2021 MGMA DataDive Cost and Revenue Glossary

The Cost and Revenue glossary is organized by the "Benchmark category" found in "Step 1: Choose a specialty and benchmark category" of MGMA DataDive Cost and Revenue. Clicking on an item in the Table of Contents will bring you to that section of the glossary.

Demographics (Filters)

Accountable Care Organization (ACO)

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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.

Ancillary/Supplementary Services

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Ancillary services are those services that supplement the routine (professional) services personally performed by the practice's provider staff. Such services are billed under separate CPT codes and reimbursed separately, either by third-party payers and/or patients. Examples of ancillary services include: Advanced Radiology, Aesthetics and Cosmetic Services, Allergy/Asthma/Immunology, Ambulatory Surgery Center, Audiology/Hearing Aid(S)/Center, Clinical Laboratory Services, Complementary Alternative Medicine, Drug Administration, Durable Medical Equipment (DME), General Radiology, Health Education/Counseling Services, Optical Shop, PT/OT/Cardiac Rehabilitation, Radiation Therapy, and Sleeping Lab/Center.

Care Team Model

PRO REPORT BUILDER ONLY - ANESTHESIOLOGY PRACTICES ONLY

According to the American Society of Anesthesiologists, the care team model consists of anesthesiologists supervising qualified advanced practice anesthesia providers and/or resident physicians who are training in the provision of anesthesia care. The anesthesiologist may delegate patient monitoring and appropriate tasks to these advanced practice providers while retaining overall responsibility for the patient.

Members of the Anesthesia Care Team work together to provide the optimal anesthesia experience for all patients. Core members of the anesthesia care team include both physicians (anesthesiologist, anesthesiology fellow, anesthesiology resident) and advanced practice (anesthesiologist assistant, nurse anesthetist, anesthesiologist assistant student, student nurse anesthetist). Other healthcare professionals also make important contributions to the perianesthetic care of the patient.

To provide optimum patient safety, the anesthesiologist directing the Anesthesia Care Team is responsible for management of team personnel, patient pre-anesthetic evaluation, prescribing the anesthetic plan, management of the anesthetic, post- anesthesia care and anesthesia consultation.

Demographic Classification

- **Metropolitan area (population of 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 (population of 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 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 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 has 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 metro 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 metro 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 metro area and has a population of 20,000 or more.

EHR Years

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The number of years that an EHR system has been implemented at a practice.

- 1 or less
- 2 to 5
- 6 to 10
- 11 or more

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.

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.

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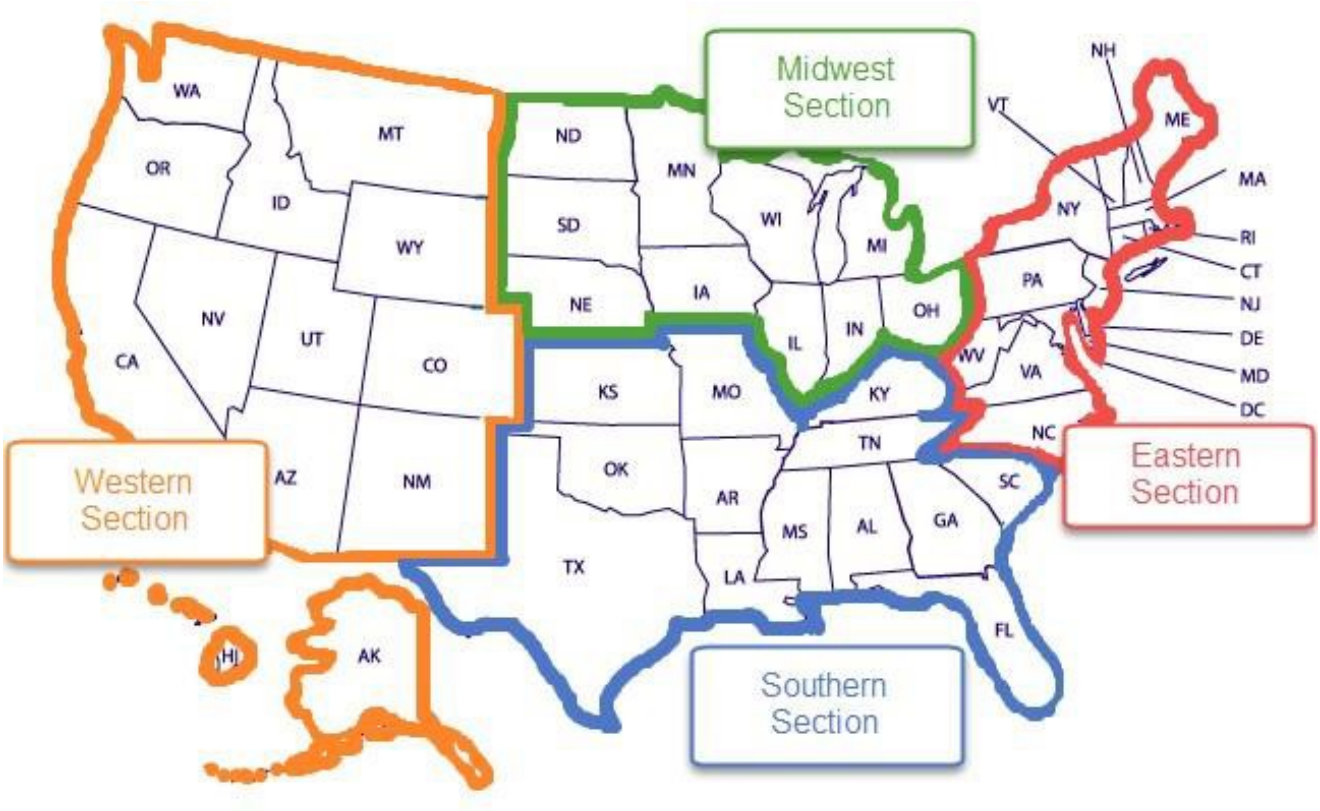
Geographic Section



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

Health and Human Services (HHS) Regions

PRO REPORT BUILDER ONLY

HHS Region 1:
Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island

HHS Region 2:
New Jersey
New York

HHS Region 3:
Delaware
District of Colombia
Maryland
Pennsylvania
Virginia
West Virginia

HHS Region 4:
Alabama
Florida
Georgia
Kentucky
Mississippi
North Carolina
South Carolina
Tennessee

HHS Region 5:
Illinois
Indiana
Michigan
Minnesota
Ohio
Wisconsin

HHS Region 6:
Arkansas
Louisiana
New Mexico
Oklahoma
Texas

HHS Region 7:
Iowa
Kansas
Missouri
Nebraska

HHS Region 8:
Colorado
Montana
North Dakota
South Dakota
Utah
Wyoming

HHS Region 9:
Arizona
California
Hawaii
Nevada

HHS Region 10:
Alaska
Idaho
Oregon
Washington

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:** Legal organization is not one of the above

Minor Geographic Regions

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

Number of Branch Clinics

PRO REPORT BUILDER ONLY

The primary clinic location is the clinic with the most FTE physicians out of all the practice branches. A branch or satellite clinic is a smaller clinical facility for which the practice incurs occupancy costs such as lease, depreciation and utilities. A branch is in a separate location from the practice's principal facility. Merely having a physician practice in another location does not qualify that location as a branch or satellite clinic. For example, if a physician sees patients in a hospital, this would not normally be counted as a branch or satellite clinic unless the practice pays rent for the space.

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):** An IHS/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.

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:

- **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.
- **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.
- **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.
- **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.

Patient Centered Medical Home (PCMH)

PRO REPORT BUILDER ONLY

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.

Practice Type

Multispecialty: A medical practice that consists of physicians practicing in different specialties.
Multispecialty with Primary and Specialty Care: A medical practice that consists of physicians practicing in different specialties, including at least one of the following primary care specialties/subspecialties: family medicine (general, with obstetrics, sports medicine, or urgent care), geriatrics, internal medicine (general), or pediatrics (general, adolescent medicine, or sports medicine).
Multispecialty with Primary Care only: A medical practice that consists of physicians practicing in more than one of the primary care specialties listed in "Multispecialty with primary and specialty care" or the surgical specialties of obstetrics/gynecology, gynecology (only), and obstetrics (only).
Single Specialty: This classification focuses on the clinical work of the practice and not necessarily on the specialties of the physicians in the practice. For example, a single-specialty neurosurgery practice may include a neurologist and a radiologist.

Rent vs. Own Practice Space

PRO REPORT BUILDER ONLY

Whether a practice rents or owns their medical practice space.

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 advanced practice 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 advanced practice provider. RHCs may also provide other healthcare services, such as mental health or vision services, but reimbursement for those services may not be based on their allowable costs.

Staffing Model for Anesthesiology Practices

PRO REPORT BUILDER ONLY – ANESTHESIOLOGY ONLY

Designation for various Anesthesiology practice staffing models.

