MGMA 2020 Monthly Survey Guide

In an effort to help us understand the impact of the COVID pandemic in healthcare operations, and provide more meaningful benchmarks in the future, please consider completing data for each month of the 2020 calendar year.

This document is intended to serve as a guide for completing the MGMA 2020 Monthly Survey. An explanation of each survey question and the provided answer options are included.

Getting Started:

- Only report providers who were employed as of January 1, 2020. If a provider was hired during 2020, please include and indicate as such in the Employment Status question.
- Please complete all questions for each month inputting **BOTH** provider and practice monthly information using the survey tabs to navigate to each.
- Questions with an asterisk * are required. Questionnaires with required questions left blank may not be eligible for submission.
- The survey should be completed for the 2020 calendar year.

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PRACTICE DEMOGRAPHICS

*Practice Name

Enter a unique name, ID, or tracking code for your practice(s), one per row, under the Practice Name header.

*Practice State

Enter the state location of the practice for which the data is being reported.

*Practice Zip

Enter the zip code of the practice for which the data is being reported.

*Who is your practice's majority owner?

Select the choice that represents the majority owner of your practice. If your practice's ownership is not listed in the options provided, please select "Other" and enter the type of entity in the corresponding write-in field.

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 healthcare 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 healthcare 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 healthcare 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.

Telehealth: A telehealth practice uses electronic information and telecommunication technologies to support and deliver long-distance clinical healthcare, patient and professional health-related education, public health, and health administration.

Other: If your majority owner is not listed, select “other” and enter the type of entity in the corresponding write-in field.

*What is your practice’s practice or specialty type?

Select 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 the practice or specialty type in the corresponding write-in field.

PROVIDER DEMOGRAPHICS

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.

*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 more than 50 percent of their time.

NOTE: If the appropriate subspecialty is not available in the drop down list, please select the main specialty or "Other Physician Specialty (please specify)" and type the subspecialty in the "Other Physician Specialty" column.

***** 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 *****

*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 more than 50 percent of their time.

NOTE: If the appropriate subspecialty is not available in the drop down list, please select the main specialty or "Other Specialty (please specify)" and write-in the subspecialty in the "Other NPP Specialty" column.

***** 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 *****

PROVIDER DATA

*Complete the following questions for each month in the 2020 calendar year.

*Employment Status

New hire (hired after January 1, 2020): The provider was hired by the practice during the 2020 calendar year.

Actively employed (hired prior to January 1, 2020): The provider was employed prior to the start of the 2020 calendar year.

Furloughed: The provider was furloughed during the 2020 calendar year. A furlough is a temporary, yet mandatory, leave of absence in which the provider expected to return to work at a future date.

Laid Off: The provider was laid off during the 2020 calendar year. A layoff is termination in the provider's work status in which the provider holds no blame in the termination.

No longer employed (not furloughed or laid off): The provider left the practice for any reason other than furloughed or laid off during the 2020 calendar year.

Re-Hired: The provider left the practice during the 2020 calendar year, likely due to a furlough or temporary layoff, and was re-hired back into the practice.

Temp provider or locum tenens: The provider is temporary or they are hired to fill a spot for a temporary period of time during the 2020 calendar year.

Not Applicable: Select this option if none of the other options are applicable.

*Full-Time Equivalent (FTE)

Report the full-time equivalent this provider is considered to be employed by your practice. A 1.0 FTE 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 FTE of a part-time provider, divide the total hours worked by the provider 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 provider as more than 1.0 FTE regardless of the number of hours worked.

*Monthly Compensation

Report direct compensation plus all voluntary salary reductions. This amount should include salary, bonus and/or incentive payments, research stipends, honoraria, and distribution of profits. However, it should not include the dollar value of expense reimbursements; fringe benefits paid by the medical practice such as retirement plan contributions; life and health insurance; automobile allowances; or any employer contributions to a 401(k), 403(b), or Keogh Plan.

Include:

- Total Medicare wages – this includes on-call compensation;
- On-call compensation – included in total Medicare wages;
- 401K;
- Life insurance; and
- Any other pre-taxed deductions (employee contributions).

