2021 MGMA DataDive Provider Compensation Glossary

Academic Status <PROVIDER PLACEMENT ONLY>

Academic: An organization whose majority owner is a university, or their organization type is a medical school or university hospital.

Non-Academic: An organization whose majority owner is not a university, and their organization type is not a medical school or a university hospital.

Accountable Care Organization (ACO)

PRO REPORT BUILDER ONLY

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.

Amount Paid to Relocate <PROVIDER PLACEMENT ONLY>

The dollar value that the provider received in his or her contract for expenses associated with relocation.

Annualized Compensation — See Compensation

ASA Units

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:

- Survey participants are instructed to adjust ASA units if the provider supervises a CRNA that is not employed by the reporting practice.
- Survey participants are also instructed not to duplicate ASA units for split bills. Instead, units are reported on a per case basis.

Base Compensation — See Compensation

Base Compensation as a Percentage of Total Compensation — See Formulas

Base Salary Plus Incentive

Payment of a guaranteed base salary along with an incentive component that must be earned. The incentive is awarded based on one or more criteria such as individual production, performance, or patient satisfaction.

Bonus/Incentive — See Compensation

Business Corporation — See Legal Organization

Clinical Full Time Equivalent (FTE)

A measure based upon the number of hours worked on clinical activities for each provider. A provider cannot be more than 1.0 FTE but may be less. For example, a physician administrator who is 80 percent clinical and 20 percent administrative would be 0.8 clinical FTE; a physician with a normal workweek of 32 hours (4 days) working in a clinic or hospital for 32 hours would be a 1.0 clinical FTE; a physician with a normal workweek of 50 hours (5 days) working 32 clinical or hospital hours would be a 0.64 clinical FTE (32 divided by 50 hours).

Continuing Medical Education (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 healthcare to the public.

CME Amount Paid <PROVIDER PLACEMENT ONLY>: The dollar value that the provider received for CME in his or her contract.

CME Paid Time Off (in Weeks) <PROVIDER PLACEMENT ONLY>: The number of weeks that the provider was given for continuing medical education (CME) in his or her first year of placement.

Collections 0% TC*

The actual dollars collected that can be attributed to a physician for all professional services.

Included:

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

Not included:

- Collections on drug charges, including vaccinations, allergy injections, and immunizations, as well as chemotherapy and antinauseant drugs;
- The technical component (TC) associated with any laboratory, radiology, medical diagnostic or surgical procedure collections;
- Collections attributed to the advanced practice providers;
- Infusion-related collections;
- Facility fees;
- Supplies; or
- Revenue associated with the sale of hearing aids, eyeglasses, contact lenses, etc.

*Collections 1-10% TC and Collections > 10% TC are in the Pro Report Builder Only. If needing the definition for 0% TC, please refer to the definition for **Technical Component (TC)**.

Collections to ASA Units Ratio – See Formulas

Collections to Total RVUs Ratio — See Formulas

Collections to Work RVUs Ratio — See Formulas

Compensation

Annualized Compensation <MEDICAL DIRECTORSHIP ONLY>: The total compensation for medical directorship duties expected for the fiscal year. This figure is only for medical directorship duties and the hourly, monthly, weekly, etc. rates are annualized to represent a full 12-month period.

Base Compensation <ACADEMIC ONLY>: 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.

Not included:

- Incentive payments, honoraria, bonuses, profit-sharing distributions, expense reimbursements, fringe benefits paid by the medical school or department such as life and health insurance, retirement plan contributions, automobile allowances, or any employer contributions to 401(k), 403(b), or Keogh Plan.

Bonus/Incentive: The total dollar amount for any bonus or incentive payments received by each provider. It is important to understand that any bonus or incentive dollar amounts are NOT included as percentages of overall productivity. The amount listed as a bonus/incentive is included in the "Total Compensation" amount.

Compensation per On-Call Coverage Method <ON-CALL ONLY>: On-call is the scheduled state of availability to return to duty, work ready, within a specified period of time. This is the amount compensated per provider, per the method that the provider made for taking call. 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, $650 is reported as the on-call compensation.

Directorship Compensation per Method <MEDICAL DIRECTORSHIP ONLY>: The amount the provider is compensated per the method for directorship duties.

Guaranteed Compensation <PROVIDER PLACEMENT ONLY>: The first-year guaranteed contract dollar amount.

Not included:

- The dollar value of a signing bonus and other dollar amounts received through a bonus system such as production-based bonuses; or
- 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.

Holiday On-Call Compensation Amount (per day) <ON-CALL ONLY>: 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.

Retirement Benefits: 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.