- Physician Only
- Fewer than 1 CRNA/Anesthesia Assistant (AA) per Physician
- 1 CRNA/Anesthesia Assistant (AA) per Physician or more

Telehealth services

PRO REPORT BUILDER ONLY

Telehealth/Telemedicine is the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration.

Charges & Revenue

Total gross charges

The sum of "Gross fee-for-service charges" and "Gross charges for patients covered by capitation contracts."

Total medical revenue

The sum of "Total net fee-for-service collections/revenue," "Net capitation revenue," and "Net other medical revenue."

Total medical revenue after operating cost

The difference between "Total operating cost" and "Total medical revenue."

Total medical revenue after operating and advanced practice provider cost

"Total operating cost" plus "Total medical revenue" minus "Total advanced practice provider cost"

Total net fee-for-service collections/revenue [4300-4330, 4350-4420][11]

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

Gross fee-for-service charges (excludes capitation charges) [4100-4130][11]

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

Included:

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

  For purchased services, note the following:
  - The revenue for such services is included in "Total net fee-for-service collections/revenue";
  - The cost for such services is included, as appropriate, in "Clinical laboratory," "Radiology and imaging" or "Other ancillary services"; and
  - The count of the number of purchased procedures for fee-for-service patients are included in Total Procedures

Not included:

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

Adjustments to fee-for-service charges (value of services performed for which payment is not expected) [4200-4240, 4500-4600][11]

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

Included:

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

Adjusted fee-for-service charges

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

Bad debts due to fee-for-service activity (accounts assigned to collection agencies) [6900-6920][11]

The difference between "Adjusted fee-for-service charges" and the amount collected.

Included:

- Losses on settlements for less than the billed amount;
- Accounts written off as not collectible;
- Accounts assigned to collection agencies; and
- In the case of accrual accounting, the provision for bad debts.

Net capitation revenue

The difference between "Purchased services for capitation patients" and "Gross capitation revenue."

Gross charges for patients covered by capitation contracts [4170][11]

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

Included:

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

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

Not included:

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

Gross capitation revenue (per member per month capitation payments, capitation patient copayments) [4700-4770][11]

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

Included:

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

Not included:

- Payments paid to a practice by an HMO under the terms of a discounted fee-for-service managed care contract. Such payments are included in "Total net fee-for-service collections/revenue."

Purchased services for capitation patients [7810-7828][11]

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

Included:

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

Net other medical revenue

The difference between "Cost of sales and/or cost of other medical activities" and "Gross revenue from other medical activities."

Gross revenue from other medical activities

The sum of "Incentive-based revenue," "Other medical revenue" and "Revenue from the sale of medical goods and services."

Not included:

- Interest income, which is reported as "Nonmedical revenue";
- Income from practice nonmedical property such as parking areas or commercial real estate, which is reported as "Nonmedical revenue";
- Income from business ventures such as a billing service or parking lot, which is reported as "Nonmedical revenue";
- One-time gains from the sale of equipment or property, which is reported as "Nonmedical revenue"; or
- Cash received from loans, which is not reported anywhere in this survey.

Incentive-based revenue [4800-4860][11]

Payments received from insurance companies and government agencies for incentive-based activities such as pay-for-performance, risk-sharing, shared savings, quality and technology.

Included:

- Pay-for-performance payments for reporting quality, efficiency, or patient satisfaction metrics for patients insured under feed-for-service payment contracts;
- Risk pool insurance;
- Shared savings payments (i.e. Accountable Care Organization (ACO)); and
- Incentive payments for adopting Certified EHR Technology and/or meeting quality standards (i.e. MACRA/MIPS).

Other medical revenue (research contract revenue, honoraria, teaching income) [4900-4950, 4970][11]

Other source of medical revenue such as grants, research/clinical studies, educational subsidies, donations, honoraria and more.

Included:

- Payments received for the reproduction of patient records;
- Medical directorship revenue received by the practice and not a specific individual for providing medical administration to hospitals, skilled nursing facilities, long-term care facilities, and other healthcare organizations;
- Grant revenue from federal, state, or local government or private foundation grants for research, provision of patient care to the indigent, or case management of the frail and elderly;

- Research and clinical studies revenue from pharmaceutical studies, medical device studies, and other research activities conducted by the practice;
- Educational subsidies received by the practice for graduate medical education and training of medical, nursing and medical technician students;
- Any endowment or gift received by the organization;
- Revenue for medical-related activities such as honoraria, education seminars, expert witness testimonies;
- Payment to the practice for physicians working in a hospital emergency room; and
- Contract revenue from a school district for physician services in conducting physical examinations or other service.

Not included:

- Charges for the delivery of services made possible by subsidies or grants were included in "Gross fee-for-service charges" and/or "Gross charges for patients covered by capitation contracts";
- Operating and nonoperating subsidies received from a parent organization such as a hospital, health system, PPMC, or MSO. Such items should be included in, "Financial support from parent organization (subsidies)"; or
- Paycheck Protection Program (PPP) loan forgiveness payment. Such items should be included in, "Extraordinary nonmedical revenue."

Revenue from the sale of medical goods and services [4340-4349][11]

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

Included:

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

Not included:

- Capitation revenue used to pay for covered goods and services for capitation patients. Such revenue is included in "Gross capitation revenue."

Cost of sales and/or cost of other medical activities [7900- 7919][11]

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

Included:

- Cost of pharmaceuticals, medical supplies and equipment sold to patients primarily for use outside the practice. Examples include prescription drugs, hearing aids, optical goods, and orthopedic supplies; and
- Any provider consultant cost(s).

Not included:

- Cost of drugs used in providing services including vaccinations, allergy injections, immunizations, chemotherapy, and anti-nausea drugs. Such cost is included in "Drug supply"; or
- Cost of medical/surgical supplies and instruments used in providing medical/surgical services. Such cost is included in "Medical and surgical supply."

Net nonmedical income or loss

The sum of ("Nonmedical revenue," "Extraordinary nonmedical revenue," and "Financial support from parent organization"), minus ("Goodwill amortization," "Nonmedical cost," and "Extraordinary nonmedical cost").

Nonmedical revenue (investment and rental revenue) [9100-9140, 9160-9170, 9190][11]

Included:

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

"Nonmedical cost."

Not included:

- Cash received from loans, which is not reported anywhere our survey.

Extraordinary nonmedical revenue [9150, 9700][11]

Revenue that is unusual in nature and infrequent in occurrence.

Included:

- Legal settlement receipts;
- Environmental disaster recovery funds; and
- Paycheck Protection Program (PPP) loan forgiveness payment.

Not included:

- Revenues included in "Nonmedical revenue."

Financial support from parent organization (subsidies) [4960, 9180][11]

Medical practices may receive financial support from a parent organization such as a hospital, health system, PPMC or MSO.

Included:

- Operating subsidy income provided to the practice from a parent organization such as a hospital, health system, PPMC or MSO; and
- Nonoperating subsidy income received from parent organization such as a hospital, health system, PPMC or MSO. (i.e. Capitalization projects such as a facility construction).

Not Included:

- Payments received by the practice and not a specified individual for providing medical administration to hospitals, skilled nursing facilities, long-term care facilities, and other healthcare organizations. Such items should be included in "Other Medical Revenue".

Goodwill amortization [9250][11]

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

Not included:

Depreciation of tangible or identifiable intangible assets such as the building or equipment. These depreciation costs are reported as a component of "Information technology" cost, "Building depreciation" cost, "Furniture and equipment depreciation" cost, "Clinical laboratory" cost, "Radiology and imaging" cost, and "Other ancillary services" cost.

Nonmedical cost (income taxes) [9200-9210, 9230-9240, 9260, 9300-9530][11]

Included:

- Income taxes based on net profit that is paid to federal, state, or local government. For cash basis accounting, income taxes equal the cash payment or refund for the most recent tax year paid or received in the most recent tax year plus, periodic withholding paid for those taxes. For accrual accounting, the income tax equals the total tax liability for the most recent tax year regardless of when the tax was paid, or refunds were received;
- All costs required to maintain the productivity of income producing rental property and parking lots;
- Losses on the sale of real estate or equipment and losses from the sale of marketable securities;
- Other nonmedical cost;
- All direct costs related to business ventures such as rental property, parking lots, or billing services, for which gross revenue is reported as "Nonmedical revenue"; and
- State taxes on medical revenue.

Extraordinary nonmedical cost [9220, 9600, 9800][11]

Cost that is unusual in nature and infrequent in occurrence.

Included:

- Legal settlement cost; and
- Environmental disaster recovery cost.

Not included:

- Cost included in "Nonmedical cost."

Net income, excluding financial support (all practices)

"Total medical revenue" minus "Operating cost" minus "Provider cost" plus "Net nonmedical income or loss" for all practices, regardless of hether

they received financial support for operating costs or not.

Net income, practices with financial support

"Total medical revenue" minus "Operating cost" minus "Provider cost" plus "Net nonmedical income or loss" for all practices that reported a value for "Financial support for operating cost."

