This document is intended to serve as a guide for completing the MGMA 2017 Provider Compensation and Production Survey. An explanation of each survey question and the provided answer options are included. For additional participation resources, including video tips and tricks, change notices and participation benefits, check out our Survey Participation Resources page (www.mgma.com/participate).

Getting Started:

✓ Find available surveys on data.mgma.org in the participation section.
✓ Fill out your Practice Profile data as completely as possible before continuing on to your provider information for this survey. We need this profile information in order to customize your survey for you. If the Practice Profile is not completed, we will not be able to customize your survey and you may see additional questions that are not relevant to your practice.
✓ The quality of our reported results depends upon the completeness and accuracy of every response. The more you give the more you get. Learn more.
✓ Questions with an asterisk * are required. Questionnaires with required questions left blank may not be eligible for submission.

Guide Contents:

- Practice Profile
- Practice Demographics
- Provider Demographics
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- Provider Compensation
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- Provider Production
- Additional Questions for Placements
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Practice Profile

Complete this section in order to move on to the Provider Compensation, Management and Staff, Cost and Revenue, and Practice Operations surveys.

*Practice Name
Add all practices you intend to submit data for by clicking the “Add Practice” button at the top of the grid. Enter the practice name(s), one per row, under the Practice Name header.

Practice Address
Enter the street address of the organization for which the data is being reported.
Practice City
Enter the city of the organization for which the data is being reported.

Practice State
Enter the state of the organization for which the data is being reported.

Practice Zip
Enter the zip code of the organization for which the data is being reported.

*What type of organization do you work for?*
Select your work organization type from the list provided. If the type of work organization you work for isn't listed, please select “Other” and type the name in the other text box.

- **Medical Group Practice**: Physicians working in associations with the joint use of equipment and technical personnel and with centralized administration and financial organization.
- **Hospital**: A hospital is an inpatient facility that admits patients for overnight stays, incurs nursing care costs, and generates bed-day revenues.
- **Integrated Health System (IHS) 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.
- **Independent Practice Association (IPA)**: An independent practice association (IPA) is an association of independent physicians, or other organizations that contract with independent physicians, and provides services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service basis.
- **Health Maintenance Organization (HMO)**: 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.
- **Freestanding Ambulatory Surgery Center (ASC)**: 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. A freestanding ambulatory surgery center does not employ physicians and should not complete the survey. ASCs ARE NOT ELIGIBLE TO PARTICIPATE. Please contact MGMA Data Solutions for information on the ASC Survey.
- **Physician Hospital Organization (PHO):** Physician hospital organizations (PHOs) are group practice arrangements where hospitals and physicians organize for contracting with managed care organizations. These relationships are formal, contractual, or corporate in nature and include physicians outside the hospital's medical staff.

- **Medical School Administration (University Level):** A medical school administration (University Level) is a centralized administrative department which provides administrative services to multiple areas and departments within the University whole.

- **Medical School Faculty Practice Plan:** A medical school faculty practice plan is an organized group of physicians and other health care professionals that treat patients referred to an academic medical center.

- **Medical School Clinical Science Department (Department Level):** A medical school clinical science department (department level) is a graduate school department within a University that offers study leading to a medical degree.

- **Medical School (School of Medicine Level):** A medical school (school of medicine level) is a graduate school of medicine within a University that offers study leading to a medical degree.

- **University Hospital:** A university hospital (or teaching hospital) is a hospital that provides clinical education and training to future and current doctors, nurses, and other health professionals, in addition to delivering medical care to patients. They are generally affiliated with medical schools or universities, and may be owned by a university or may form part of a wider regional or national health system.

- **Consulting Firm:** A consulting firm is a person or group of persons who provide professional advice to an organization for a fee.

- **Recruitment Services Firm:** A recruitment services firm is a person or group of persons who provide recruitment services to an organization for a fee.

- **Other:** Describe the type of entity in the "other work organization" box.

*Report Recipient Email*

- Enter the email address for the report recipient. The email address must be associated with an MGMA account in order to grant access to the results in MGMA DataDive.

*Who is your practice’s majority owner? (Recruiting firms do not need to answer)*

From the options listed, select the choice that represents the majority owner of your organization. If your organization's ownership is not listed in the options provided, please select "Other" and type the name in the other text box.

- **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:** A hospital is an inpatient facility that admits patients for overnight stays, incurs nursing care costs, and generates bed-day revenues.

- **Integrated Health System (IHS) 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.

- **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.

- **Other:** Describe the type of entity in the “Other” box.

*What was your practice’s practice or specialty type? (Recruiting firms do not need to answer)*
Select the name of the practice type or single specialty that most closely describes your practice. If your single specialty is not listed, select "Other Single Specialty" and enter your specialty in the "Other" text box.

**Practice is affiliated with Accountable Care Organization (Recruiting firms do not need to answer)**
(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.

**Practice is Patient Centered Medical Home (Recruiting firms do not need to answer)**
(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.