Not included:

- Employer contributions to social security mandated by the Federal Insurance Contributions Act (FICA);
- Voluntary employee contributions that are an allocation of salary to a 401(k), 403(b), or Keogh Plan; or
- The dollar value of any other fringe benefits paid by the practice, such as life and health insurance or automobile allowances.

Retirement Benefits as a Percent of Total Compensation:

PRO REPORT BUILDER ONLY

All employer contributions to retirement plans including defined benefit and contribution plans, 401(k), 403(b), and Keogh Plans, and any non-qualified funded retirement plan divided by the total compensation amount paid annually.

Not included:

- Employer contributions to social security mandated by the Federal Insurance Contributions Act (FICA);
- Voluntary employee contributions that are an allocation of salary to a 401(k), 403(b), or Keogh Plan; or
- The dollar value of any other fringe benefits paid by the practice, such as life and health insurance or automobile allowances.

Total Compensation: The amount reported as direct compensation on a W2, 1099, or K1 (for partnerships) plus all voluntary salary reductions such as 401(k), 403(b), Section 125 Tax Savings Plan, and Medical Savings Plan. The amount includes salary, bonus and/or incentive payments, research stipends, honoraria, and distribution of profits. However, it does 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.

- For C corporations (under United States federal income tax law, this refers to any corporation that is taxed separately from its owners), the dollar amount reported as direct compensation in Box 5 (Medicare wages and tips) from the provider's W-2.
  - Included:
    - 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).
  - Not included:
    - Expense reimbursements;
    - Fringe benefits paid by the medical practice;
    - Flex spending accounts (FSA);
    - Health insurance or
    - Employer contributions.
- For partnerships (or LLCs that file as a partnership) 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:
  - Included:
    - In box 13: Codes A through W (this includes 401K)
- For S corporations (or LLCs that file as an S corporation) the dollar amount reported as direct compensation in Box 5 (Medicare wages and tips) from the provider's W-2 PLUS Box1 minus Box 11 minus Box 12 from the provider's K-1 form 1120S (combine amounts from both forms).
  - Included:
    - In box 12: Codes A through S (this includes 401K)

2021 MGMA DataDive Provider Compensation Glossary

Compensation Plan

% of Total Compensation Based on On-Call Compensation: Compensation based on "on-call" time.
% 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.
% 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.
% of Total Compensation Based on Straight/Base Salary: Compensation is a fixed, guaranteed salary.
% of Total Compensation Based on Other Compensation Metrics: A compensation plan metric that is not listed here (medical directorship stipend, honoraria, etc.).

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.

Compensation to ASA Units Ratio – See Formulas

Compensation to Collections Ratio — See Formulas

Compensation to Gross Charges Ratio — See Formulas

Compensation to Total RVUs Ratio — See Formulas

Compensation to Work RVUs Ratio — See Formulas

Demographic Classification

Metropolitan Area (50,000 or More): The county in which the practice is located is defined as a metropolitan (metro) county by the Office of Management and Budget (OMB), based on recent Census Bureau data.
Nonmetropolitan Area (49,999 or Fewer): The county in which the practice is located is defined as a nonmetropolitan (nonmetro) county by the Office of Management and Budget (OMB), based on recent Census Bureau data.

Demographic Classification (Expanded)

PRO REPORT BUILDER ONLY

Metro - Counties in metro areas of fewer than 250,000 population: The county in which the practice is located is a Census Bureau defined urbanized area with a population less than 250,000.
Metro - Counties in metro areas of 250,000 to 1 million population: The county in which the practice is located is a Census Bureau defined urbanized area with a population of 250,001 to 1,000,000.
Metro - Counties in metro areas of 1 million population or more: The county in which the practice is located is a Census Bureau defined urbanized area with a population of 1,000,001 or more.
Nonmetro - Completely rural or less than 2,500 urban population: The county in which the practice is located is referred to as "rural." It may or may not be adjacent to a metropolitan area and has a population less than 2,500.
Nonmetro - Urban population of 2,500 to 19,999: The county in which the practice is located is referred to as "rural." It may or may not be adjacent to a metropolitan area and has a population between 2,500 and 19,999.
Nonmetro - Urban population of 20,000 or more: The county in which the practice is located is referred to as "rural." It may or may not be adjacent to a metropolitan area and has a population of 20,000 or more.

Encounters

A documented interaction, regardless of setting (including tele-visits and e-visits), between a patient and healthcare provider(s) for the purpose of providing medical services, assessing illness or injury, and determining the patient's health status. If a patient sees two different providers on the same day for one diagnosis, it is one encounter. If a patient sees two different providers on the same day for two unrelated issues, then it is considered two encounters. Encounters are procedures from the evaluation and management chapter (CPT codes 99201-99499) or the medicine chapter (CPT codes 90281-99607) of the Physicians' Current Procedural Terminology, Fourth Edition, copyrighted by the American Medical Association (AMA).

