

2018 MGMA Cost and Revenue Survey Guide

Due Date: April 13, 2018



This document is intended to serve as a guide for completing the 2018 MGMA Cost and Revenue Survey. An explanation of each survey question and the provided answer options are included. For additional participation resources including FAQs, change notices, and participation benefits, check out our Survey Participation Resources page (mgma.org/participate).

Getting Started:

- Find available surveys on data.mgma.org in the participation section.
- The Practice Profile must be completed in full before beginning any of the MGMA surveys. It is intended to help tailor your survey to be relevant to your practice and therefore must be completed first.
- The quality of our reported results depends upon the completeness and accuracy of every response. The more you give the more you get. Learn more (www.mgma.org/industry-data/participate/benefits).
- Questions with an asterisk * are required. Questionnaires with required questions left blank may not be eligible for submission.

Guide Contents:

- Practice Demographics
- Charges
- Revenue
- Staff
- Expenses
- Providers
- Net Income
- Performance
- Production

Note: Practices that are "Multispecialty with specialty care only" will be asked to break out data for each specialty in the Cost and Revenue Survey.



PRACTICE DEMOGRAPHICS

*What is your practice NPI number?

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

*For the purpose of reporting the information in this questionnaire, what fiscal year was used?

Enter the beginning month, beginning year, end month and end year of your most recently completed fiscal year. **Data reported for periods less than 12 months will not be eligible for submission.** If your medical practice was involved in a merger or acquisition during the 2017 fiscal year and you cannot assemble 12 months of practice data, you may not be able to participate. Please call Data Solutions at 877.275.6462, ext. 1895, if you are uncertain about your eligibility to participate.

***Beginning month:** Enter the beginning month of your most recently completed fiscal year.

***Beginning year:** Enter the year that your most recently completed fiscal year began.

***Ending month:** Enter the ending month of your most recently completed fiscal year.

***Ending year:** Enter the year that your most recently completed fiscal year ended.

What is your practice’s legal organization?

Business corporation: A for-profit organization recognized by law as a business entity separate and distinct from its shareholders. Shareholders need not be licensed in the profession practiced by the corporation.

Limited liability company: A legal entity that is a hybrid between a corporation and a partnership, because it provides limited liability to owners like a corporation while passing profits and losses through to owners like a partnership.

Not-for-profit corporation/foundation: An organization that has obtained special exemption under Section 501(c) of the Internal Revenue Service code that qualifies the organization to be exempt from federal income taxes. To qualify as a tax-exempt organization, a practice or faculty practice plan would have to provide evidence of a charitable, educational, or research purpose.

Partnership: An unincorporated organization where two or more individuals have agreed that they will share profits, losses, assets, and liabilities, although not necessarily on an equal basis. The partnership agreement may or may not be formalized in writing.

Professional corporation/association: A for-profit organization recognized by law as a business entity separate and distinct from its shareholders. Shareholders must be licensed in the profession practiced by the organization.

Sole proprietorship: An organization with a single owner who is responsible for all profit, losses, assets, and liabilities.

Other: If your practice’s legal organization is not listed, describe in the “Other” text box.



Is your practice a Federally Qualified Health Center (FQHC)?

FQHC: A reimbursement designation that refers to several health programs funded under Section 330 of the Public Health Service Act of the United States of America's Federal Government. These 330 grantees in the Health Center Program include:

- Community Health Centers which serve a variety of underserved populations and areas;
- Migrant Health Centers which serve migrant and seasonal agricultural workers;
- Health Care for the Homeless Programs which reach out to homeless individuals and families and provide primary and preventive care and substance abuse services; 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.

Is your practice a Rural Health Clinic (RHC)?

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

How did the practice store information for the majority of patients served by your practice?

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

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

How many years has your EHR been fully implemented in your practice?

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



How many branch/satellite clinics did your practice have, not counting the primary location?

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.

What was the gross square footage of all practice facilities?

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, include any leased or rented administrative office space, regardless of whether it is inside or outside hospital setting.

What accounting method was used for tax reporting purposes?

Cash: An accounting system where revenues are recorded when cash is received and costs are recorded when cash is paid out. Receivables, payables, accruals, and deferrals arising from operations are ignored. On a pure cash basis, long-lived (fixed) assets are expensed when acquired, leaving cash and investments as the only assets, and borrowings and payroll withholds as the only liabilities.