*Do you plan to submit data specific to your practice’s medical directorships? (Recruiting firms do not need to answer)*
Answer "Yes" if your practice had at least one medical directorship for the full 2016 fiscal year and you wish to answer specific directorship questions for those medical directorships. By answering those additional questions, you will receive access to the Medical Directorship Compensation results in DataDive. Answer "No" if your practice did not have any medical directorships, your medical directorships were not for the full 2016 fiscal year, or you do not wish to submit data for those medical directorships.
*Do you plan to submit data specific to your providers that take call? (Recruiting firms do not need to answer)
Answer "Yes" if your practice had at least one provider who provided on-call services, paid or unpaid and you wish to answer specific on-call questions for those providers. By answering those additional questions, you will receive access to the On-Call Compensation results in DataDive. Answer "No" if none of your providers worked on-call or you do not wish to submit data for those providers.

*Were any of your providers hired during your 12-month fiscal year? (Recruiting firms do not need to answer)
Answer "Yes" if your practice placed any new providers in the 2016 fiscal year. Answer "No" if your practice did not place any new providers.

MGMA is communicating with various healthcare software vendors in the industry to streamline survey participation. Please identify your systems to help guide us in our communications. (Recruiting firms do not need to answer)

- What is your practice’s EHR system?
- What is your practice’s management system?
- What is your clearinghouse (or “Network Transaction Company”)?
- What is your practice’s payroll system?
- What is your practice’s financial system?

**Practice Demographics**

*Practice NPI
What is your practice NPI number? The National Provider Number (NPI) is a unique, 10-digit identification number assigned to health care providers to submit claims or conduct other transactions specified by the Health Insurance Portability and Accountability Act (HIPAA). A health care provider is defined as an individual, group or organization that provides medical or other health services. If you are unsure of your practice’s NPI number, you can look it up here: https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistrySearch.do?

*For the purpose of reporting the information in this survey, what fiscal year was used? Enter the beginning month, beginning year, end month and end year of your most recently completed fiscal year. Data reported for periods less than 12 months will not be eligible for submission. If your medical practice was involved in a merger or acquisition during the 2016 fiscal period and you cannot assemble 12 months of practice data, you may not be able to participate. Please call Data Solutions at 877.275.6462, ext. 1895, if you are uncertain about your eligibility to participate.

  *Beginning month: Enter the beginning month of your most recently completed fiscal year.
  *Beginning year: Enter the year that your most recently completed fiscal year began.
  *Ending month: Enter the ending month of your most recently completed fiscal year.
  *Ending year: Enter the year that your most recently completed fiscal year ended.

*University Name
Select your University Name from the list provided. If your university is not listed, please select "Other" and type the name in the other text box.

*Medical School Name
Enter the name of the medical school for which the data is being reported.
*Department Name*
Select your Department Name from the list provided. If your department is not listed, please select "Other" and type the name in the other text box.

What is your practice’s 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.
- **Other:** If your practice’s legal organization is not listed, describe in the "Other" text box.

Which demographic classification best describes the area surrounding the primary location of your practice?
If your practice had multiple sites, choose the option that represents the location with the largest number of full time equivalent (FTE) physicians.

- **Rural/Nonmetropolitan (4,999 or fewer):** The community in which the practice is located within a "metropolitan statistical area" (MSA), as defined by the United States Office of Management and Budget, and has a population of 4,999 or fewer.
- **Nonmetropolitan (5,000 to 10,000):** The community in which the practice is located within a "metropolitan statistical area" (MSA), as defined by the United States Office of Management and Budget, and has a population of 5,000 to 10,000.
- **Nonmetropolitan (10,001 to 50,000):** The community in which the practice is located within a "metropolitan statistical area" (MSA), as defined by the United States Office of Management and Budget, and has a population of 10,001 to 50,000.
- **Metropolitan (50,001 to 100,000):** The community in which the practice is located within a "metropolitan statistical area" (MSA) or Census Bureau defined urbanized area with a population of 50,001 to 100,000.
- **Metropolitan (100,001 to 250,000):** The community in which the practice is located within a "metropolitan statistical area" (MSA) or Census Bureau defined urbanized area with a population of 100,001 to 250,000.
- **Metropolitan (250,001 to 500,000):** The community in which the practice is located within a "metropolitan statistical area" (MSA) or Census Bureau defined urbanized area with a population of 250,001 to 500,000.
- **Metropolitan (500,001 to 1,000,000):** The community in which the practice is located within a "metropolitan statistical area" (MSA) or Census Bureau defined urbanized area with a population of 500,001 to 1,000,000.
• **Metropolitan (1,000,001 or more):** The community in which the practice is located within a "metropolitan statistical area" (MSA) or Census Bureau defined urbanized area with a population of 1,000,001 or more.

**Practice is Federally Qualified Health Center**

(FQHC): A reimbursement designation that refers to several health programs funded under Section 330 of the Public Health Service Act of the US 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; and
- 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.