Included:

- Pre- and post-operative visits and other visits associated with a global charge;
- Visits that resulted in a coded procedure;
- The total number of procedures or reads for **diagnostic radiologists and pathologists**, 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). The delivery is counted as a single encounter; and
- Encounters that include procedures from the surgery chapter (CPT codes 10021-69979) or anesthesia chapter (CPT codes 00100-01999).

Not included:

- Encounters attributed to advanced practice providers.
- Encounters with direct provider to patient interaction for the specialties of pathology or diagnostic radiology (see #3 above under "Included");
- Visits where there is not an identifiable contact between a patient and a physician or advanced practice 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.

Evaluation and Management (E/M) Codes

PRO REPORT BUILDER ONLY

Inpatient Codes

Included:

- 99221-99223, 99231, 99239, hospital inpatient services;
- 99251-99255, inpatient consultations;
- 99291-99292, 99471- 99472, 99468-99469, critical care services;
- 99356-99359, prolonged physician service in the inpatient setting;
- 99360, physician standby services;
- 99366-99368, medical team conference;
- 99460, 99462-99465, newborn care;
- 99466-99467, 99485-99486, pediatric patient transport;
- 99468-99476, inpatient neonatal and pediatric critical care;
- 99477, initial hospital care, neonatal intensive care services;
- 99478-99480, subsequent hospital care, neonatal intensive care services;
- 99487, 99489, 99490, complex chronic care coordination;
- 99495-99496, transitional care management services; and
- 99497-99498, advance care planning.

Not included:

- 99499, unlisted evaluation and management services; or
- Evaluation and management codes attributed to advanced practice providers.

Outpatient Codes

Included:

- 99201-99205, 99211- 99215, office or other outpatient services;
- 99217-99220, 99234-99236, hospital observation services;
- 99241-99245, office consultations;
- 99281-99288, emergency department services;
- 99304-99310, 99315-99316, 99318, nursing facility services;
- 99324-99328, 99334-99337, domiciliary, rest home or custodial care services;
- 99339- 99340, domiciliary, rest home, or home care plan overnight services;

- 99341-99345, 99347-99350, home services;
- 99354-99355, prolonged physician service in the office or outpatient setting;
- 99366-99368, medical team conference;
- 99374-99375, 99377-99380, care plan oversight services;
- 99381-99387, 99391-99397, 99401-99404, 99406-99409, 99411-99412, 99420, 99429, preventive medicine services;
- 99441-99444, non-face-to-face physician services;
- 99446-99449, interprofessional telephone/internet consultations;
- 99450, 99455-99456, special evaluation and management services;
- 99461, normal newborn care in other than hospital or birthing room setting;
- 99483, cognitive assessment and care plan services; and
- 99492-99494, psychiatric collaborative care management services.

Not included:

- 99499, unlisted evaluation and management services; or
- Evaluation and management codes attributed to advanced practice providers.

Faculty Rank <ACADEMIC ONLY>

The highest academic rank held by the faculty physician.

Included:

- Instructor
- Assistant Professor
- Associate Professor
- Professor
- Division Chair/Chief
- Non-Faculty

Not included:

- Itinerary volunteers or commissioned physicians who teach; or
- Fellows

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.

Fiscal Year

The corporate year established by the practice for business purposes. For many practices, this is January through December of the same year. The data reported is representative of the completed fiscal year.