Accrual: An accounting system where revenues are recorded as earned when services are performed rather than when cash is received. Cost is recorded in the period during which it is incurred, that is, when the asset or service is used, regardless of when cash is paid. Costs for goods and services that will be used to produce revenues in the future are reported as assets and recorded as costs in future periods. The accrual system balance sheet includes not only the assets and liabilities from the cash basis balance sheet but also includes the receivables from patients, prepayments and deferrals of costs, accruals of costs and revenues, and payables to suppliers.

What accounting method was used for internal management purposes?

Cash: An accounting system where revenues are recorded when cash is received and costs are recorded when cash is paid out. Receivables, payables, accruals and deferrals arising from operations are ignored. On a pure cash basis, long-lived (fixed) assets are expensed when acquired, leaving cash and investments as the only assets, and borrowings and payroll withholds as the only liabilities.

Modified Cash: An accounting system that is primarily a cash basis system, but allows the cost of long-lived (fixed) assets to be expensed through depreciation. The modified cash system recognizes inventories of goods intended for resale as assets. Under a modified cash system, purchases of buildings and equipment, leasehold improvements, and payments of insurance premiums applicable to more than one accounting period are normally recorded as assets. Costs for these assets are allocated to accounting periods in a systematic manner over the length of time the practice benefits from the assets.



Accrual: An accounting system where revenues are recorded as earned when services are performed rather than when cash is received. Cost is recorded in the period during which it is incurred, that is, when the asset or service is used, regardless of when cash is paid. Costs for goods and services that will be used to produce revenues in the future are reported as assets and recorded as costs in future periods. The accrual system balance sheet includes not only the assets and liabilities from the cash basis balance sheet but also includes the receivables from patients, prepayments and deferrals of costs, accruals of costs and revenues, and payables to suppliers.

Did your practice provide ancillary/supplementary services? Such services are those that are provided as part of, or are wholly owned by the practice.

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

Advanced radiology: Examples of such services include but are not limited to mammography, CT, MRI, nuclear medicine, ultrasound, bone densitometry, cardiac catheterization lab, ECP, MRA, EMG, and EEG.

Aesthetics and cosmetic services: Examples of such services include but are not limited to Botox, laser hair removal, skin care, and vein removal.

Allergy/Asthma/Immunology: Examples of such services include allergy injections, pulmonary function tests, and vaccinations.

Ambulatory surgery center: An ambulatory surgery center (ASC) is specifically licensed to provide surgery services performed on a same-day outpatient basis, including endoscopy centers. Select if your practice or physicians owned or had financial interest in an ASC as part of, or wholly owned by the practice. Do not select if the ASC is a separate legal entity.

Audiology/Hearing Aid(s)/Center: Examples of such services include hearing aids and centers where audiology tests take place.

Clinical laboratory services: (tests of high complexity under CLIA): Select if your practice provided lab tests of high complexity as determined under CLIA. Do not select if your practice performed only tests of waived or moderate level complexity under CLIA.

Clinical research/drug studies: Select if your practice participated and provided services under a clinical/drug trial study or research program.

Complementary alternative medicine: Examples of such services include but are not limited to massage therapy, acupuncture, and acupressure.

Drug administration: Examples of such services include, but are not limited to, chemotherapy.

Durable Medical Equipment (DME): Examples of such products include but are not limited to hearing aids, orthotics, diabetic meters and supplies, aids to daily living, and orthopedic supplies.

General radiology: Examples of such services include general and routine X-rays.

Health education/counseling services: Select if your practice provided billable services for health education and guidance to patients related to diet, weight control, diabetes, physiological, and/or genetic counseling.

Optical shop: Select if your practice or physicians owned or had financial interest in an optical service shop. Do not select if that optical shop is a separate legal entity.

PT/OT/Cardiac rehabilitation: Examples of therapies and testing that pertain to these lines of services include biofeedback and phase II cardiac rehabilitation.



Radiation therapy: Examples of such services include but are not limited to radiotherapy and X-ray therapy.

Sleeping lab/center: Examples include sleep studies or polysomnogram.

