-call coverage.

### Hospitals in primary location area
The number of hospitals in the primary location area, which is the area the practice currently serves or could serve for on-call coverage.

### Hourly rate compensation
The amount the individual was paid hourly.

### Housekeeping, maintenance, security
Cost of housekeeping, maintenance, and security staff.

**Not Included:**
1. Cost of parking attendants if parking generates revenue, which is reported as "Nonmedical revenue" in the Nonmedical Revenue and Cost section. The cost of parking attendants should be included as "Nonmedical cost."

### Housekeeping, maintenance, security
FTE of housekeeping, maintenance, and security staff.

**Not Included:**
1. FTE of parking attendants if parking generates revenue, which is reported as "Nonmedical revenue" in the Nonmedical Revenue. The cost of parking attendants should be included as "Nonmedical cost."
Hysterectomy Procedures
For OB/GYN practices only.
For the CPT codes 58150, 58260, 58552, and the total.

Hysteroscopy Procedures
For OB/GYN practices only.
For the CPT codes 58555, 58558-58563, 58565, 58579, and the total.

Industry sponsored clinical trials
Sponsored clinical trials are typically funded by nonfederal, noninstitutional sources, i.e. pharmaceutical clinical trials.

Information technology
Cost of practice-wide data processing, computer, telephone, and telecommunications services.

  Included:
  1. Cost of local and long-distance telephone, radio paging, and answering services;
  2. Rental and/or depreciation cost of major data processing, computer and telecommunications furniture, equipment, hardware, and software subject to capitalization;
  3. Hardware and software repair and maintenance contract cost;
  4. Cost of data processing services purchased from an outside service bureau; and
  5. Cost of data processing supplies and minor software and equipment not subject to capitalization.
  6. Cost of IT purchased services including maintaining of EHRs and patient portals.

  Not Included:
  1. Cost of specialized information services equipment dedicated for exclusive use in the departments of clinical laboratory, radiology, and imaging, or other ancillary services departments. Such cost is included in “Clinical laboratory”, “Radiology and imaging”, and “Other ancillary services”; and
  2. Cost of contract programmers, which is included in “Total contracted support staff”, Cost column.

Information technology
Cost and FTE of information technology staff, such as data processing, computer programming, telecommunications staff, department director, or manager.

In-Office Procedures
For OB/GYN practices only
For the CPT codes 51725-51798, 56501, 57452, 57454, 57522, 58100, 58565, 59025, and the total.

Inpatient E and M codes
Inpatient Evaluation and Management Codes include:
  1. 99217-99220, 99234-99236, hospital observation services
  2. 99221-99223, 99231-99233, 99238-99239, hospital inpatient services
  3. 99251-99255, inpatient consultations
  4. 99291-99292, 99471-99472, 99468-99469, critical care services
  5. 99356-99359, prolonged physician service in the inpatient setting
  6. 99360, physician standby services
  7. 99366-99368, medical team conference
  8. 99460, 99462-99465, newborn care
  9. 99466-99467, pediatric patient transport
10. 99477, initial hospital care  
11. 99478-99480, continuing intensive care services  
12. 99485-99489, critical care  
13. 99495-99496, transitional care management services  

Not included:  
1. 99499, unlisted evaluation and management service  
2. Evaluation and management codes attributed to nonphysician providers.  

**Internal or external directorship**  
- **Internal directorship:** A directorship is considered internal if the same federal tax ID is used for the provider’s clinical work and directorship duties. For example, if the physician is employed by his medical practice for his medical directorship duties, the directorship would be considered "Internal".  
- **External directorship:** A directorship is considered external if a different federal tax ID is used for the provider’s clinical work and directorship duties. For example, if the physician is employed by a medical director for an organization other than the one he practices at, the directorship would be considered "External".  

**Joint Commission Accreditation**  
For hospital/IDS practices only.  
Joint Commission Accreditation standards address the organization’s level of performance in key functional areas, such as patient rights, patient treatment, medication safety, and infection control. They carry a CMS designation, which means that organizations accredited by The Joint Commission may choose to be “deemed” as meeting Medicare and Medicaid certification requirements.  

**Labor epidurals (CPT codes 59409, 01967)**  
For anesthesiology practices only.  
**Included:**  
1. Labor epidurals (59409 or 01967) and C-sections (59514 or 01968). If a labor epidural is started and then a C-section is performed, count as one of each.  

**Laparoscopy Procedures**  
For OB/GYN practices only.  
For the CPT codes 49320, 58660-58662, 58670, and the total.  

**Legal fees**  
Fees for professional legal services performed on a one-time or sporadic basis, and are not employees of the organization.  
**Included:**  
1. Fees related to legal services paid to attorneys who are not employees of the organization.  

**Legal organization**  
- **Business corporation:** A for-profit organization recognized by law as a business entity separate and distinct from its shareholders. Shareholders need not be licensed in the profession practiced by the corporation.  
- **Limited liability company:** A legal entity that is a hybrid between a corporation and a partnership, because it provides limited liability to owners like a corporation while passing profits and losses through to owners like a partnership.  
- **Not-for-profit corporation/foundation:** An organization that has obtained special exemption under Section 501(c) of the Internal Revenue Service code that qualifies the organization to be
exempt from federal income taxes. To qualify as a tax-exempt organization, a practice or faculty practice plan would have to provide evidence of a charitable, educational, or research purpose.

- **Partnership**: An unincorporated organization where two or more individuals have agreed that they will share profits, losses, assets, and liabilities, although not necessarily on an equal basis. The partnership agreement may or may not be formalized in writing.
- **Professional corporation/association**: A for-profit organization recognized by law as a business entity separate and distinct from its shareholders. Shareholders must be licensed in the profession practiced by the organization.
- **Sole proprietorship**: An organization with a single owner who is responsible for all profit, losses, assets, and liabilities.

**Legal tax status**
For hospital/IDS practices only.
The Internal Revenue Service (IRS) classified the medical practice for filing federal income taxes. The medical practice may have had the same tax status of its parent, or it may have had a different legal tax status.

- **Not-for-profit**: Classified as not-for-profit for IRS purposes.
- **For-profit**: Classified as for-profit for IRS purposes.

**Licensed practical nurses**
Cost and FTE of licensed practical nurses.

**Not Included:**
1. Cost and FTE of licensed practical nurses who worked exclusively in the departments of clinical laboratory, radiology and imaging, or other ancillary departments. Such cost is included in “Clinical laboratory”, “Radiology and imaging”, and “Other medical support services”.

**Magnetic resonance imaging (MRI)**
For orthopedic practices only.
Noninvasive radiology technique that uses magnetism, radio waves, and a computer to produce images of body structures.

**Magnetic resonance imaging (MRI) service provided**
For orthopedic practices only.
Noninvasive radiology technique that uses magnetism, radio waves, and a computer to produce images of body structures.

**Malpractice/liability**
For hospital/IDS practices only.

- **Commercial Market**: Coverage purchased through a commercial entity that protects the system’s assets and reputation against claims of negligent acts or omissions that result in injury or harm to your patients.
- **Self-Funded**: Self-funded coverage is the establishment and professional operation of a proactive mechanism for the funding, investigation, management, defense, and payment of claims with the purpose of minimizing the system’s exposure to loss of assets.
- **Occurrence**: Occurrence policy protects you from any incident occurring while the policy is in force. Any incident that occurred while the policy was in force will be covered forever.
- **Claims Made**: The claims made policy will only respond when the claim is made, as long as the policy continues to be in effect.

**Mammography**
For OB/GYN practices only.
Cost and FTE for staff that perform mammography procedures.

**Included:**
1. Registered technologists; and
2. Technicians that are not necessarily licensed but are trained and perform bone densitometry procedures such as LPNs, RNs, or MAs.

**Managed care administrative**
Cost and FTE of managed care administrative staff, such as supporting secretaries, administrative assistants.

**Included:**
1. HMO/PPO contract administrators, case management staff, actuaries, managed care medical directors and managed care marketing, quality assurance, referral coordinators, utilization review, credentialing staff, patient care coordinators and case managers.

**Management fees paid to an MSO or PPMC**
Medical practices may receive management or other services from an MSO, PPMC, hospital or other parent organization in return for a fee. The fee could be a contracted fixed amount, a percentage of collections or any other mutually agreed upon arrangement. Whatever the methodology, report the amount here.

**Included:**
1. Fees paid to an MSO/PPMC, hospital or parent organization for management services including management, administrative, and/or related support services; and
2. The cost of support staff employed by the MSO/PPMC, if these costs were not reported separately in the “Support staff and cost” section. The decision of whether to report these support staff costs in the “Support staff and cost” section, or in the “Management fees paid to an MSO or PPMC” depends on the quality of the FTE data. If FTE data for the MSO/PPMC support staff is accurate and easily obtainable, it is preferable to report the MSO/PPMC support staff FTE and cost in the “Support staff and cost” section. If the FTE counts are not known, it is suggested that the support staff cost be treated as a purchased service and be reported in “Management fees paid to an MSO or PPMC.”

**Not Included:**
1. The cost of support staff employed by the MSO/PPMC, if these costs were reported in the “Support staff and cost” section.

**Meaningful use**
Meaningful Use is utilizing EHR technology to improve the following through setting specific objectives that enable healthcare professionals to qualify for Center for Medicare & Medicaid Services (CMS) Incentive Programs:
- Quality, efficiency, and safety of health care delivery
- Patient and family engagement
- Care coordination, population, and public health

**Medicaid**
Included are all fee-for-service, managed care fee-for-service and capitated charges for all services provided to Medicaid or similar state health care program patients.

- **Medicaid: fee-for-service:** Fee-for-service gross charges, at the practice’s established undiscounted rates, for all services provided to Medicaid or similar state health care program patients on a fee-for-service basis.

**Not Included:**
1. Fee-for-service equivalent gross charges for services provided to Medicaid or other state health care program patients under capitated, prepaid or other “at-risk” arrangements; or
2. Charges for patients covered under discounted fee-for-service contract arrangements.

- Medicaid: managed care fee-for-services: Fee-for-service gross charges, at the practice’s established undiscounted rates, for all services provided to Medicaid or similar state health care program patients under a managed care plan. If patients are covered by both Medicare and Medicaid or a similar state health care plan on a fee-for-service basis, all charges for such patients should be included as Medicare fee-for-service charges.

  Included:
  1. Charges for patients covered under discounted fee-for-service contract arrangements.

- Medicaid: capitation: Fee-for-service equivalent gross charges, at the practice’s undiscounted rates, for all services provided to Medicaid or similar state health care program patients under a capitated contract.

  Not Included:
  1. Charges for fee-for-service patients; or
  2. Charges for patients covered under discounted fee-for-service contract arrangements.

Medical and surgical supply
Cost of supplies purchased for general practice use.

  Included:
  1. Cost of medical/surgical supplies and instruments used in providing medical/surgical services; and
  2. Cost of laundry and linens.

  Not Included:
  1. Cost of specialized supplies dedicated for exclusive use in the departments of clinical laboratory, radiology and imaging, or other ancillary services departments. Such cost is included in “Clinical laboratory”, “Radiology and imaging”, and “Other ancillary services”;
  2. Cost of pharmaceuticals, medical supplies and equipment sold to patients primarily for use outside the practice and not used in providing medical/surgical services. Examples include prescription drugs, hearing aids, optical goods, and orthopedic supplies. Such cost is included in “Cost of sales and/or cost of other medical activities”; or
  3. The cost of any equipment subject to depreciation. Such cost is reported as a subset in “Information technology”, “Furniture and equipment”, “Clinical laboratory”, “Radiology and imaging”, and “Other ancillary services.”

Medical assistants, nurse’s aides
Cost and FTE of medical assistants and nurse’s aides.

  Not Included:
  1. Cost of medical assistants and nurse aides who worked exclusively in the departments of clinical laboratory, radiology and imaging, or other ancillary departments. Such cost is included in “Clinical laboratory”, “Radiology and imaging”, and “Other medical support services”.

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Medical directorship duties and responsibilities

Individual duties and responsibilities for which the medical directorship was served can be selected in the Pro Report Builder and include:

- Attend standing meetings
- Clinical patient complaints
- Clinical peer review
- Community relations
- Develop policies/procedures
- Documentation/care planning
- Emergency issues
- Equipment selection/maintenance/planning
- Monitor quality/appropriateness of medical care
- Physician behavior/impairment issues
- Physician education
- Physician relations/representation
- Provide guidance/leadership for performance guidelines
- Provider of last resort/call availability
- Recruitment Regulation/licensure/credentialing
- Research
- Strategic development
- Technical oversight

Medical directorship organization type

- **Ambulatory Surgery Center**: An entity that is specifically licensed to provide surgery services that are performed on a same-day outpatient basis.
- **Community Health Program**: Program that provides a type of health related service within the patient's community environment, such as an AIDS Clinic.
- **FQHC/RHC**: Federally Qualified Health Center or Rural Health Clinic as defined by US Department of Health and Human Services.
- **Group Practice**: A single legal entity or collection of legal entities consisting of at least three physicians who deliver health care services.
- **Health Plan**: An individual or group plan that provides, or pays the cost of, medical care.
- **Home Care**: An entity that provides health care in a patient's own residence on an ongoing basis. Hospice: A program or facility that provides special care for people who are near the end of life and for their families. Hospice care can be provided at home, in a hospice or another freestanding facility, or within a hospital.
- **Hospital/Hospital Service Line/IDS**: An inpatient facility that admits patients for overnight stays, incurs nursing care costs and generates bed per day revenues or a particular service line within such facility.
- **Independent Lab/Diagnostic Imaging Center**: An entity that provides laboratory work or diagnostic imaging for other health care organizations.
- **IPA/Physician Network**: An association or network of licensed providers and/or medical practices. Typically, the primary purpose of these organizations is to secure and maintain contractual relationships between providers and health plans.
- **Long Term Care**: A facility that provides rehabilitative, restorative, and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living. Long-term care facilities include nursing homes, rehabilitation facilities, inpatient behavioral health facilities, and long-term chronic care hospitals.
• **Mental Health**: A facility that specializes in the delivery of health care services relating to the patients’ mental health.

• **Other**: An organization that is not described by one of the above categories.

**Medical graduate type**

- **American Education**: An American graduate is defined as any provider, regardless of nationality, who graduated from a medical program within the United States.

- **Foreign Education**: An international medical graduate is defined as any provider, regardless of nationality, who graduated from a medical program outside the United States.

**Medical procedures conducted inside the practice’s facilities**

When reporting procedure counts and gross charges for practice activities, it is necessary to identify whether the activity occurred inside or outside the practice’s facilities. This inside/outside distinction enables the proper assignment of operating costs to develop cost per unit output statistics. The Centers for Medicare and Medicaid Services (CMS) “place of service” codes are used to make this inside/outside distinction. There is one “place of service” code, the “office” code (11), which indicates activity inside the practice’s facilities. All other place of service codes (12-81) are for activities occurring outside the practice’s facilities. Examples of “outside” locations are the patient’s home, inpatient or outpatient hospital, psychiatric or rehabilitation facility, emergency room, freestanding ambulatory surgery center, birthing center, skilled nursing or custodial care facility, hospice, ambulance, independent laboratory or radiology and imaging center, ambulatory emergency center, etc.

**Included:**

1. Procedures performed by all practice physicians, nonphysician providers, and other health care professionals such as nurses, medical assistants, and technicians; and
2. Purchased procedures from external providers and facilities on behalf of the practice’s fee-for-service patients for which revenue is reported as a subset of “Total net fee-for-service collections/revenue” and for which costs are reported as a subset of “Clinical laboratory”, “Radiology and imaging”, and “Other ancillary services”.

**Not included:**

1. Purchased procedures from external providers and facilities on behalf of the practice’s capitation patients for which costs are reported as “Purchased services for capitation patients.”

**If the observed medical practice uses CMS Procedural Coding System (CMS PCS) codes, please use your best judgment to assign the G, H, M, Q, S, and T code counts and gross charges to the appropriate categories.**


→ **Medical procedures conducted outside the practice’s facilities**

**Included:**

The same items listed under “Medical procedures conducted inside the practice’s facilities”, given an appropriate location code:

1. 99217-99226, hospital observation services;
2. 99221-99223, 99231-99236, 99238-99239, hospital inpatient and observation services;
3. 99251-99255, inpatient consultations;
4. 99281-99285, 99288, emergency services;
5. 99291-99292, critical care services;
6. 99466-99467, 99471-99472, 99475-99476, pediatric critical care services;
7. 99468-99469, 99477-99480, neonatal critical and intensive care services;
8. 99304-99310, 99315-99316, 99318, nursing facility services;
9. 99324-99328, 99934-99937, domiciliary, rest home, or custodial care services;
10. 99354-99360, prolonged and standby services;
11. 99341-99345, 99347-99350, home services; 
12. 99460-99465, newborn care; and 
13. 99500-99602, home health services.

→ Surgery and anesthesia procedures conducted inside the practice’s facilities (CPT codes 00100-01999, 10021-69990, 99100-99150, (exclude 36415-36416))

Included:
1. 00100-01999, anesthesia procedures; 
2. 10021-36410, 36420-69990, surgery procedures; 
3. 99100-99140, anesthesia procedures; and 
4. Surgery and anesthesia procedures performed in the practice’s own ambulatory surgery unit.

Not included:
1. 36415 and 36416, venous and capillary blood collection.

→ Surgery and anesthesia procedures conducted outside the practice’s facilities (CPT codes 00100-01999, 10021-69990, 99100-99150, (exclude 36415-36416))

Included:
1. Surgery and anesthesia procedures performed in an inpatient hospital or a freestanding ambulatory surgery center.

Not included:
1. 36415 and 36416, venous and capillary blood collection.

→ Clinical laboratory and pathology procedures (CPT codes 80048-89356, 36415-36416)

Included:
1. 36415 and 36416, venous and capillary blood collection; 
2. 80047-89398, a panel of tests represented by a single CPT code is considered to be one procedure; 
3. HCPCS P codes; 
4. All clinical laboratory and pathology procedures conducted by laboratories outside of the practice’s facilities as long as the practice pays the outside laboratory directly for the procedures and the procedures are only for the practice’s fee-for-service patients. The cost for these purchased laboratory services should be reported as a subset of “Clinical laboratory;” and 
5. All procedures done either at the practice (where the practice bills at a global rate for both the technical and professional components) or procedures done at an outside facility (where the practice bills at a professional rate only).

Not included:
1. Purchased laboratory services from external providers and facilities on behalf of the practice’s capitation patients for which costs are reported as “Purchased services for capitation patients”.

→ Diagnostic radiology and imaging procedures (CPT codes 70010-76499, 76506-76999, 78012-78999)

Included:
1. 70010-76499, diagnostic radiology; 
2. 76506-76999, diagnostic ultrasound; 
3. 78012-78999, diagnostic nuclear medicine;
4. All diagnostic radiology and imaging procedures conducted by laboratories outside of the practice’s facilities as long as the practice pays the outside laboratory directly for the procedures and the procedures are only for the practice’s fee-for-service patients; and
5. All procedures done either at the practice (where the practice bills at a global rate for both the technical and professional components) or procedures done at an outside facility (where the practice bills at a professional rate only).