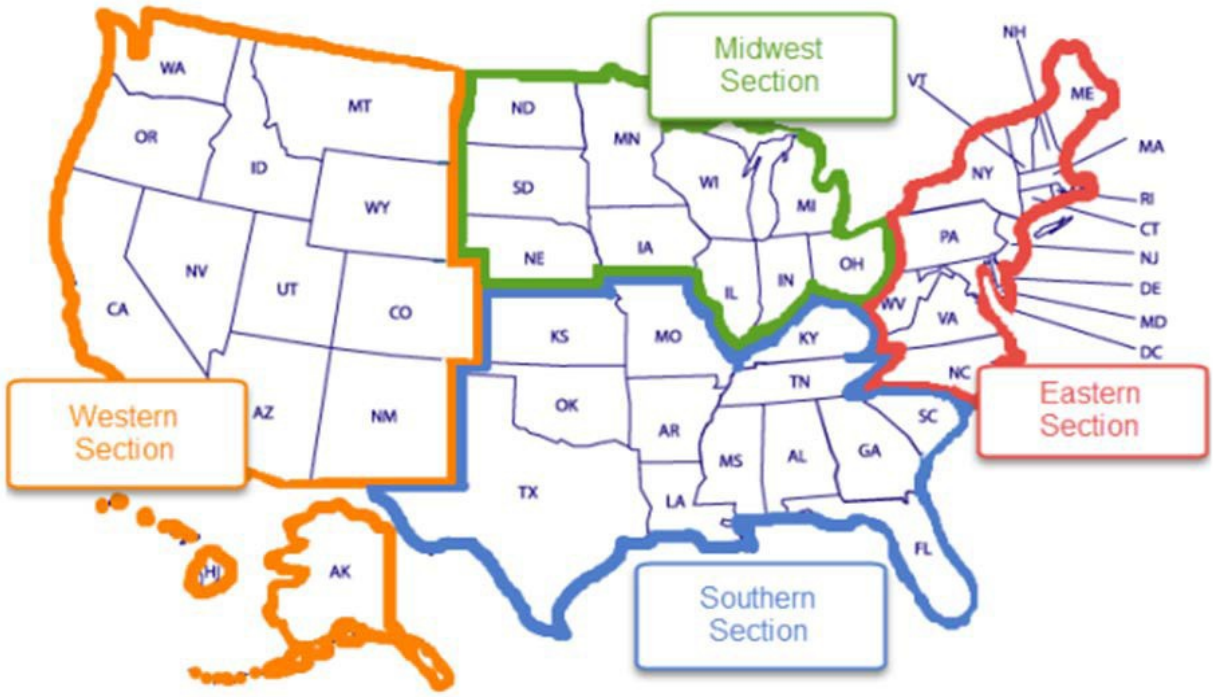
Freestanding Ambulatory Surgery Center

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. **They are not eligible for this report.**

Full Time Equivalent (FTE)

A measure based upon the number of actual hours worked regardless of whether it's spent in clinical or nonclinical activities. A 1.0 FTE provider works the 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. Regardless of the number of hours worked, a provider cannot be counted as more than 1.0 FTE.

Geographic Section



Eastern Section:
Connecticut
Delaware
District of Columbia
Maine
Maryland
Massachusetts
New Hampshire
New Jersey
New York
North Carolina
Pennsylvania
Rhode Island
Vermont
Virginia
West Virginia

Western Section:
Alaska
Arizona
California
Colorado
Hawaii
Idaho
Montana
Nevada
New Mexico
Oregon
Utah
Washington
Wyoming

Midwest Section:
Illinois
Indiana
Iowa
Michigan
Minnesota
Nebraska
North Dakota
Ohio
South Dakota
Wisconsin

Southern Section:
Alabama
Arkansas
Florida
Georgia
Kansas
Kentucky
Louisiana
Mississippi
Missouri
Oklahoma
South Carolina
Tennessee
Texas

Full-Time — See Work Status

Gross Charges 0% TC*

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, and bad debts. For both Medicare participating and nonparticipating providers, gross charges include the practice's full, undiscounted charge and not the Medicare limiting charge.

Included:

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

Not included:

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

***Undiscounted rates:** The full retail prices before Medicare/Medicaid charge restrictions, third-party payer such as commercial insurance and/or managed care organization contractual adjustments, and other charitable, professional courtesy or employee adjustments.

*Gross Charges 1-10% TC and Gross Charges > 10% TC are in the Pro Report Builder Only. If needing the definition for 0% TC, please refer to the definition for **Technical Component (TC)**.

Guaranteed Compensation — See Compensation

Health and Human Services (HHS) Regions

PRO REPORT BUILDER ONLY

HHS Region 1:	HHS Region 2:	HHS Region 3:	HHS Region 4:	HHS Region 5:
Connecticut	New Jersey	Delaware	Alabama	Illinois
Maine	New York	District of Colombia	Florida	Indiana
Massachusetts		Maryland	Georgia	Michigan
New Hampshire		Pennsylvania	Kentucky	Minnesota
Rhode Island		Virginia	Mississippi	Ohio
Vermont		West Virginia	North Carolina	Wisconsin
			South Carolina	
			Tennessee	

HHS Region 6:	HHS Region 7:	HHS Region 8:	HHS Region 9:	HHS Region 10:
Arkansas	Iowa	Colorado	Arizona	Alaska
Louisiana	Kansas	Montana	California	Idaho
New Mexico	Missouri	North Dakota	Hawaii	Oregon
Oklahoma	Nebraska	South Dakota	Nevada	Washington
Texas		Utah		
		Wyoming		

Hired Out of Residency or Fellowship <PROVIDER PLACEMENT ONLY>

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.

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.

Holiday On-Call Compensation Amount (per day) – See Compensation

Hospital/IDS Owned — See Organization Ownership

Hours Per On-Call Coverage Method <ON-CALL ONLY>

The number of hours spent on-call per method.