**Practice is Rural Health Clinic**

(RHC): A clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is to improve access to primary care in underserved rural areas. RHCS are required to use a team approach of physicians and nonphysician providers (nurse practitioners, physician assistants, and certified nurse midwives) to provide services. The clinic must be staffed at least 50% of the time with a nonphysician provider. 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.

*Is your program sponsored by a medical school, or is it a nonmedical-school-sponsored program?*

Select "Medical-school-sponsored program" if the program is accredited by the Accreditation Council of Graduate Medical Education (ACGME), is a direct branch of a university medical school, and staffed with university faculty. Select "Nonmedical-school-sponsored program" if the residency/fellowship is an ACGME-accredited program that is not sponsored by a university medical school. If your training program is not ACGME accredited, you may not be able to participate this year. Please call Data Solutions (877.275.6462, ext. 1895) to determine your eligibility to participate.

*Total physician FTE in practice*

Report the practice's full-time-equivalent (FTE) physician count. If an exact number is not known, a best estimate is acceptable.

*Number of FTE physician faculty in organization <Academic Only>*

Report the full-time equivalency of all department faculty with an MD or DO degree (or equivalent) and a minimum rank of instructor.

**Include:**

1. All clinical, research, academic, and administrative activities performed in a department, faculty practice plan, medical school, hospital, or Veterans' Administration (VA) setting. The minimum number of weekly work hours for 1.0 FTE is the number of hours that your department considers to be 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.

**Do not include:**

1. Individuals with a faculty rank of less than instructor or uncompensated (volunteer) faculty. To report the FTE of part-time physician faculty, divide the total hours worked by the physician faculty on behalf of your department by 40 (or the number used by
the department to define a normal workweek). For example, faculty working in a clinic or hospital on behalf of the department for 20 hours compared to a normal work week of 40 hours would be classified as 0.5 FTE. Likewise, faculty working full-time for six months during a 12-month reporting period would be classified as 0.5 FTE. The total number of FTE physician faculty equals the sum of full-time physician faculty and the full-time equivalent of the part-time physician faculty. All other faculty: Report the fulltime equivalency of all department faculty with a degree other than an MD or DO and a minimum rank of instructor, except nonphysician providers.

*Other FTE faculty
Report the full-time equivalency of all other department faculty.

*Total nonphysician provider FTE in practice
Report the number of FTE nonphysician providers in your practice. 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.

*Total support staff FTE in practice
Report the total support staff FTE in your practice. 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.

How did the practice store information for the majority of patients served by your practice?
Choose the method in which the practice stored health/medical records for the majority of patients served by the practice. A fully functional Electronic Health Record (EHR) would include the following four functions:

• Collect patient data;
• Display test results;
• Allow providers to enter medical orders and prescriptions; and
• Aid physicians in making treatment decisions.

How many years has your EHR been fully implemented in your organization?
Enter the number of years that an EHR has been fully implemented. If your practice has had more than one EHR, enter the number since the first EHR was fully implemented.

*What was the total medical revenue for your practice or department?
• Total medical revenue is 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.

*What was the total patient care revenue for your department?
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.

What is your Accountable Care Organization (ACO) affiliation?
**ACO PRACTICES ONLY**
Indicate your accountable care organization affiliation by selecting from the options listed:

• **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**

How is your PCMH accredited/recognized? (Select all that apply)
**PCMH PRACTICES ONLY**

• **Accreditation Association of Ambulatory Health Care (AAAHC):** A private, not-for-profit organization formed in 1979 to assist ambulatory health care organizations in improving the quality of care provided to patients. They establish, review, and revise standards; measure performance; and provide consultation and education.

• **Bridges of Excellence:** A program that measures the quality of care delivered in provider practices. They emphasize managing patients with chronic conditions who are most at risk of incurring potentially avoidable complications.

• **The Joint Commission (JC):** An independent, not-for-profit organization, which accredits and certifies thousands of health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards.

• **National Committee for Quality Assurance (NCQA):** A private, 501(c) (3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

• **Utilization Review Accreditation Commission (URAC):** An independent, not-for-profit organization, which is a well-known leader in promoting health care quality through its accreditation, education, and measurement programs. URAC offers a wide range of quality benchmarking programs and services that model the rapid changes in the health care system and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry.

• **Not formally accredited**
Provider Demographics

Include all providers employed by the group for the full fiscal year indicated in the Practice Demographics section, as well as any new hires during the same fiscal year. Do not include providers that left the practice during the fiscal year, or providers that did not work at all during the fiscal year. Enter each provider on a separate row; do not group multiple providers together on the same line.

*Provider Name
Enter a unique name, ID, or tracking code for each provider. This may be the provider’s actual name, initials, NPI, last four numbers of SSN, or an internal code used to identify the provider. If we have questions on your submission, we will refer to your providers by the name entered here.