Net income, practices without financial support

"Total medical revenue" minus "Operating cost" minus "Provider cost" plus "Net nonmedical income or loss" for all practices that did not report a value for "Financial support for operating cost."

Expenses

Participants provided the associated cost (to the nearest whole dollar) for each provider and staffing category.

Provider Expenses

Included:

- Practice providers such as shareholders/partners, salaried associates, employed and contracted providers, and locum tenens;
- Residents and fellows working at the practice; and
- Only providers involved in clinical care.

Not included:

- Full-time provider administrators or the time that a provider devotes to medical director activities. The FTE and cost for such activities are included as "General administrative."

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's assistants.

- Advanced practice providers are also known as APPs, physician extenders and/or mid-levels.

NOTE: Residents are not considered advanced practice providers in MGMA datasets

Provider

Both physician and advanced practice providers (APP) that provide medical care and billable services. For more information on advanced practice providers, please see the corresponding definition.

Total provider cost

The sum of "Total advanced practice provider" and "Total physician" costs.

Total physician cost

The sum of "Primary care physicians," "Nonsurgical specialty physicians," and "Surgical specialty physicians" costs.

Total physician compensation cost [8110-8116, 8119, 8210-8216, 8219, 8310-8316, 8319, 8610-8616, 8619][11]

The total compensation paid to physicians.

Included:

- Compensation for shareholders/partners, associates on salary, employed physicians, contract physicians, locum tenens, residents, and fellows;
- Compensation for full-time and part-time physicians;
- Provider wages reported as direct compensation in
  - Box 5 on the W2.
  - Box 7 on the 1099.
  - Box 1 plus Box 4 minus Box 12 minus Box 13 from the provider's K-1 form 1065.
  - Box 5 (Medicare wages and tips) from the providers W-2 plus Box 1 minus Box 11 minus Box 12 from the provider's K- 1 form 1120S.
- Bonus and/or incentive payments, research stipends, honoraria, distribution of profits;
- Voluntary employee salary deductions used as contributions to 401(k), 403(b),or Section 12 plans; and
- Compensation attributable to activities related to revenue in "Nonmedical revenue."

Not included:

- Amounts included in "Total physician benefit cost," Cost column;
- Provider consultant cost;
- 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.

Total physician benefit cost [8117-8118, 8120-8180, 8217-8218, 8220-8280, 8317-8318, 8320-8380,8617-8618, 8620-8680][11]

The total benefits paid to physicians.

Included:

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

Not included:

- Voluntary employee salary deductions used as contributions to 401(k) and 403(b) plans;or
- Expense reimbursements.

Total advanced practice provider cost

The sum of the cost for full-time advanced practice providers and part-time advanced practice providers.

Advanced practice provider benefit cost [8417-8418, 8420-8480, 8517-8518, 8520-8580][11]

Included:

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

Not included:

- Voluntary employee salary deductions used as contributions to 401(k) and 403(b) plans; or
- Expense reimbursements.

Advanced practice provider compensation cost [8410-8416, 8419, 8510-8516, 8519]11

The number of FTE advanced practice providers in the practice. Advanced practice providers are specifically trained and licensed providers who can provide medical care and billable services. Examples of advanced practice providers include audiologist, certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs), clinical social worders (CSWs), dieticians/nutritionists, midwives, nurse practitioners, occupational therapists, optometrist, physical therapists, physician assistants, psychologists and surgeon assistants. The total compensation paid to advanced practice providers who comprise the count of "Total advanced practice provider," Cost column.

Included:

- Compensation for both employed and contracted advanced practice providers;
- Compensation for full-time and part-time advanced practice providers;
- Provider wages reported as direct compensation in
  - Box 5 on the W2.
  - Box 7 on the 1099.
  - Box 1 plus Box 4 minus Box 12 minus Box 13 from the provider's K-1 form 1065.
  - 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.
- Bonus and/or incentive payments, research stipends, honoraria, distribution of profits; and
- Voluntary employee salary deductions used as contributions to 401(k), 403(b), or Section 125 plans.

Not included:

- Amounts included in "Advanced practice provider benefit cost," Cost column;
- 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

Staff Expenses

Included:

- Salaries, bonuses, incentive payments, honoraria, and profit distributions;
- Voluntary employee salary deductions used as contributions to 401(k), 403(b), or Section 125 plans;
- Compensation paid to the total FTE count;
- Compensation for all support staff employed by all the legal entities working in support of the medical practice represented on this survey;
- The allocated support staff cost where the practice consists of multiple legal entities; and
- Compensation for both full-time and part-time employed support staff.

Not included:

- Expense reimbursements; or
- Any benefits or the cost of contracted support staff who do not work for any of the legal entities that comprise the medical practice.

Total support staff cost

The sum of "Total support staff cost," "Total employed support staff cost" and "Total contracted support staff cost."

Total employed support staff cost [5100, 5200][11]

The sum of "Total business operations support staff cost," "Total front office support staff cost," "Total clinical support staff cost," and "Total ancillary support staff cost."

Total employed support staff benefit cost [5170, 5180, 5300-5460][11]

The "Total employed support staff benefit cost" benchmark represents the total benefits of all employed support staff reported in "Total employed support staff" FTE.

Included:

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

Not included:

- Voluntary employee salary deductions used as contributions to 401(k) and 403(b) plans; or
- Expense reimbursements.

Total contracted support staff cost (temporary) [5500-5570][11]

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

One example of this type of cost would be purchased services for billing and collections activities. When a practice decides to hire a billing company to conduct billing activities that the practice employees, it is often not possible to track the hours that the billing company devotes to the given practice. Such cost is reported as "Billing and collections purchased services."

Included:

- Temporary staff working for temporary agencies; and
- Traveling nurses.

Not included:

- The cost of support staff employed directly by the practice or any of the legal entities comprising the medical practice. Such related costs are included in the "Total Employed Support Staff" section; or
- The cost for legal, accounting, management, and/or other consultants for services performed on a one time or sporadic basis. The costs for these types of consultants are reported as "Legal fees," "Consulting fees," and/or "Outside professional fees."

Total business operations support staff cost

The sum of the costs for "General administrative," "Patient accounting," "General accounting," "Managed care administrative," "Information technology" and "Housekeeping, maintenance, security." Participants were required to provide this total even if they were unable to provide all the values requested below.

General administrative cost [5110-5111, 5117, 5210-5211, 5217][11]

See Staffing section.

Patient accounting cost [5112, 5212][11]

See Staffing section.

General accounting cost [5113, 5213][11]

See Staffing section.

Managed care administrative cost [5114, 5214][11]

See Staffing section.

Information technology cost [5115, 5215][11]

See Staffing section.

Housekeeping, maintenance, security cost [5116, 5216][11]

See Staffing section.

Total front office support staff cost [5120, 5220][11]

A sum of the costs for "Medical receptionists," "Medical secretaries, transcribers," "Medical records" and "Other administrative support." Participants were required to provide this total even if they were unable to provide all the values requested in previous questions.

Medical receptionists cost [5121, 5221][11]

See Staffing section.

Medical secretaries, transcribers cost [5122, 5222][11]

See Staffing section.

Medical records cost [5123, 5223][11]

See Staffing section.

Other administrative support cost [5124, 5224][11]

See Staffing section.

Total clinical support staff cost

A sum of the costs for "Registered nurses," "Licensed practical nurses" and "Medical assistants, nurse's aides." Participants were required to provide this total even if they were unable to provide all the values requested in the previous questions.

Registered nurses cost [5131, 5231][11]

See Staffing section.

Licensed practical nurses cost [5132, 5232][11]

See Staffing section.

Medical assistants, nurse's aides cost [5133, 5134, 5233, 5234][11]

See Staffing section.

Total ancillary support staff cost [5140, 5240][11]

A sum of the costs for "Clinical laboratory," "Radiology and imaging" and "Other medical support services." Participants were required to provide this total even if they were unable to provide all the variables requested in previous questions.

Clinical laboratory cost [5142, 5242][11]

See Staffing section.

Radiology and imaging cost [5141, 5241][11]

See Staffing section.

Other medical support services cost [5143-5160, 5243-5260][11]

See Staffing section.

Operating Expenses

Not included:

- "Cost of sales and/or cost of other medical activities";
- Support staff cost, which is included in the Business Operations, Front Office, Clinical and Ancillary staff sections;
- Provider costs, which is included in the Providers section;
- Cost included in "Purchased services for capitation patients"; and
- "Nonmedical cost."

Participants were asked to provide the following operating costs (to the nearest whole dollar):

Total general operating cost

A sum of "Information technology" through "Cost allocated to medical practice from parent organization."

Information technology [6800-6860][11]

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

Included:

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

Not included:

- Cost of specialized information services equipment dedicated for exclusive use in the departments of clinical laboratory, radiology, and imaging, or other ancillary services departments. Such cost is included in "Clinical laboratory," "Radiology and imaging," and "Other ancillary services"; or
- Cost of contract programmers, which is included in "Total contracted support staff".

Drug supply [7210-7213][11]

Cost of drugs purchased for general practice use.