Hours Worked per Week

PRO REPORT BUILDER ONLY

The actual number of hours the provider worked per week. This includes hours for taking on call because it is reflective of total compensation.

Hours Spent on Directorship per Week <MEDICAL DIRECTORSHIP ONLY>

The number of hours the physician works on directorship duties during a normal (typical) workweek.

Hours Worked per Year

PRO REPORT BUILDER ONLY

The actual number of hours the provider worked over the fiscal year which includes hours for taking on call because it is reflective of total compensation.

Internal or External Directorship <MEDICAL DIRECTORSHIP ONLY>

External Directorship: A directorship is considered external if a different federal tax ID is used for the provider's clinical work and directorship duties. For example, if the physician is employed by a medical director for an organization other than the one he or she practices at, the directorship would be considered "External".

Internal Directorship: A directorship is considered internal if the same federal tax ID is used for the provider's clinical work and directorship duties. For example, if the physician is employed by his medical practice for his medical directorship duties, the directorship would be considered "Internal".

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.

Limited Liability Company — See Legal Organization

Medical Records Storage System

PRO REPORT BUILDER ONLY

The method in which the practice stored health/medical records for the majority of patients served by the practice.

Medical School <ACADEMIC ONLY>

A medical school is an institution that trains physicians and awards medical and osteopathic degrees.

Method for Medical Directorship Compensation <MEDICAL DIRECTORSHIP ONLY>

Annual Stipend: The provider is paid a defined amount for the entire year for all time spent performing medical directorship duties.

Daily Stipend: The provider is paid a defined amount for each day that is 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.

Hourly Rate: The provider is paid a defined amount for each hour 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.
No Additional Compensation: The provider is not paid additional compensation for performing medical directorship duties.
Quarterly Stipend: The provider is paid a defined amount for each quarter 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.

Method for On-Call Coverage Compensation <ON-CALL ONLY>

Annual Stipend: The provider is paid a defined amount for the entire year for all time spent providing on-call coverage.
Daily Stipend: The provider is paid a defined amount for each day that is spent providing on-call coverage.
Hourly Rate: The provider is paid a defined amount for each hour 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.
No Additional Compensation: The provider is not paid additional compensation for providing on-call coverage.
Per Procedure: The provider is paid a defined amount for each procedure that is completed while 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.
Weekly Stipend: The provider is paid a defined amount for each week that is spent providing on-call coverage.

Minor Geographic Region

PRO REPORT BUILDER ONLY

Northeast Region:
Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

North Atlantic:
New Jersey
New York
Pennsylvania

Northwest:
Idaho
Oregon
Washington

Mid Atlantic:
Delaware
District of Columbia
Maryland
Virginia
West Virginia

Southeast:
Alabama
Florida
Georgia
Mississippi
North Carolina
South Carolina
Tennessee

Eastern Midwest:
Illinois
Indiana
Kentucky
Michigan
Ohio

Upper Midwest:
Iowa
Minnesota
Nebraska
North Dakota
South Dakota
Wisconsin

Lower Midwest:
Arkansas
Kansas
Louisiana
Missouri
Oklahoma
Texas

Rocky Mountain:
Arizona
Colorado
Montana
Nevada
New Mexico
Utah
Wyoming

California, Alaska, Hawaii:
Alaska
California
Hawaii

Modifier

A factor that causes an increase or decrease to RVU values such as modifiers 21, 22, 51, and 80 for additional complexity or multiple procedures.

Multispecialty — See Practice Type

Multispecialty with Primary and Specialty Care – See Practice Type (expanded)

Multispecialty with Primary Care only – See Practice Type (expanded)

Multispecialty with Specialty Care only – See Practice Type (expanded)

Advanced Practice Provider(APP)*

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

- APPs are known as advanced practice practitioners (APPs), physician extenders and/or mid-levels.

Note: ***Residents are not considered advanced practice providers in MGMA Datasets.***

Advanced Practice Provider to Physician Ratio

PRO REPORT BUILDER ONLY

The practice's ratio of advanced practice providers to physicians.

- Physicians only
- Fewer than one APP per Physician
- One or more APPs per Physician

Not-for-profit Corporation/Foundation — See Legal Organization

Number of FTE Advanced Practice Providers

PRO REPORT BUILDER ONLY

The practice's full-time-equivalent (FTE) advanced practice provider count. For further detail on FTE or Advanced Practice Providers, see corresponding definitions.

- No advanced practice providers
- 3 or fewer
- 4 to 9
- 10 or more

Number of FTE Advanced Practice Providers (expanded)

PRO REPORT BUILDER ONLY

The practice's full-time-equivalent (FTE) advanced practice provider count. For further detail on FTE or Advanced Practice Providers, see corresponding definitions.