*NPI
Indicate the provider’s National Provider ID (NPI), which is 10 digits in length. If you do not know your provider’s NPI number, you can find it on the following link: https://npiregistry.cms.hhs.gov/

*** Choose either a physician specialty OR a nonphysician provider specialty for each provider entered. Do not enter a value for both columns on the same row ***

*Physician Specialty
Select only one specialty for each physician using the specialties listed in the dropdown provided. A physician should be classified in the specialty or subspecialty where he or she spends 50 percent or more time. If you select "Other specialty", type the specialty in the "Other" box provided.
- **NOTE:** If the appropriate subspecialty is not available in the drop down list, please select the main specialty or “Other Specialty” and type the subspecialty in the "Other Physician Specialty" column.

*Nonphysician Provider Specialty
Select only one specialty for each nonphysician provider using the specialties listed in the dropdown provided. A nonphysician provider should be classified in the specialty or subspecialty where he or she spends 50 percent or more time. If you select "Other specialty" write the specialty in the "Other" box provided.
- **NOTE:** If the appropriate subspecialty is not available in the drop down list, please select the main specialty or “Other Specialty” and write-in the subspecialty in the "Other NPP Specialty" column.

*Provider Rank
Select the appropriate provider status from the dropdown. Options include: Non-Academic Provider, NonFaculty Academic Provider, Instructor, Assistant Professor, Associate Professor, Professor, Division Chair/Chief, or Department Chair.

Provider Gender
Report gender for which each individual provider identifies as by choosing “Male” or “Female” from the dropdown provided or by selecting “Prefer not to Answer” if you do not wish to provide this information.

*Provider is a Placement/New Hire
Answer “yes” if the provider was hired by the practice during the 2016 fiscal year. Answer “no” if the provider was employed for the full 2016 fiscal year. If the provider was hired during the 2016 fiscal year, but is not expected to begin work until the 2017 fiscal year, do not enter this provider on this survey.
*Type of On-Call Coverage Provided*
Select the type of call that most closely describes that which was provided by the provider.

- **No call provided**
- **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.
- **General ED Call**: The provider must only be available for general emergency department call while providing on-call coverage.
- **Other Call**: The provider must provide a type of coverage other than those listed above, please describe.

*Provider had Medical Directorship Duties*
Answer "yes" if the provider had medical directorship duties.

*Type of Compensation Tax Form*
Select the form (W2, K1, 1099) you use to report employee wages.

*Years in Specialty*
Report the number of years each physician and nonphysician provider has practiced in the specialty reported. The count of the number of years should begin at the time the physician completes the latter of the residency or fellowship.

**FTE Demographics**

*Full-Time Equivalent*
Report the full-time equivalent this physician is considered to be employed by your 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). Do not report a physician as more than 1.0 FTE regardless of the number of hours worked.

*% Billable Clinical*
Report in whole numbers the billable clinical percent for each provider listed. 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, Teaching, Research and Other must equal 100%.

*% Administrative
Report in whole numbers the administrative percent for each provider listed. 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
Report 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
Report 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
Report in whole numbers the other percent for each provider listed. 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.

Actual Hours Worked per Week
Report the average number of hours the provider worked per week.

Actual Hours Worked per Year
Report the actual number of hours each physician worked over the fiscal year.

Vacation (in Weeks)
Report the amount of weeks that the provider was given for vacation.

Do not include:
1. Any paid time off for continuing medical education (CME) for their first year of placement.

CME: Educational activities that serve to maintain, develop or increase the knowledge, skills and professional performance and relationships a physician uses to provide services for patients, the public or the profession. The content of CME is the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine and the provision of health care to the public.
Provider Compensation

*Base Compensation*

Report the amount paid as routine or regular compensation, regardless of the provider's funding sources or productivity. This amount is guaranteed by the hospital, practice, medical school, practice plan, or Veterans Administration to the provider.

Do not include:

1. 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.
Total Compensation

Please read all instructions first to find what scenario fits your medical group. There are separate instructions for how to report total compensation depending on your medical group’s tax status.

For C corporations (under United States federal income tax law, this refers to any corporation that is taxed separately from its owners), state the dollar amount reported as direct compensation in Box 5 (Medicare wages and tips) from the provider’s W-2.

**Include:**
1. Total Medicare wages - this includes On-Call compensation
2. On-Call compensation – included in total Medicare wages
3. 401K;
4. Life insurance;
5. Any other pre-taxed deductions (Employee contributions).

**Do not include:**
1. Expense reimbursements;
2. Fringe benefits paid by the medical practice
3. Flex spending accounts (FSA);
4. Health insurance;
5. Employer contributions.