Included:

- Cost of chemotherapy drugs, allergy drugs, and vaccines used in providing medical/surgical services.

Not included:

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

Medical and surgical supply [7200, 7220-7224, 7720][11]

Cost of supplies purchased for general practice use.

Included:

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

Not included:

- 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."

Building and occupancy [6100, 6120-6190][11]

Cost of general operation of buildings and grounds.

Included:

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

Not included:

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

Building depreciation [6110-6113][11]

Depreciation cost for buildings and grounds.

Not included:

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

Furniture and equipment [6200, 6220-6230, 7100, 7120, 7130, 7710, 7712-7713][11]

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

Included:

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

Not included:

- Cost of specialized furniture and equipment dedicated for exclusive use in the information technology, clinical laboratory, radiology and imaging, or other ancillary services departments. Such cost is reported as a subset in "Information technology," "Clinical laboratory," "Radiology and imaging," and "Other ancillary services" ;or
- Depreciation costs.

Furniture and equipment depreciation [6210, 7110, 7711][11]

Depreciation cost of furniture and equipment in general use in the practice.

Included:

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

Not included:

- Cost of specialized furniture and equipment dedicated for exclusive use in the information technology, clinical laboratory, radiology and imaging, or other ancillary services departments. Such cost is included in "Information technology," "Clinical laboratory," "Radiology and imaging," and "Other ancillary services"; or
- Other costs related to clinic furniture and equipment such as maintenance cost.

Administrative supplies and services [6300-6336, 6346, 6350-6353, 6356, 6358, 6361,6363-6524, 7230-7240, 7730][11]

Cost of printing, postage, books, subscriptions, administrative and medical forms, stationery, payroll services, practice regulatory, licensure and accreditation, employee relations dinners, picnics, entertainment, practice uniforms, business vehicle/ transportation, recruiting, job position classified advertising, moving costs and other administrative supplies and services Included:

- Purchased medical transcription services; and
- Purchased answering services.

Professional liability insurance premiums [6720-6726][11]

Premiums paid or self-insurance cost for malpractice and professional liability insurance for practice physicians, advanced practice providers, and employees.

Malpractice/liability

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

Other insurance premiums [6700-6718][11]

Cost of other policies such as cyber insurance, fire, flood, theft, casualty, general liability, officers' and directors' liability, and reinsurance.

Legal fees [6342][11]

Fees for professional legal services performed on a one-time or sporadic basis and are not employees of the organization.
Included:

- Fees related to legal services paid to attorneys who are not employees of the organization.

Consulting fees [6345][11]

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

- Fees for management, financial, and other outside consulting services.

Outside professional fees [6340-6341, 6343-6344, 7830-7839][11]

Fees for professional services performed on a one time or sporadic basis.
Included:

- Fees for accounting services; and
- Fees for actuarial consultants, and other professional fees not listed.

Not included:

- Information services, architectural and public relations consultant fees. Such costs are included in "Information technology," "Building and occupancy," and "Promotion and marketing";
- Cost for contracted support staff, which is reported as "Total contracted support staff,"; or
- Cost for contracted physicians and locum tenens, which is reported as "Total physician" FTE and Cost.

Clinical laboratory [7400-7440][11]

Cost of clinical laboratory and pathology procedures defined by CPT codes 80047-89398, 36415, and 36416 00100-01999, 10021-36410 and 99100-99140.
Included:

- Rental and/or depreciation cost of major furniture and equipment subject to capitalization;

- Repair and maintenance contract cost;
- Cost of supplies and minor equipment not subject to capitalization;
- Other costs unique to the clinical laboratory; and
- Cost of purchased laboratory technical services for fee-for-service patients.

Not included:

- Cost of purchased laboratory technical services for capitation patients. Such cost is reported as "Purchased services for capitation patients."

Radiology and imaging [7300-7340][11]

Cost of diagnostic radiology and imaging procedures defined by diagnostic radiology CPT codes 70010-764, diagnostic ultrasound CPT codes 76506-76999, diagnostic nuclear medicine CPT codes 78012-78999, echocardiography CPT codes 93303- 93355, noninvasive vascular diagnostic studies CPT codes 93880-93998, and electrocardiography CPT codes 93000-93042.

Included:

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

Not included:

- Cost of purchased radiology technical services for capitation patients. Such costs are reported as "Purchased services for capitation patients"; or
- Cost of procedures for radiation oncology CPT codes 77261-77799 or therapeutic nuclear medicine CPT codes 79005-79999. Such costs are included in "Other ancillary services."

Promotion and marketing [6600][11]

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

Other ancillary services [7500-7640][11]

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

Included:

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

Not included:

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

Billing and collections purchased services [6354-6355, 6357,6930][11]

When a medical practice decides to purchase billing and collections services from an outside organization as opposed to hiring and developing its own employed staff to conduct billing and collections activities, the cost for such purchased services is considered "Billing and collections purchased services."

Included:

- Claims clearinghouse cost.

Management fees paid to an MSO or PPMC [6360, 6362][11]

Medical practices may receive management or other services from an MSO, PPMC, hospital or other parent organization in return for a fee. The fee could be a contracted fixed amount, a percentage of collections or any other mutually agreed upon arrangement.

Included:

- Fees paid to an MSO/PPMC, hospital or parent organization for management services including management, administrative, and/or related

support services; and
- The cost of support staff employed by the MSO/PPMC, if these costs were not reported separately in the Staff section.

Not included:
- The cost of support staff employed by the MSO/PPMC, if these costs were reported in the "Staff" section.

Miscellaneous operating cost [7740][11]

Operating cost not included above.

Not included:
- Federal or state income taxes, which are included in "Nonmedical cost;" or
- Principal paid on loans, which is not reported anywhere in this dataset.

Cost allocated to medical practice from parent organization

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

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

Not included:
- Cash loans made to subsidiaries. Cash for loans does not appear anywhere in this dataset.

Total operating cost

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

Total operating and advanced practice provider cost

The sum of "Total operating cost," and "Total advanced practice provider cost."

Total cost

The sum of "Total operating cost," "Total physician cost," and "Total advanced practice provider cost."

Staffing

Provider Staffing FTE

The number of full-time (1.0 FTE) providers to the FTE count for the part-time providers in their practice. A full-time 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. A provider working 30 hours compared to a normal workweek of 40 hours would be 0.75 FTE (30 hours divided by 40 hours). A provider working full-time for three months during a year would be 0.25 FTE (3 months divided by 12 months). A medical director devoting 50 percent effort to clinical activity would be 0.5 FTE. A provider cannot be counted as more than 1.0 FTE regardless of the number of hours worked.

Included:
- Practice physicians such as shareholders/partners, salaried associates, employed and contracted physicians, and locum tenens;
- Residents and fellows working at the practice; and
- Only physicians involved in clinical care.

Not included:
- Full-time physician administrators or the time that a physician devotes to medical director activities. The FTE and cost for such activities are included as "General administrative."

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's assistants.

- Advanced practice providers are also known APPs, physician extenders and/or mid-levels.

NOTE: Residents are not considered advanced practice providers in MGMA datasets

Provider

Both physician and advanced practice providers (APP) that provide medical care and billable services. For more information on advanced practice providers, please see the corresponding definition.

Total providers

The sum of "Total advanced practice providers" and "Total physicians" FTE and costs.

Total physicians

The sum of "Primary care physicians," "Nonsurgical specialty physicians," and "Surgical specialty physicians" FTE and costs.

Primary care physicians

Included:

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

Nonsurgical specialty physicians

Included:

- Allergy/Immunology
- Bariatrics (Nonsurgical)/Obesity Medicine
- Cardiology: Electrophysiology
- Cardiology: Invasive
- Cardiology: Invasive-Interventional
- Cardiology: Noninvasive
- Clinical Pharmacology
- Critical Care: Intensivist
- Dentistry
- Dermatology
- Dermatology: Dermatopathology
- Emergency Medicine
- Endocrinology/Metabolism
- Gastroenterology
- Gastroenterology: Hepatology
- Genetics
- Hematology/Oncology
- Hematology/Oncology: Oncology (Only)
- Hyperbaric Medicine/Wound Care
- Infectious Disease
- Nephrology
- Nephrology: Transplant
- Neurology
- Neurology: Epilepsy/EEG
- Neurology: Neuromuscular
- Neurology: Stroke Medicine
- OB/GYN: Gynecological Oncology
- OB/GYN: Maternal and Fetal Medicine
- OB/GYN: Reproductive Endocrinology
- OB/GYN: Urogynecology
- Occupational Medicine
- Orthopedics (Nonsurgical)
- Pain Management: Nonanesthesia
- Pathology: Anatomic and Clinical
- Pathology: Anatomic
- Pathology: Anatomic-Autopsy
- Pathology: Anatomic-Cytopathology
- Pathology: Anatomic-Neuropathology
- Pathology: Anatomic-Renal
- Pathology: Clinical
- Pathology: Clinical-Hematopathology
- Pathology: Clinical-Transfusion Medicine
- Pediatrics: Allergy/Immunology
- Pediatrics: Anesthesiology
- Pediatrics: Bone Marrow Transplant
- Pediatrics: Cardiology
- Pediatrics: Child Development
- Pediatrics: Clinical and Lab Immunology
- Pediatrics: Critical Care/Intensivist
- Pediatrics: Dermatology
- Pediatrics: Emergency Medicine
- Pediatrics: Endocrinology
- Pediatrics: Gastroenterology
- Pediatrics: Genetics
- Pediatrics: Hematology/Oncology
- Pediatrics: Infectious Disease
- Pediatrics: Neonatal Medicine
- Pediatrics: Nephrology