- 3 or fewer
- 4 to 6
- 7 to 10
- 11 to 25
- 26 to 50
- 51 to 75
- 76 to 150
- 151 or more

Number of FTE Physicians

The practice's full-time-equivalent (FTE) physician count. For further detail on FTE, see Full-Time Equivalent above.

- 6 or fewer
- 7 to 10
- 11 to 25
- 26 to 50
- 51 to 75
- 76 to 150
- 151 or more

Number of FTE Physicians (expanded)

PRO REPORT BUILDER ONLY

The practice's full-time-equivalent (FTE) physician count. For further detail on FTE, see Full-Time Equivalent above.

- 3 or fewer
- 4 to 6
- 7 to 10
- 11 to 25
- 26 to 50
- 51 to 75
- 76 to 150
- 151 or more

Number of Total FTE Faculty <ACADEMIC ONLY>

The practice's full-time-equivalent (FTE) faculty count. For further detail on FTE or Providers, see corresponding definitions.

- 10 or fewer
- 11 to 25
- 26 to 50
- 51 to 100
- 101 to 150
- 151 or more

Number of FTE Support Staff

PRO REPORT BUILDER ONLY

The practice's total support staff FTE including business operations staff, front office support staff, clinical support staff, ancillary support staff, and contracted support staff.

- No support staff
- 3 or fewer
- 4 to 9
- 10 or more

Number of FTE Support Staff (expanded)

PRO REPORT BUILDER ONLY

The practice's total support staff FTE including business operations staff, front office support staff, clinical support staff, ancillary support staff, and contracted support staff.

- 3 or fewer
- 4 to 6
- 7 to 10
- 11 to 25
- 26 to 50
- 51 to 75
- 76 to 150
- 151 to 250
- 251 to 500
- 501 or more

On-Call Compensation Method <ON-CALL ONLY>

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

Organization Ownership

Hospital/IDS Owned:

- **Hospital:** A hospital is an inpatient facility that admits patients for overnight stays, incurs nursing care costs, and generates bed-day revenues.
- **Integrated Health System or Integrated Delivery System (IDS):** 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 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):** Publicly held or entrepreneurial directed enterprises that acquire total or partial ownership interests in physician organizations. PPMCs are a type of MSO, however their motivations, goals, strategies, and structures arising from their unequivocal ownership character – development of growth and profits for their investors, not for participating providers – differentiate them from other MSO models.

Physician Owned:

- **Advanced Practice Providers:** Any advanced practice provider (e.g. nurse practitioners, physical therapists, etc.) duly licensed and qualified under the law of jurisdiction in which treatment is received.
- **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.

Other Majority Owner:

- **Insurance Company or Health Maintenance Organization (HMO):** 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. An organization that indemnifies an insured party against a specified loss in report for premiums and paid as stipulated by a contract.
- **Government:** A governmental organization at the federal, state, or local level. Government funding is not enough 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 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.
- **University or Medical School:** 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.

Other Majority Owner — See Organization Ownership

Paid Time Off (PTO) Offered (in Hours)

PRO REPORT BUILDER ONLY

The amount of paid time off allocated to each FTE provider per year. This will only reflect practices that combine vacation and sick time.

Included:

- Vacation days;
- Sick leave; and
- Personal days.

Not included:

- Holidays;
- Short-term or long-term disability leave;
- Workers' compensation leave;
- Family and medical leave;
- Sabbatical leave; or
- Community service leave.

Partnership — See Legal Organization

Part-Time — See Work Status

Partially Clinical — See Work Status

Patient Care Revenue <ACADEMIC ONLY>

PRO REPORT BUILDER ONLY

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/sub-capitation) revenue and net other patient care/medical services revenue equals total patient care revenue.

Net Prepaid (Capitation/Sub-Capitation) Revenue: A sum of 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: A sum of 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.

Total FFS Revenue: A sum of 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.

Patient Centered Medical Home (PCMH)

PRO REPORT BUILDER

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.

Physician Owned — See Organization Ownership

Physician Work Hours Allocation <Additional Data Table>

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

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

% Billable Clinical: Those activities performed by the physician in which patients are seen in the office, outpatient clinic, emergency room, nursing home, operating room, or labor and delivery; any time spent on hospital rounds, telephone conversations with patients, consultations with providers, interpretation of diagnostic tests, and chart review. This should also include "on-call" hours if the provider is required to be present in the medical facility, such as a medical clinic or hospital. 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.

% Research: Measures used by the department to track productivity of research efforts. The 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."

Included:

- Research activities including specific research, training, and other projects that are separately budgeted and accounted for by the medical school; and
- Clinical research funded or nonfunded.