Do not include:

- Expense reimbursements;
- Fringe benefits paid by the medical practice;
- Flex spending accounts (FSA);
- Health insurance; or
- Employer contributions.

*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 "Does this provider's productivity include any that is not their own?" 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:

- RVUs for the "physician work RVUs" only, including any adjustments made as a result of modifier usage;
- Work RVUs for all professional medical and surgical services performed by providers;
- Work RVUs for the professional component of laboratory, radiology, medical diagnostic, and surgical procedures;
- 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;
- Work RVUs for procedures for both fee-for-service and capitation patients;
- Work RVUs for all payers, not just Medicare;
- Work RVUs for purchased procedures from external providers on behalf of the practice's fee-for-service patients;
- 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
- All RVUs associated with professional charges, including both medically necessary and cosmetic RVUs.

Do not include:

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

Percent of Work RVUs Conducted Virtually

Report the percent of work RVUs that are conducted virtually. If an exact number is not known, a best estimate is acceptable.

ASA Units (Anesthesiology Only)

For anesthesiology practices, provide the American Society of Anesthesiologists (ASA) units. The ASA units for a given procedure consist of three components:

- Base unit;
- Time in 15-minute increments; and
- Risk factors.

Please note:

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

Virtual Patient Encounters

Report the number of instances of direct provider to patient interactions that occurred in a virtual setting (e.g. tele-visits and e-visits) between a patient 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:

- Pre- and post-operative visits and other visits associated with a global charge;
- Visits that resulted in a coded procedure;
- For diagnostic radiologists and pathologists, total number of procedures or reads are reported, regardless of place of service;
- For obstetrics care, where a single CPT-4 code is used for a global service, each is counted as a separate ambulatory encounter (e.g., each prenatal visit and postnatal visit is one encounter). A delivery is a single encounter; and
- Encounters that include procedures from the surgery chapter (CPT codes 10021-69990) or anesthesia chapter (CPT codes 00100-01999).

Do not include:

- Encounters with direct provider to patient interaction for the specialties of pathology or diagnostic radiology (see #3 above under “Include”);
- Visits where there is not an identifiable contact between a patient and provider (i.e. patient comes into the practice solely for an injection, vein puncture, EKGs, EEGs, etc. administered by an RN or technician);
- Administration of chemotherapy drugs; or
- Administration of immunizations.

Face-to-Face Patient Encounters

Report the number of instances of direct provider to patient interactions that occurred in a face-to-face, in-person setting between a patient 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:

- Pre- and post-operative visits and other visits associated with a global charge;
- Visits that resulted in a coded procedure;
- For diagnostic radiologists and pathologists, total number of procedures or reads are reported, regardless of place of service;
- For obstetrics care, where a single CPT-4 code is used for a global service, each is counted as a separate ambulatory encounter (e.g., each prenatal visit and postnatal visit is one encounter). A delivery is a single encounter; and
- Encounters that include procedures from the surgery chapter (CPT codes 10021-69990) or anesthesia chapter (CPT codes 00100-01999).

Do not include:

- Encounters with direct provider to patient interaction for the specialties of pathology or diagnostic radiology (see #3 above under "Include");
- 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);
- Administration of chemotherapy drugs; or
- Administration of immunizations.

Averages Hours Worked per Week

Report the average number of hours the provider worked per week including hours for taking call.

PRACTICE DATA

Complete the following questions for each month in the 2020 calendar year.

*Practice Collections for Professional Charges

Report the amount of collections attributed for all professional services.

Include:

- Fee-for-service collections;
- Allocated capitation payments;
- Administration of chemotherapy drugs; and
- Administration of immunizations.

Do not include:

- Collections on drug charges, including vaccinations, allergy injections, biologics, and immunizations, as well as chemotherapy and antinauseant drugs if the physician themselves administer;
- The technical component associated with any laboratory, radiology, medical diagnostic or surgical procedure collections.
- Infusion-related collections;
- Facility fees;
- Supplies; or
- Revenue associated with the sale of hearing aids, eyeglasses, contact lenses, etc.

*Practice Professional Gross Charges

Report the total gross patient charges attributed 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.