**Not included:**
1. 77261-77799, radiation oncology;
2. 79005-79999, therapeutic nuclear medicine. Radiation oncology and therapeutic nuclear medicine activity is included in “Medical procedures”, depending on location code; or
3. Purchased radiology services from external providers and facilities on behalf of the practice’s capitation patients for which costs are reported as “Purchased services for capitation patients.”

**Medical receptionists**
Cost and FTE of medical receptionist staff, such as switchboard operators, schedulers, and appointment staff.

**Not Included:**
1. Cost of medical receptionists who worked exclusively in the departments of clinical laboratory, radiology and imaging, or other ancillary departments. Such cost is included in “Clinical laboratory”, “Radiology and imaging”, and “Other medical support services”.

**Medical records**
Cost and FTE of medical records staff such as medical records clerks and department director or manager.

**Not Included:**
1. Cost of medical records and coding staff who worked exclusively in the departments of clinical laboratory, radiology and imaging or other ancillary departments. Such cost is included in “Clinical laboratory”, “Radiology and imaging”, and “Other medical support services”.

**Medical secretaries, transcribers**
Cost and FTE of medical secretaries and transcribers.

**Not Included:**
1. Cost of medical secretaries and transcribers who worked exclusively in the departments of clinical laboratory, radiology and imaging, or other ancillary departments. Such cost is included in “Clinical laboratory”, “Radiology and imaging”, and “Other medical support services.”

**Medicare**
Included are all fee-for-service, managed care fee-for-service and capitated charges for all services provided to Medicare patients.

- **Medicare: Fee-for-service:** Fee-for-service gross charges, at the practice’s established undiscounted rates, for all services provided to Medicare patients on a fee-for-service basis. If patients are covered by both Medicare and Medicaid or a similar state health care plan, all charges for such patients should be included as Medicare fee-for-service charges.

**Not Included:**
1. Fee-for-service equivalent gross charges for services provided to Medicare/TEFRA (Tax Equity and Fiscal Responsibility Act) patients under capitated, prepaid or other “at-risk” arrangements.
**Medicare: Managed care fee-for-service:** Fee-for-service gross charges, at the practice’s established undiscounted rates, for all services provided to Medicare patients through a managed care plan. If patients are covered by both Medicare and Medicaid or a similar state health care plan on a fee-for-service basis, all charges for such patients should be included as Medicare fee-for-service charges.

**Included:**
1. Charges for patients covered under discounted fee-for-service contract arrangements.

**Not Included:**
1. Fee-for-service equivalent gross charges for services provided to Medicare/TEFRA (Tax Equity and Fiscal Responsibility Act) patients under capitated, prepaid arrangements.

**Medicare: Capitation:** Fee-for-service equivalent gross charges, at the practice’s undiscounted rates, for all services provided to patients under a Medicare/TEFRA, received from a capitated contract.

**Not Included:**
1. Charges for fee-for-service patients; or
2. Charges for patients covered under discounted fee-for-service contract arrangements.

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### Minor Regions

**Northeast Region:**
- Connecticut
- Maine
- Massachusetts
- New Hampshire
- Rhode Island
- Vermont

**North Atlantic:**
- New Jersey
- New York
- Pennsylvania

**Northwest:**
- Idaho
- Oregon
- Washington

**Mid Atlantic:**
- Delaware
- District of Columbia
- Maryland
- Virginia
- West Virginia

**Southeast:**
- Alabama
- Florida
- Georgia
- Mississippi
- North Carolina
- South Carolina
- Tennessee

**Eastern Midwest:**
- Illinois
- Indiana
- Kentucky
- Michigan
- Ohio

**Upper Midwest:**
- Iowa
- Minnesota
- Nebraska
- North Dakota
- South Dakota
- Wisconsin

**Lower Midwest:**
- Arkansas
- Kansas
- Louisiana
- Missouri
- Oklahoma
- Texas

**Rocky Mountain:**
- Arizona
- Colorado
- Montana
- Nevada
- New Mexico
- Utah
- Wyoming

**California, Alaska, Hawaii:**
- Alaska
- California
- Hawaii

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**Miscellaneous operating cost**
Operating cost not stated above, such as charitable contributions, employee relations dinners, picnics, entertainment, practice uniforms, business transportation, interest on loans, health,
business and property taxes, recruiting cost, job position classified advertising, moving cost, and payouts to retired physicians from accounts receivable.

**Not Included:**
1. Federal or state income taxes, which are included in “Nonmedical cost;” or
2. Principal paid on loans, which is not reported anywhere in this survey.

**MSO or PPMC provided services**

- **Management Services Organization (MSO):** An entity organized to provide various forms of practice management and administrative support services to health care providers. These services may include centralized billing and collection services, management information services, and other components of the managed care infrastructure. MSOs do not actually deliver health care services. MSOs may be jointly or solely owned and sponsored by physicians, hospitals, or other parties. Some MSOs also purchase assets of affiliated physicians and enter into long-term management service arrangements with a provider network. Some expand their ownership base by involving outside investors to help capitalize the development of such practice infrastructure.

- **Physician Practice Management Company (PPMC):** An entity that maintains full or partial ownership interest in, and provides management services to, multiple physician organizations. PPMC may own practices that span multiple specialties, or may be focused on a single specialty such as emergency medicine or hospital medicine.

**Nerve blocks for post op pain (CPT codes 64400-64530)**
For anesthesiology practices only.

**Included:**
1. Nerve blocks for post op pain (CPT codes 64400-64530)

**Net capitation revenue**
Subtract “Purchased services for capitation patients” from "Gross capitation revenue."

**Net nonmedical income or loss**
Add (“Nonmedical revenue”, “Extraordinary nonmedical revenue”, and “Financial support for operating costs”), then subtract (“Goodwill amortization”, “Nonmedical cost”, and “Extraordinary nonmedical cost”).

**Net other medical revenue**
Subtract “Cost of sales and/or cost of other medical activities” from “Gross revenue from other medical activities.”

**Net practice income or loss**
Subtract ‘Total provider's cost’ from ‘Total medical revenue after operating cost’, and add ‘Net nonmedical income or loss’.

**NIH/federal awards**
The number of research grants and contracts awarded to the department, including federal and nonfederal awards, and new, renewal and continuation grants. Direct costs awarded for each of the grants and contracts are included in the number reported.

**Nonmedical cost (income taxes)**

**Included:**
1. Income taxes based on net profit that is paid to federal, state, or local government. For cash basis accounting, income taxes equal the cash payment or refund for the
most recent tax year paid or received plus periodic withholding paid for those taxes during the most recent tax year. For accrual accounting, the income tax equals the total tax liability for the most recent tax year regardless of when the tax was paid or refunds were received;

2. All costs required to maintain the productivity of income producing rental property and parking lots;
3. Losses on the sale of real estate or equipment and losses from the sale of marketable securities;
4. Other nonmedical cost;
5. All direct costs related to business ventures such as rental property, parking lots, or billing services, for which gross revenue is reported as “Nonmedical revenue”, as long as these costs are not also included in “Total operating cost”; and
6. State taxes on medical revenue.

**Nonmedical revenue (investment and rental revenue)**

**Included:**

1. Interest and investment revenue such as interest, dividends, and/or capital gains earned on savings accounts, certificates of deposit, securities, stocks, bonds, and other short-term or long-term investments;
2. Gross rental revenue such as rent or lease income earned from practice-owned property not used in practice operations;
3. Capital gains on the sale of practice real estate or equipment, etc.;
4. Interest paid by insurance companies for failure to pay claims on time;
5. Bounced check charges paid by patients; and
6. Gross revenue from business ventures such as a billing service or parking lot. The direct costs of such ventures should be reported as “Nonmedical cost”.

**Not Included:**

1. Cash received from loans, which is not reported anywhere in this report.

**Nonphysician provider**

Nonphysician providers are specially trained and licensed providers who can provide medical care and billable services. Examples of nonphysician providers include audiologists, certified registered nurse anesthetists (CRNAs), dieticians/nutritionists, midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physician assistants, psychologists, and surgeon assistants.

**Residents are not considered nonphysician providers in MGMA reports.**

**Nonphysician provider benefit cost**

**Included:**

1. Employer’s share of FICA, payroll, and unemployment insurance taxes;
2. Employer’s share of health, disability, life, and workers’ compensation insurance;
3. Employer payments to defined benefit and contribution, 401(k), 403(b), and nonqualified retirement plans;
4. Deferred compensation paid or expensed during the year;
5. Dues and memberships in professional organizations, state, and local license fees;
6. Allowances for education, professional meetings, travel, automobile; and
7. Entertainment, country/athletic club membership, travel for spouse, etc.

**Not Included:**

1. Voluntary employee salary deductions used as contributions to 401(k) and 403(b) plans; or
2. Expense reimbursements.
Nonphysician provider compensation
Nonphysician providers are specially trained and licensed providers who can provide medical care and billable services. Examples of nonphysician providers include audiologists, certified registered nurse anesthetists (CRNAs), dieticians/nutritionists, midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physician assistants, psychologists, and surgeon’s assistants. Report the total compensation paid to nonphysician providers who comprise the count of “Total nonphysician provider”, Cost column.

Included:
1. Compensation for both employed and contracted nonphysician providers;
2. Compensation for full-time and part-time nonphysician providers;
3. Provider wages reported as direct compensation in Box on a W2, 1099 or K1 (for partnerships);
4. Bonus and/or incentive payments, research stipends, honoraria, distribution of profits; and
5. Voluntary employee salary deductions used as contributions to 401(k), 403(b), or Section 125 plans.

Not Included:
1. Amounts included in “Nonphysician provider benefit cost”, Cost column; or
2. Expense reimbursements.
3. Fringe benefits paid by the medical practice (such as retirement plan contributions, life and health insurance, automobile allowances); and/or
4. Any employer contributions to a 401(k), 403(b), or Keogh Plan.

Nonphysician provider specialty
A nonphysician provider is classified in the specialty or subspecialty where he or she spends 50 percent or more time.

Nonprocedural gross charges (include chemotherapy drug charges)
Other charges not reported in “Medical procedures conducted inside the practice’s facilities” through “Diagnostic radiology and imaging procedures” in the Gross Charges column.

Included:
1. Facility fee charges for the operation of an ambulatory surgery unit;
2. Facility fee charges in a hospital-affiliated practice that utilizes a split billing system where both facility fees and professional charges are billed;
3. Charges for drugs and medications, administered inside the practice’s facilities, such as chemotherapy drugs; and

Not Included
1. Charges for the sale of medical goods and services. Such charges are not reported anywhere on this survey.

Number of anesthetizing locations
For anesthesiology practices only.
The number of anesthetizing locations including cath lab, ESWL, MRI, or OB suite, you cover at 7:30 AM (or another time that represents your typical first case of the day) in each facility type category. If one person “floats” to multiple places during the day such as MRI in the morning and cath lab in the afternoon within the same facility, please count this as one anesthetizing location. If some anesthetizing locations are not staffed daily, use partial numbers. For example, if you provide services at two hospitals and Hospital A has eight operating rooms (OR) and a cath lab where you provide services two days per week (0.4 anesthetizing locations) and Hospital B has 16 OR, an OB suite, an ESWL truck that comes twice per week (0.4 anesthetizing locations) and an MRI lab that you cover once per week (0.2 anesthetizing locations), you would list “2” as the number of facilities under “hospitals”. For hospital anesthetizing locations you would add the 8.4 (8 OR + 0.4 cath lab)
at Hospital A and the 17.6 (16 OR + 1 OB + 0.4 ESWL + 0.2 MRI) at Hospital B to list a total of “26”. Recognizing that some facilities may have eight OR’s but only run six or seven on some days, include only those OR’s that you are committed to cover on a daily basis and exclude or use partial numbers for rooms that you only cover on a “staff available” basis.

**Number of Beds**
For anesthesiology practices only.
The number of licensed beds for the entity listed in "Total stipend amount", Entity 1, Entity 2, Entity 3, and total.
- **Entity 1 Amount**: The number of licensed beds for the entity with the largest total stipends, use the same entity reported in "Total stipend amount".
- **Entity 2 Amount**: The number of licensed beds for the entity with the second largest total stipends, use the same entity reported in "Total stipend amount".
- **Entity 3 Amount**: The number of licensed beds for the entity with the third largest total stipends, use the same entity reported in "Total stipend amount".

**Number of cases in ASC**
For orthopedic practices only.
The number of cases performed in the ASC. One case equals one patient on a given day. Multiple procedures done on the same patient, in one day is one case. If the same patient comes back to the center on more than one date, each date is counted as a case.

**Number of facilities staffed**
For anesthesiology practices only.
The number of facilities you covered in each facility type category. Please count as separate facilities any which are not physically in the same location. For example, if you provide services (inpatient and outpatient) at one hospital in the same block of operating rooms, please count this as one facility. If the outpatient department is sufficiently removed that a separate staff is assigned to cover that “facility” on any given day, please count that as a separate facility (hospital or same day surgery center, as appropriate).

**Number of faculty in division/section**
The total number of FTE physician or doctorate level faculty for the division, section, or functional area the administrator oversees.

**Number of hospitals comprised the IDS**
For hospital/IDS practices only.
Number of separately licensed hospitals that comprised the IDS. If there was a single hospital, indicate this by stating “one”.

**Number of individual patients**
The total number of individual patients who received services from the practice during the 12-month reporting period.

**Included:**
1. Fee-for-service and capitation patients. A patient is simply a person who received at least one service from the practice during the 12-month reporting period, regardless of the number of encounters or procedures received by that person. If a person was a patient during 2012, but did not receive any services at all during 2013, that person would not be counted as a patient for 2013. A patient is not the same as a covered life. The number of capitated patients, for example, could be less than the number of capitated covered lives if a subset of the covered lives did not utilize any services during the 12-month reporting period.
Number of medical practices the IDS/hospital/MSO owned or managed
For hospital/IDS practices only.
The number of separate medical practices that the IDS/hospital/MSO owned or managed.

Number of operating room (ORs) suites used in ASC
For orthopedic practices only.
The number of suites used as OR suites in which sterile procedures are performed – typically the suite will contain piped in oxygen and gases and contain overhead surgical lighting.

Number of patient encounters
An encounter is an instance of direct provider to patient interaction, regardless of setting (including tele-visits and e-visits), between a patient and a healthcare provider who is vested with the primary responsibility of diagnosing, evaluating, and/or treating the patient's condition, where the provider exercises clinical judgment that may or may not be billable.

Included:
1. Pre- and post-operative visits and other visits associated with a global charge;
2. Visits that resulted in a coded procedure;
3. For Diagnostic Radiologists and Pathologists, report the total number of procedures or reads, regardless of place of service;
4. For Obstetrics care, where a single CPT-4 code is used for a global service, count each as a separate ambulatory encounter (e.g., each prenatal visit and postnatal visit is one encounter). Count the delivery as a single encounter; and
5. Encounters that include procedures from the surgery chapter (CPT codes 10021-69979) or anesthesia chapter (CPT codes 00100-01999).

Not Included:
1. Encounters attributed to nonphysician providers. If your practice cannot break this out, report encounters and answer “Yes” on the NPP Productivity Included question;
2. Encounters for the physician specialties of pathology or diagnostic radiology (see #3 above under “Include”);
3. Visits where there is not an identifiable contact between a patient and a physician or nonphysician provider (i.e., patient comes into the practice solely for an injection, vein puncture, EKGs, EEGs, etc. administered by an RN or technician);
4. Administration of chemotherapy drugs; or
5. Administration of immunizations.

Number of trauma centers serviced at each level
For anesthesiology practices only.
If the participating group provides services to a level one, two, or three trauma center, specify the number of trauma centers serviced at each level.

Number of treatment/procedure room suites used in ASC
For orthopedic practices only.
The Number of suites used as treatment/procedure room suites in which nonsterile procedures are performed such as GI procedures, minor lacerations, and mole removals. May or may not contain general anesthesia equipment, OR lights, or piped in gases.

Occupational therapist
For orthopedic practices only.
FTE of occupational therapists who are licensed health professionals trained to evaluate patients with joint conditions such as arthritis, to determine the impact the disease has on activities of daily living.
**Occupational therapy**
For orthopedic practices only.
A therapy based on engagement in meaningful activities of daily life, especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning.

**Occupational therapy service provided**
For orthopedic practices only.
A therapy based on engagement in meaningful activities of daily life, especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning.

**Office-based nuclear imaging**
For cardiology practices only.
Nuclear imaging is the use of a radioactive substance to produce images of the heart muscle.

**Office-based ultrasound imaging**
For cardiology practices only.
Ultrasound imaging is the use of high-frequency sound waves to detect heart damage and other cardiac related diagnoses.

**On-call compensation method**
- **Annual Rate On-Call Compensation**: The provider is paid a defined amount for the entire year for all time spent providing on-call coverage.
- **Daily Rate On-Call Compensation**: The provider is paid a defined amount for each day that is spent providing on-call coverage.
- **Hourly Rate On-Call Compensation**: The provider is paid a defined amount for each hour that is spent providing on-call coverage.
- **Monthly Rate On-Call Compensation**: The provider is paid a defined amount for each month that is spent providing on-call coverage.
- **On-Call Compensation per Shift**: The provider is paid a defined amount for each shift that is spent providing on-call coverage.
- **On-Call Compensation per Work RVU**: The provider is paid a defined amount for each work RVU that is generated while providing on-call coverage.
- **Weekly Rate On-Call Compensation**: The provider is paid a defined amount for each week that is spent providing on-call coverage.

**On-call coverage funding**
The organization that helps to provide funding for on-call coverage within the practice.
- **Annual On-Call Hours**: The number of hours per year that the provider is on-call, if paid an annual on-call rate.
- **Daily On-Call Hours**: The number of hours per day that the provider is on-call, if paid a daily on-call rate.
- **Monthly On-Call Hours**: The number of hours per month that the provider is on-call, if paid a monthly on-call rate.
- **Unpaid On-Call Hours**: The number of unpaid hours per week if the provider is not paid additional compensation for providing on-call coverage.
• **Weekly On-Call Hours:** The number of hours per week that the provider is on-call, if paid a weekly on-call rate.

**Operating cost**

**Not Included:**
1. “Cost of sales and/or cost of other medical activities”;
2. Support staff cost, which is included in the Business Support, Clinical Support and Total Staff sections;
3. Nonphysician provider cost, which is included in the Provider Staffing and Cost section;
4. Cost included in “Purchased services for capitation patients”; and
5. “Nonmedical cost.”

**Organization ownership**

**Physician Owned:**
- **Physicians:** Any doctor of medicine (MD) or doctor of osteopathy (DO) who is duly licensed and qualified under the law of jurisdiction in which treatment is received.
- **Nonphysician Providers:** Any nonphysician provider (e.g., nurse practitioners, physical therapists, etc.) duly licensed and qualified under the law of jurisdiction in which treatment is received.