% Teaching: Measures used by the department to track effectiveness and/or productivity of teaching efforts. 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."

Included:

- Academic activities including teaching, tutoring, lecturing, and supervision of laboratory course work and residents where patient care is not provided; and
- Nonclinical classroom time.

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

Practice Type

Multispecialty: A medical practice that consists of physicians practicing in different specialties.
Single Specialty: A medical practice that focuses its clinical work in one specialty. The determining factor for classifying the type of specialty is the focus of clinical work and not necessarily the specialties of the physicians in the practice.

Practice Type (Expanded)

PRO REPORT BUILDER ONLY

Multispecialty: A medical practice that consists of physicians practicing in different specialties.

- **Multispecialty with Primary and Specialty Care:** Medical practices that consist of physicians practicing in different
- specialties, including at least one primary care specialty listed below:
  - Family Medicine: General
  - Family Medicine: Sports Medicine
  - Family Medicine: Urgent Care
  - Family Medicine: With Obstetrics
  - Family Medicine: Without Obstetrics
  - Geriatrics
  - Internal Medicine: General
  - Pediatrics: Adolescent Medicine
  - Pediatrics: General
  - Pediatrics: Sports Medicine
  - Urgent Care
- **Multispecialty with Primary Care Only:** A medical practice that consists of physicians practicing in more than one of the
- primary care specialties listed above or one of the specialties below:
  - Obstetrics/gynecology
  - Gynecology (only)
  - Obstetrics (only)
- **Multispecialty with Specialty Care Only:** A medical practice that consists of physicians practicing in different specialties, none of which are the primary care specialties listed above.

Single Specialty: A medical practice that focuses its clinical work in one specialty. The determining factor for classifying the type of specialty is the focus of clinical work and not necessarily the specialties of the physicians in the practice.

Professional Corporation/Association — See Legal Organization

Provider FTE Category

The provider's full-time-equivalent (FTE) category. For further detail on FTE, see Full-Time Equivalent above.

- 0.30 to 0.40
- 0.40 to 0.50
- 0.50 to 0.55
- 0.55 to 0.60
- 0.60 to 0.65
- 0.65 to 0.70
- 0.70 to 0.75
- 0.75 to 0.80
- 0.80 to 0.85
- 0.85 to 0.90
- 0.90 to 0.95
- 0.95 to 1.00

Relative Value Units (RVUs)

The relative value units (RVUs), as measured by the Resource Based Relative Value Scale (RBRVS), not weighted by a conversion factor, attributed to all professional services. An RVU is a nonmonetary standard unit of measure that indicates the value of services provided by physicians, advanced practice providers, and other health care professionals. The RVU system is explained in detail in the Federal Register. The Physician Fee Schedule Relative Value Files present tables of RVUs by CPT code. Please note the following:

- The RVUs published in the Federal Register, effective for the most recent calendar year, are used; and
- The total RVUs for a given procedure consist of three components:
  - Physician work RVUs;
  - Practice expense (PE) RVUs; and
  - Malpractice RVUs.

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

"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.

"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. Participants reported total RVUs that are a function of "nonfacility" practice expense RVUs.

Not reported:

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

Total RVUs

The total RVUs reported in the dataset will only reflect those performed by the physician or advanced practice provider in the practice.

Included:

- RVUs for the "physician work RVUs," "practice expense," and "malpractice RVUs," including any adjustments made because of modifier usage;
- RVUs for all professional medical and surgical services performed by physicians, advanced practice providers, and other physician extenders such as nurses and medical assistants;
- RVUs for the professional component of laboratory, radiology, medical diagnostic and surgical procedures;
- RVUs for procedures for both fee-for-service and capitation patients; and
- RVUs for all payers, not just Medicare.

Not included:

- RVUs for other scales such as McGraw-Hill, California;
- The technical component (TC) associated with any medical diagnostic, laboratory, radiology, or surgical procedure.
- RVUs attributed to advanced practice providers or any other external provider within the physician RVU data; or
- 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

The work RVUs reported in the dataset will only reflect those performed by the physician or advanced practice provider in the practice.

Included:

- RVUs for the "physician work RVUs" only, including any adjustments made because of modifier usage;
- Physician work RVUs for all professional medical and surgical services performed by providers;
- Physician work RVUs for the professional component of laboratory, radiology, medical diagnostic, and surgical procedures;
- 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;
- Physician work RVUs for procedures for both fee-for-service and capitation patients;

- Physician work RVUs for all payers, not just Medicare;
- Physician 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.

Not included:

- RVUs for "malpractice RVUs" or "practice expense RVUs";
- RVUs attributed to advanced practice 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. The departments reported ASA units.