Include:

- Fee-for-service charges;
- In-house equivalent gross fee-for-service charges for capitated patients;
- Administration of chemotherapy drugs; and
- Administration of immunizations.

Do not include:

- Charges for drugs, including vaccinations, allergy, injections, biologics, and immunizations as well as chemotherapy, and antinauseant drugs;
- The technical component associated with any laboratory, radiology, medical diagnostic or surgical Procedure charges.
- Infusion-related charges;
- Facility fees;
- Supplies; or
- Charges associated with the sale of hearing aids, eyeglasses, contact lenses, etc.

*Total Operating Cost

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

Total support staff cost: The practice's total expense for support staff. The sum of "Total business operations support staff," "Total front office support staff," "Total clinical support staff," and "Total ancillary support staff" categories plus any "Total contracted support staff."

Total general operating cost: The practice's total general operating cost, which should not include support staff or provider expenses. The sum of "Information technology," "Drug supply," "Medical and surgical supply," "Building and occupancy," "Building depreciation," "Furniture and equipment," "Furniture and equipment depreciation," "Administrative supplies and services," "Professional liability insurance premiums," "Other insurance premiums," "Legal fees," "Consulting fees," "Outside professional fees," "Promotion and marketing," "Clinical laboratory," Radiology and imaging," "Other ancillary services," "Billing and collections purchased services," "Management fees paid to an MSO or PPMC," "Miscellaneous operating cost," and "Cost allocated to medical practice from parent organization."

Do not include:

- Physician and nonphysician providers costs, including compensation.

Medical and Surgical Supply Cost

Cost of supplies purchased for general practice use.

Include:

- Cost of medical/surgical supplies and instruments used in providing medical/surgical services; and
- Cost of laundry and linens.

Do not include:

- 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";
- 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
- 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."

NOTE: This expense should also be reflected in "Total Operating Cost".

Total Business Operations Support Staff FTE

The sum of "General administrative," "Patient accounting," "General accounting," "Managed care administrative," "Information technology" and "Housekeeping, maintenance, security."

Include:

- 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;
- A full-time support staff employee works whatever number of hours the practice considers to be the minimum for a normal work week, which could be 37.5, 40, 50 hours or some other standard. 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
- The allocated FTE where the practice consists of multiple legal entities.

Do not include:

- The FTE of contracted support staff.

Total Front Office Support Staff FTE

The sum of "Medical receptionists," "Medical secretaries, transcribers," "Medical records" and "Other administrative support."

Include:

- 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;
- A full-time support staff employee works whatever number of hours the practice considers to be the minimum for a normal work week, which could be 37.5, 40, 50 hours or some other standard. 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
- The allocated FTE where the practice consists of multiple legal entities.

Do not include:

- The FTE of contracted support staff.

Total Clinical Support Staff FTE

The sum of "Registered nurses," "Licensed practical nurses" and "Medical assistants, nurse's aides."

Include:

- 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;
- A full-time support staff employee works whatever number of hours the practice considers to be the minimum for a normal work week, which could be 37.5, 40, 50 hours or some other standard. 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
- The allocated FTE where the practice consists of multiple legal entities.

Do not include:

- The FTE of contracted support staff.

Total Ancillary Support Staff FTE

The sum of “Clinical laboratory,” “Radiology and imaging” and “Other medical support services.”

Include:

- 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;
- A full-time support staff employee works whatever number of hours the practice considers to be the minimum for a normal work week, which could be 37.5, 40, 50 hours or some other standard. 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
- The allocated FTE where the practice consists of multiple legal entities.

Do not include:

- The FTE of contracted support staff.

*Total Support Staff FTE

Report the practice’s full-time-equivalent (FTE) support staff count. The sum of the “Total business operations support staff,” “Total front office support staff,” “Total clinical support staff,” and “Total ancillary support staff” categories plus any “Total contracted support staff.”

*Total Physician FTE

Report the practice's full-time-equivalent (FTE) physician count.

*Total Nonphysician Provider FTE

Report the practices’ full-time-equivalent (FTE) nonphysician provider count. Nonphysician providers are especially 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.