- Pediatrics: Neurology
- Pediatrics: Pulmonology
- Pediatrics: Radiology
- Pediatrics: Rheumatology
- Physiatry (Physical Medicine and Rehabilitation)
- Podiatry: General
- Psychiatry: General
- Psychiatry: Addiction Medicine
- Psychiatry: Chemical Dependency
- Psychiatry: Child and Adolescent
- Psychiatry: Forensic
- Psychiatry: Geriatric
- Pulmonary Medicine: General
- Pulmonary Medicine: Critical Care
- Pulmonary Medicine: General and Critical Care
- Radiation Oncology
- Radiology: Interventional
- Radiology: Diagnostic
- Radiology: Neurological
- Radiology: Nuclear Medicine
- Rheumatology
- Sleep Medicine

Surgical specialty physicians

Included:

- Anesthesiology
- Anesthesiology: Pain Management
- Dermatology: Mohs Surgery
- OB/GYN: Minimally Invasive Gynecologic Surgery
- Ophthalmology
- Ophthalmology: Corneal and Refractive Surgery
- Ophthalmology: Glaucoma
- Ophthalmology: Neurology
- Ophthalmology: Oculoplastic and Reconstructive Surgery
- Ophthalmology: Retina
- Orthopedic Surgery: General
- Orthopedic Surgery: Foot and Ankle
- Orthopedic Surgery: Hand
- Orthopedic Surgery: Hip and Joint
- Orthopedic Surgery: Oncology
- Orthopedic Surgery: Shoulder/Elbow
- Orthopedic Surgery: Spine
- Orthopedic Surgery: Trauma
- Orthopedic Surgery: Sports Medicine
- Otorhinolaryngology
- Pathology: Surgical
- Pediatrics: Cardiovascular Surgery
- Pediatrics: Neurosurgery
- Pediatrics: Ophthalmology
- Pediatrics: Orthopedic Surgery
- Pediatrics: Otorhinolaryngology
- Pediatrics: Plastic and Reconstruction Surgery
- Pediatrics: Surgery
- Pediatrics: Urology
- Podiatry: Surgery-Foot and Ankle
- Podiatry: Surgery-Forefoot Only
- Surgery: General
- Surgery: Bariatric
- Surgery: Breast
- Surgery: Cardiovascular
- Surgery: Colon and Rectal
- Surgery: Endocrine
- Surgery: Endovascular (Primary)
- Surgery: Neurological
- Surgery: Oncology
- Surgery: Oral
- Surgery: Plastic and Reconstruction
- Surgery: Plastic and Reconstruction-Hand
- Surgery: Thoracic (Primary)
- Surgery: Transplant
- Surgery: Transplant-Heart
- Surgery: Transplant-Heart/Lung
- Surgery: Transplant-Kidney
- Surgery: Transplant-Liver
- Surgery: Trauma
- Surgery: Trauma-Burn
- Surgery: Vascular (Primary)
- Urology

Total advanced practice providers (APPs)

The sum of full-time (1.0 FTE) advanced practice providers and the FTE count for part-time advanced practice providers. A full-time advanced practice 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. A advanced practice provider cannot be counted as more than 1.0 FTE regardless of the number of hours worked.

Support Staff FTE

The total full-time equivalent (FTE) support staff to the nearest tenth FTE. For “Total business operations support staff,” “Total front office support staff,” “Total clinical support staff,” “Total ancillary support staff,” and “Total support staff.” Participants provided the total if the breakout components were not available.

Included in all FTE questions:

- 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.

Not included:

- The FTE of contracted support staff.

Total support staff

The sum of "Total employed support staff" and "Total contracted support staff."

Total employed support staff FTE

The sum of "Total business operations support staff," "Total front office support staff," "Total clinical support staff," and "Total ancillary support staff."

Total contracted support staff FTE (temporary)

The sum of all total temporary/contracted support staff.

Total business operations support staff FTE

The sum of "General administrative," "Patient accounting," "General accounting," "Managed care administrative," "Information technology" and "Housekeeping, maintenance, security." Participants were required to provide this total even if they were unable to provide all the values requested below.

General administrative

Position titles included (but not limited to):

- Associate/Assistant Medical Director
- Chief Medical Officer (CMO)
- Medical Director
- Physician Chief Executive Officer (CEO/President)
- Administrator
- Chief Department Administrator (CDA)
- Associate/Assistant Department Administrator
- Contracts/Grants Department Administrator
- Division/Section Administrator
- Assistant Administrator
- Chief Compliance Officer
- Chief Executive Officer (CEO)/Executive Director
- Chief Financial Officer (CFO)
- Department Financial Officer
- Chief Information Officer (CIO)
- Chief Nursing/Clinical Officer (CNO)
- Chief Operating Officer (COO)
- Chief Legal Counsel
- Chief Strategy Officer
- Human Resources Executive
- Marketing Executive
- MSO Administrator/Executive Director
- Patient Care Executive
- Ambulatory/Clinical Services Director
- Ancillary Services Director
- Branch/Satellite Clinic Director
- Building and Grounds Director
- Business Services Director
- Clinical Research Director
- Compliance Director
- Contracting Director
- Development Director
- Education and Training Director
- Finance Director
- Health Plan Director
- Human Resources Director
- Information Systems Director
- Laboratory Services Director
- Managed Care Director
- Marketing and Sales Director
- Materials Management Director
- Medical Records Director
- Nursing Services Director
- Operations Director
- Pharmacy Services Director
- Physician Recruitment Director
- Physician Relations Director
- Quality Improvement/Quality Assurance Director
- Radiology Services Director
- Reimbursement Director
- Revenue Cycle Director
- Strategy/Business Planning Director
- Branch/Satellite Clinic Manager
- Business Office Manager
- Call Center Manger
- Clinical Department Manager
- Clinical Practice Manager
- Compliance Manager
- Front Office Manager
- Human Resources Manager
- Marketing Manager
- Materials Management Manager
- Office Manager
- Operations Manager
- Training/Education Manager
- Human Resources Specialist
- Marketing/Communications Specialist
- Recruiter
- Business Office Supervisor
- Clinic Supervisor
- Front Office Supervisor
- Administrative Assistant
- Administrative Secretary
- Business Office Assistant Manager
- Business Office Staff
- Data Analyst
- Executive Assistant
- Human Resources Generalist

Patient accounting

Position titles included (but not limited to):

- Billing Manager
- Coding Manager
- Credit/Collections Manager
- Insurance Manager
- Patient Accounting Manager
- Reimbursement/Collections Manager
- Authorization Specialist
- Billing Specialist
- Coding Specialist
- Billing Staff
- Cashier
- Coder
- Collections Staff
- Insurance Clerk
- Patient Accounts Representative

General accounting

Position titles included (but not limited to):

- Benefits Manager
- General Accounting Manager
- Accountant
- Benefits/Payroll Specialist
- Accounting Staff
- Bookkeeper
- Financial Analyst
- Workers Compensation Liaison

Managed care administrative

Position titles included (but not limited to):

- Utilization Review Manager
- Credentialing Specialist
- Care Coordinator
- Care/Case Manager
- Managed Care Coordinator
- QA/QI Coordinator
- QA/UR Nurse
- Referral Coordinator

Information technology

Position titles included (but not limited to):

- IS Manager/Network Administrator
- Information Systems Manager
- IT Implementation Specialist
- IT Programming Staff
- IT Support Technician

Housekeeping, maintenance, security

Position titles included (but not limited to):

- Building and Grounds Manager
- Housekeeping Supervisor
- Building Engineer/Maintenance
- Housekeeper

Total front support staff FTE

The sum of “Medical receptionists,” “Medical secretaries, transcribers,” “Medical records” and “Other administrative support.” Participants were required to provide this total even if they were unable to provide all the values requested in previous questions.

Medical receptionists

Position titles included (but not limited to):

- Appointment Secretary
- Front Desk Staff
- Patient Service Coordinator
- Receptionist
- Scheduling Staff (excluding Surgical Scheduler)
- Surgical Scheduler
- Switchboard Operator

Medical secretaries, transcribers

Position titles included (but not limited to):

- Medical Transcription Manager
- Transcription Manager
- Medical Scribe
- Medical Secretary
- Transcriptionist

Medical records

Position titles included (but not limited to):

- Medical Records Manager
- Clinical Documentation Specialist
- Medical Records Staff

Other administrative support

Position titles included (but not limited to):

- Courier

Total clinical support staff FTE

The sum of "Registered nurses," "Licensed practical nurses" and "Medical assistants, nurse's aides." Participants were required to provide this total even if they were unable to provide all the values requested in the previous questions.