**Hospital/IDS Owned:**
- **Hospital:** A hospital is an inpatient facility that admits patients for overnight stays, incurs nursing care costs, and generates bed-day revenues.
- **Health system or integrated delivery system (IDS):** An IDS is a network of organizations that provide or coordinate and arrange for the provision of a continuum of health care services to consumers and is willing to be held clinically and fiscally responsible for the outcomes and the health status of the populations served. Generally consisting of hospitals, physician groups, health plans, home health agencies, hospices, skilled nursing facilities, or other provider entities, these networks may be built through "virtual" integration processes encompassing contractual arrangements and strategic alliances as well as through direct ownership.
- **Management services organization (MSO):** An MSO is an entity organized to provide various forms of practice management and administrative support services to health care providers. These services may include centralized billing and collections services, management information services, and other components of the managed care infrastructure. MSOs do not actually deliver health care services. MSOs may be jointly or solely owned and sponsored by physicians, hospitals, or other parties. Some MSOs also purchase assets of affiliated physicians and enter into long-term management service arrangements with a provider network. Some expand their ownership base by involving outside investors to help capitalize the development of such practice infrastructure.
- **Physician practice management company (PPMC):** A PPMC is an entity that maintains full or partial ownership interest in, and provides management services to, multiple physician organizations. PPMCs may own practices that span multiple specialties, or may be focused on a single specialty such as emergency medicine or hospital medicine.

**Other Majority Ownership:**
- **Insurance company or health maintenance organization (HMO):** An insurance company is an organization that indemnifies an insured party against a specified loss in return for premiums paid, as stipulated by a contract. An HMO is an insurance company that accepts responsibility for providing and delivering a predetermined set of comprehensive health maintenance and treatment services to a voluntarily enrolled population for a negotiated and fixed periodic premium.
- **University or medical school**: A university is an institution of higher learning with teaching and research facilities comprising undergraduate, graduate and professional schools. A medical school is an institution that trains physicians and awards medical and osteopathic degrees.
- **Government**: A governmental organization at the federal, state, or local level. Government funding is not a sufficient criterion. Government ownership is the key factor. An example would be a medical clinic at a federal, state, or county correctional facility.
- **Private investor(s)**: A private investor is a company or individual that takes their own money and uses it to fund another organization. Some investors have the option to invest passively, which means they give their funding and play no further role, while others have a more significant role in the organization.

**Organization's legal tax status**

*Hospital/IDS Practices Only*

How the Internal Revenue Service classified the organization for which the medical directorship was served, for filing federal income taxes.

- **For-profit**: Classified as not-for-profit for IRS purposes
- **Not-for-profit**: Classified as for-profit for IRS purposes

**Other (lines, intubations, etc.) (CPT codes, 36555-36558, 36568-36569, 36620, 93503, 93312-93318, 31500)**

For anesthesiology practices only.

**Included**:

1. Central venous lines (36555-36558, 36568-36569), arterial lines (36620), and Swan Ganz catheters (93503) placed by members of your group;
2. TEEs (93312-93318) that are performed and/or monitored by your group. Each separate CPT code billed is counted as one service;
3. Intubations (31500) that are not associated with anesthetic cases; and
4. Other flat fee procedures that are not applicable to any other category. For example, if an E&M visit has been included under critical care, acute or chronic pain, do not double count here.

**Other administrative support**

Cost and FTE of other administrative staff such as shipping and receiving, cafeteria, mailroom, and laundry staff.

**Other ancillary services**

Operating costs for all ancillary services departments except clinical laboratory and radiology and imaging.

**Included**:

1. Operating costs for departments such as physical therapy, optical, ambulatory surgery, radiation oncology, therapeutic nuclear medicine, etc.;
2. Rental and/or depreciation cost of major furniture and equipment subject to capitalization;
3. Repair and maintenance cost;
4. Cost of supplies and minor equipment not subject to capitalization;
5. Other costs unique to the ancillary services departments; and
6. Cost of purchased "other ancillary" technical services for fee-for-service patients.

**Not Included**:

1. Cost of purchased "other ancillary" technical services for capitation patients. Such cost should be reported as "Purchased services for capitation patients;"
2. Cost of physical therapy and orthopedic items, such as crutches and braces, sold to patients. Such cost is included in "Cost of sales and/or cost of other medical activities;" or
3. Cost of optical items, such as eyeglasses and contact lenses, sold to patients. Such cost is included in “Cost of sales and/or cost of other medical activities.”

Other ancillary services service provided
For orthopedic practices only.
Provide the name and information requested for any other ancillary services not listed above.

Other federal government payers
Fee-for-service gross charges, at the practice’s undiscounted rates, for all services provided to patients who are covered by other federal government payers other than Medicare.

Included:
1. Charges for TRICARE patients.

Not Included:
1. Charges for Medicare and Medicaid patients.

Other insurance premiums
Cost of other policies such as fire, flood, theft, casualty, general liability, officers’ and directors’ liability, and reinsurance.

Other medical revenue (research contract revenue, honoraria, teaching income)
Grants, honoraria, research contract revenues, government support payments, educational subsidies, meaningful use revenue, administrative payment for a patient centered medical home, and payments from an accountable care organization for shared savings distribution.

Included:
1. Federal, state or local government or private foundation grants to provide indigent patient care or for case management of the frail and elderly;
2. Honoraria income for practice participation in educational programs;
3. Research contract revenues for activities such as pharmaceutical studies;
4. Educational subsidies used to train residents;
5. Quality based bonuses (pay for performance); and
6. Risk pool insurance.

Not Included:
1. Charges for the delivery of services made possible by subsidies or grants were included in “Gross fee-for-service charges” and/or “Gross charges for patients covered by capitation contracts”; or
2. The value of operating subsidies from parent organizations such as hospitals or integrated systems. Such subsidies should be included in “Financial support for operating costs.”

Other medical support services
Cost and FTE of support staff in any ancillary services department other than 'Clinical laboratory' and 'Radiology and imaging'.

Included:
1. Cost and FTE of support staff who provide assistance to patients, such as patient relations staff or lay counselors;
2. Cost and FTE of support staff such as nurses, secretaries, technicians, physical therapy aides and assistants in ancillary services departments such as physical
therapy, optical, ambulatory surgery, radiation oncology, therapeutic nuclear medicine, clinical research, pharmacists, and pharmacy support staff; and
3. Cost and FTE of the department directors and managers in these ancillary services departments.

Not Included:
1. Nonphysician providers such as nurse practitioners, physician’s assistants and physical therapists. These providers should be reported in “Nonphysician provider compensation”, “Nonphysician provider benefit cost”, and “Total nonphysician providers”.

Outpatient E and M codes
Outpatient Evaluation and Management Codes include:
1. 99201-99205, 99211-99215, office or other outpatient services
2. 99241-99245, office consultations
3. 99281-99288, emergency department services
4. 99304-99310, 99315-99316, 99318, nursing facility services
5. 99324-99328, 99334-99337, domiciliary, rest home or custodial care services
6. 99339-99340, domiciliary, rest home, or home care plan overnight services
7. 99341-99345, 99347-99350, home services
8. 99354-99355, prolonged physician service in the office or outpatient setting
9. 99363-99364, anticoagulant management
10. 99374-99375, 99377-99380, care plan oversight services
11. 99381-99387, 99391-99395, 99401-99404, 99411-99412, 99420, 99429, preventive medicine services
12. 99441-99444, non-face-to-face physician services
13. 99450, 99455-99456, special evaluation and management services
14. 99461, normal newborn care in other than hospital or birthing room setting

Not Included:
1. 99499, unlisted evaluation and management service
2. Evaluation and management codes attributed to nonphysician providers.

Outside professional fees
Fees for professional services performed on a one time or sporadic basis.

Included:
1. Fees for accounting services; and
2. Fees for actuarial consultants, and other professional fees not listed.

Not Included:
1. Information services, architectural and public relations consultant fees. Such costs are included in “Information technology”, “Building and occupancy”, and “Promotion and marketing”; or
2. Cost for contracted support staff, which is reported as “Total contracted support staff”, Cost.

Overtime compensation
The annual overtime compensation accrual.

Ownership interest in an ambulatory surgery center (ASC) where physicians perform outpatient procedures
For cardiology practices only.
• An ambulatory surgery center (ASC) is a freestanding entity that is specifically licensed to provide surgery services that are performed on a same-day outpatient basis.
• If your practice did have sole ownership or joint venture/partnership in an ambulatory surgery center, answer "Sole ownership" or "Joint venture/partnership."

Ownership interest in an ASC
For orthopedic practices only.
If either the practice or the physicians in the practice, had an equity position in an ASC, they are included in the “Yes” breakout. If no equity position existed for either the practice or its physicians, they are included in the “No” breakout.

Ownership interest in an outpatient cath lab
For cardiology practices only.
• A laboratory facility in which comprehensive diagnostic invasive procedures are performed on the heart. The questions in this section should be answered only if your practice had sole ownership or joint venture/partnership in an outpatient catheterization lab during the fiscal year reported.
• If the practice did not have an ownership interest in an outpatient catheterization lab, answer "No ownership interest."
• If the practice did have sole ownership or joint venture/partnership in an outpatient cath lab, answer "Sole ownership" or "Joint venture/partnership."

Parent organization contribution to total general operating cost
For hospital/IDS practice only.
The amount of parent contribution to general operating cost.

Partner/shareholder in practice
The physician has a partner, shareholder, or other ownership status in the practice, regardless of the particular form of legal entity used for the practice. Partner and shareholder status represents ownership in which the physician agrees to share profits, losses, assets and liabilities, although not necessarily on an equal basis. Shareholder status also includes formal possession of shares in the practice.

Patient accounting
Cost and FTE of patient accounting (billing and collections) staff, such as department supervisor, billing/accounts receivable manager, coding, charge entry, insurance, billing, collections, payment posting, refund, adjustment, and cashiering staff.

Patient care revenue
In general, all revenue received by the department from patient care activities, net of all refunds, returned checks, contractual discounts and allowances, bad debts and write-offs. The sum of total fee-for service (FFS) revenue, net prepaid (capitation/subcapitation) revenue and net other patient care/medical services revenue equals total patient care revenue.
• Total FFS revenue: Include net collections (receipts) from patients who are self-insured, or reimbursements from a third party insurer that compensates the department (practice plan) on a fee-for-service, or discounted fee-for-service basis.
• Net prepaid (capitation/subcapitation) revenue: Include all capitation revenue received from Health Maintenance Organizations (HMOs), risk-sharing revenue, hospital/utilization withholds, co-payments and revenue received from a benefits coordination and/or reinsurance recovery situation minus professional and medical services purchased from outside providers.
• Net other patient care/medical services revenue: Include all revenue received from the sale of goods and services such as durable medical equipment rental, revenue from medical service contracts with nursing homes or ambulatory care centers, hospital reimbursements
for direct patient care, and revenue from providing ancillary services on a fixed fee or percentage contract that are not billed as fee-for-service.

Patient Centered Medical Home (PCMH):
A care delivery model where patient treatment and care is coordinated through their primary care provider to ensure they receive high quality care when care is necessary. The objective is collaboration between the patient and physicians with care delivered in a way the patient can understand. PCMHs seek to improve the quality, effectiveness, and efficiency of the care delivered while focusing on meeting patient needs first.

- **Patient Centered Medical Home**
  - Yes
  - No
- **PCMH NCQA Level**
  - Level 1
  - Level 2
  - Level 3
  - No Level of Designation

Payer Mix
The percentage of your practice’s “Total gross charges” by type of payer (Medicare, Medicaid, Commercial, Workers’ compensation, Charity care, Self-pay, and Other government payers).

- **Managed care**: Managed health care is a system in which the provider of care is incentivized to establish mechanisms to contain costs, control utilization, and deliver services in the most appropriate settings. There are three key factors:
  1. Controlling the utilization of medical services;
  2. Shifting financial risk to the provider; and
  3. Reducing the use of resources in rendering treatments to patients.
- **Capitation**: Capitation is when a provider organization receives a fixed, previously negotiated periodic payment per member covered by the health plan in exchange for delivering specified health care services to the members for a specified length of time regardless of how many or how few services are actually required or rendered. Per member per month (PMPM) is the commonplace calculation unit for such capitation payments.

Percentage of clinical support staff
For hospital/IDS practices only.
Percentage of staff that is employed by either the IDS/hospital or medical practice. The combined percentages for each employer should add up to 100%.

Phone triage
For OB/GYN practices only.
Cost and FTE for staff that work on phone triage duties.

**Included**:
1. LPNs, RNs, MAs and any other clinical staff that are assigned phone triage duties.

**Not Included**:
1. Administrative staff such as medical receptionists.

Physical and occupational therapy (combined)
For orthopedic practices only.
ONLY for physical and occupational therapy that was not able to be reported separately. Indicate the total gross charges, total medical revenue, direct operating cost and number of procedures for each ancillary service.
Physical and occupational therapy (combined) service provided
For orthopedic practices only.
Complete ONLY if physical and occupational therapy cannot be reported separately.

Physical therapist
For orthopedic practices only.
FTE of physical therapists who are individuals trained and certified by a state or accrediting body to design and implement physical therapy programs.

Physical therapy
For orthopedic practices only.
The treatment of disease by physical and mechanical means.

Physical therapy service provided
For orthopedic practices only.
The treatment of disease by physical and mechanical means.

Physician specialty
A physician is classified in the specialty or subspecialty where he or she spends 50 percent or more time.

Physician work hours allocation
The percentage of a physician’s total work hours allotted to billable clinical, administrative, teaching, research and/or other work.

- **% Billable Clinical:** Billable clinical percent can be calculated a variety of ways. In general, the calculations are all the same - the clinical effort divided by the total effort. Often, the difference between formulas equals the units of measurement, such as hours per day or sessions per week. Clinical effort and activities include direct patient care and consultation, individually or in a team-care setting, where a patient bill is generated or a fee-for-service equivalent charge is recorded. The sum of % Billable Clinical, Administrative, and Other must equal 100%.

- **% Administrative:** Administrative percent can be calculated a variety of ways. In general, the calculations are all the same - the clinical effort divided by the total effort. Often, the difference between formulas equals the units of measurement, such as hours per day or sessions per week. Administrative effort includes medical directorships as well as other administrative duties.

- **% Teaching:** The percent of time the provider spent in teaching activities such as classroom time, office hours, grading papers, and class preparation. For example, a faculty member spending approximately 40 percent of his/her time in teaching activities should report "40". 
  **Include:**
  1. Academic activities including teaching, tutoring, lecturing, and supervision of laboratory course work and residents where patient care is not provided; and
  2. Nonclinical classroom time.

- **% Research:** The percent of time the provider spent in research activities. For example, a faculty member spending approximately 30 percent of his/her time in research activities should report "30". 
  **Include:**
  1. Research activities including specific research, training, and other projects that are separately budgeted and accounted for by the medical school; and
  2. Clinical research, funded or nonfunded.

- **% Other:** Other percent can be calculated a variety of ways. In general, the calculations are all the same - the clinical effort divided by the total effort. Often, the difference between formulas
equals the units of measurement, such as hours per day or sessions per week. Other effort and activities include all activities not included in clinical, administrative, teaching or research effort, such as professional development.

**Physicians cover multiple organizations**
Based on whether or not the provider provides on-call coverage for other practices during the same time period that they are providing on-call coverage for the reporting practice.

**Position title rollups**

**Physician Executives**
- Physician chief executive officer (CEO/president)
- Chief medical officer (CMO)
- Chief medical informatics officer (CMIO)
- Medical director
- Associate/assistant medical director

**Executive Management Positions**
- CEO/Executive director (26 or more FTE physicians)
- CEO/Executive director (25 or fewer FTE physicians)
- Administrator (26 or more FTE physicians)
- Administrator (7 to 25 FTE physicians)
- Administrator (6 or fewer FTE physicians)

- Chief department administrator (CDA)
- MSO administrator/Executive director
- Chief compliance officer
- Chief operating officer (COO)
- Chief financial officer (CFO)
- Department financial officer
- Chief information officer (CIO)
- Chief nursing officer (CNO)
- Chief legal counsel
- Chief strategy officer
- Division chair
- Human resources executive

**Marketing executive**
- Patient care executive
- Assistant administrator
- Associate/Assistant department administrator
- Contracts/Grants department administrator
- Division/Section administrator
- IS manager/network administrator
- Other executive

**Senior Management Positions**
- Ambulatory/clinical services director
- Ancillary services director
- Branch/satellite clinic director
- Building and grounds director
- Business services director
- Clinical research director
- Compliance director
- Contracting director
- Development director
- Education and training director
- Finance director
- Health plan director
- Human resources director
- Information systems director
- Laboratory services director
- Managed care director
- Marketing and sales director
- Materials management director
- Medical records director
Nursing services director  
Operations director  
Pharmacy services director  
Physician recruitment director  
Physician relations director  
Quality improvement/Quality assurance director  
Radiology services director  
Reimbursement director  
Revenue cycle director  
Strategy/business planning director  
Other director  

**General Management Positions**

Benefits manager  
Billing manager  
Branch/satellite clinic manager  
Building and grounds manager  
Business office manager  
Clinical department manager  
Clinical practice manager  
Clinic research manager  
Coding manager  
Compliance manager  
Credit/collections manager  
General accounting manager  
Human resources manager  
Information systems manager  
Insurance manager  
Laboratory services manager  
Materials management manager  
Medical records manager  
Medical transcription manager  
Nursing manager  
Office manager  
Operations manager  
Patient accounting manager  
Radiology services manager  
Reimbursement/Collections manager  
Training/education manager  
Transcription manager  
Utilization management/care coordinator  
Other manager  

**Specialists**

Accountant  
Benefits/payroll specialist  
Billing specialist  
Coding specialist  
Credentialing specialist  
IT implementation/EHR specialist  
Human resources specialist  
Marketing/communication specialist  
Recruiter  
Other specialist  

**Supervisors**

Business office supervisor  
Clinic supervisor  
EEG lab supervisor  
EKG lab supervisor  
Front office supervisor  
Housekeeping supervisor  
Lab section supervisor  
Nursing supervisor  
Optical shop supervisor  
Other supervisor  

**Clinical Laboratory**

Certified lab assistant (CLA)  
Histotechnologist  
Laboratory aide  
Medical lab technician (MLT)  
Medical technologist (ASCP)  

**Radiology and Imaging**

CAT scan technician  
Mammography technician  
Radiology technologist  
Ultrasound technician
Other Medical Support Services
- Aesthetician
- Athletic trainer
- Dosimetrist
- EEG technician
- EKG technician
- Nuclear medicine technologist
- Ophthalmic assistant
- Ophthalmic technician
- Orthopedic/cast technician
- Pharmacist
- Pharmacy technician
- Phlebotomist
- Physical therapist aide
- Physical therapy assistant
- Physicist
- PT education coordinator
- Radiation therapist
- Respiratory therapist
- Social worker
- Speech therapist
- Surgical technologist

General Accounting Positions
- Accounting staff
- Bookkeeper

General Administrative Positions
- Administrative assistant
- Administrative secretary
- Business office assistant manager
- Executive assistant
- Business office staff

Managed Care Administrative Positions
- Managed care coordinator
- Quality assurance/utilization review nurse

Patient Accounting Positions
- Billing staff
- Cashier
- Certified professional coder
- Insurance clerk
- Patient accounts representative
- Workers’ compensation liaison

Nursing Positions
- Licensed practical nurse
- Registered nurse
- Triage nurse

Front Office Positions
- Appointment secretary
- Front desk staff
- Receptionist
- Scheduling staff (excluding surgical scheduler)
- Surgical scheduler
- Switchboard operator
- Medical record positions
- Accredited records technician (ART)
- Medical records staff

Medical Secretary Positions
- Medical scribe
- Medical secretary
- Transcriptionist

Position titles

Physician Executive Positions
- Associate/Assistant Medical Director:
  - Position requires candidate to be a licensed physician;
  - Time is devoted to both administrative duties and the delivery of health care services;
• Typically assists the medical director in all respects, from the administration of medical care and clinical services to utilization review and medical protocol development. If there are multiple associate/assistant medical directors, the functional areas of medical administration are usually divided up among physicians with this position title; and
  o Usually reports to the senior physician executive.