Other: Indicate any other ancillary services provided by your practice in the space provided.

What is your ACO affiliation?

ACO PRACTICES ONLY

Indicate your ACO affiliation by selecting from the options listed:

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

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

PCMH PRACTICES ONLY

Accreditation Association of Ambulatory Health Care (AAAHC): A private, non-profit organization formed in 1979 to assist ambulatory healthcare organizations in improving the quality of care provided to patients. They do this by establishing, reviewing, and revising standards, measuring performance, and providing consultation and education.

Bridges to Excellence: A program that measures the quality of care delivered in provider practices. They place a special emphasis on managing patients with chronic conditions, who are most at risk of incurring potentially avoidable complications. Their recognitions cover all major chronic conditions, plus office systems – and a real Medical Home measurement scheme to promote comprehensive care delivery and strong relationships between patients and their care teams.

The Joint Commission (JC): An independent, not-for-profit organization, which accredits and certifies more than 20,000 healthcare organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

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

URAC: An independent, nonprofit organization, which is a well-known leader in promoting healthcare quality through its accreditation, education, and measurement programs. URAC offers a wide range of quality benchmarking programs and services that model the rapid changes in the healthcare system and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire healthcare industry.

Not formally accredited.



*Did your practice utilize a care team model?

ANESTHESIOLOGY PRACTICES ONLY

According to the American Society of Anesthesiologists, the care team model consists of anesthesiologists supervising qualified nonphysician 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 nonphysician 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 nonphysicians (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.

*What best describes the structure of the medical practice's billing functions?

HOSPITAL/IDS PRACTICES ONLY

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

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

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

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

How many hospitals comprised the IDS?

HOSPITAL/IDS PRACTICES ONLY

Report the number of separately licensed hospitals that comprised the IDS. If there was a single hospital, indicate this by entering "1."

How many total licensed beds were in the IDS or hospital?

HOSPITAL/IDS PRACTICES ONLY

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



How many separate medical practices did the IDS/hospital/MSO own or manage?

HOSPITAL/IDS PRACTICES ONLY

Report the number of separate medical practices that the IDS/hospital/MSO owned or managed. If the respondent is the only medical practice in the system, indicate this by stating “one.”

How many total full-time-equivalent (FTE) physicians were employed by all the medical practices reported in the previous question?

HOSPITAL/IDS PRACTICES ONLY

Report the total number of FTE physicians that were employed by all medical practices owned by the IDS/hospital/MSO. If the respondent is the only medical practice in the system, indicate your practice’s total number of FTE physicians.



CHARGES

Gross fee-for-service charges (do not include capitation charges) (4110, 4120)⁹⁹ / [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 noncapitated patients for all payers.

Include:

- Professional services provided by physicians, nonphysician 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 should be included in “Total net fee-for-service collections/revenue”;
- The cost for such services should be included, as appropriate, in “Clinical laboratory,” “Radiology and imaging,” “Other ancillary services”; and
- The count of the number of purchased procedures for fee-for-service patients should be included in the Production tab, Number of Procedures column.

Do not include:

- 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) (4510, 4520, 4600-4700)⁹⁹ / [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.

Include:

- 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

Subtract “Adjustments to fee-for-service charges” from “Gross fee-for-service charges.”



Bad debts due to fee-for-service activity (accounts assigned to collection agencies) (6710, 6720)⁹⁹ / [6900-6920]¹¹

The difference between “Adjusted fee-for-service charges” and the amount actually collected.

Include:

- 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.

Gross charges for patients covered by capitation contracts (4130)⁹⁹ / [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.

Include:

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, nonphysician 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”; 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.

Do not include:

- 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. If capitation charges are not tracked, leave space blank.



Total gross charges

Add “Gross fee-for-service charges” and “Gross charges for patients covered by capitation contracts.”



REVENUE

*Total net fee-for-service collections/revenue [4300-4420]¹¹

Report the total technical and professional net fee-for-service revenue.

If the practice used accrual basis accounting, “Total net fee-for-service collections/revenue” should equal “Gross fee-for-service charges” less “Adjustments to fee-for-service charges,” less “Bad debts due to fee-for-service activity.”