Registered nurses

Position titles included (but not limited to):

- Nursing Manager
- Nursing Supervisor*
- Registered Nurse
- Triage Nurse

Licensed practical nurses

Position titles included (but not limited to):

- Nursing Supervisor*
- Licensed Practical Nurse

Medical assistants, nurse's aides

Position titles included (but not limited to):

- Nursing Supervisor*
- Certified Nursing Assistant
- Medical Assistant
- Patient Care Assistant

*Categorize based on credentials

Total ancillary support staff FTE

The sum of "Clinical laboratory," "Radiology and imaging" and "Other medical support services." Participants were required to provide this total even if they were unable to provide all the variables requested in previous questions.

Clinical laboratory

Position titles included (but not limited to):

- Laboratory Services Manager
- Lab Section Supervisor
- Histotechnologist
- Laboratory Assistant
- Medical Lab Technician
- Medical Technologist
- Phlebotomist

Radiology and imaging

Position titles included (but not limited to):

- Radiology Services Manager
- EEG Lab Supervisor
- EKG Lab Supervisor
- CAT Scan Technician
- Echocardiographer/Echo Tech
- EEG Technician
- EKG Technician
- Mammography Technician
- MRI Tech
- Radiology Technologist
- Ultrasound Technician

Other medical support services

Position titles included (but not limited to):

- Clinic Research Manager
- Optical Shop Supervisor
- Aesthetician
- Athletic Trainer
- Cardiovascular Technologist
- Clinical Research Coordinator
- Dental Assistant
- Dental Hygienist

- DME Technician
- Dosimetrist
- Endoscopy Technician
- Massage Therapist
- Medical Interpreter
- Nuclear Medicine Technologist
- Occupational Therapy Assistant
- Ophthalmic Assistant
- Ophthalmic Technician
- Optician
- Orthopedic/Cast Technician
- Paramedic
- Pharmacist
- Pharmacy Technician
- Physical Therapist Aide
- Physical Therapy Assistant
- Physicist
- Polysomnographic/Sleep Technician
- PT Education Coordinator
- Radiation Therapist
- Respiratory Therapist
- Social Worker (non-clinical)
- Speech Therapist
- Surgical Technologist
- Sterile Processing Technician
- Therapist/Counselor

A/R, Collections, Payer Mix

Accounts receivable

The age of a practice's accounts receivable (to the nearest whole dollar). Accounts that had are assigned to collection agencies are not included.

Total AR per physician

See Data Normalization Calculations (Data cuts) section. Refer to “Per FTE Physician.”

Total AR per provider

See Data Normalization Calculations (Data cuts) section. Refer to “Per FTE Physician.”

Current to 30 days

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

Not included:

- Capitation payments owed to the practice by HMOs.

31 to 60 days – See Current to 30 days

61 to 90 days – See Current to 30 days

91 to 120 days – See Current to 30 days

Over 120 days – See Current to 30 days

Re-aged and Not re-aged accounts receivable

We asked participants to answer “Yes” or “No” if accounts receivable were re-aged when a second insurance company or the patient was billed after the first insurance company refused to pay the entire billed amount.

Months gross FFS charges in AR

See Formulas section.

Months adjusted FFS charges in AR

See Formulas section.

Days gross FFS charges in AR

See Formulas section.

Days adjusted FFS charges in AR

See Formulas section.

Gross FFS collection percent

See Formulas section.

Adjusted FFS collection percent

See Formulas section.

Payer mix

The percentage of a practice's "Total gross charges" by type of payer. The sum of the percentages for Medicare, Medicaid, Commercial, Workers' compensation, Charity care, Self-pay, and other federal government payers must have added to 100 percent.

Medicare

The sum of all fee-for-service, managed care fee-for-service and capitated charges for all services provided to Medicare patients.

Medicaid

The sum of all fee-for-service, managed care fee-for-service and capitated charges for all services provided to Medicaid or similar state healthcare program patients.

Commercial

The sum of all fee-for-service, managed care fee-for-service and capitated charges for all services provided patients under a commercial capitated contact.

Workers' compensation

Fee-for-service gross charges, at the practice's undiscounted rates, for all services provided to patients covered by workers' compensation insurance.

Not included:

- Charges for Medicare patients;
- Charges for Medicaid patients;
- Charges for charity or professional courtesy patients; or
- Charges for self-pay patients.

Charity care

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

Self-pay

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

Included:

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

Other federal government payers

Fee-for-service gross charges, at the practice's undiscounted rates, for all services provided to patients who are covered by other federal

government payers other than Medicare.

Included:

- Charges for TRICARE patients.

Not included:

- Charges for Medicare and Medicaid patients.

Productivity

Total procedures

The sum of "Medical procedures conducted inside the practice," "Medical procedures conducted outside the practice," "Surgery/anesthesia procedures conducted inside the practice," "Surgery/anesthesia procedures conducted outside the practice," "Clinical laboratory and pathology procedures," and "Diagnostic radiology and imaging procedures."

Patients

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

Included:

- Fee-for-service and capitation patients. A patient is simply a person who received at least one service from the practice during the 12-month reporting period, regardless of the number of encounters or procedures received by that person. If a person was a patient during the most recent fiscal year but did not receive any services at all during that fiscal year, that person would not be counted as a patient. A patient is not the same as a covered life. The number of capitated patients, for example, could be less than the number of capitated covered lives if a subset of the covered lives did not utilize any services during the 12-month reporting period.

Relative value units (RVUs)

Relative value units (RVUs), are measured by the Resource Based Relative Value Scale (RBRVS), not weighted by a conversion factor, and are 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 healthcare professionals.

- 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.

- There are two different types of practice expense RVUs:
  - Fully implemented non-facility practice expense RVUs; and
  - Fully implemented facility practice expense RVUs.
- "Non-facility" 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. "Non-facility" also applies to services performed in settings other than a hospital, skilled nursing facility, or ambulatory surgery center.
- "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. Total RVUs that are a function of "facility" practice expense RVUs are not reported.
- To summarize, there are two different types of total RVUs:
  - Fully implemented non-facility total RVUs; and
  - Fully implemented facility total RVUs.

Work RVUs

Included:

- 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 byproviders;
- 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.

Not included:

- RVUs for “malpractice RVUs”;
- RVUs for other scales, such as McGraw-Hill, 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; or
- RVUs where the Geographic Practice Cost Index (GPCI) equals any value other than one. The GPCI must be set to 1.000 (neutral).

Total RVUs

Included:

- RVUs for the “physician work RVUs,” “practice expense,” and “malpractice RVUs,” including any adjustments made as a result 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;
- 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;
- 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; or
- RVUs where the Geographic Practice Cost Index (GPCI) equals any value other than one. The GPCI must be set to 1.000 (neutral).

Total ASA units

ANESTHESIOLOGY PRACTICES ONLY

Anesthesiology practices report 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.

Total 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). 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).

Not included:

- 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 advance 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.

Panel size

CARDIOLOGY AND PRIMARY CARE PRACTICES ONLY

The “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. The following methodologies are used to calculate panel size:

- If a patient has only seen one physician in the practice, assign the patient to that physician.

- If a patient has seen more than one physician in the practice, assign the patient to the physician seen most frequently.
- 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.
- If a patient has not had a physical, assign him/her to the physician seen most recently.

Number of exam/treatment rooms

The number of exam/treatment rooms located in the practice.

- This is available for per FTE Physician and per FTE Provider data cut selections only.

Square footage

The total number of finished and occupied square feet within outside walls for all the facilities (both administrative and clinical) that comprise the practice. Hallways, closets, elevators, stairways and other such spaces are included. For anesthesia practices, any leased or rented administrative office space are included, regardless of whether it is inside or outside the hospital setting.

Number of Hospital, Same-Day Surgery Center, Surgeon Offices and Other facilities staffed

ANESTHESIOLOGY PRACTICES ONLY

The number of facilities an anesthesiology practice covered in each facility type category. Any facilities not physically in the same location as separate facilities are counted. For example, if the practice provides services (inpatient and outpatient) at one hospital in the same block of operating rooms, this is counted as one facility. If the outpatient department is sufficiently removed that a separate staff is assigned to cover that "facility" on any given day, that is counted as a separate facility (hospital or same day surgery center, as appropriate).

Number of Hospital, Same-Day Surgery Center, Surgeon Offices and Other anesthetizing locations

ANESTHESIOLOGY PRACTICES ONLY

The number of anesthetizing locations including cath lab, ESWL, MRI, or OB suite, a practice covers at 7:30 AM (or another time that represents a typical first case of the day) in each facility type category.