• **Chief Medical Officer (CMO):**
  o Elected by the medical staff and acts as a liaison between the medical staff and administration;
  o Ensures that projects and policies are completed in a timely manner;
  o Principle duty is to ensure that the executive decisions are carried out and oversee that staff members follow these guidelines;
  o Typically, a one to two-year term;
  o Required to be a licensed physician; and
  o Usually reports to the senior physician executive.

• **Chief Medical Informatics Officer (CMIO):**
  o Develops and manages the organization’s capabilities in information systems and tools that are applied to medical information;
  o Coordinates analytical support for medical management, including profiling, health economics and business analytics/performance metrics;
  o Works with the Information Systems Department to prioritize medical management needs; and
  o Usually reports to the senior executive manager.

• **Medical Director:**
  o Position requires candidate to be a licensed physician;
  o The senior medical administrative position within a medical group practice;
  o Physician’s time is devoted to both administrative duties and the delivery of health care services;
  o In larger organizations, there may be more than one medical director;
  o Responsible for all activities related to the delivery of medical care and clinical services such as cost management, utilization review, quality assurance, and medical protocol development;
  o Typically oversees the activities of group physicians, including the recruiting and credentialing processes; and
  o Usually reports to the senior physician executive.

• **Physician CEO/President:**
  o Position requires candidate to be a licensed physician;
  o Usually found in larger practices or in some form of an integrated system or network, such as physician hospital organization (PHO) or MSO;
  o Since administrative duties are substantial, the delivery of health care services is minimal;
  o Develops and monitors organizational policy with other management personnel and board of directors;
  o Responsible for the overall operation of the organization, including patient care and contract relations;
  o Oversees activities related to the growth and expansion of the organization;
  o Plays a major role in the organization’s strategic process;
  o Typically serves as the liaison between the organization, the community, and the board of directors;
  o Oversees a team of senior management personnel; and
  o Usually reports to the governing body of the organization.

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**Executive Management Positions**

• **Administrator**
  o The top nonphysician professional administrative position with less authority than a CEO;
• Maintains broad responsibilities for all administrative functions of the medical group, including operations, marketing, finance, managed care/third party contracting, physician compensation and reimbursement, human resources, medical and business information systems, and planning and development;
• Typically oversees management personnel with direct responsibilities for the specific functional areas of the organization; and
• Reports to the governing body of the organization.

- **Chief Department Administrator (CDA):**
  - Top administrative officer of one or more clinical science departments;
  - Oversees, plans, guides and evaluates the nonmedical activities of the department including full or partial direct responsibility for the operation of ambulatory services;
  - Broad responsibilities within the department include development of the department budget and approval of department expenditures;
  - Responsibilities may include full or partial management of hospital functions, supervising the department administrative staff; and
  - Assists and reports to the department chair.

- **Associate/Assistant Department Administrator:**
  - Generally, consults, advises, and assists the top departmental administrator in providing leadership and direction in planning and coordinating activities;
  - Generally, has a limited scope of responsibility such as marketing or human resources;
  - Multiple associate/assistant administrators may assume leadership of the department in the absence of the top administrator; and
  - Reports to the top administrative officer.

- **Contracts/Grants Department Administrator:**
  - Oversees the disbursement, financial reporting, and the use of all extramural funds associated with the department’s clinical and basic research programs;
  - Coordinates the development and submission of grant and contract proposals to internal and external agencies; and
  - Reports to the CDA.

- **Division/Section Administrator:**
  - Top administrative officer of one or more divisions or sections of a clinical science department;
  - Manages the nonclinical activities of the division(s) or section(s) and typically supervises the division or section administrative staff; and
  - Usually reports to the CDA and/or a division/section chair.

- **IS Manager/Network Administrator**
  - Coordinates the activities of the IS department including determining data processing requirements, managing department networks, determining feasibility of data projects, and performing analysis of department production; and
  - Maintains and upgrades hardware and software.

- **Assistant Administrator:**
  - Provides assistance to the CEO and/or administrator with the management of one or more functional areas of the medical practice such as administration, managed care, human resources marketing, patient accounting, or operations;
  - Has a more limited scope of responsibility than a chief operating officer (COO);
  - A medical group may have multiple assistant administrators;
  - Responsible for assisting the CEO and/or administrator in accomplishing organizational objectives; and
  - Usually reports to a senior executive manager.

- **Chief Compliance Officer:**
  - Develops and reviews policies and procedures for the general operation of the organization to prevent improper and/or illegal conduct;
  - Manages day-to-day operations of the implemented policies;
• Investigates any reported violations of policies or procedures;
• Works with the Human Resources Department and other appropriate areas to develop effective compliance training; and
• Usually reports to a senior executive manager.

• Chief Executive Officer (CEO)/Executive Director:
  • Highest nonphysician executive position in the organization;
  • Typically found in larger practices, or in some form of an integrated system such as PHO or MSO;
  • Develops and monitors organizational policy in conjunction with other management personnel and board of directors;
  • Responsible for the overall operation of the organization, including patient care, contract relations, and activities that relate to the future growth of the organization such as strategic planning and marketing;
  • Oversees a team of senior management personnel who have direct responsibility for specific functional areas of the organization;
  • Typically serves as a liaison between the organization and staff members, businesses, individuals in the community, and board of directors; and
  • Usually reports to the governing body of the organization.

• Chief Financial Officer (CFO):
  • Usually the organization’s senior financial position;
  • Develops financial policies and oversees their implementation;
  • Typically monitors a variety of financial activities, including budgeting, analysis, accounting, billing, payer contracting, collections, and the preparation of tax returns;
  • Usually prepares or oversees the preparation of annual reports and long-term projections to ensure that the organization’s financial obligations are met;
  • May obtain funds for capital development;
  • May hold a designation as a certified public accountant (CPA); and
  • Usually reports to a senior executive manager.

• Department Financial Officer:
  • Top financial position, which develops financial policies and oversees their implementation;
  • Prepares short range and long-term projections to ensure that the department’s financial obligations are met; and
  • Develops growth plans for the department; and
  • Reports to the CDA or the department chair.

• Chief Information Officer (CIO):
  • Usually found in large organizations;
  • The top level contact in information systems development and solutions;
  • Contributes to general business planning regarding technology;
  • Accountable for directing data integrity and confidentiality of the medical practice’s patient care information;
  • Identifies new developments in information systems technology, and strategizes organizational modifications;
  • Requires a masters or bachelor’s degree in MIS, CIS, or a related field; and
  • Usually reports to the senior physician executive.

• Chief Operating Officer (COO):
  • Consults, advises, and assists the CEO and/or administrator in providing leadership and direction in planning, directing, and coordinating both patient and non-patient care activities;
  • May be the second senior administrative position, and assume the duties of the top administrator when necessary;
  • Oversees the daily operations of the medical practice and/or other affiliated health care organizations;
  • Responsibilities may include facilities management, business services, human resources management; and

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• Usually reports to a senior executive manager.

Chief Nursing/Clinical Officer (CNO):
- Provides leadership to assure standardization of clinical care work processes through collaboration of all organization disciplines;
- Possesses current licensure as a registered nurse;
- Responsible for the overall direction of patient care services, monitoring standards of patient care, and setting facility performance goals; and
- Usually reports to the senior physician executive.

Chief Legal Counsel:
- Serves as chief legal advisor to the senior leadership;
- Responsible for coordination of all legal issues and ensuring compliance with state and federal rules, laws, and regulations;
- Reviews, drafts, and negotiates contracts with payers and/or providers;
- Builds, manages, and mentors a team of legal professionals/outsources legal resources in accordance with group needs; and
- Usually reports to a senior physician executive.

Chief Strategy Officer:
- Provides assistance in developing and implementing a strategic plan for the organization/company to ensure continued growth and success;
- Coaches the management team so they understand long-term profit and performance goals, and provides ongoing support and expertise to all management personnel;
- Ensures that the organization’s policies and procedures meet legal and ethical compliance with all laws and regulations; and
- Usually reports to a senior physician executive

Human Resources Executive:
- Usually found in larger practices or hospitals;
- Recommends and establishes company policies and procedures;
- Oversees all functions of an established human resources department within an organization;
- Develops, implements, and coordinates policies relating to all aspects of personnel administration using the organization’s objectives. This includes recruitment, salary and benefits administration, EEO/AA and labor law compliance, and employee relations; and
- Usually reports to the CEO.

Marketing Executive:
- The top marketing position in an organization with a distinct marketing and sales function;
- Directs and coordinates company sales, marketing functions, and implementation or related policies and procedures that relate to the promotion of the organization;
- May oversee the communications function;
- Develops marketing policies and programs that reflect the organization’s goals and objectives;
- Oversees or conducts research designed to evaluate the organization’s market position;
- Usually reports to the senior physician executive.

MSO Administrator/Executive Director:
- Oversees all activities of a hospital or investor owned MSO that provides practice management services to physician practices and clinics;
- Responsibilities range from the daily operations of multiple sites to developing strategic plans;
- Monitors the marketing of MSO services to physician clients;
- Typically serves as a liaison between various organization levels, from the physicians to the governing entities of the organization such as a hospital or health system, investors in the MSO, or a board of directors;
- Oversees the provision of management services to newly integrated practices; and
• Patient Care Executive:
  o Usually reports to a senior physician executive.

Senior Management Positions

• Ambulatory/Clinical Services Director:
  o A clinical operations position;
  o Monitors the daily operations of the organization’s clinical function;
  o Develops, implements, and monitors policies and procedures;
  o Monitors the activities of the nonphysician technical staff such as radiology and laboratory technicians; and
  o Usually reports to a senior executive manager.

• Ancillary Services Director:
  o Formulates policies, programs and procedures related to ancillary services;
  o Develops and implements programs for expansion or contraction of patient care services as necessary;
  o Oversees Joint Commission on the Accreditation of Healthcare Organization (JCAHO) standards of compliance within the ancillary departments;
  o May manage laboratory, radiology, transportation/stores and pharmacy supervisors;
  o Coordinates with other departments in clinic activities and in developing measures of success;
  o Aligns ancillary department initiatives with the larger organization’s strategic goals and mission; and
  o Usually reports to a senior executive manager.

• Branch/Satellite Clinic Director:
  o Oversees the administrative and operations activities of multiple clinical practice sites;
  o Develops financial policy for the clinical operation in concert with the organization’s top financial officer;
  o Oversees the implementation of the organization’s policies and procedures, including budget management, human resources management, and compliance with state and federal regulations;
  o Supervises clinic managers and indirectly supervises clinic staff; and
  o Usually reports to a senior executive manager.

• Building and Grounds Director:
  o Usually found in an organization with a facilities or building services department;
  o Develops and implements policies and procedures related to the organization’s physical facilities such as buildings;
  o Oversees related activities such as building maintenance, housekeeping, grounds preservation; and
  o Usually reports to a senior executive manager.

• Business Services Director:
  o Usually found in large organizations;
  o Directs and coordinates business office activities in an organization that has a top administrator;
  o Monitors the medical billing system;
  o Oversees areas of responsibility such as third-party reimbursement, physician billing, collections, contract administration, and management reporting; and
  o Usually reports to a senior executive manager.

• Clinical Research Director:
• Analyzes and summarizes clinical data and outcomes with responsibility for research design, methodology, and data collection protocols;
• Prepares grant proposals;
• Participates in investigator meetings, seminars, and regional or national research conferences;
• Coordinates the activities of associates and investigators to ensure compliance with protocols and overall research objectives; and
• Usually reports to a senior physician executive.

• **Compliance Director:**
  - Develops, plans, organizes, and administers programs to comply with applicable state and federal statutes, regulations, policies, and procedures within the organization to ensure administrative and operational objectives are met;
  - Identifies operational business risk issues;
  - Develops a Corporate Compliance Plan or a Code of Conduct Handbook; and
  - Usually reports to a senior executive manager.

• **Contracting Director:**
  - Responsible for the overseeing, negotiations, and maintenance of the organization’s medical revenue contracts;
  - The contracts include commercial and/or governmental, capitated and/or non-capitated; and
  - Usually reports to an executive manager.

• **Development Director:**
  - Directs and coordinates fundraising programs for the organization, such as the annual fund, planned (deferred) giving, foundation and corporate fundraising, direct mail and phone solicitations, grant proposals, donor research, donor recordkeeping, donor recognition, special fundraising events, etc.; and
  - Usually reports to an executive manager.

• **Education and Training Director:**
  - Only found in very large organizations with multiple locations;
  - Supervises training managers;
  - Develops and delivers education and training programs for the training needs of the organization’s staff and patients;
  - Evaluates programs to determine whether the training goals and objectives have been met;
  - Monitors the delivery of ongoing programs; and
  - Usually reports to a senior executive manager.

• **Finance Director:**
  - Responsible for preparing financial statements and all general accounting functions;
  - Develops, implements, and monitors tax compliance such as income, sales, and use and has payroll oversight;
  - Responsible for internal accounting policies and procedures;
  - Supervises the financial department;
  - Directs all statistical analysis and reporting including monthly operating and medical management statistics; and
  - Usually reports to a senior executive manager.

• **Health Plan Director:**
  - In charge of all basic non-medical operations, i.e., plan operations, membership enrollment, plan marketing, claims processing/reporting, and health plan quality assurance data collection/reporting; and
  - Usually reports to an executive manager.

• **Human Resources Director:**
  - Usually found in larger practices;
  - Oversees all functions of an established human resources department within an
organization;
  o Using the organization’s objectives and philosophies as a guide, develops, implements, and coordinates policies relating to all aspects of personnel administration. This includes recruitment, salary and benefits administration, EEO/AA and labor law compliance, and employee relations; and
  o Usually reports to a senior executive manager.

- **Information Systems Director:**
  o Implements and monitors all activities that relate to the organization’s information system, including functions such as physician practice billing, scheduling, data processing, networking, and system security;
  o Oversees or resolves systems implementation and integration issues;
  o Performs programming tasks when necessary; and
  o Usually reports to a senior executive manager.

- **Laboratory Services Director:**
  o Responsible for all activities related to the operations of a laboratory or several laboratories from the initiation and implementation of test procedures to the oversight of laboratory personnel;
  o May perform and monitor testing procedures in addition to administrative duties;
  o Monitors budget activities that relate to the laboratory function; and
  o Usually reports to a senior executive manager.

- **Managed Care Director:**
  o Initiates and maintains relationships with managed care organizations as well as physician and ancillary providers;
  o Develops and directs all managed care activities of the organization including contract negotiations, product development, and capitation payment procedures;
  o May oversee risk and utilization management activities or claims administration for professional/medical purchased services; and
  o Usually reports to a senior physician executive.

- **Marketing and Sales Director:**
  o The top marketing position in an organization without a marketing and sales executive, that has a distinct marketing and sales function;
  o Typically found in larger organizations;
  o May oversee the communications function;
  o Develops marketing policies and programs that reflect the organization’s goals and objectives;
  o Oversees or conducts research designed to evaluate the organization’s market position;
  o Directs the implementation of policies and procedures that relate to the promotion of the organization;

- **Materials Management Director:**
  o Provides overall leadership above all material managers;
  o Obtains and reviews bids for vendors;
  o Performs audits to determine items needing restock and to prevent loss and damage;
  o Usually reports to an executive manager.

- **Medical Records Director:**
  o The individual in this position usually holds professional licensure in the area of medical records management;
  o Usually found in large organizations and is considered part of the senior management team;
  o Responsible for medical records library such as patient records;
  o Oversees all medical records personnel;
• Monitors budget activities that relate to the medical records function; and
  – Usually reports to a senior executive manager.

  **Nursing Services Director:**
  – Oversees all aspects of the organization’s nursing practices;
  – Typically found in large organizations;
  – Is part of the senior management team;
  – In most cases, requires certification as a registered nurse (RN);
  – Oversees the nursing staff; and
  – Usually reports to a senior executive manager.

  **Operations Director:**
  – Oversees all aspects of the practice operations for a specific site(s) (often times a single location for organizations with multiple locations);
  – Directs, administers, and controls the day to day operations and activities of the group;
  – Ensures compliance with established company and regulatory guidelines and procedures within the facility;
  – Typically found in large organizations; and
  – Usually reports to a senior executive manager.

  **Pharmacy Services Director:**
  – Directs and coordinates subordinate supervisory personnel, activities, and functions of hospital pharmacy;
  – Utilizes pharmacy information systems to manage inventory control;
  – Ensures compliance with all state and federal legal, accreditation, and certification requirements;
  – Initiates and implements quality improvement for the pharmacy department;
  – Prepares and dispenses medicines, chemicals, and pharmaceutical preparations according to written orders by authorized medical practitioners;
  – Provides hospital staff with timely information relative to new drugs, policies and standards of care that relate to medication use/safety; and
  – Usually reports to a senior executive manager.

  **Physician Recruitment Director:**
  – Researches and recruits physicians and other allied health personnel;
  – Completes the entire recruitment cycle from initial contact to contract by organizing schedules, problem resolution, spouse and children considerations, travel, hotel arrangements, meals, references, license, housing, banking, and all other general hosting of candidates; and
  – Usually reports to a senior executive manager.

  **Physician Relations Director:**
  – Directs and oversees programs designed to foster positive relations between physicians and the hospital or healthcare facility;
  – Promotes the organization among members of the medical community in order to establish partnerships and affiliations; and
  – Usually reports to a senior manager.