Gross capitation revenue (per member per month capitation payments, capitation patient copayments) (4230-4283, 4530, 4291)⁹⁹ / [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.

Include:

- 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.

Do not include:

- 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 (7800)⁹⁹ / [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.



Include:

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

Net capitation revenue

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

Other medical revenue (research contract revenue, honoraria, teaching income) (4140, 4150, 4421, 4430-4480, 4540, 4550)⁹⁹ / [4810-4820, 4900-4910, 4930-4950, 4970]¹¹

Grants, honoraria, research contract revenues, government support payments, educational subsidies, meaningful use revenue, administrative payment for a Patient Centered Medical Home (PCMH), and payments from an Accountable Care Organization (ACO) for Shared Savings distribution.

Include:

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

Do not include:

- Charges for the delivery of services made possible by subsidies or grants were included in “Gross fee-for-service charges” and/or “Gross charges for patients covered by capitation contracts”; or
- The value of operating subsidies from parent organizations such as hospitals or integrated systems. Such subsidies should be included in “Financial support for operating costs.”

Revenue from hospital (include hospital subsidies) [4920, 4960]¹¹

Include all hospital subsidies and/or stipends paid to the practice which is part of a larger health system.

Include:

- 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; and



- Revenue for operational support provided to the practice from a parent organization such as a hospital, integrated delivery system, or other entity.

Revenue from the sale of medical goods and services (4140, 4410, 4420, 4540)⁹⁹ / [4340-4349]¹¹

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

Include:

- 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.

Do not include:

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

Gross revenue from other medical activities

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

Do not include:

- 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.



Cost of sales and/or cost of other medical activities (7600)⁹⁹ / [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.”

Include:

- 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) within this question total.

Do not include:

- 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 other medical revenue

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

*Total medical revenue

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

Nonmedical revenue (investment and rental revenue) (9110-9160, 9300)⁹⁹ / [9100-9140, 9160-9170, 9190]¹¹

Include:

- 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.”

Do not include:

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



Extraordinary nonmedical revenue [9150]¹¹

Revenue that is unusual in nature and infrequent in occurrence.

Include:

- Legal settlement receipts; and
- Environmental disaster recovery funds.

Do not include:

- Revenues included in “Nonmedical revenue.”

Financial support for operating costs (from parent organization) (4490, 9170)⁹⁹ / [9180]¹¹

Medical practices may receive operational support from a parent organization such as a hospital, IDS, or other entity.

Include:

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

Goodwill amortization

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

Do not include:

- 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) (9200-9243, 9300)⁹⁹ / [9200-9210, 9230-9240, 9260, 9300-9530]¹¹

Include:

- 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 2016 tax year paid or received in 2016 plus periodic withholding paid for 2016 taxes during 2016. For accrual accounting, the income tax equals the total tax liability for 2016 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,” as long as these costs are not also included in “Total operating cost”; and
- State taxes on medical revenue.

Extraordinary nonmedical cost [9220, 9600]¹¹

Cost that is unusual in nature and infrequent in occurrence.

Include:

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

Do not include:

- Cost included in “Nonmedical cost.”

Net nonmedical income or loss

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



STAFF

Provide the total full-time equivalent (FTE) support staff (to the nearest tenth FTE) in the FTE column and the associated cost (to the nearest whole dollar) in the Cost column. For “Total business operations support staff,” “Total front office support staff,” “Total clinical support staff,” “Total ancillary support staff,” and “Total support staff,” provide the total if the components are not available.

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



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

Do not include:

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

Include in Cost questions:

- 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 reported in the FTE column;
- Compensation for all support staff employed by all of 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. For example, an MSO managing two medical practices and employing one billing clerk who devotes an equal amount of time to each practice would add 50 percent of the one billing clerk’s compensation to the total cost of “Patient accounting,” Cost column, for each managed practice; and
- Compensation for both full-time and part-time employed support staff.

Do not include:

- Nonphysician provider cost, which is reported in the Provider Staffing and Cost section, Cost column;
- Any benefits for employed support staff, which should be reported as “Total employed support staff benefit cost,” Cost column;
- 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. These costs should be reported as “Total contracted support staff,” Cost column.