Surgical anesthesia

ANESTHESIOLOGY PRACTICES ONLY

Included:

- Any case with base and time units where anesthesia services such as general, regional or MAC are provided, regardless of whether or not there were multiple providers on the case. Generally, these are the "0" anesthesia codes or services which cross over to these codes. Obstetrical cases, critical care, chronic and acute pain services, as well as flat fee procedures are each listed as a separate category for which you will give separate counts.
- Listed base units and minutes for surgical anesthesia cases only. For the "Charge per ASA unit," the monetary fee that is applied to an American Society of Anesthesiologists (ASA) unit is included.

Labor epidurals (CPT codes 59409, 01960, 01967)

ANESTHESIOLOGY PRACTICES ONLY

Included:

- Labor epidurals (59409, 01960 or 01967). If a labor epidural was started and then a C-section was performed, one of each is counted.

C-Sections (CPT codes 59514, 01961, 01968)

ANESTHESIOLOGY PRACTICES ONLY

Included:

- C-sections (59514, 01961 or 01968). If a labor epidural was started and then a C-section was performed, one of each is counted.

Epidurals (CPT codes 62324, 62326)

ANESTHESIOLOGY PRACTICES ONLY

Included:

- The epidural (62324, 62326) for the day that the procedure was performed and each day of subsequent follow-up is counted as one follow-

up visit (01996). For example, if patient A has an epidural placed for post-op pain on Monday and you visit him/her on Tuesday, Wednesday, and Thursday, one epidural and three days of follow-up visits are listed.

Follow-up visits (CPT codes 01996, 99231-99233)

ANESTHESIOLOGY PRACTICES ONLY

Included:

- The epidural (62318, 62319) for the day that the procedure was performed and each day of subsequent follow-up is counted as one follow-up visit (01996). For example, if patient A has an epidural placed for post-op pain on Monday and you visit him/her on Tuesday, Wednesday, and Thursday, one epidural and three days of follow-up visits are listed.

Nerve blocks for post op pain (CPT codes 64400-64530)

ANESTHESIOLOGY PRACTICES ONLY

Included:

- Nerve blocks for post op pain (CPT codes 64400-64530).

Critical care services (CPT codes 99291, 99292)

ANESTHESIOLOGY PRACTICES ONLY

Included:

- Critical care services (CPT codes 99291, 99292).

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

ANESTHESIOLOGY PRACTICES ONLY

Included:

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

Cost Allocation (Pro Report Builder only)

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

The first step in achieving this objective is for practices to understand what activities they perform (outputs) and what resources (inputs) go into performing these activities. Examples of outputs include surgical and radiology procedures; inputs include support staff labor, physician labor, supplies, rent, and insurance. Input costs can allocate to one or more activities to determine cost per activity or procedure. Evaluation at this level helps practices benchmark cost performance and budget and analyze payer contracts.

Using input and output data collected in the survey, Data Solutions developed an activity-based cost allocation model that allocates medical practice input costs to medical practice outputs. The model calculates operating cost, provider cost, and total cost per procedure. We collected the procedure and charge data for the six types of medical practice activities listed in Table 1: Outputs, Procedures, and Charges.

Cost data fell into two categories: operating cost and provider cost, as shown in Table 2: Inputs, Costs, and Allocation Patterns. These data provided the framework for the model.

Due to the complexity of the model, a case study best illustrates the model's structure, how costs allocate to activities, and the method used to determine cost per procedure. The medical practice in the example is a multispecialty practice with 40 FTE physicians. Tables 1 and 2 show the case study data. This case study only calculates total cost per procedure. We applied the same logic to generate the operating cost per procedure and provider cost per procedure data that appear in the Cost and Revenue Survey tables.

Step 1: Identify the procedure(s) to receive cost allocations. Data Solutions staff analyzed each cost in Table 2 to determine which procedure or procedures should receive an allocation of the cost. We considered the type of procedure and whether the procedure took place inside or outside the practice. Depending on the costs' characteristics, we allocated costs to one or multiple types of procedures. For instance, general administrative support staff cost and total physician cost allocate to all six types of procedures (A through F), while registered nurses' support staff costs allocate only to medical and surgical procedures that took place within the practice (A and C). Clinical laboratory costs allocate only to laboratory procedures (E). In Table 2, the Cost Allocation Pattern column shows the allocation pattern for each cost.

The following summary outlines the cost allocation patterns in Table 2, where the letters refer to the procedure types described in Table 1:

ABCDEF – All procedures
ACEF – Medical and surgical procedures that occur inside the practice's facilities and the ancillary procedures of laboratory and radiology
AC – Medical and surgical procedures that occur inside the practice's facilities but not ancillary procedures
E – Laboratory procedures only
F – Radiology procedures only

Step 2: Determine the total cost associated with each cost allocation pattern. Using the last column in Table 2 to identify the cost allocation pattern, sum the associated costs for each pattern. For example, the first five cost rows listed in Table 2 would all be added to the total for pattern ABCDEF, and so on. The second column of Table 8: Total Cost per Procedure Worksheet lists total costs for each pattern. This column sums to $21,780,000, which is equal to total cost listed on the bottom row of Table 2.

Table 1: Outputs, Procedures, and Charges

Procedure Type	Procedure (Activity) Name	Number of Procedures	Total Gross Charges
A	Medical procedures inside the practice	200,000	$11,000,000
B	Medical procedures outside the practice	30,000	$6,300,000
C	Surgery and anesthesia procedures inside the practice	10,000	$1,300,000
D	Surgery and anesthesia procedures outside the practice	10,000	$13,000,000
E	Clinical laboratory and pathology procedures	135,000	$4,000,000
F	Diagnostic radiology and imaging procedures	25,000	$3,000,000
	Totals	**410,000**	**$38,600,000**

Table 2a: Inputs, Costs, and Allocation Patters (APP as a Provider Cost)

	Inputs (Type of Cost)	Cost	Cost Allocation Pattern
	General administrative	$400,000	ABCDEF
	Patient accounting	$400,000	ABCDEF
	General accounting	$100,000	ABCDEF
	Managed care administrative	$200,000	ABCDEF
	Information technology	$100,000	ABCDEF
	Housekeeping, maintenance, security	$20,000	ACEF
	Medical receptionist	$500,000	ACEF
	Medical secretaries, transcribers	$200,000	ABCDEF
	Medical records	$200,000	ABCDEF
	Other administrative support	$30,000	ACEF
	Registered nurses	$100,000	AC
	Licensed practical nurses	$500,000	AC
	Medical assistants, nurse's aides	$600,000	AC
	Clinical laboratory	$300,000	E
	Radiology and imaging	$200,000	F
	Other medical support services	$250,000	ACEF
	Total employed support staff benefits	$800,000	ABCDEF
	Total contracted support staff	$300,000	ABCDEF
	Total operating cost, support staff	**$5,200,000**	

	Information technology	$225,000	ABCDEF
	Drug supply	$500,000	AC
	Medical and surgical supply	$275,000	AC
	Building and occupancy	$1,000,000	ACEF
	Building depreciation	$350,000	ACEF
	Furniture and equipment	$300,000	AC
	Furniture and equipment depreciation	$175,000	AC
	Administrative supplies and services	$300,000	ABCDEF
	Professional liability insurance	$450,000	ABCDEF
	Other insurance premiums	$10,000	ABCDEF
	Legal fees	$15,000	ABCDEF
	Consulting fees	$10,000	ABCDEF
	Outside professional fees	$60,000	ABCDEF
	Promotion and marketing	$35,000	ABCDEF
	Clinical laboratory	$700,000	E
	Radiology and imaging	$300,000	F
	Other ancillary services	$150,000	ACEF
	Billing and collections purchased services	$0	ABCDEF
	Management fees paid to MSO or PPMC	$100,000	ABCDEF
	Miscellaneous operating cost	$1,375,000	ABCDEF
	Cost allocated to practice from parent organization	$0	ABCDEF
	Total operating cost, general	**$6,330,000**	
	Total operating cost	**$11,530,000**	
	Total advanced practice provider cost	$250,000	AC
	Total physician cost	$10,000,000	ABCDEF
	Total provider cost	$10,250,000	
	Total cost	**$21,780,000**	

Table 2B: Inputs, Costs, and Allocation Patters (APP as an Operating Cost)

	Inputs (Type of Cost)	Cost	Cost Allocation Pattern
	General administrative	$400,000	ABCDEF
	Patient accounting	$400,000	ABCDEF
	General accounting	$100,000	ABCDEF
	Managed care administrative	$200,000	ABCDEF
	Information technology	$100,000	ABCDEF
	Housekeeping, maintenance, security	$20,000	ACEF
	Medical receptionist	$500,000	ACEF
	Medical secretaries, transcribers	$200,000	ABCDEF
	Medical records	$200,000	ABCDEF
	Other administrative support	$30,000	ACEF
	Registered nurses	$100,000	AC
	Licensed practical nurses	$500,000	AC
	Medical assistants, nurse's aides	$600,000	AC
	Clinical laboratory	$300,000	E
	Radiology and imaging	$200,000	F
	Other medical support services	$250,000	ACEF
	Total employed support staff benefits	$800,000	ABCDEF
	Total contracted support staff	$300,000	ABCDEF
	Total operating cost, support staff	**$5,200,000**	
	Information technology	$225,000	ABCDEF
	Drug supply	$500,000	AC