  **Quality Improvement/Quality Assurance Director:**
  – Develops and monitors programs designed to improve the quality of health care delivery such as outcome measurement;
  – Develops policies and procedures designed to measure the quantitative and qualitative aspects of health care delivery;
  – More likely to be found in larger organizations with some degree of integration with other health care organizations; and
  – Usually reports to a senior executive manager.

  **Radiology Services Director:**
• Usually found in large organizations with several radiology departments;
  o Responsible for all activities relating to the delivery of radiological services including the
development of policies and procedures;
  o Oversees radiology personnel activities;
  o Monitors the quality of all film products used;
  o Monitors budget activities related to the radiology departments; and
  o Usually reports to a senior executive manager.

• Reimbursement Director:
  o Oversees payment services for the practice including establishing and maintaining the
  practice’s fee schedules and fees that relate to managed care activities;
  o Conducts regular analyses of reimbursement rates;
  o Oversees coding activities; and
  o Usually reports to a senior executive manager.

• Revenue Cycle Director:
  o Implements appropriate revenue management procedures to ensure the financial
  success and soundness of the organization;
  o Assists and/or oversees recovering patient accounts receivable; and
  o Usually reports to an executive manager

• Strategy/Business Planning Director
  o Works with the senior management team to evaluate the business direction and strategy;
  o Ensures that commercial goals of the organization are met while simultaneously
    maintaining financial control and asset protection; and:
  o Usually reports to a senior executive manager

General Management Positions
• Benefits Manager:
  o Oversees all aspects of the organization’s salary/wage administration program as well
    as the benefits program;
  o Determines eligibility for the benefits program;
  o May provide assistance and information to employees with the selection of benefits
    and filing claims; and
  o Usually reports to a senior executive manager.

• Billing Manager:
  o Plans and manages registration, patient insurance, billing and collections, and data
    processing to ensure accurate and efficient account collection;
  o Monitors daily operating activity of department and makes adjustments as necessary;
  o Responsible for addressing collection and business office problems;
  o Usually reports to a senior executive manager.

• Branch/Satellite Clinic Manager:
  o Oversees the daily administrative and operations activities of an assigned clinic in an
    organization with multiple clinics;
  o Prepares the clinic’s annual budget and supervises clinic staff;
  o Oversees financial transactions such as purchasing of supplies; and
  o Usually reports to a senior executive manager.

• Building and Grounds Manager:
  o Responsible for major building projects and facilities expansions, space planning,
    remodeling of current facilities, and maintenance of equipment;
  o Responsible for operation and maintenance of facility; and
  o Usually reports to a senior manager.

• Business Office Manager:
  o Responsible for directing and coordinating the overall functions of the business office;
  o The top business office position in a mid-size or small organization without a director
    of business services;
- Exercises general supervision over business office staff;
- Plans and directs registration, patient insurance, billing, collections, and data processing to ensure accurate patient billing and efficient account collection; and
- Usually reports to an executive manager

**Clinical Practice Manager:**
- Coordinates and prioritizes resources, including staff, space and equipment;
- Manages all aspects of the facility such as an ambulatory clinic, including building operations;
- Develops and implements practice standards and oversees all tasks related to the financial performance of the practice, including strategic planning such as forecasting, developing projections, and providing recommendations and justifications; and
- May report to the CDA or to the top administrative position in charge of ambulatory services.

**Clinical Department Manager:**
- Manages operation of one or more medical/surgical departments, ancillary service departments, or an ambulatory surgery facility;
- Usually found in larger practices;
- Assists with budget planning and approves department expenditures;
- May supervise department nonmedical staff; and
- Usually reports to an executive manager.

**Clinic Research Manager:**
- Collects and analyzes clinical data and outcomes;
- The top clinic research position in a mid-size or small organization without a clinical research director; and
- Usually reports to a senior executive manager.

**Compliance Manager:**
- Oversees all aspects of professional billing compliance;
- Responsible for adhering to all regulatory, credentialing, and licensing requirements, and for developing compliance policies and standards, overseeing and monitoring compliance activities, and achieving and maintaining compliance;
- May also have responsibility for research grants and contracts compliance; and
- Usually reports to the CDA.

**Coding Manager:**
- Responsible for managing and coordinating the medical coding staff;
- Has expertise in ICD-9, ICD-10, and CPT coding;
- Responsible for the security and accuracy of the patient records;
- Accountable for designing, implementing and enforcing coding policies and procedures;
- Has knowledge of reimbursement systems, regulations, and policies pertaining to documentation, coding, and billing; and
- Usually reports to a senior executive manager.

**Credit/Collections Manager:**
- Supervises personnel involved in the mailing of collection letters and counselors who interview patients to arrange methods of payment or extension of credit;
- Interviews patients, evaluates credit history, and determines payment dates based on patient's ability to pay and clinic policy; and
- Makes decisions on which delinquent accounts to turn over to a collection agency or recommends such action.

**General Accounting Manager:**
- The second or third highest financial position in the organization;
- Assists the CFO or finance director with the financial responsibilities of the organization;
- Develops and oversees activities related to implementing and maintaining the integrity of the organization's financial reporting system;
• Assists with or oversees the budgeting process; and
  • Usually reports to a senior executive manager.

**Human Resources Manager:**
- Assists with all aspects of human resource activities, including recruitment, employment, compensation, labor relations, benefits, training, and development;
- Serves as a link between management and employees by handling questions, interpreting and administering contracts, and helping resolve work-related issues;
  • Usually reports to an executive manager.

**Information Systems Manager:**
- Manages backup, security, and user help systems;
- Researches and recommends new systems and hardware;
- Oversees system and software installation and maintenance;
- Schedules upgrades and security backups of hardware and software systems; and
  • Usually reports to an executive manager.

**Insurance Manager:**
- Responsible for supervision and coordination of all medical group patient third-party indemnity insurance and state and federal medical assistance programs (Medicare, Medicaid, etc.);
- Involved in the implementation of insurance systems with the data processing department; and
  • Supervises all insurance personnel.

**Laboratory Services Manager:**
- The top laboratory position in a mid-size or small organization without a laboratory services director;
- Responsible for the activities related to the delivery of laboratory services;
- Monitors the quality of services, products, and supplies used;
- May monitor budget activities related to the laboratory department; and
  • Usually reports to a senior executive manager.

**Materials Management Manager:**
- Usually found in organizations with a separate purchasing department or function;
- Oversees all activities that involve the acquisition of equipment and supplies;
- May monitor budget activities, including the capital equipment budget; and
  • Usually reports to a senior executive manager.

**Medical Records Manager:**
- The top medical records position in a mid-size or small organization without a medical records director;
- Oversees and coordinates all activities of the medical library from maintenance tasks to the movement of patient records;
- Oversees all medical records personnel;
- May monitor budget activities that relate to the medical records function; and
  • Usually reports to a senior executive manager.

**Medical Transcription Manager:**
- Directs the functions and staff of the transcription department to provide timely, accurate medical transcription services for the medical group practice;

**Nursing Manager:**
- Responsible for managing, supervising, and administering the patient/nursing services in the practice;
- In most cases, requires certification as a registered nurse (RN);
- Supervises nursing staff; and
  • Usually reports to an executive manager.

**Office Manager:**
- Manages the nonmedical activities of a larger medical practice;
- Typically found in a practice that does not have an administrator;
- The focus of this position usually rests on the daily operations of the organization;
• May oversee some financial activities such as billing and collections; and
  • Usually reports to an executive manager.

• **Operations Manager:**
  • Assists the top operations administrator;
  • Coordinates and directs the overall operation of specific departments;
  • Coordinates between departments to ensure that the organization meets internal and external regulatory requirements; and
  • Usually reports to a senior executive manager

• **Patient Accounting Manager:**
  • Manages the billing process and billing staff for the practice;
  • Manages insurance and other reimbursement functions; and
  • Usually reports to a senior executive manager.

• **Radiology Services Manager:**
  • Not a director or senior management level position;
  • The top radiology position in a mid-size or small organization without a radiology director;
  • Responsible for activities related to the delivery of radiological services;
  • Monitors the quality of all film products used;
  • May monitor budget activities related to the radiology departments; and
  • Usually reports to a senior executive manager.

• **Reimbursement/Collection Manager:**
  • Oversees payment and collection services for the department including establishing and maintaining the department's fee schedules and fees that relate to managed care activities;
  • Conducts regular analyses of reimbursement rates;
  • Negotiates out-of-network fees;
  • May be responsible for the practice's central billing office;
  • Oversees coding activities; and
  • Usually reports to the managed care director, the CFO, or the senior administrative officer.

• **Training/Education Manager:**
  • Assists in delivering education and training programs for staff members and patients;
  • Helps to identify the training needs;
  • Evaluates programs to determine whether the goals and objectives have been met;
  • Monitors the delivery of ongoing programs; and
  • Usually reports to an executive manager.

• **Transcription Manager:**
  • Oversees all medical transcription staff;
  • Assists the process of converting voice-recorded reports dictated by physician and other healthcare professionals into text format;
  • Creates procedures to ensure accuracy; and
  • Usually reports to a senior manager.

• **Utilization Management/Care Coordinator:**
  • Directs collections, monitoring, and assessment of data pertaining to patient services and treatment;
  • Evaluates aspects of patient care, such as timeliness of services, number of bed days used in a hospital, amount of prescribed medication, patient's recovery time, etc.; and
  • Usually reports to a senior manager.

**Specialists**

• **Accountant:**
  • Performs tasks related to bookkeeping and standard accounting functions;
• Accountable for completing journal entries and reconciling balance sheet accounts;  
  • Prepares statements and reports relating to assigned areas of responsibility; and  
  • Usually reports to a general accounting manager.

**Benefits/Payroll Specialist:**
  • Oversees the entire payroll system, which includes implementing and converting the payroll system for newly acquired sites;  
  • Recommends policies and standards that pertain to payroll activities;  
  • Responsible for the accuracy of the payroll system; and  
  • Usually reports to a senior general manager.

**Billing Specialist:**
  • Responsible for collecting, posting and managing account payments;  
  • Responsible for submitting claims and following up with insurance companies; and  
  • Generally, reports to a billing supervisor or office manager.

**Coding Specialist:**
  • Maintains procedure code master file;  
  • Reviews reimbursement from third-party payers;  
  • Maintains diagnosis code master files;  
  • Audits, corrects patient demographic information and total charges; and  
  • Works to resolve coding issues and maintains fee schedules for Medicare, fee for service, health maintenance organizations.

**Credentialing Specialist:**
  • Provides support to medical credentialing functions within the appointment and evaluation process of physicians and health care professionals;  
  • Receives and reviews applications for all required legal and organization documentation;  
  • Reviews privilege requests; and  
  • Usually reports to a senior executive manager.

**Human Resources Specialist:**
  • Provides support for various human resources (HR) employee programs;  
  • Develops, monitors, and maintains HR documents and databases;  
  • Interprets labor laws and administers them accordingly;  
  • Supports hiring process by placing employment ads, screening applicants, scheduling interviews, etc.; and  
  • Usually reports to a human resources manager

**IT Implementation/EHR Specialist:**
  • Responsible for the EHR program from implementation to daily operations;  
  • Manage internal EHR and IT projects; and  
  • Duties include training, development, support, and upgrading of the EHR system.

**Marketing/Communication Specialist:**
  • Usually found in organizations in which there is a separate publications/communications function;  
  • In some organizations, this person may be known as the “Public Relations Manager” and may report to the top marketing and sales position;  
  • Represents the organization at all media and other public relations events;  
  • May oversee the activities of public relations/communications staff; and  
  • Usually reports to a senior executive manager.

**Recruiter:**
  • Works with human resources staff to develop and execute recruiting plans;  
  • Drives and manages the recruiting process for both hiring managers and applicants; and  
  • Networks through industry contacts, association memberships, trade groups, and employees.
Supervisors

- **Business Office Supervisor:**
  - Responsible for supervising and coordinating activities of the business office;
  - This position may be implemented in a multiple clinic setting;
  - Supervises assigned business office staff; and
  - Usually reports to a senior general manager.

- **Clinic Supervisor:**
  - Exercises supervision over assigned staff;
  - Responsible for supervising and coordinating day to day activities of the clinic; and
  - Usually reports to a general manager.

- **EEG Lab Supervisor:**
  - Responsible for the operation of the EEG (electroencephalography) lab, evoked potential lab, and all night sleep lab; and
  - Supervises, plans, and reviews the work of the technical staff and performs their duties when required.

- **EKG Lab Supervisor:**
  - Responsible for the supervision of all electrocardiography (EKG) lab personnel; and
  - Proficient in the use of EKG machines, Holter monitor scanners, treadmill equipment, and heart station computers.

- **Front Office Supervisor:**
  - Responsible for supervising the front office;
  - Maintains and coordinates the policies and procedures;
  - Responsible for training and daily activities of front office staff; and
  - Usually reports to a general manager.

- **Housekeeping Supervisor:**
  - Directs and administers the housekeeping program;
  - Establishes and maintains standards, work procedures, schedules, training and supervision for the housekeeping staff; and
  - Interviews, hires, and terminates housekeeping personnel.

- **Lab Section Supervisor:**
  - Assigns, coordinates, supervises, and evaluates individual categories of procedures as well as the personnel assigned to a specific section in the lab; and
  - Usually reports to the laboratory director.

- **Nursing Supervisor:**
  - Supervises nursing staff;
  - In a large organization, may be one of several supervisors;
  - Splits time between patient care and supervision of staff;
  - Responsibilities are more limited than the nursing manager; and
  - Usually reports to a general manager.

- **Optical Shop Supervisor:**
  - Supervises the dispensing, fitting, and fabricating of eyeglasses and other eyewear;
  - Negotiates with lens and frame manufacturers; and
  - Considerable time may be spent working as an optician.

Support Staff

- **Accredited Records Tech (ART):**
  - Responsible for preparing and coding statistical reports, diagnoses, and procedures;
  - Maintains indexes according to established plans and procedures; and
  - Accredited by the American Association of Medical Record Administrators.

- **Administrative Assistant:**
  - Carries out work projects assigned by the CEO/administrator relative to the total clinic operation or to specific patient services;
  - Investigates procedures and operations and gathers data for preparation of statistical
and operational reports and makes recommendations for revision; and
  o Performs administrative duties as directed.

- Administrative Secretary:
  o Assists members of the administrative staff by performing secretarial, clerical, and
    minor executive duties; and
  o Answers telephone, interviews and screens office callers, makes appointments, and
    composes correspondence and memoranda.

- Aesthetician:
  o Performs facials, waxing, facial peels, acne treatments, laser hair removal,
    microdermabrasion, makeup application and skin care consultations.

- Appointment Secretary:
  o Assesses patient's appointment needs;
  o Schedules, changes, cancels, or confirms appointments as appropriate;
  o Schedules tests, procedures, or surgeries as requested; and
  o Sends appropriate forms, questionnaires, and instructions to patients as needed.

- Athletic Trainer:
  o Provides athletic training in office in therapy environment under the direction of
    providers.

- Bookkeeper:
  o Maintains accounts receivable and payable;
  o Maintains a general ledger;
  o Sends out and prepare bills for distribution; and
  o Prepares financial statements, income statements, and cost reports.

- Billing Staff:
  o Responsible for duties relating to billing, collecting, payment posting, refunding and
    adjusting.

- Building Engineer/Maintenance:
  o Repairs routine to difficult electrical, plumbing, heating, and ventilating equipment
    problems;
  o Develops and carries out the preventive maintenance program for the mechanical,
    electrical, steam, plumbing, heating, and air conditioning systems; and
  o Monitors energy consumption to control cost and use.

- Business Office Assistant Manager:
  o Responsible for the direction of one or more major functions of the business office;
    and
  o Is involved with difficult or unusual billing or insurance problems.

- Business Office Staff:
  o Performs routine clerical work involving an elementary degree of skill and
    responsibility;
  o Typical duties include filing, sorting, recording, answering telephone, and typing; and
  o Responds to inquiries and requests from referring facilities.

- Cashier:
  o Collects payment and posts payment for services rendered;
  o Works with billing of patients; and
  o Verifies account balances.

- CAT Scan Technician:
  o Operates the computed axial tomography machine;
  o Applies prescribed radiation for the purpose of obtaining diagnostic information; and
  o Is typically a graduate of an accredited program for radiographers with experience in
    special procedures.

- Certified Lab Assistant (CLA):
  o Performs routine tests in various areas of the lab using standard techniques and
    equipment;
o Prepares sterile media; and
o Must be certified from the Board of Certified Laboratory Assistants.

**Certified Professional Coder:**
- Analyzes and codes surgeries, procedures and diagnoses from health records by using appropriate classification systems, standards and procedures;
- Links diagnoses with procedures and adds appropriate modifiers;
- Validates charge classification systems, standards and procedures;
- Confers with providers to assure complete, current medical records; and
- Audits incomplete records.

**Clinical Research Coordinator:**
- Provides direction and support for all clinical research activities including paperwork, registration, monitoring and reporting.

**Courier:**
- Moves and distribute information, documents, and small packages; and
- Picks up and delivers letters, important business documents, or packages that need to be sent or received quickly within a local area.

**Dosimetrist:**
- Has overall knowledge of radiation oncology treatment machines and equipment;
- Is familiar with the procedures commonly used in brachytherapy; and
- Can generate radiation dose distributions/calculations in collaboration with the medical physicist and radiation oncologist.

**EEG Technician:**
- Operates electroencephalograph (EEG) machine for use in diagnosing brain disorders; and
- Must be a graduate of a two-year technical school with an EEG Tech. program.

**EKG Technician:**
- Records electromotive variations in action of the heart muscle on an electrocardiograph (EKG);
- Attaches electrodes to specified areas of patient's body and removes electrodes after completing test;
- Reviews recording from each electrode for clarity and for deviations from the norm; and
- Requires high school degree and completion in an approved training course in EKG techniques.

**Executive Assistant:**
- Provides high-level administrative support to executive level;
- Maintains scheduling meetings and prioritizing calendar requests;
- Makes travel arrangements, prepares itineraries and expense reports;
- Manages incoming and outgoing phone calls; and
- Monitors office supply inventory.

**Front Desk Staff:**
- Assists patients and visitors by providing directions and information;
- Usually stationed by main entrance;
- Registers patients who do not have an appointment, and may schedule return visits;
- May take payments and also provide check-out services;
- Checks that all records needed by physician are available and notifies physician of patient's arrival; and
- Answers telephones.

**Histotechnologist:**
- Member of a laboratory team who employs histologic technology to diagnose diseases or conduct research as requested by pathologists; and
- Ensures accurate completion of all histology laboratory records.

**Housekeeper:**
• Maintains an assigned area of the building in a clean, orderly, and attractive condition; and
• Dusts and damp mops floors, cleans window sills, blinds, furniture, fixtures, and equipment within hand reach.

• Insurance Clerk:
  • Collects and posts payments for services rendered
  • Reviews EOBs for appropriate contractual write-offs and other adjustments to charges;
  • Researches and appeals inappropriate denials; and
  • Verifies patient account balances prior to preparing patient statements.