An example has been provided:

<table>
<thead>
<tr>
<th>Employee’s social security number</th>
<th>OWE No. 1545-0008</th>
</tr>
</thead>
<tbody>
<tr>
<td>b Employer identification number (EIN)</td>
<td>1 Wages, tips, other compensation</td>
</tr>
<tr>
<td>c Employer’s name, address, and ZIP code</td>
<td>3 Social security wages</td>
</tr>
<tr>
<td>d Control number</td>
<td>5 Medicare wages and tips</td>
</tr>
<tr>
<td>e Employee’s first name and initial Last name</td>
<td>7 Social security tips</td>
</tr>
<tr>
<td>f Employee’s address and ZIP code</td>
<td>9</td>
</tr>
<tr>
<td>g Employer’s state ID number</td>
<td>10 Dependent care benefits</td>
</tr>
<tr>
<td>h State wages, tips, etc.</td>
<td>12 Social security tax withheld</td>
</tr>
<tr>
<td>i State income tax</td>
<td>13 Nonqualified plan</td>
</tr>
<tr>
<td>j Local wages, tips, etc.</td>
<td>14 Other</td>
</tr>
<tr>
<td>k Local income tax</td>
<td>15a</td>
</tr>
<tr>
<td>l Less than or equal to 15b</td>
<td></td>
</tr>
<tr>
<td>m Larger than 15b, 15c, 15d</td>
<td></td>
</tr>
</tbody>
</table>

Form W-2 Wage and Tax Statement 2016

Department of the Treasury—Internal Revenue Service
**Total Compensation (CONT.)**

For partnerships (or LLCs that file as a partnership) state the dollar amount reported as direct compensation in Box 1 plus Box 4 minus Box 12 minus Box 13 from the provider's K-1 form 1065. An example has been provided:

**Include:**

1. In box 13:
   a. Codes A through W (this includes 401K)

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**Schedule K-1 (Form 1065)**

Department of the Treasury
Internal Revenue Service

For calendar year 2015, or tax year beginning ________, 20____

**Partner's Share of Income, Deductions, Credits, etc.**

**Part I Information About the Partnership**

<table>
<thead>
<tr>
<th>A</th>
<th>Partnership's employer identification number</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1</td>
<td>What type of entity is this partner?</td>
</tr>
<tr>
<td>I2</td>
<td>If this partner is a retirement plan (IRA/SEP/Keogh/etc.), check here</td>
</tr>
<tr>
<td>J</td>
<td>Partner's share of profit, loss, and capital (see instructions):</td>
</tr>
<tr>
<td></td>
<td>Beginning</td>
</tr>
<tr>
<td></td>
<td>Profit</td>
</tr>
<tr>
<td></td>
<td>Loss</td>
</tr>
<tr>
<td></td>
<td>Capital</td>
</tr>
<tr>
<td>K</td>
<td>Partner's share of liabilities at year end:</td>
</tr>
<tr>
<td></td>
<td>Noncourse</td>
</tr>
<tr>
<td></td>
<td>Qualified noncourse financing</td>
</tr>
<tr>
<td></td>
<td>Recourse</td>
</tr>
<tr>
<td>L</td>
<td>Partner's capital account analysis:</td>
</tr>
<tr>
<td></td>
<td>Beginning capital account</td>
</tr>
<tr>
<td></td>
<td>Capital contributed during the year</td>
</tr>
<tr>
<td></td>
<td>Current year increase (decrease)</td>
</tr>
<tr>
<td></td>
<td>Withdrawals &amp; distributions</td>
</tr>
<tr>
<td></td>
<td>Ending capital account</td>
</tr>
</tbody>
</table>

**Part III Partner's Share of Current Year Income, Deductions, Credits, and Other Items**

| 1 | Ordinary business income (loss) |
| 2 | Net rental real estate income (loss) |
| 3 | Other net rental income (loss) |
| 4 | Guaranteed payments |
| 5 | Interest income |
| 12 | Section 179 deduction |
| 13 | Other deductions |
| 14 | Self-employment earnings (loss) |
| 15 | Credits |
| 16 | Foreign transactions |
| 18 | Distributions |
| 19 | Other information |

*See attached statement for additional information.

For IRS Use Only

- Tax basis
- GAAP
- Section 704(b) book
- Other (explain)

**Did the partner contribute property with a built-in gain or loss?**

- Yes
- No

If "Yes," attach statement (see instructions)
For S corporations (or LLCs that file as an S corporation) state the dollar amount reported as direct compensation in Box 5 (Medicare wages and tips) from the provider’s W-2 **PLUS** Box 1 minus Box 11 minus Box 12 from the provider’s K-1 form 1120S (combine amounts from both forms). An example has been provided:

**Include:**

1. In box 12:
   a. Codes A through S (this includes 401K)
First Year Guaranteed Compensation (For new hires)
Report the first year guaranteed contract dollar amount.

**Do not include:**
1. The dollar value of a signing bonus and other dollar amounts received through a bonus system such as production-based bonuses; or
2. 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.

**Indicate the percentage of each method used for each of your providers:**
Indicate the percentage of each method for the provider’s compensation plan utilized in your practice. Provide the whole-number proportion that each method makes up of the entire plan, ensuring that all percentages add up to 100.