General administrative (5710, 8170, 8370)⁹⁹/ [5110-5111, 5117, 5210-5211, 5217]¹¹

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

Include:

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

Do not include:

- FTE and cost of directors of departments listed separately on this survey. Examples include information technology director, medical records director, laboratory director, and radiology director. Such FTE and cost should be reported in “Information technology,” “Medical records,” “Clinical laboratory,” or “Radiology and imaging,” as appropriate; or



- Credentialing staff as they pertain to managed care departments, such FTE and cost should be reported in “Managed care administrative.”

Patient accounting (5715)⁹⁹ / [5112, 5212]¹¹

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

General accounting (5715)⁹⁹ / [5113, 5213]¹¹

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

Managed care administrative (5720)⁹⁹ / [5114, 5214]¹¹

FTE and cost of managed care administrative staff, such as supporting secretaries and administrative assistants.

Include:

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

Information technology (5725)⁹⁹ / [5115, 5215]¹¹

FTE and cost of information technology staff, such as data processing, computer programming, telecommunications staff, EHR or initiative compliance specialists, department director, or manager.

Housekeeping, maintenance, security (5730)⁹⁹ / [5116, 5216]¹¹

FTE and cost of housekeeping, maintenance, and security staff.

Do not include:

- FTE and cost of parking attendants if parking generates revenue, which is reported as “Nonmedical revenue” in the Revenue section. The cost of parking attendants should be included as “Nonmedical cost.”

*Total business operations support staff FTE and Cost

Total the FTE and cost for “General administrative,” “Patient accounting,” “General accounting,” “Managed care administrative,” “Information technology” and “Housekeeping, maintenance, security.” Provide this total even if you are unable to provide all the values requested in previous questions.

Medical receptionists (5735)⁹⁹ / [5121, 5221]¹¹

FTE and cost of medical receptionist staff, such as switchboard operators, schedulers, and appointment staff.

**Do not include:**

- FTE and cost of medical receptionists who worked exclusively in the departments of clinical laboratory, radiology and imaging, or other ancillary departments. Such FTE and cost is included in “Clinical laboratory,” “Radiology and imaging,” and “Other medical support services.”

Medical secretaries, transcribers (5740)⁹⁹ / [5122, 5222]¹¹

FTE and cost of medical secretaries and transcribers.

Do not include:

- FTE and cost of medical secretaries and transcribers who worked exclusively in the departments of clinical laboratory, radiology and imaging, or other ancillary departments. Such FTE and cost is included in “Clinical laboratory,” “Radiology and imaging,” and “Other medical support services.”

Medical records (5745)⁹⁹ / [5123, 5223]¹¹

FTE and cost of medical records staff such as medical records clerks and department director or manager.

Do not include:

- FTE and cost of medical records and coding staff who worked exclusively in the departments of clinical laboratory, radiology and imaging or other ancillary departments. Such FTE and cost is included in “Clinical laboratory,” “Radiology and imaging,” and “Other medical support services.”

Other administrative support (5750)⁹⁹ / [5124, 5224]¹¹

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

***Total front office support staff FTE and Cost [5120, 5220]¹¹**

Total the FTE and cost of “Medical receptionists,” “Medical secretaries, transcribers,” “Medical records” and “Other administrative support.” Provide this total even if you are unable to provide all the values requested in previous questions.

Registered nurses (5755)⁹⁹ / [5131, 5231]¹¹

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

Do not include:

- FTE and cost of nonphysician providers such as nurse practitioners, certified registered nurse anesthetists (CRNAs), or nurse midwives, who are included in “Total nonphysician provider” FTE and cost; or
- FTE and cost of registered nurses who worked exclusively in the departments of clinical laboratory, radiology and imaging or other ancillary departments. Such FTE and cost is included in “Clinical laboratory,” “Radiology and imaging,” and “Other medical support services.”



Licensed practical nurses (5760)⁹⁹ / [5132, 5232]¹¹

FTE and cost of licensed practical nurses.

Do not include:

- FTE and cost of licensed practical nurses who worked exclusively in the departments of clinical laboratory, radiology and imaging, or other ancillary departments. Such FTE and cost is included in “Clinical laboratory,” “Radiology and imaging,” and “Other medical support services.”