• IT Programming/Support Staff:
  • Responsible for system analysis, program design, coding, documentation, and other programming tasks.

• Laboratory Aide:
  • Cleans laboratory equipment;
  • Prepares simple stains, solutions, and culture media;
  • Under close supervision, may perform simple laboratory tests such as qualitative determinations of sugar and albumin in urine;
  • Keeps records of specimens held in the laboratory; and
  • May perform minor repairs to laboratory apparatus.

• Licensed Practical Nurse:
  • Performs assigned nursing procedures for the comfort and well-being of patients;
  • Takes and records patient's vital signs and collects specimens for analysis;
  • Dresses wounds and administers prescribed medications and procedures utilizing a variety of medical equipment when necessary; and
  • Must be state licensed.

• Mammography Technician:
  • Responsible for screening and diagnostic exams of the breast, aiding in the early detection of breast cancer; and
  • Requires ARRT certification.

• Managed Care Coordinator:
  • Responsible for maintaining information flow in the managed care referral process for all contracted managed care health plans.

• Medical Assistant:
  • Prepares treatment rooms as well as sterilizes and cleans instruments;
  • Assists physician with materials, instruments, procedures, and equipment during exam;
  • Collects specimens and takes blood pressure, pulse, and temperature;
  • Maintains inventory of supplies;
  • Completes paperwork for lab tests, x-rays, and referrals; and
  • Must be a graduate of and certified from a technical school medical assistant program.

• Medical Lab Technician (MLT):
  • Conducts routine tests in clinical labs for use in the treatment and diagnosis of disease;
  • Prepares sterile media for use in growing bacterial cultures;
  • Keeps detailed records of all tests performed and reports lab findings to authorized personnel; and
  • Graduation from a technical school either as a MLT or ASCP certification is required.

• Medical Records Staff:
  • Files charts returned to record room and sends charts out upon request; and
  • Keeps medical records in correct filing order.

• Medical Scribe:
• Works to facilitate patient flow and ensure an accurate and complete medical record for each patient;
• Accompanies physician into the patient examination room in order to transcribe a history and physician exam; and
• Accurately documents the physician’s encounter with the patient.

• **Medical Secretary:**
  - Performs secretarial duties utilizing knowledge of medical terminology and hospital, clinic, or laboratory procedures;
  - Takes dictation in shorthand or uses transcribing machine; and
  - Compiles and records medical charts, records, and correspondence.

• **Medical Technologist (ASCP):**
  - Performs variety of microscopic, chemical, and bacterial tests to obtain data for use in diagnosis and treatment of disease.
  - Performs routine and special laboratory tests in accordance with written requisition of physician.
  - May perform clinical tests in any one or combination of areas of specialization in smaller labs, and may be more specialized in one area of clinical pathology in larger labs; and
  - Requires ASCP certification.

• **Nuclear Medicine Technologist:**
  - Responsible for administering radiopharmaceuticals to patients for diagnostic purposes;
  - May also perform radioimmunoassay studies; and
  - Requires ARRT certification.

• **Ophthalmic Assistant:**
  - Usually employee is trained in history-taking, basic skills in lensometry, and instrument maintenance; and
  - May assist patients in proper insertion, removal, and care of contact lenses.

• **Ophthalmic Technician:**
  - Assists ophthalmologist or optometrist with patient care;
  - Performs different levels of eye tests such as visual fields, tonometry, and ocular motility required by ophthalmologist;
  - May assist ophthalmologist in surgery; and
  - May be certified by JCAHPO (Joint Commission on Allied Health Personnel in Ophthalmology) as a COT (Certified Ophthalmic Technician).

• **Orthopedic/Cast Technician:**
  - Assists physicians and nursing personnel with orthopedic casting procedures to include the application and removal of a variety of casts and splints.

• **Patient Accounts Representative:**
  - Interviews and assists patients;
  - Works with patient and patient's insurance carrier to determine benefits available and assist families in getting financial aid; and
  - Responsible for billing, servicing, and collecting delinquent accounts receivable.

• **Pharmacy Technician:**
  - Helps licensed pharmacists prepare prescription medications, provide customer service, and perform administrative duties within a pharmacy setting;
  - Is generally responsible for receiving prescription requests, counting tablets, and labeling bottles; and
  - May perform administrative functions such as answering phones, stocking shelves, and operating cash registers.

• **Phlebotomist:**
  - Responsible for drawing blood and other body fluids for sampling; and
  - Assists in other assigned laboratory functions.
- **Physical Therapist Aide:**
  - Performs specific nonclinical physical therapy procedures and related tasks under the direction of a physical therapist or physical therapy assistant.

- **Physical Therapy Assistant:**
  - Prepares patients and equipment for therapy;
  - Assists physical therapist in administering treatments;
  - Maintains department in an orderly condition; and
  - Requires a two-year technical degree.

- **PT Education Coordinator:**
  - Responsible for determining the patient education needs of the clinic;
  - Developing, implementing and evaluating programs to address education needs; and
  - Coordinates and supervises community health care needs of patients in an ambulatory setting.

- **QA/UR Nurse:**
  - Implements programs designed to improve the quality of healthcare delivery;
  - Measures the quantitative and qualitative aspects of health care delivery;
  - Likely to be found in larger organizations with some degree of integration with other healthcare organizations; and
  - Monitors inpatient and outpatient care activities to ensure that accepted utilization management procedures are maintained.

- **Radiation Therapist**
  - Responsible for administering radiation treatment to patients under the direction of a radiation oncologist; and
  - Requires ARRT certification.

- **Radiology Technologist:**
  - Provides technical skills involving radiology and fluoroscopy; and
  - Takes and may develop radiographs of various parts of the body to assist physician in the detection of foreign bodies and diagnosis of disease or injury.

- **Receptionist:**
  - Greets patients or others arriving for appointments;
  - Obtains information, answers questions, and provides assistance or directions as appropriate;
  - Notifies physician of patient's arrival;
  - Checks to assure all records needed by physician are available;
  - Answers telephones; and
  - May schedule return visits and make appointments.

- **Registered Nurse:**
  - Renders professional nursing care for the comfort and well-being of the patients;
  - Prepares equipment and assists physician during examinations and treatments;
  - Administers prescribed medications, changes dressings, cleans wounds, and monitors patient's vital signs;
  - Observes and maintains records on patient's care, conditions, reaction, and progress; and
  - Must be state licensed and a graduate of a registered nurse program.

- **Respiratory Therapist**
  - Responsible for evaluating, treating, and caring for patients with breathing or other cardiopulmonary disorders under the direction of a physician;
  - May supervise respiratory therapy technicians; and
  - Most states require licensure.

- **Scheduling Staff (excluding Surgical Scheduler)**
  - Responsible for scheduling appointments for patients following medical practice procedures.

- **Surgical Scheduler:**
• Responsible for scheduling surgical procedures and tests under the direction of providers and clinical staff.

**Surgical Technologist**
- Responsible for assisting in surgical operations as part of a team under the supervision of surgeons, registered nurses, or other surgical personnel; and
- Helps prepare operating room by setting up surgical instruments and equipment, sterile drapes, and sterile solutions.

**Switchboard Operator:**
- Operates a telephone switchboard to relay incoming and outgoing calls; and
- Pages personnel over the intercom system.

**Transcriptionist**
- Responsible for transcribing dictated recordings made by physicians and other health care professionals into medical reports, correspondence, and other administrative material, which typically become part of patients’ permanent files; and
- May require CMT certificate.

**Triage Nurse:**
- Primarily responsible for screening and placement of patients who walk in or telephone with medical problems or questions;
- Orders medical record and takes medical history;
- Administers first aid as appropriate;
- Sets up appointment with appropriate department as necessary; and
- Requires a registered nurse degree and a state license.

**Ultrasound Technician:**
- At the direction of a qualified physician, performs a variety of procedures requiring independent judgment and initiative in the utilization of ultrasonic equipment for the diagnosis of disease in humans; and
- Must be a graduate of a formal ultra-sonographer program or trained on the job by a radiologist and eligible for certification.

**Workers Comp Liaison:**
- Provides communication, paperwork, authorization and information for staff and providers on worker’s compensation claim activities.

**Practice panel size**
For cardiology and primary care practices only. The number of individual unique patients that have been seen by any provider within the practice over the past 18 months. To determine the panel size per physician, use the following methodologies:

1. If a patient has only seen one physician in the practice, assign the patient to that physician.
2. If a patient has seen more than one physician in the practice, assign the patient to the physician seen most frequently.
3. If a patient has seen more than one physician in the practice the same number of times, assign the patient to the physician who did the patient’s last physical.
4. If a patient has not had a physical, assign him/her to the physician seen most recently.

**Practice type**
**Single Specialty**
- A medical practice that focuses its clinical work in one specialty. The determining factor for classifying the type of specialty is the focus of clinical work and not necessarily the specialties of the physicians in the practice. For example, a single specialty neurosurgery practice may include
a neurologist and a radiologist. Practices that include only the subspecialties of internal medicine should be classified as a single specialty internal medicine practice.

**Multispecialty**

- **Multispecialty with primary and specialty care**: Medical practices that consist of physicians practicing in different specialties, including at least one primary care specialty listed below:
  - Family medicine: general
  - Family medicine: sports medicine
  - Family medicine: urgent care
  - Family medicine: with obstetrics
  - Family medicine: without obstetrics
  - Geriatrics
  - Internal medicine: general
  - Pediatrics: adolescent medicine
  - Pediatrics: general
  - Pediatrics: sports medicine
  - Urgent care
- **Multispecialty with primary care only**: A medical practice that consists of physicians practicing in more than one of the primary care specialties listed above or one of the specialties below:
  - Obstetrics/gynecology
  - Gynecology (only)
  - Obstetrics (only)

- **Multispecialty with specialty care only**: A medical practice that consists of physicians practicing in different specialties, none of which are the primary care specialties listed above.

**Primary Care Specialties**

- Family Medicine (with OB)
- Family Medicine (without OB)
- Family Medicine: Ambulatory Only (No Inpatient Work)
- Family Medicine: Sports Medicine
- Family Medicine: Urgent Care
- Geriatrics
- Hospice/Palliative Care
- Hospitalist: Family Medicine
- Hospitalist: Internal Medicine
- Pediatrics: Hospitalist-Internal Medicine
- Hospitalist: OB/GYN
- Internal Medicine: General
- Internal Medicine: Ambulatory Only (No Inpatient Work)
- Pediatrics: Internal Medicine
- Obstetrics/Gynecology: General
- OB/GYN: Gynecology (Only)
- Pediatrics: General
- Pediatrics: Adolescent Medicine
- Pediatrics: Sports Medicine
- Pediatrics: Urgent Care
- Urgent Care

**Professional gross charges**

The total gross patient charges attributed to a physician for all professional services. Gross patient charges are the full dollar value, at the practice’s established undiscounted rates, of services provided to all patients, before reduction by charitable adjustments, professional courtesy adjustments, contractual
adjustments, employee discounts, bad debts, etc. For both Medicare participating and nonparticipating providers, gross charges should include the practice’s full, undiscounted charge and not the Medicare limiting charge.

**Included:**
1. Fee-for-service charges;
2. In-house equivalent gross fee-for-service charges for capitated patients;
3. Administration of chemotherapy drugs; and
4. Administration of immunizations.

**Not included:**
1. Charges for drugs, including vaccinations, allergy, injections, and immunizations as well as chemotherapy and antinauseant drugs;
2. The technical component associated with any laboratory, radiology, medical diagnostic or surgical procedure.
3. Charges attributed to nonphysician providers;
4. Infusion-related charges;
5. Facility fees;
6. Supplies; or
7. Charges associated with the sale of hearing aids, eyeglasses, contact lenses, etc.

**Professional liability insurance premiums**
Premiums paid or self-insurance cost for malpractice and professional liability insurance for practice physicians, nonphysician providers, and employees

**Professional organization fees**
The dollar amount paid for professional organization dues and memberships, and educational conference fees and travel expenses related to those conferences over the fiscal year for each physician executive, executive management and senior management positions.

**Promotion and marketing**
Cost of promotion, advertising and marketing activities, including patient newsletters, information booklets, flyers, brochures, yellow page listings, and public relations consultants.

**Provider-based billing (PPB)**
Provider-based billing has two bills: the first is a bill for the outpatient hospital clinic which includes the facility fee charge and the practice expense RVUs, and the second is a bill for professional or physician fee charge.

**Provider classification groupings**
- **Primary care** — Family medicine (with OB), family medicine (without OB), family medicine: ambulatory only (no inpatient work), family medicine: sports medicine, family medicine: urgent care, geriatrics, hospice/palliative care, hospitalist: family medicine, hospitalist: internal medicine, internal medicine: general, internal medicine: ambulatory only (no inpatient work), OB/GYN: general, OB/GYN: gynecology (only), pediatrics: general, pediatrics: adolescent medicine, pediatrics: hospitalist, pediatrics: hospitalist-internal medicine, pediatrics: internal medicine, pediatrics: sports medicine, pediatrics: urgent care, urgent care
- **Surgical specialist** — Ophthalmology, orthopedic surgery: general, otorhinolaryngology, surgery: general, otorhinolaryngology, surgery: general, urology
• **Nonsurgical specialist** — Allergy/immunology, anesthesiology, bariatrics (nonsurgical), clinical pharmacology, critical care: intensivist, dentistry, dermatology, emergency medicine, endocrinology/metabolism, gastroenterology, genetics, hematology/oncology, hematology/oncology: oncology (only), hyperbaric medicine/wound care, infectious disease, nephrology, neurology, occupational medicine, orthopedic (nonsurgical), pathology: anatomic and clinical, pathology: anatomic, pathology: clinical, physical medicine and rehabilitation, podiatry: general, psychiatry: general, pulmonary medicine: general, pulmonary medicine: critical care, pulmonary medicine: general and critical care, radiation oncology, rheumatology, sleep medicine


**Provider specialty roll-ups**

Due to low response rates for subspecialties, the following specialties are reported as aggregates:
• **Allergy/immunology**
• **Anesthesiology: all** — Anesthesiology, anesthesiology: pain management
• **Cardiology: electrophysiology**
• **Cardiology: invasive**
• **Cardiology: invasive-interventional**
• **Cardiology: noninvasive**
• **Critical care: intensivist**
• **Dermatology** — Dermatology, dermatology: dermatopathology, dermatology: Mohs surgery
• **Emergency medicine**
• **Endocrinology/metabolism**
• **Family medicine** — Family medicine (with OB), family medicine (without OB), family medicine: ambulatory only (no inpatient work), family medicine: sports medicine, family medicine: urgent care
• **Gastroenterology** — Gastroenterology, gastroenterology: hepatology
• **Hematology/oncology** — Hematology/oncology, hematology/oncology: oncology (only)
• **Hospice/palliative care**
• **Hospitalist** — Hospitalist: family medicine, hospitalist: internal medicine, hospitalist: OB/GYN
• **Infectious disease**
• **Internal medicine** — Internal medicine: general, internal medicine: ambulatory only (no inpatient work)
• **Nephrology**
• **Neurology** — Neurology, neurology: epilepsy/EEG, neurology: neuromuscular, neurology: stroke medicine
• **Obstetrics/gynecology** — Obstetrics/gynecology: general, OB/GYN: gynecology (only), OB/GYN: gynecological oncology, OB/GYN: maternal and fetal medicine, OB/GYN: reproductive endocrinology, OB/GYN: urology/gynecology
• **Occupational medicine**
• **Otorhinolaryngology**
• **Pediatrics: general**
pulmonology, pediatrics: radiology, pediatrics: rheumatology, pediatrics: sports medicine, pediatrics: urgent care, pediatrics: urology

- **Physiatry (physical medicine and rehabilitation)**
- **Podiatry** — Podiatry: general, podiatry: surgery-foot and ankle, podiatry: surgery-forefoot only
- **Psychiatry** — Psychiatry: general, psychiatry: child and adolescent, psychiatry: forensic, psychiatry: geriatric
- **Pulmonary medicine** — Pulmonary medicine: general, pulmonary medicine: critical care, pulmonary medicine: general and critical care
- **Radiation oncology**
- **Radiology: all** — Radiology: interventional, radiology: diagnostic, radiology: neurological, radiology: nuclear medicine
- **Rheumatology**
- **Sleep medicine**
- **Surgery: general**
- **Surgery: cardiovascular**
- **Surgery: neurological**
- **Surgery: plastic and reconstruction (all)** — Surgery: plastic and reconstruction, surgery: plastic and reconstruction-hand
- **Surgery: trauma**
- **Surgery: vascular (primary)**
- **Urgent care**
- **Urology**
- **Other primary care specialty** — Geriatrics
- **Other nonsurgical specialty** — Bariatrics (nonsurgical), clinical pharmacology, dentistry, genetics, hyperbaric medicine/wound care, orthopedic (nonsurgical)
- **Other nonsurgical subspecialty** — Pain management: nonanesthesia

*Additional nonphysician provider specialty roll-ups included in the On-Call Compensation Report:*

- **Anesthesia assistant**
- **Certified registered nurse anesthetist**
- **Nurse midwife** — Nurse midwife: outpatient/inpatient deliveries, nurse midwife: outpatient (only), nurse midwife: inpatient (only)
- **PA (primary care)** — Physician assistant (primary care), PA: family medicine (with OB), PA: family medicine (without OB), PA: hospitalist, PA: internal medicine, PA: pediatric, PA: urgent care (primary care), PA: OB/GYN/women's health
Purchased services for capitation patients

Fees paid to health care providers and organizations external to the practice for services provided to capitation patients under the terms of capitation contracts.

** Included:

1. Payments to providers outside the practice for physician professional, nonphysician professional, clinical laboratory, radiology and imaging, hospital inpatient and emergency, ambulance, out of area emergency and pharmacy services; and
2. Accrued expenses for “incurred but not reported” (IBNR) claims for purchased services for capitation patients for which invoices have not been received.

Quality metrics

Quality metrics tied to any medical director in the practice include the following:

- CMS core measures
- Compliance
- Financial performance
- Length of stay
- Patient safety
- Patient satisfaction
- Quality of care
- Re-admissions
- Satisfaction (staff, provider)
- Other quality metric

Radiology and imaging

Cost of diagnostic radiology and imaging procedures defined by diagnostic radiology CPT codes 70010-76499, diagnostic ultrasound CPT codes 76506-76999, diagnostic nuclear medicine CPT codes 78012-78999, echocardiography CPT codes 93303-93352, noninvasive vascular diagnostic studies CPT codes 93880-93998, and electrocardiography CPT codes 93303-93352.

** Included:

1. Rental and/or depreciation cost of major furniture and equipment subject to capitalization;
2. Repair and maintenance contract cost;
3. Cost of radiological diagnostics (isotopes);
4. Cost of supplies and minor equipment not subject to capitalization. This amount is the net after subtracting the revenue from silver recovery from X-ray film and processing fixer;
5. Other costs unique to the radiology and imaging department; and
6. Cost of purchased radiology technical services for fee-for-service patients.