	Medical and surgical supply	$275,000	AC
	Building and occupancy	$1,000,000	ACEF
	Building depreciation	$350,000	ACEF
	Furniture and equipment	$300,000	AC
	Furniture and equipment depreciation	$175,000	AC
	Administrative supplies and services	$300,000	ABCDEF
	Professional liability insurance	$450,000	ABCDEF
	Other insurance premiums	$10,000	ABCDEF
	Legal fees	$15,000	ABCDEF
	Consulting fees	$10,000	ABCDEF
	Outside professional fees	$60,000	ABCDEF
	Promotion and marketing	$35,000	ABCDEF
	Clinical laboratory	$700,000	E
	Radiology and imaging	$300,000	F
	Other ancillay services	$150,000	ACEF
	Billing and collections purchased services	$0	ABCDEF
	Management fees paid to MSO or PPMC	$100,000	ABCDEF
	Micellaneous operating cost	$1,375,000	ABCDEF
	Cost allocated to practice from parent organization	$0	ABCDEF
	Total operating cost, general	**$6,330,000**	
	Total advanced practice provider cost	$250,000	AC
	Total operating cost	**$$11,780,000**	
	Total physician cost	$10,000,000	ABCDEF
	Total provider cost	$10,000,000	
	Total cost	**$21,780,000**	

Step 3: Use procedural gross charges data to calculate ratios of specific procedure charges to total charges. The cost allocated to each procedure type depends on the gross charges generated by each procedure compared to total gross charges for all procedures. In this case study, Table 1 shows the charges generated by each procedure type. For example, surgical procedures performed outside the practice generated 33.68 percent of the total gross charges for cost allocation pattern ABCDEF (see row D in Table 3). For costs that allocate to all procedures (the ABCDEF pattern costs), surgical procedures performed outside the practice would share 33.68 percent of the ABCDEF total costs. In the model, the ratios of procedure gross charges to total gross charges determine the proportion of total cost allocated to each procedure type.

For each cost allocation pattern, Data Solutions summed the gross charges for each type of procedure (see the bottom row of Tables 3 through 7 for these sums). Then, we calculated the ratios of procedure charges to total charges (the allocation ratios) by dividing the individual procedure charge amount by the total gross charges. Tables 3 through 7: Ratio of Procedure Charges to Total Charges for Cost Allocation Patterns present the complete set of ratios for all cost allocation patterns.

Step 4: Calculate the total cost allocated to each procedure type. The structure of the cost allocation model is now in place. Table 8: Total Cost per Procedure Worksheet illustrates the final step in this process. Data Solutions determined the total cost allocated to each procedure by multiplying the total cost (column 2 of Table 8) by the appropriate ratio of procedure charges to total charges.

Table 3: Ratio of Procedure Charges to Total Charges for Cost Allocation Pattern ABCDEF

Procedure Type	Procedure (Activity) Name	Total Gross Charges	Ratio of Procedure Charges to Total Charge
A	Medical procedures inside the practice	$11,000,000	0.2850
B	Medical procedures outside the practice	$6,300,000	0.1632
C	Surgery and anesthesia procedures inside the practice	$1,300,000	0.0337
D	Surgery and anesthesia procedures outside the practice	$13,000,000	0.3368
E	Clinical laboratory and pathology procedures	$4,000,000	0.1036
F	Diagnostic radiology and imaging procedures	$3,000,000	0.0777
	Totals	**$38,600,000**	**1.0000**

Table 4: Ratio of Procedure Charges to Total Charges for Cost Allocation Pattern ACEF

Procedure Type	Procedure (Activity) Name	Total Gross Charges	Ratio of Procedure Charges to Total Charge

A	Medical procedures inside the practice	$11,000,000	0.5699
C	Surgery and anesthesia procedures inside the practice	$1,300,000	0.0674
E	Clinical laboratory and pathology procedures	$4,000,000	0.2073
F	Diagnostic radiology and imaging procedures	$3,000,000	0.1554
	Totals	**$19,300,000**	**1.0000**

Table 5: Ratio of procedure Charges to Total Charges for Cost Allocation Pattern AC

Procedure Type	Procedure (Activity) Name	Total Gross Charges	Ratio of Procedure Charges to Total Charge
A	Medical procedures inside the practice	$11,000,000	0.8943
C	Surgery and anesthesia procedures inside the practice	$1,300,000	0.1057
	Totals	**$12,300,000**	**1.0000**

Table 6: Ratio of procedure Charges to Total Charges for Cost Allocation Pattern E

Procedure Type	Procedure (Activity) Name	Total Gross Charges	Ratio of Procedure Charges to Total Charge
E	Clinical laboratory and pathology procedures	$4,000,000	1.0000
	Totals	**$4,000,000**	**1.0000**

Table 7: Ratio of procedure Charges to Total Charges for Cost Allocation Pattern F

Procedure Type	Procedure (Activity) Name	Total Gross Charges	Ratio of Procedure Charges to Total Charge
F	Diagnostic radiology and imaging procedures	$3,000,000	1.0000
	Totals	**$3,000,000**	**1.0000**

Then, Data Solutions summed the costs for each combination. Table 8 displays the sums of these costs (the total cost allocated to each procedure type) in columns A through F.

For example, the following calculates the total cost allocated to "medical procedures inside the practice":

$15,280,000 × 0.2850	=	$ 4,354,800
$ 2,300,000 × 0.5699	=	$ 1,310,770
$ 2,700,000 × 0.8943	=	$ 2,414,610
Total	=	$ 8,080,180

Table 8, column A presents a total of $8,080,180. The other five procedures allocate total costs in a similar manner.

Step 5: Calculate total cost per procedure. Divide the total cost allocated to each procedure type by the total number of procedures for each procedure type to get the total cost per procedure. Table 8 displays the final results for this case study.

Analyzing the data at the procedural level is now possible. This information can help assess a practice's fee schedule and the impact of managed care discounts. Also, the data is useful in evaluating capitation contracts and a baseline measurement when compared to national medians. Tables *.11b through *.11g of each data section in the report display these national standards.

Table 8: Total Cost per Procedure Worksheet

Cost allocation pattern	Total cost for each pattern	Procedure Type					
		A	B	C	D	E	F
		Medical procedures inside the practice	**Medical procedures outside the practice**	**Surgery and anesthesia procedures inside the practice**	**Surgery and anesthesia procedures outside the practice**	**Clinical laboratory and pathology procedures**	**Diagnostic radiology and imaging procedures**

		Ratio of procedure charges to total charges by cost allocation pattern					
All procedures							
(ABCDEF)	$15,280,000	0.2850	0.1632	0.0337	0.3368	0.1036	0.0777
Medical/surgical inside and lab/ radiology (ACEF)	$2,300,000	0.5699		0.0674		0.2073	0.1554
Medical/surgical inside (AC)	$2,700,000	0.8943		0.1057			
Laboratory (E)	$1,000,000					1.0000	
Radiology (F)	$500,000						1.0000
Total	$21,780,000						
		Total cost allocated to each procedure type					
		$8,080,180	$2,493,696	$955,346	$5,146,304	$3,059,798	$2,044,676
		Total number of procedures					
		200,000	30,000	10,000	10,000	135,000	25,000
		Total cost per procedure					
		$40.40	$83.12	$95.53	$514.63	$22.67	$81.79

Formulas

Months of gross fee-for-service charges in accounts receivable =

(Total accounts receivable) / (Gross FFS charges) x (1/12)

Days of gross fee-for-service charges in accounts

receivable =

(Total accounts receivable)
(Gross FFS charges) x (1/365)

Gross fee-for-service collection percentage =

(Net FFS revenue) x 100
(Gross FFS charges)

Total cost =

(Total operating cost) + (Total provider cost)

Months of adjusted fee-for-service charges in accounts receivable =

(Total accounts receivable)
(Adjusted FFS charges) x (1/12)

Days of adjusted fee-for-service charges in accounts receivable =

(Total accounts receivable)
(Adjusted FFS charges) x (1/365)

Net capitation revenue percentage of gross capitation charges =

(Net capitation revenue) x 100
(Gross capitation charges)

Adjusted fee-for-service collection percentage =

(Net FFS revenue) x 100
(Adjusted FFS charges)

Data Normalization Calculations (Data cuts)

Per FTE physician =

<performance measure>
(Total physician FTE)

As a percentage of total medical revenue =

<performance measure>
(Total medical revenue)

Per FTE provider =

<performance measure>
(Total provider FTE)

Per square foot =

<performance measure>
(Square feet)

Per total RVU =

<performance measure>
(Total RVUs)

Per work RVU =

<performance measure>
(Physician work RVUs)

Per patient =

<performance measure>
(Number of patients)

Per encounter =

<performance measure>
(Total encounters)