Medical assistants, nurse’s aides (5765)⁹⁹ / [5133, 5134, 5233, 5234]¹¹

FTE and cost of medical assistants and nurse's aides.

Do not include:

- FTE and cost of medical assistants and nurse aides who worked exclusively in the departments of clinical laboratory, radiology and imaging, or other ancillary departments. Such FTE and cost is included in “Clinical laboratory,” “Radiology and imaging,” and “Other medical support services.”

*Total clinical support staff FTE and Cost [5130, 5230]¹¹

Total the FTE and cost answers of “Registered nurses,” “Licensed practical nurses” and “Medical assistants, nurse’s aides.” Provide this total even if you are unable to provide all the values requested in the previous questions.

Clinical laboratory (5520)⁹⁹ / [5142, 5242]¹¹

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

Include:

- FTE and cost of support staff such as nurses, phlebotomists, secretaries and technicians; and
- FTE and cost of department director or manager.

Radiology and imaging (5510)⁹⁹ / [5141, 5241]¹¹

Film library staff and the diagnostic radiology and imaging department conducts procedures for diagnostic radiology CPT codes 70010-76499, diagnostic ultrasound CPT codes 76506-76999, and diagnostic nuclear medicine CPT codes 78012-78999, echocardiography CPT codes are 93303-93355, noninvasive vascular diagnostic studies CPT codes 93880-93998, and electrocardiograph CPT codes 93000-93042.

Include:

- FTE and cost of support staff such as nurses, secretaries, and technicians; and
- FTE and cost of department director or manager.

Do not include:

- FTE and staff cost for radiation oncology CPT codes 77261-77799 or therapeutic nuclear medicine CPT codes 79005-79999. Such FTE and cost is included as “Other medical support services.”



Other medical support services (5530-5550)⁹⁹ / [5143-5160, 5243-5260]¹¹

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

Include:

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

Do not include:

- Nonphysician providers such as nurse practitioners, physician's assistants and physical therapists. These providers should be reported in "Nonphysician provider compensation," "Nonphysician provider benefit cost," and "Total nonphysician providers."

*Total ancillary support staff FTE and Cost [5140, 5240]¹¹

Subtotal the FTE and cost for "Clinical laboratory," "Radiology and imaging" and "Other medical support services." Provide this total even if you are unable to provide all the variables requested in previous questions.

*Total employed support staff FTE and Cost [5100, 5200]¹¹

Add "Total business operations support staff," "Total front office support staff," "Total clinical support staff," and "Total ancillary support staff" answers.

*Total employed support staff benefit cost (5610-5695, 5810-5895)⁹⁹ / [5170, 5180, 5300-5460]¹¹

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

Include:

- 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.

**Do not include:**

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

Total contracted support staff (temporary) (5903, 5904, 5913, 5914, 7710)⁹⁹ / [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 described in the “Staff” section. Instead, the practice contracts to have these full-time and/or ongoing activities conducted by contracted staff.

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

Include:

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

Do not include:

- The FTE and cost of support staff employed directly by the practice or any of the legal entities comprising the medical practice. Such FTE counts and related costs are included in the “Staff” section, FTE and Cost columns; or
- The FTE and cost for legal, accounting, management, and/or other consultants for services performed on a one time or sporadic basis. The FTE counts for these types of consultants are not reported on this portion of the survey. The costs for these types of consultants are reported as “Legal fees, Consulting fees, and/or Outside professional fees.”

In the case where the exact FTE count is unknown, use your best judgment to estimate the FTE counts for “Total contracted support staff.” One method is to estimate the annual total hours worked by all the “contracted support staff” and divide that estimate by the total number of hours that the practice expects one full-time support staff employee to work during the course of one year.

***Total support staff**

For “Total support staff” FTE, add answers “Total employed support staff” and “Total contracted support staff,” FTE column.

For “Total support staff” cost, add answers “Total employed support staff,” “Total employed support staff benefit cost,” and “Total contracted support staff,” Cost column.



Phone triage

OB/GYN PRACTICES ONLY

FTE and cost for staff that work on phone triage duties.

Include:

- LPNs, RNs, MAs and any other clinical staff that are assigned phone triage duties.

Do not include:

- Administrative staff such as medical receptionists.