** Not Included:

1. Cost of purchased radiology technical services for capitation patients. Such cost should be reported as “Purchased services for capitation patients”;
2. Cost of procedures for radiation oncology CPT codes 77261-77799 or therapeutic nuclear medicine CPT codes 79005-79999. Such costs are included in “Other ancillary services” in this section.

Radiology and imaging

Film library staff and the diagnostic radiology and imaging department conducts procedures for diagnostic radiology CPT codes 70010-76499, diagnostic ultrasound CPT codes 76506-76999, and diagnostic nuclear medicine CPT codes 78012-78999, echocardiography CPT codes are 93303-
93352, noninvasive vascular diagnostic studies CPT codes 93880-93998, and electrocardiograph CPT codes 93303-93352.

**Included:**
1. Cost of support staff such as nurses, secretaries, and technicians; and
2. Cost of department director or manager.

**Not Included:**
1. Staff cost for radiation oncology CPT codes 77261-77799 or therapeutic nuclear medicine CPT codes 79005-79999. Such FTE and cost is included as “Other medical support services”.

**Rank**
The highest rank held by the faculty physician.

**Not included:**
3. Itinerary volunteers or commissioned physicians who teach; or
4. Fellows.

**Re-age accounts receivable**
Accounts receivable were re-aged when a second insurance company or the patient was billed after the first insurance company refused to pay the entire billed amount.

**Reasonable utilization percentage for a new operating room**
For anesthesiology practices only.
The percentage of utilization of new operating rooms.

**Registered nurses**
FTE of registered nurse staff and registered nurses working as frontline managers or lead nurses including home health nurses.

**Not Included:**
1. Cost and FTE of nonphysician providers such as nurse practitioners, certified registered nurse anesthetists (CRNAs), or nurse midwives, who are included in “Total nonphysician provider” FTE; or
2. Cost and FTE of registered nurses who worked exclusively in the departments of clinical laboratory, radiology and imaging or other ancillary departments. Such FTE is included in “Clinical laboratory”, “Radiology and imaging”, and “Other medical support services”.

**Residency**
A period of advanced medical training and education that normally follows graduation from medical school and licensing to practice medicine. This process consists of supervised practice of a specialty in a hospital and in its outpatient department and instruction from specialists on the hospital staff.

**Retirement benefits**
All employer contributions (excluding FICA) to retirement plans including defined benefit and contribution plans, 401(k), 403 (b) and Keogh Plans, and any non-qualified funded retirement plan. For defined benefit plans, the employer’s contribution made on behalf of each plan participant is estimated by multiplying the employer’s total contribution by each plan participant’s compensation divided by the total compensation of all plan participants.

**Not Included:**
Employer contributions to social security mandated by the Federal Insurance Contributions Act (FICA); Voluntary employee contributions that are an allocation of salary to a 401(k), 403(b), or Keogh Plan; or The dollar value of any other fringe benefits paid by the practice, such as life and health insurance or automobile allowances.
Revenue from hospital (include hospital subsidies)
All hospital subsidies and/or stipends paid to the practice which is part of a larger health system.

Included:
1. Payments received by the practice and not a specified individual for providing medical administration to hospitals, skilled nursing facilities, long-term care facilities, and other healthcare organizations.
2. Revenue for operational support provided to the practice from a parent organization such as a hospital, integrated delivery system, or other entity.

Revenue from the sale of medical goods and services
Income from the sale of medical products and revenue paid to the practice for professional services provided by practice physicians and staff members.

Included:
1. Revenue from pharmaceuticals, medical supplies and equipment sold to patients primarily for use outside the practice. This amount should be net of write-offs and discounts. Examples include prescription drugs, hearing aids, optical goods, orthopedic supplies, etc.;
2. Compensation paid by a hospital, skilled nursing facility, or insurance company to a practice physician for services as a Medical Director;
3. The hourly wages of physicians working in a hospital emergency room;
4. Contract revenue from a hospital for physician services in staffing a hospital indigent care clinic or emergency room;
5. Contract revenue from a school district for physician services in conducting physical exams for high school athletes;
6. Revenue from the preparation of court depositions, expert testimony, postmortem reports, and other special reports; and
7. Fees received from patients for the photocopying of patient medical records.

Not Included:
1. Capitation revenue used to pay for covered goods and services for capitation patients. Such revenue is included in "Gross capitation revenue."

RVUs
The relative value units (RVUs), as measured by the Resource Based Relative Value Scale (RBRVS), not weighted by a conversion factor, attributed to all professional services. An RVU is a nonmonetary standard unit of measure that indicates the value of services provided by physicians, nonphysician providers, and other health care professionals. The RVU system is explained in detail in the Federal Register. The Physician Fee Schedule Relative Value Files present tables of RVUs by CPT code. Please note the following:
- The RVUs published in the Federal Register, effective for the most recent calendar year, are used; and
- The total RVUs for a given procedure consist of three components:
  - Physician work RVUs;
  - Practice expense (PE) RVUs; and
  - Malpractice RVUs.

Thus, total RVUs = physician work RVUs + practice expense RVUs + malpractice RVUs.
For the current year, there are two different types of practice expense RVUs:
1. Fully implemented nonfacility practice expense RVUs; and
2. Fully implemented facility practice expense RVUs.

"Nonfacility" refers to RVUs associated with a medical practice that is not affiliated with a hospital and does not utilize a split billing system that itemizes facility (hospital) charges and professional charges.
“Nonfacility” also applies to services performed in settings other than a hospital, skilled nursing facility, or ambulatory surgery center. You should report total RVUs that are a function of “nonfacility” practice expense RVUs.

“Facility” refers to RVUs associated with a hospital affiliated medical practice that utilizes a split billing fee schedule where facility (hospital) charges and professional charges are billed separately. “Facility” also refers to services performed in a hospital, skilled nursing facility, or ambulatory surgery center.

Not reported:
Total RVUs are a function of “facility” practice expense RVUs. Hospital affiliated medical practices that utilizes a split billing fee schedule, reported their total RVUs as if they were a medical practice not affiliated with a hospital.

⇒ Total RVUs

Included:
1. RVUs for the "physician work RVUs", “practice expense”, and “malpractice RVUs”, including any adjustments made as a result of modifier usage;
2. RVUs for all professional medical and surgical services performed by physicians, nonphysician providers, and other physician extenders such as nurses and medical assistants;
3. RVUs for the professional component of laboratory, radiology, medical diagnostic and surgical procedures;
4. For procedures with either no listed CPT code or with an RVU value of zero, RVUs can be estimated by dividing the total gross charges for the unlisted or unvalued procedures by the practice’s known average charge per RVU for all procedures that are listed and valued;
5. RVUs for procedures for both fee- for-service and capitation patients; and
6. RVUs for all payers, not just Medicare.

Not included:
1. RVUs for other scales such as McGraw-Hill, California;
2. The technical component (TC) associated with any medical diagnostic, laboratory, radiology, or surgical procedure. If your practice cannot break this out, report RVUs and select the appropriate response to the question regarding technical component. If you can report total RVUs without technical component, answer 0% for the technical component question;
3. RVUs attributed to nonphysician providers. If your practice cannot break this out, report RVUs and answer "Yes" to the question regarding external nonphysician provider productivity. If you can report total RVUs without nonphysician providers, answer "No" for the nonphysician provider question; or
4. RVUs where the Geographic Practice Cost Index (GPCI) equals any value other than one. The GPCI must be set to 1.000 (neutral).

⇒ Work RVUs

Included:
1. RVUs for the "physician work RVUs" only, including any adjustments made as a result of modifier usage;
2. Physician work RVUs for all professional medical and surgical services performed by providers;
3. Physician work RVUs for the professional component of laboratory, radiology, medical diagnostic, and surgical procedures;
4. Physician work RVUs for all procedures performed by the medical practice. For procedures with either no listed CPT code or with an RVU value of zero, RVUs can be estimated by dividing the total gross charges for the unlisted or unvalued procedures by the practice’s known average charge per RVU for all procedures that are listed and valued;
5. Physician work RVUs for procedures for both fee-for-service and capitation patients;
6. Physician work RVUs for all payers, not just Medicare;
7. Physician work RVUs for purchased procedures from external providers on behalf of the practice’s fee-for-service patients;
8. Anesthesia practices should provide the physician work component of the RVU for flat fee procedures only such as lines, blocks, critical care visits, intubations, and post-operative management care; and
9. All RVUs associated with professional charges, including both medically necessary and cosmetic RVUs.

Not Included:
1. RVUs for “malpractice RVUs”; or “practice expense”
2. RVUs for other scales such as McGraw-Hill or California;
3. RVUs for purchased procedures from external providers on behalf of the practice’s capitation patients;
4. RVUs that have been weighted by a conversion factor. Do not weigh the RVUs by a conversion factor;
5. RVUs where the Geographic Practice Cost Index (GPCI) equals any value other than one. The GPCI must be set to 1.000 (neutral); or
6. Anesthesiology RVUs. Instead, provide ASA units and leave this question blank.

Self-pay
Fee-for-service gross charges, at the practice’s undiscounted rates, for all services provided to patients who pay the medical practice directly. Note that these patients may or may not have insurance.

Included:
1. Charges for patients who have no insurance but do have the resources to pay for their own care and do so; and
2. Charges for patients who have insurance but choose to pay for their own care and submit claims to their insurance company directly. Since the practice may or may not be aware of this situation, all charges paid directly by the patient should be considered as self-pay.

Sonography
For OB/GYN practices only.
Cost and FTE for staff that perform ultrasound/sonography procedures.

Included:
1. Registered technologists; and
2. Technicians that are not necessarily licensed but are trained and perform ultrasound procedures such as LPNs, RNs, or MAs.

Std Benchmarks (Standardized to 100% billable clinical activity)
Benchmarks submitted for providers who have less than 100% billable clinical activity are standardized to 100% billable clinical. For example, if a provider is indicated as 50% billable clinical with 1,000 work RVUs, their billable clinical percentage is multiplied by 2 to standardize to 100% (50%*2 = 100%), and the same multiplier is used for their work RVUs (1,000*2 = 2,000). Unless specified as Standardized (Std) or otherwise, all productivity benchmarks reported are for providers with more than 67% billable clinical activity.

Starting salary specific practice type categories
- **Solo practice:** A medical practice where there is only one "solo" physician within the practice.
- **Single specialty:** A medical practice that focuses its clinical work in one specialty. The determining factor for classifying the type of specialty is the focus of clinical work and not
necessarily the specialties of the physicians in the practice. For example, a single-specialty neurosurgery practice may include a neurologist and a radiologist.

- **Multispecialty**: A medical practice which consists of physicians practicing in different specialties which could include more than one primary care specialty and a surgical specialty such as obstetrics/gynecology.

- **Hospital Department Practice**: A medical practice which consists of physicians practicing in a hospital which could include more than one primary care specialty and a surgical specialty.

- **Rural Health Clinic**: A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners (nurse practitioners, physician assistants, and certified nurse midwives) to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner. RHCs may also provide other health care services, such as mental health or vision services, but reimbursement for those services may not be based on their allowable costs.

- **Federally Qualified Health Center (FQHC)**: is a reimbursement designation that refers to several health programs funded under Section 330 of the Public Health Service Act of the United States of America's Federal Government. These 330 grantees in the Health Center Program include: Community Health Centers which serve a variety of underserved populations and areas; Migrant Health Centers which serve migrant and seasonal agricultural workers; Health Care for the Homeless Programs which reach out to homeless individuals and families and provide primary and preventive care and substance abuse services; Public Housing Primary Care Programs that serve residents of public housing and are located in or adjacent to the communities they serve. FQHCs are community based organizations that provide comprehensive primary and preventive health, oral, and mental health/substance abuse services to persons in all stages of the life cycle, regardless of their ability to pay.

- **Academic Department**: A department in an institution that trains physicians and awards medical and osteopathic degrees.

### Structure of the medical practice's billing functions

For hospital/IDS practices only.

- **Decentralized**: Charges were entered at each branch or clinic location and each branch or clinic location submitted claims to payers and invoices to patients.

- **Centralized**: All charges were forwarded to a single location in the IDS/hospital where charge entry occurred along with all other billing functions.

- **Both/hybrid**: the practice’s billing functions were a combination of decentralized and centralized.

- **Other**: Some other method was used. If your billing structure was other than the options provided, describe the structure in the "Other" box.

### Supervises residents

Based on whether or not the provider supervises residents while providing on-call coverage.

### Surgical anesthesia

For anesthesiology practices only.

**Included**:

1. Any case with base and time units where anesthesia services such as general, regional or MAC are provided, regardless of whether or not there were multiple providers on the case. Generally, these are the “0” anesthesia codes or services which cross over to these codes. Obstetrical cases, critical care, chronic and acute pain services, as well as flat fee procedures are each listed as a separate category for which you will give separate counts.
2. List base units and minutes for surgical anesthesia cases only.
   a. For base units and time minutes, list one set of base units and time minutes per case only. Do not double-count medically directed cases. The best way for most practices to do this is to list physician base units and physician minutes only.
   b. Academic practices should beware not to double count resident units and should only count units for the supervising attending.
   c. If you have a significant number of cases which involve unsupervised CRNAs (QZ modifier), the base units and minutes for these cases should be added.

For the “Charge per ASA unit”, indicate the monetary fee that is applied to an American Society of Anesthesiologists (ASA) unit. The ASA units for a given procedure consist of three components:

- Base unit;
- Time in 15-minute increments; including time converted from 10-minute or 12-minute time units to 15-minute increments. The divisor to convert a pool of 10-minute time units to 15-minute units is 0.6667, and the divisor to convert a pool of 12-minute time units to 15-minute units is 0.80. For example, a 4-hour case will generate 24 10-minute time units, which is the equivalent of 16 15-minute time units (24 / 0.6667 = 16) or 20 12-minute time units, which is still the equivalent of 16 15-minute time units (20 / 0.80 = 60); and
- Risk factors, which include the full value, at the practice’s undiscounted rates, of all services provided to fee-for-service, discounted fee-for-service, and non-capitated patients for all payers. If you charge time units based upon something other than 15 minute units, use your best efforts to convert your charge per unit to an equivalent amount that you would charge if you were billing based upon 15 minute time units.

Technical component for ancillary service radiology and imaging revenue
For hospital/IDS practices only. The amount of the ancillary service revenue was posted for radiology and imaging services for the medical practice's patients.

- All: Revenue for all services was posted to the medical practice.
- Some: Some revenue for services was posted to the IDS/hospital/MSO and some revenue was posted to the medical practice.
- None: Revenue for all services was posted to the IDS/hospital/MSO.

The average utilization percentage for operating rooms in hospital
For anesthesiology practices only.

- The percentage for operating rooms that you covered at your largest hospital.
- Utilization percentage reflects the percentage of time that billable cases are occurring in the operating room(s). The utilization percentage between the peak hours of 7:00 a.m. - 3:00 p.m., Monday-Friday.
- To calculate utilization, take the total number of billable minutes and divide by the possible number of minutes in the time period. For example, if operating room three had cases going from 7:30 a.m. until 1:00 p.m., with a 30 minute break for turnover, that room would have been utilized for 300 minutes out of a possible 480 minutes (7:00 a.m. – 3:00 p.m.), or 62.5 percent of the time. To calculate this statistic in the aggregate, take the total number of minutes billed between these hours at the facility in question and divide by the available minutes in the month (480 minutes x 23 days x number of operating rooms staffed).
- If possible, use data that represents a twelve month period.
- If you require assistance in calculating the utilization percentage, you may want to refer to the American Society of Anesthesiologists Web site at http://www.asahq.org.
The average utilization percentage for the operating rooms in largest surgery center
For anesthesiology practices only.
The percentage for operating rooms that you covered at your largest surgery center.

The full value, at the practice’s undiscounted rates, of all services provided to fee-for-service, discounted fee-for-service, and noncapitated patients for all payers.

 Included:
1. Professional services provided by physicians, nonphysician providers, and other physician extenders such as Nurses and Medical Assistants;
2. Both the professional and technical components (TC) of laboratory, radiology, medical diagnostic, and surgical procedures;
3. Drug charges, including vaccinations, allergy injections, immunizations, and chemotherapy and anti-nausea drugs;
4. Charges for supplies consumed during a patient encounter inside the practice’s facilities. Charges for supplies sold to patients for consumption outside the practice’s facilities are reported as a subset of “Revenue from the sale of medical goods and services”;
5. Facility fees. Examples of facility fees include fees for the operation of an ambulatory surgery unit or fees for the operation of a medical practice owned by a hospital where split billing for professional and facility services is utilized;
6. Charges for fee-for-service services allowed under the terms of capitation contracts;
7. Charges for professional services provided on a case-rate reimbursement basis; and
8. Charges for purchased services for fee-for-service patients. Purchased services for fee-for-service patients are defined as services that are purchased by the practice from external providers and facilities on behalf of the practice’s fee-for-service patients.

For purchased services, note the following:
   a. The revenue for such services should be included in “Total net fee-for-service collections/revenue”;
   b. The cost for such services should be included, as appropriate, in “Clinical laboratory”, “Radiology and imaging”, “Other ancillary services”; and
   c. The count of the number of purchased procedures for fee-for-service patients should be included in “Output Measures”, Number of Procedures column.

 Not Included:
1. Charges for services provided to capitation patients. Such charges are included in “Gross charges for patients covered by capitation contracts”;
2. Charges for pharmaceuticals, medical supplies and equipment sold to patients primarily for use outside the practice. Examples include prescription drugs, hearing aids, optical goods, orthopedic supplies, etc. The revenue generated by such charges is included in “Revenue from the sale of medical goods and services”; or
3. Charges for any other activities that generate the revenue reported in “Revenue from the sale of medical goods and services.”

Total accounts receivable
The sum of “Current to 30 days”, “31 to 60 days”, “61 to 90 days”, “91 to 120 days”, and “Over 120 days.”
Total ancillary services
For orthopedic practices only.
Added MRI, DEXA, diagnostic radiology (film, digital CR, digital DR, C-arm), diagnostic radiology (X-ray), electromyography, occupational therapy, physical therapy, physical and occupation therapy (combined) and other ancillary services.

Total ancillary services
For OB/GYN practices only.
Added bone densitometry (DEXA) and ultrasound (sonography).

Total ancillary support staff
Subtotal the Cost/FTE for 'Clinical laboratory', Radiology and imaging' and 'Other medical support services'.

Total annualized compensation
The total compensation for medical directorship duties expected for the fiscal year. This figure should only be for medical directorship duties and annualized to represent a full 12-month period.

Total business operations support staff
Total the Cost/FTE for 'General administrative', 'Patient accounting', 'General accounting', 'Managed care administrative', 'Information technology' and 'Housekeeping, maintenance, security'.

Total clinical support staff
Total of 'Registered nurses', 'Licensed practical nurses' and 'Medical assistants, nurse’s aides'.