- **Indicate the % of Total Compensation based on Straight/Base Salary:**
  Compensation is a fixed, guaranteed salary.
- **Indicate the % of Total Compensation based on Productivity or Equal Share of Compensation Pool %:**
  Productivity measures volume of physician work RVUs, collections, etc. this also includes 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. The production metric is measured on the individual physician’s output level.
- **Indicate the % of Total Compensation based on Quality and Patient Experience Metrics:**
  Examples of quality measures include, but are not limited to, clinical process/effectiveness, patient safety, care coordination, patient and family engagement, efficient use of healthcare resources, population/public health and patient satisfaction.
- **Indicate the % of Total Compensation based on On-Call Compensation:**
  Compensation based on "on-call" time.
- **Indicate the % of Total Compensation based on Other Compensation Metrics:**
  A compensation plan metric that is not listed here (medical directorship stipend, honoraria, etc.).

*Method by which the Provider is Compensated for On-Call Coverage*
From the options listed, select the period for which the compensation amount was paid for each provider.

- **Hourly Rate:** The provider is paid a defined amount for each hour that is spent providing on-call coverage.
- **Daily Stipend:** The provider is paid a defined amount for each day that is spent providing on-call coverage.
- **Weekly Stipend:** The provider is paid a defined amount for each week that is spent providing on-call coverage.
- **Monthly Stipend:** The provider is paid a defined amount for each month that is spent providing on-call coverage.
- **Annual Stipend:** The provider is paid a defined amount for the entire year for all time spent providing on-call coverage.
- **Per Work RVU:** The provider is paid a defined amount for each work RVU that is generated while providing on-call coverage.
- **Per Procedure:** The provider is paid a defined amount for each procedure that is completed while providing on-call coverage.
- **Other:** If the provider is compensated based on a method other than those listed above, select "Other" and describe the compensation method in the "Other" box.
• **No Additional Compensation**: The provider is not paid additional compensation for providing on-call coverage.

• **Not applicable**: The options provided do not pertain to the provider for type of compensation for on-call coverage.

*Amount Compensated per On-Call Coverage Method*

On-call is the scheduled state of availability to return to duty, work ready, within a specified period of time. List the amount compensated per method per provider. Perform a blend if different rates are paid at the practice, hospitals, or for different days, excluding holiday or weekend pay in the blend. For example, if the provider is compensated $600 at the practice and $700 at the hospital, report $650 as the on-call compensation.

*Number of Hours per On-Call Coverage Method*

Indicate the number of hours spent on call per method (from the "Type of Compensation for On-Call Coverage" question). For example, if the provider is compensated a "Daily Stipend", indicate the number of hours the provider works per day for on-call coverage.

**Holiday On-Call Compensation Amount (per day)**

List the amount compensated per day for holiday on-call coverage, even if the holiday on-call compensation is part of the provider's overall compensation.

**Weekend On-Call Compensation Amount (per day)**

List the amount compensated per day for weekend (i.e. Saturday or Sunday) on-call coverage, even if the weekend on-call compensation is part of the provider's overall compensation.

*Method by which the Medical Director is Compensated:*

• **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.

• **Other Method (please describe)**: A method that is not described by one of the above methods. Please provide a brief description.

• **No Additional Compensation**: The provider is not paid additional compensation for performing medical directorship duties.

• **Not applicable**: The options provided do not pertain to the provider for additional compensation for performing medical directorship duties.
**Directorship Compensation per Method**
State the amount of compensation for the method selected under "Compensation Method".

**Directorship Hours per Week**
Indicate the number of hours the physician works on directorship duties during a normal (typical) workweek.

**Total Annualized Directorship Compensation**
Enter the total compensation for medical directorship duties expected for the fiscal year reported in the Practice Profile. This figure should only be for medical directorship duties and annualized to represent a full 12-month period.

**Additional Provider Information**

**Additional Compensation**
Report all additional compensation contributed to the provider not already reported in the Total Compensation, Retirement Benefits, and Bonus/Incentive Amount questions.

**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, CME amount paid, licenses and dues paid);
3. The employer side of Social Security and Medicare taxes paid on behalf of the provider;
4. Any employer contributions to a 401(k), 403(b), or Keogh Plan;
5. Any additional unreported compensation attributed to practice partner/shareholder status; and/or
6. Any additional compensation received from third parties such as stock ownership.

**Bonus/Incentive Amount**
Report 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".

**Retirement Benefits**
Report all employer contributions to retirement plans including defined benefit and contribution plans, 401(k), 403(b) and Keogh Plans, and any nonqualified funded retirement plan. For defined benefit plans, estimate the employer's contribution made on behalf of each plan participant by multiplying the employer's total contribution by each plan participant's compensation divided by the total compensation of all plan participants.

**Do not include:**
1. Employer contributions to social security mandated by the Federal Insurance Contributions Act (FICA);
2. Voluntary employee contributions that are an allocation of salary to a 401(k), 403(b), or Keogh Plan; or
3. The dollar value of any other fringe benefits paid by the practice, such as life and health insurance or automobile allowances.