Retirement Benefits — See Compensation

Retirement Benefits as a Percent of Total Compensation — See Compensation

Signing Bonus Amount <PROVIDER PLACEMENT ONLY>

The dollar value that the provider received as a signing bonus in his or her contract.

Not included:

- The dollar value of stipends, student loan repayments or relocation expenses.

Single Specialty — See Practice Type

Sole Proprietorship — See Legal Organization

Standardized (Benchmarks Standardized To 100% Billable Clinical Activity) <ACADEMIC ONLY>

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

Standardized Productivity — See Formulas

Technical Component (TC)

Modifier-TC, when attached to an appropriate CPT code, represents the technical component of the procedure and includes the cost of equipment and supplies to perform that procedure. This modifier corresponds to the equipment/facility part of a given procedure.

- Collections for professional charges and gross charges for laboratory, radiology, medical diagnostic and surgical procedures may have two components: the physician's professional charge such as interpretation and the technical charge for the operation and use of the equipment. If collections for professional charges and gross charges did not include the technical component (TC), referred to as professional services only billing, that would be considered "0% TC." If collections for professional charges and gross charges did include the technical component, referred to as global fee billing, we provide approximate percentage of charges represented by the technical component, which will be either "1-10%" or "greater than 10%."

Telehealth services

PRO REPORT BUILDER ONLY

Whether or not a practice offered telehealth services to their patients.

Total Compensation — See Compensation

Total Medical Revenue

The sum of fee-for-service collections (revenue collected from patients and third-party payers for services provided to fee-for service, discounted fee-for-service, and non-capitated Medicare/Medicaid patients), capitation payments (gross capitation revenue minus purchased services for capitation payments), and other medical activity revenues.

Net Prepaid (Capitation/Sub-Capitation) Revenue: Includes 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: Includes 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.

Other Medical Revenue: includes grants, honoraria, research contract revenues, government support payments, and educational subsidies plus the revenue from the sale of medical goods and services.

Total Department Revenue: 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/sub-capitation) revenue and net other patient care/medical services revenue equals total patient care revenue.

Total FFS Revenue: Includes 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.

Total RVUs — See Relative Value Units (RVUs)

Type of Compensation Tax Form

The form (W2, K1, 1099) used to report employee wages.

Type of On-Call Coverage Provided <ON-CALL ONLY>

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.

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

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

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.

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.

Other Call: Coverage outside of those listed above

Vacation Offered (in Hours)

PRO REPORT BUILDER ONLY

The number of hours per year the provider was given for vacation. This will only reflect practices that separate out vacation and sick time.

Not included:

- Any paid time off for continuing medical education (CME).

Work RVUs — See Relative Value Units (RVUs)

Work RVUs to Total Encounters Ratio — See Formulas

Work Status

PRO REPORT BUILDER ONLY

- Full-Time 0.75 – 1.0 FTE and ≥ 75% billable clinical
- Part-Time 0.35 – 0.75 FTE and ≥ 75% billableclinical
- Partially Clinical 0.75 – 1.0 FTE and 35% - 75% billableclinical

Years in Specialty

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

Formulas

Full-Time Provider:
0.75 – 1.0 FTE

Part-Time Provider:
0.35 – 0.75 FTE

Compensation to ASA Units Ratio

$$\frac{\text{Total Compensation}}{\text{ASA Units}}$$

Collections to ASA Units Ratio

$$\frac{\text{Collections}}{\text{ASA Units}}$$

Standardized Provider:
0.40 – 1.0 clinical FTE

Base Compensation as a Percentage of Total Compensation:

$$\frac{\text{Base Compensation} \times 100}{\text{Total Compensation}}$$

Compensation to Collections Ratio:

$$\frac{\text{Total Compensation}}{\text{Collections}}$$

Compensation to Gross Charges Ratio:

$$\frac{\text{Total Compensation}}{\text{Gross Charges}}$$

Collections to Total RVUs Ratio:

$$\frac{\text{Collections}}{\text{Total RVUs}}$$

Collections to Work RVUs Ratio:

$$\frac{\text{Collections}}{\text{Work RVUs}}$$

Compensation to Total RVUs Ratio:

$$\frac{\text{Total Compensation}}{\text{Total RVUs}}$$

Compensation to Work RVUs Ratio:

$$\frac{\text{Total Compensation}}{\text{Work RVUs}}$$

Work RVUs to Total Encounters Ratio:

$$\frac{\text{Work RVUs}}{\text{Total Encounters}}$$

Standardized Productivity:

$$\frac{\text{Productivity Measure} \times 100}{\text{Percentage of Billable Clinical Activity}}$$

Note: ***All formulas that generate a ratio are from providers that submitted data for both benchmarks.***