Total Compensation
State the dollar amount reported as direct compensation on the following forms: W2, 1099, or K1. If using a W2, report Box 5. If using a K1, report the sum of boxes 1 and 4, minus deductions. Contact MGMA with questions.

  Include:
  1. Provider wages (including contracted wages, on-call compensation coming from the reporting practice, and all other salary included in Box 5)
  2. Bonus and/or incentive payments
  3. Research stipends
  4. Honoraria
  5. Distribution of profits

  Do not include:
  1. The dollar value of expense reimbursements;
  2. Fringe benefits paid by the medical practice (such as retirement plan contributions, life and health insurance, automobile allowances); and/or
  3. Any employer contributions to a 401(k), 403(b), or Keogh Plan

*Groups fully or partially acquired by a third party: Do not include stock or equity related compensation. This should be included in "Additional Compensation".

Total contracted support staff (temporary)
• Contracted support staff represents all the staff hired on a contract basis, not employed by any of the legal entities that comprise the medical practice. The utilization of contracted support staff occurs when the medical practice (including all the associated legal entities that comprise the medical practice) decides not to hire support staff as employees to
conduct the ongoing support staff activities described in the “Support Staffing and Cost” section. Instead, the practice contracts to have these full-time and/or ongoing activities conducted by contracted staff.

- A defining characteristic of contracted support staff is that the hours worked (hence the FTE) by the contracted support staff are easily identified and reported. If the hours worked are not easily identified and reported, then the FTE count cannot be accurately reported and the cost for such services should be reported on the appropriate line within the “General operating cost” section. One example of this type of cost would be purchased services for billing and collections activities. When a practice decides to hire a billing company to conduct billing activities that the practice decides not to fulfill with practice employees, it is often not possible to track the hours that the billing company devotes to the given practice. Such cost should be reported as “Billing and collections purchased services”.

**Included:**
1. Temporary staff working for temporary agencies.
2. Traveling nurses.

**Total Delivery Procedures**
For OB/GYN practices only.
Added 'Vaginal', 'Cesarean' and 'VBAC'.

**Total direct expenditures**
The total direct costs dollar amount of all extramural research expenditures for the department under the scope of responsibility for the chief department administrator for current capitalized research activities and projects.

**Total E&M Procedures**
For OB/GYN practices only.
Added 'New patient visits', 'Established patient visits', 'Consults', 'New patient preventative', 'Established patient preventative', and 'Preventative counseling'.

**Total employed support staff**
Add “Total business operations support staff”, “Total front office support staff”, “Total clinical support staff”, and “Total ancillary support staff” answers.

**Total employed support staff benefit cost**
The "Total employed support staff benefit cost" should represent the total benefits for the FTE count of all employed support staff reported in "Total employed support staff" FTE.

**Included:**
1. Employer’s share of Federal Insurance Contributions Act (FICA), payroll and unemployment insurance taxes;
2. Employer’s share of health, disability, life, and workers’ compensation insurance;
3. Employer payments to defined benefit and contribution, 401(k), 403(b), and nonqualified retirement plans;
4. Deferred compensation paid or expensed during the year;
5. Dues and memberships in professional organizations, state, and local license fees;
6. Allowances for education, professional meetings, travel, and automobile; and
7. Entertainment, country/athletic club membership, travel for spouse.

**Not Included:**
1. Voluntary employee salary deductions used as contributions to 401(k) and 403(b) plans; or
2. Expense reimbursements.

Total encounters
An encounter is an instance of direct provider to patient interaction, regardless of setting (including tele-visits and e-visits), between a patient and a healthcare provider who is vested with the primary responsibility of diagnosing, evaluating, and/or treating the patient’s condition, where the provider exercises clinical judgment that may or may not be billable.

Included:
1. Pre- and post-operative visits and other visits associated with a global charge;
2. Visits that resulted in a coded procedure;
3. For diagnostic radiologists and pathologists, report the total number of procedures or reads, regardless of place of service;
4. For obstetrics care, where a single CPT-4 code is used for a global service, count each as a separate ambulatory encounter (e.g., each prenatal visit and postnatal visit is one encounter). Count the delivery as a single encounter; and
5. Encounters that include procedures from the surgery chapter (CPT codes 10021-69979) or anesthesia chapter (CPT codes 00100-01999).

Not included:
1. Encounters attributed to nonphysician providers;
2. Encounters for the physician specialties of pathology or diagnostic radiology (see #3 above under “Include”);
3. Visits where there is not an identifiable contact between a patient and a physician or nonphysician provider (i.e., patient comes into the practice solely for an injection, vein puncture, EKGs, EEGs, etc. administered by an RN or technician);
4. Administration of chemotherapy drugs; or
5. Administration of immunizations.

Total for anesthesiology procedures
For anesthesiology practices only.
Added 'Surgical anesthesia', 'Labor epidurals', 'C-Sections', 'Epidurals', 'Follow-up visits', 'Nerve blocks for post op pain', 'Other acute pain services', 'Critical care services', and 'Other flat fees' for total number of cases, total gross charges and total revenue.

Total front office support staff FTE and Cost
Total the Cost of 'Medical receptionists', 'Medical secretaries, transcribers', 'Medical records' and 'Other administrative support'.

Total FTE physician faculty in organization
The full-time equivalency of all department faculty with an MD or DO degree (or equivalent) and a minimum rank of instructor.

Total full-time equivalent (FTE) support staff
For 'Total business operations support staff', 'Total front office support staff', 'Total clinical support staff', 'Total ancillary support staff', and 'Total support staff'.

Included in FTE:
1. The full-time equivalent (FTE) for all support staff employed by all the legal entities working in support of the medical practice represented on this survey;
2. The FTE for both full-time and part-time support staff. To compute FTE, add the number of full-time (1.0 FTE) support staff to the FTE count for the part-time support staff. A full-time support staff employee works whatever number of hours the practice considers to be the minimum for a normal workweek, which could be
37.5, 40, 50 hours or some other standard. To compute the FTE of a part-time support staff employee, divide the total hours worked in an average week by the number of hours that your practice considered to be a normal workweek. An employee working 30 hours compared to a normal workweek of 40 hours would be 0.75 FTE (30 divided by 40 hours). An employee working full-time for three months during a year would be 0.25 FTE (3 divided by 12 months). A support staff employee cannot be counted as more than 1.0 FTE regardless of the number of hours worked; and

3. The allocated FTE where the practice consists of multiple legal entities. For example, an MSO managing two medical practices and employing one billing clerk who devotes an equal amount of time to each practice would add 0.5 FTE to the total FTE count in “Patient accounting”, FTE column, for each managed practice.

Not Included:

1. The FTE of contracted support staff, which should be reported as “Total contracted support staff”, FTE column.

Included in Cost:

1. Salaries, bonuses, incentive payments, honoraria, and profit distributions;
2. Voluntary employee salary deductions used as contributions to 401(k), 403(b), or Section 125 plans;
3. Compensation paid to the total FTE count reported in the FTE column;
4. Compensation for all support staff employed by all of the legal entities working in support of the medical practice represented on this survey;
5. The allocated support staff cost where the practice consists of multiple legal entities. For example, an MSO managing two medical practices and employing one billing clerk who devotes an equal amount of time to each practice would add 50 percent of the one billing clerk’s compensation to the total cost of “Patient accounting”, Cost column, for each managed practice; and
6. Compensation for both full-time and part-time employed support staff.

Not Included:

1. Nonphysician provider cost, which is reported in the Provider Staffing and Cost section, Cost column;
2. Any benefits for employed support staff, which should be reported as “Total employed support staff benefit cost”, Cost column;
3. Expense reimbursements; and
4. Any benefits or the cost of contracted support staff who do not work for any of the legal entities that comprise the medical practice. These costs should be reported as “Total contracted support staff”, Cost column.

Total full-time-equivalent (FTE) physicians employed by medical practices
For hospital/IDS practices only.
The total number of FTE physicians that were employed by all medical practices owned by the IDS/hospital/MSO.

Total general operating cost
Add “Information technology” through “Cost allocated to medical practice from parent organization.”

Total gross charges
Add “Gross fee-for-service charges” and “Gross charges for patients covered by capitation contracts.”
Total gross charges in ASC
For orthopedic practices only.
The amount of total gross charges generated from the services provided in the ASC.

Total Hysterectomy Procedures
For OB/GYN practices only.
Added 'TAH', 'Laparoscopy, surgical with total hysterectomy', 'Vaginal hysterectomy' and 'LAVH'.

Total Hysteroscopy Procedures
For OB/GYN practices only.
Added 'Hysteroscopy: Diagnostic', 'Hysteroscopy w/ biopsy/polypectomy', 'Hysteroscopy w/ lysis of intrauterine adhesions', 'Hysteroscopy w/ division or resection of intrauterine septum', 'Hysteroscopy w/ removal of leiomyomata', 'Hysteroscopy w/ removal of impacted foreign body', 'Hysteroscopy w/ endometrial ablation', 'Hysteroscopy w/ bilateral fallopian tube cannulation' and 'Unlisted hysteroscopy procedure'.

Total In-Office Procedures
For OB/GYN practices only.
Added 'Urodynamic procedures', 'Destruction of vulvar lesions', 'Colposcopy w/ biopsy and curettage', 'Colposcopy w/ out biopsy or curettage', 'LEEP', 'Endometrial biopsy', 'Ablations' and 'Fetal non-stress test'.

Total Laparoscopy Procedures
For OB/GYN practices only.
Added 'Lap: diagnostic', 'Lap w/ lysis of adhesions', 'Lap w/ total or partial S/O', 'Lap w/ fulguration of endometriosis' and 'Lap w/ BTF'.

Total licensed beds in IDS or hospital
For hospital/IDS practices only.
The number of acute care inpatient beds that the parent IDS or hospital was licensed to maintain for all the hospitals in the system. The number of actual beds in use may have been less than the number of licensed beds.

Total medical revenue
The sum of fee-for-service collections (revenue collected from patients and third-party payers for services provided to fee-for-service, discounted fee-for-service, and non-capitated Medicare/Medicaid patients), capitation payments (gross capitation revenue minus purchased services for capitation payments), and other medical activity revenues. Other medical revenue includes grants, honoraria, research contract revenues, government support payments, and educational subsidies plus the revenue from the sale of medical goods and services.

Total medical revenue
Add “Total net fee-for-service collections/revenue”, “Net capitation revenue”, and “Net other medical revenue.”

Total medical revenue after operating cost
Subtract 'Total operating cost' from 'Total medical revenue'.
Total medical revenue in ASC
For orthopedic practices only.
The amount of total medical revenue generated from the services provided in the ASC.

Total net fee-for-service collections/revenue
The total technical and professional net fee-for-service revenue. If the practice used accrual basis accounting, "Total net fee-for-service collections/revenue" should equal "Gross fee-for-service charges" less "Adjustments to fee-for-service charges", less "Bad debts due to fee-for-service activity."

Total nonphysician providers
To compute "Total nonphysician provider", Cost, add "Nonphysician provider compensation" and "Nonphysician provider benefit cost", Cost. To compute "Total nonphysician providers," FTE, add the number of full-time (1.0 FTE) nonphysician providers to the FTE count for part-time nonphysician providers. A full-time nonphysician provider works whatever number of hours the practice considers to be the minimum for a normal workweek, which could be 37.5, 40, 50 hours, or some other standard. To compute the FTE of a part-time nonphysician provider, divide the total hours worked by the number of hours that your practice considered to be a normal workweek. A nonphysician provider working 30 hours compared to a normal workweek of 40 hours would be 0.75 FTE (30 hours divided by 40 hours). A nonphysician provider working full-time for three months during a year would be 0.25 FTE (3 months divided by 12 months). A nonphysician provider cannot be counted as more than 1.0 FTE regardless of the number of hours worked.

Total nonphysician provider FTE
The number of full-time-equivalent (FTE) in the practice (see full-time equivalent definition on page 6). Nonphysician providers are specially trained and licensed providers who can provide medical care and billable services. Examples of nonphysician providers include audiologists, certified registered nurse anesthetists (CRNAs), dieticians/nutritionists, midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physician assistants, psychologists, and surgeon assistants.
**For academic data, residents are not considered nonphysician providers in MGMA reports.

Total number of hospitals covered that paid a stipend
For anesthesiology practices only.
The total number of hospitals staffed by the practices physicians and nonphysician providers that received a stipend.

Total operating cost
The sum of "Total support staff" and "Total general operating cost".

Total payer mix gross charges

Total physician benefit cost
The total benefits paid to physicians who comprise "Total physicians", FTE.

Included:
1. Employer’s share of Federal Insurance Contributions Act (FICA), payroll, and unemployment insurance taxes;
2. Employer’s share of health, disability, life, and workers’ compensation insurance;
3. Employer payments to defined benefit and contribution, 401(k), 403(b), and nonqualified retirement plans;
4. Deferred compensation paid or expensed during the year;
5. Dues and memberships in professional organizations, state, and local license fees;
6. Allowances for education, professional meetings, travel, and automobile; and
7. Entertainment, country/athletic club membership, and travel for spouse.

**Not Included:**
1. Voluntary employee salary deductions used as contributions to 401(k) and 403(b) plans; or
2. Expense reimbursements.

**Total physician compensation**
The total compensation paid to physicians who comprise “Total physicians”, FTE.

**Included:**
1. Compensation for shareholders/partners, associates on salary, employed physicians, contract physicians, locum tenens, residents, and fellows;
2. Compensation for full-time and part-time physicians;
3. Provider wages reported as direct compensation in Box on a W2, 1099 or K1 (for partnerships);
4. Bonus and/or incentive payments, research stipends, honoraria, distribution of profits;
5. Voluntary employee salary deductions used as contributions to 401(k), 403(b), or Section 125 plans; and
6. Compensation attributable to activities related to revenue in “Nonmedical revenue”.

**Not Included:**
1. Amounts included in “Total physician benefit cost”, Cost column; or
2. Provider consultant cost;
3. Expense reimbursements;
4. Fringe benefits paid by the medical practice (such as retirement plan contributions, life and health insurance, automobile allowances); and/or
5. Any employer contributions to a 401(k), 403(b), or Keogh Plan.

**Total physicians**
For “Total physicians” cost, add “Total physician compensation” and “Total physician benefit cost”, Cost. For “Total physicians” FTE, add “Primary care physicians”, “Nonsurgical specialty physicians”, and “Surgical specialty physicians”, FTE.

**Total procedures and procedural gross charges**
Added 'Medical procedures conducted inside the practice's facility', 'Medical procedures conducted outside the practice's facility', 'Surgery and anesthesia procedures conducted inside the practice's facility', 'Surgery and anesthesia procedures conducted outside the practice’s facility', 'Clinical laboratory and pathology procedures' and 'Diagnostic radiology and imaging procedures' for both Total procedures and Procedural gross charges.

**Total providers**
For “Total providers” cost, add “Total nonphysician providers” and “Total physicians”, Cost. For “Total providers” FTE, add “Total nonphysician providers” and “Total physicians”, FTE.
**Total stipend amount**

For anesthesiology practices only.

Three entities’ stipends. If a participant receives stipends from more than three entities, they provided data the three entities that have been allotted the largest stipends.

- **Net stipend**: the amount of the stipend – any money you must refund the facility under the arrangement. For example, if you receive $1,000,000 for CRNA salaries but have an arrangement whereby any revenue you collect on CRNA services must be turned over to the facility and the amount of that revenue for last year was $400,000, the net stipend you received for CRNA salaries should be listed as $600,000.

- **Entity 1 Amount**: The net stipend amount for the entity with the largest total stipends.

- **Entity 2 Amount**: The net stipend amount for the entity with the second largest total stipends.

- **Entity 3 Amount**: The net stipend amount for the entity with the third largest total stipends.

**Total support staff**

The total support staff full-time-equivalent (FTE) in the practice (see full-time equivalent definition on page 6). This should include business operations staff such as managers or administrators, front office support staff, clinical support staff, ancillary support staff, and contracted support staff. For “Total support staff” FTE, add “Total employed support staff” and “Total contracted support staff”, FTE. For “Total support staff” cost, add “Total employed support staff”, “Total employed support staff benefit cost”, and “Total contracted support staff”, Cost.

**Treatment of professional services**

The treatment of the professional service fees collected while the provider is on-call.

- **Retains fees generated while on-call**: The provider generates his or her own bill and keeps all revenue generated from patient care while providing on-call coverage.

- **Subsidy for uninsured/unassigned patients**: The provider receives a subsidy for providing services to uninsured or unassigned patients for care provided during on-call coverage.

- **Reassigns to hospital**: The provider reassigns the collections to the hospital and then is compensated from the hospital for professional services performed.

**Type of on-call coverage**

- **General ED Call**: The provider must only be available for general emergency department call while providing on-call coverage.

- **Restricted**: A type of on-call coverage in which the provider must be present at the facility throughout the additional block.

- **Unrestricted**: A type of on-call coverage in which the provider must be available to respond to pages as necessary. Also referred to as “beeper only” coverage.

- **Both Restricted/Unrestricted**: A type of on-call coverage in which the provider must be present at the facility for part of the additional block and is available to respond to pages, as necessary, for the other part of his or her coverage.

- **Trauma Call—Level 1**: The provider must only be available for emergency trauma call while providing on-call coverage.

- **Trauma Call—Level 2**: The provider must only be available for emergency trauma call while providing on-call coverage.

- **Trauma Call—Level 3**: The provider must only be available for emergency trauma call while providing on-call coverage.

- **Trauma Call—Level 4**: The provider must only be available for emergency trauma call while providing on-call coverage.
Ultrasound (Sonography)
For OB/GYN practices only.
Technology that uses sound waves to obtain images of organs and tissues in the body.

Ultrasound (Sonography) service provided
For OB/GYN practices only.
Technology that uses sound waves to obtain images of organs and tissues in the body.

Weekend On-Call Compensation
The amount compensated per day for weekend (i.e. Saturday or Sunday) on-call coverage.

Weeks worked per year
The number of weeks the provider was engaged in professional activities in the practice.
  Included:
    1. Clinical and nonclinical time.

  Not included:
    1. Vacation, sick leave, medical or continuing education.

Workers’ compensation
Fee-for-service gross charges, at the practice’s undiscounted rates, for all services provided to patients covered by workers’ compensation insurance.
  Not Included:
    1. Charges for Medicare patients;
    2. Charges for Medicaid patients;
    3. Charges for charity or professional courtesy patients; or

Work Status
- Full-Time
  o 0.75 – 1.0 FTE and >75% billable clinical
- Part-Time
  o 0.35 – 0.75 FTE and > 75% billable clinical
- Partially Clinical
  o 0.75 – 1.0 FTE and 35% - 75% billable clinical

Years in position
Report the total years of experience in the individual's current reported position.

Years in specialty
Number of years the physician or nonphysician provider has practiced in the specialty reported. The count of the number of years begins at the time the physician completes the latter of the residency or fellowship.