**Compensation Includes Revenue from Separate Facility Fee**
Answer "Yes" if the physician received compensation that could be attributed to a separate facility fee. This could include compensation from ownership in an ASC or cath lab, for example.
**Internal or External Directorship**

If you answered yes to “Provider had a medical directorship,” indicate whether the directorship was internal or external by choosing the appropriate option from the dropdown box. If the same federal tax ID is used, the directorship is internal. If a different federal tax ID is used, the directorship is external. For example, if the physician is employed by his medical practice for his medical directorship duties, select "Internal". If the physician is a medical director for an organization other than the one he practices at, select "External".

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**Provider Production**

*External Providers Included in Productivity*

For physicians, state if the productivity measures (collections, charges, encounters, E&M procedures, RVUs, ASA units) include productivity attributed to a nonphysician provider working under a physician's supervision by selecting "Yes" or "No". For nonphysician providers, state whether the productivity measures include productivity attributed to another nonphysician provider by selecting "Yes" or "No".

*Can Nonphysician Provider Bill Under Themselves <NPPs Only>*

For nonphysician providers only, indicate if they can or cannot bill the procedures they perform under themselves, as opposed to under a physician within the practice.

*Total RVUs*

Report total RVUs performed only by the physician/nonphysician provider you are submitting. If total RVUs are reported, respondents must complete the question “External Providers Included in Productivity” and “% of TC Included in Collections and Charges.” If your practice cannot break out RVUs only performed by the individual physician/nonphysician provider you are submitting, report RVUs and answer “Yes” to the question regarding external provider productivity. If you can report RVUs only performed by the individual physician/nonphysician provider you are submitting, answer “No” for the question regarding external provider productivity.

Include:

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.

Do not include:

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 or any other external provider within the physician RVU data;
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**

Report work RVUs performed only by the physician/nonphysician provider you are submitting. If work RVUs are reported, respondents must complete the question “External Providers Included in Productivity.” If your practice cannot break out RVUs only performed by the individual physician/nonphysician provider you are submitting, report RVUs and answer “Yes” to the question regarding external provider productivity. If you can report RVUs only performed by the individual physician/nonphysician provider you are submitting, answer “No” for the question regarding external provider productivity.

**Include:**

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.

**Do not include:**

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

**More information on RVUs**

Report 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 October 2, 2015 Federal Register, pages 68,891-69,360. Addendum D: Relative Value Units (RVUs) and Related Information presents a table of RVUs by CPT code. Your billing system vendor should be able to load these RVUs into your system if you are not yet using RVUs for management analysis. When answering this question, note the following:

- The RVUs published in the October 2, 2015 Federal Register, effective for calendar year 2016, should be used; and
• The total RVUs for a given procedure consist of three components:
  o Physician work RVUs;
  o Practice expense (PE) RVUs; and
  o Malpractice RVUs.

  Thus, total RVUs = physician work RVUs + practice expense RVUs +
  malpractice RVUs.

• For 2015, there were 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. Do not report total
  RVUs that are a function of “facility” practice expense RVUs. If you are a hospital
  affiliated medical practice that utilizes a split billing fee schedule, you should report
  your total RVUs as if you were a medical practice not affiliated with a hospital.

• To summarize, there are two different types of total RVUs:
  1. Fully implemented nonfacility total RVUs; and
  2. Fully implemented facility total RVUs.

• The Federal Register Addendum D presents six columns of RVU data. The column
  labeled “Physician work RVUs” is what you should report as work RVUs. Any
  adjustments to RVU values through periodic adjustments and updates made by CMS
  should be included.

ASA Units <Anesthesiology Specialties Only>
For anesthesiology groups, provide the 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.

Collections for Professional Charges
Report the amount of collections attributed to a physician for all professional services. If collections for
professional charges are reported, respondents must complete the questions “External Providers
Included in Productivity” and “% of TC Included in Collections and Charges.”

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

Do not include:
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. If your practice cannot break this out, report collections and answer "Yes" to the question in this matrix regarding external nonphysician provider productivity. If you can report collections without nonphysician providers, answer "No" for the nonphysician provider question; 4. Infusion-related collections;

5. Facility fees;

6. Supplies; or

7. Revenue associated with the sale of hearing aids, eyeglasses, contact lenses, etc.

**Professional Gross Charges**

Report the total gross patient charges attributed to a physician for all professional services. If professional gross charges are reported, respondents must complete the questions “External Providers Included in Productivity” and “% of TC Included in Collections and Charges.” 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.

**Include:**

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.

**Do not include:**

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. If your practice cannot break this out, report gross charges and answer the appropriate response to the question regarding technical component. If you can report charges without technical component, answer 0% for the technical component question;

3. Charges attributed to nonphysician providers. If your practice cannot break this out, report gross charges and answer “Yes” to the last question in this matrix regarding external nonphysician provider productivity. If you can report collections without nonphysician providers, answer "No" for the nonphysician provider question;

4. Infusion-related charges;

5. Facility fees;

6. Supplies; or

7. Charges associated with the sale of hearing aids, eyeglasses, contact lenses, etc.

**% of TC Included in Collections and Charges**

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 (TC), 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%.”
Provider Panel Size
Answer the panel size, or set of patients cared for by a physician, as 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.