Sonography

OB/GYN PRACTICES ONLY

FTE and cost for staff that perform ultrasound/sonography procedures.

Include:

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

Mammography

OB/GYN PRACTICES ONLY

FTE and cost for staff that perform mammography procedures.

Include:

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

Bone densitometry

OB/GYN PRACTICES ONLY

FTE and cost for staff that perform bone densitometry procedures.

Include:

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



Who employed the medical practice's administrative staff? (Select all that apply)

HOSPITAL/IDS PRACTICES ONLY

Administrative staff includes general administrative, patient accounting, general accounting, managed care administrative, information technology, housekeeping, maintenance, security, medical receptionists, medical secretaries, transcribers, medical records, and other administrative support. If the administrative staff were employed by more than one organization, indicate the organization that employed the most staff members.

IDS/hospital: The IDS/hospital employed the staff.

Medical practice: The medical practice employed the staff.

MSO/PPMC: The MSO/PPMC employed the staff.

Other: Some other organization employed the staff.

Who employed the clinical support staff for the medical practice?

HOSPITAL/IDS PRACTICES ONLY

Clinical support staff includes registered nurses, licensed practical nurses, medical assistants and nurse's aides. If the administrative staff were employed by more than one organization, indicate the organization that employed the most staff members.

IDS/hospital/MSO: The IDS/hospital/MSO employed the staff.

Medical practice: The medical practice employed the staff.

Both: Both the IDS/hospital/MSO as well as the medical practice employed the staff.

Other: Some other organization employed the staff.

What percentage of clinical support staff was employed by the medical practice?

HOSPITAL/IDS PRACTICES ONLY

Answer the percentage of staff that is employed by either the IDS/hospital or medical practice. The combined percentages for each employer should add up to 100%.



EXPENSES

Provide the operating cost (to the nearest whole dollar).

Do not include:

- “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;
- Nonphysician provider cost, which is included in the Provider Staffing and Cost section;
- Cost included in “Purchased services for capitation patients”; and
- “Nonmedical cost.”

Information technology (6120, 6220, 6304, 6420, 6430, 6530, 7120)⁹⁹ / [6800-6860]¹¹

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

Include:

- 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.

Do not include:

- 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,” Cost column.

Drug supply (7010)⁹⁹ / [7210-7213]¹¹

Cost of drugs purchased for general practice use.

Include:

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

**Do not include:**

- Cost of specialized supplies dedicated for exclusive use in the departments of clinical laboratory, radiology, and imaging, or other ancillary services departments. Such cost is included in “Clinical laboratory,” “Radiology and imaging,” and “Other ancillary services”; 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 (7020-7040)⁹⁹ / [7200, 7220-7224]¹¹

Cost of supplies purchased for general practice use.

Include:

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

Do not include:

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

Building and occupancy (6150, 7070, 7510-7544, 7560, 7570, 7590, 7595)⁹⁹ / [6100, 6120-6190]¹¹

Cost of general operation of buildings and grounds.

Include:

- 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.

**Do not include:**

- 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.

Do not include:

- 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 (6110, 6115, 6301-6303, 6305-6307, 6510, 6515, 6580, 7100, 7110, 7161)⁹⁹ / [6200, 6220-6230, 7100, 7120, 7130]¹¹

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

Include:

- 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.

Do not include:

- 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]¹¹

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

Include:

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

Do not include:

- 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 (6130, 6140, 6160, 6190-6210, 6370, 6380, 6400, 6540-6570, 6600, 6650, 6730, 7130, 7140, 7720)⁹⁹ / [6300-6336, 6350-6351, 6353-6355, 6357, 6358, 6361, 6363-6524, 7230-7240]¹¹

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

Include:

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

Professional liability insurance premiums (6185-6189)⁹⁹ / [6720-6726]¹¹

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

Other insurance premiums (6180-6184, 7580)⁹⁹ / [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 (6320)⁹⁹ / [6342]¹¹

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

Include:

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



Consulting Fees (6350)⁹⁹ / [6345]¹¹

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

Include:

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

Outside professional fees (6310, 6330, 6340, 6360)⁹⁹ / [6340-6341, 6343-6344, 7830-7839]¹¹

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

Include:

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

Do not include:

- 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,” Cost column; or
- Cost for contracted physicians and locum tenens, which is reported as “Total physician” FTE and Cost.