Total Number of Patient Encounters
If encounters are reported, respondents must complete the question regarding NPP included in productivity. 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.

Include:

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 1002169979) or anesthesia chapter (CPT codes 00100-01999).

Do not include:

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 Outpatient E&M Codes
If Outpatient E&M codes are reported, respondents must complete the question regarding NPP included in productivity.

Include:

1. 90791, Psychiatric diagnostic evaluation
2. 90792, Psychiatric diagnostic evaluation with medical services
3. 99201-99205, 99211-99215, office or other outpatient services
4. 99241-99245, office consultations
5. 99281-99288, emergency department services
6. 99304-99310, 99315-99316, 99318, nursing facility services
7. 99324-99328, 99334-99337, domiciliary, rest home or custodial care services
8. 99339-99340, domiciliary, rest home, or home care plan overnight services
9. 99341-99345, 99347-99350, home services
10. 99354-99355, prolonged physician service in the office or outpatient setting
11. 99363-99364, anticoagulant management
12. 99374-99375, 99377-99380, care plan oversight services
13. 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420, 99429, preventive medicine services
14. 99441-99444, non-face-to-face physician services
15. 99450, 99455-99456, special evaluation and management services
16. 99461, normal newborn care in other than hospital or birthing room setting

**Do not include:**
1. 99499, unlisted evaluation and management service
2. Evaluation and management codes attributed to nonphysician providers. If your practice cannot break this out, please answer “Yes” to the question in this matrix regarding external nonphysician provider productivity. If you can report without nonphysician providers, answer “No” to the nonphysician provider question.

**Number of Inpatient E&M Codes**
If inpatient E&M codes are reported, respondents must complete the question regarding NPP included in productivity.

**Include:**
1. 99217-99220, 99223-99236, 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

**Do not include:**
1. 99499, unlisted evaluation and management service
2. Evaluation and management codes attributed to nonphysician providers. If your practice cannot break this out, please answer “Yes” to the question in this matrix regarding external nonphysician provider productivity. If you can report without nonphysician provider productivity, answer “No” to the nonphysician provider question.

**Additional Questions for Newly Placed Providers**

*Which State did the Provider Relocate from?*
If the provider relocated, report the state from which the provider relocated. If the provider was relocated from outside of the United States, please choose “Out of Country” for this question.
*Hired Out of Residency or Fellowship <Physicians Only>*
Select "Yes" if the physician was hired out of residency or fellowship. Select "No" if the physician was not hired out of residency or fellowship.

- **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.

- **Fellow:** 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.

**Amount of Relocation Expenses Paid**
Report the dollar value that the provider received in his or her contract for expenses associated with relocation. If relocation expenses were not offered by the practice, enter $0.

**Production Bonus Amount**
Report the dollar value the provider was offered as a bonus based on his or her production during the first year. If no production bonus was offered by the practice, enter $0.

**Nose Coverage Amount**
Report the dollar value of nose coverage offered to the provider in his or her contract. If nose coverage was not offered by the practice, enter $0.

**Tail Coverage Amount**
Report the dollar value of tail coverage offered to the provider in his or her contract. If tail coverage is not offered by the practice, enter $0.

**Signing Bonus Amount**
Provide the dollar value that the provider received as a signing bonus in his or her contract. If no signing bonus was offered by the practice, enter $0.

**Do not include:**
1. The dollar value of stipends, student loan repayments or relocation expenses.

**Loan Forgiveness Amount**
Select the category that best represents that dollar value that the provider received as loan forgiveness in his or her contract. If tail coverage was not offered by the practice, enter $0.

**First Year CME Paid Time Off (in Weeks)**
Report the amount of weeks that the provider was given for continuing medical education (CME) in his or her first year of placement.

**CME:** Educational activities that serve to maintain, develop or increase the knowledge, skills and professional performance and relationships a physician uses to provide services for patients, the public or the profession. The content of CME is the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine and the provision of health care to the public.

**Amount of CME Paid**
Report the dollar value that the provider received for CME in his or her contract.
What duties do your providers with directorships perform?

Answer yes or no for each provider with a directorship:

- Attend Standing Meetings
- Clinical Patient Complaints
- Peer Review
- Community Relations
- Develop Policies and Procedures
- Documentation and Care Planning
- Emergency Issues
- Employee Education
- Equipment Selection/Maintenance/Planning
- Monitor Quality/Appropriateness of Care
- Physician Behavior and Impairment Issues
- Physician Education
- Physician Relations and/or Representation
- Provide Guidance and Leadership for Performance Guidelines
- Provider of Last Resort/Call Availability
- Recruitment
- Regulation/Licensure/Credentialing
- Research
- Strategic Development
- Technical Oversight
- Other Duties and Responsibilities