Promotion and marketing (6170, 7050)⁹⁹ / [6600]¹¹

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

Clinical laboratory (7022, 7163)⁹⁹ / [7400-7440]¹¹

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

Include:

- 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.

Do not include:

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



Radiology and imaging (7021, 7162)⁹⁹ / [7300-7340]¹¹

Cost of diagnostic radiology and imaging procedures defined by diagnostic radiology CPT codes 70010-76499, diagnostic ultrasound CPT codes 76506-76999, diagnostic nuclear medicine CPT codes 78012-78999, echocardiography CPT codes 93303-93355, noninvasive vascular diagnostic studies CPT codes 93880-93998, and electrocardiography CPT codes 93000-93042.

Include:

- 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.

Do not include:

- Cost of purchased radiology technical services for capitation patients. Such cost should be 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” in this section.

Other ancillary services (7023)⁹⁹ / [7500-7640]¹¹

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

Include:

- 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.

Do not include:

- Cost of purchased “other ancillary” technical services for capitation patients. Such cost should be 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 (6520)⁹⁹ / [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 should be considered “Billing and collections purchased services.”

Include:

- Claims clearinghouse cost.

Management fees paid to an MSO or PPMC (7730-7740)⁹⁹ / [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. Whatever the methodology, report the amount here.

Include:

- 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. The decision of whether to report these support staff costs in the “Staff” section, or in the “Management fees paid to an MSO or PPMC” depends on the quality of the FTE data. If FTE data for the MSO/PPMC support staff is accurate and easily obtainable, it is preferable to report the MSO/PPMC support staff FTE and cost in the “Staff” section. If the FTE counts are not known, it is suggested that the support staff cost be treated as a purchased service and be reported in “Management fees paid to an MSO or PPMC.”

Do not include:

- The cost of support staff employed by the MSO/PPMC, if these costs were reported in the “Staff” section.

Miscellaneous operating cost (6230-6270, 6390, 6410, 6440, 7150, 7550)⁹⁹

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

Do not include:

- Federal or state income taxes, which are included in “Nonmedical cost;” or
- Principal paid on loans, which is not reported anywhere in this survey.



Cost allocated to medical practice from parent organization

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

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

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

Do not include:

- Cash loans made to subsidiaries. Cash for loans does not appear anywhere on this survey.

*Total general operating cost

Add “Information technology” through “Cost allocated to medical practice from parent organization.”

*Total operating cost

Add “Total support staff” cost column and “Total general operating cost.”



PROVIDERS

To compute the FTE numbers for the FTE column, add the number of full-time (1.0 FTE) providers to the FTE count for the part-time providers. 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. To compute the FTE of a part-time provider, divide the total hours worked by the number of hours that your practice considered to be a normal workweek. 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.

**Include:**

- 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.

Do not include:

- Full-time physician administrators or the time that a physician devotes to medical director activities. The FTE and cost for such activities should be included as "General administrative," FTE column and Cost column.

Occupational therapist

ORTHOPEDIC PRACTICES ONLY

FTE of occupational therapists who are licensed health professionals trained to evaluate patients with joint conditions such as arthritis, to determine the impact the disease has on activities of daily living.

Physical therapist

ORTHOPEDIC PRACTICES ONLY

FTE of physical therapists who are individuals trained and certified by a state or accrediting body to design and implement physical therapy programs.

Nurse practitioners

OB/GYN PRACTICES ONLY

FTE of nurse practitioners.

Physician assistants

OB/GYN PRACTICES ONLY

FTE of physician assistants.

Certified nurse midwives

OB/GYN PRACTICES ONLY

FTE of certified nurse midwives.

Nurse practitioners

PRIMARY CARE PRACTICES ONLY

FTE and cost of nurse practitioners.

Physician assistants

PRIMARY CARE PRACTICES ONLY

FTE and cost of physician assistants.



Midwives

PRIMARY CARE PRACTICES ONLY

FTE and cost of midwives.

Psychologists

PRIMARY CARE PRACTICES ONLY

FTE and cost of psychologists.

Dieticians/nutritionists

PRIMARY CARE PRACTICES ONLY

FTE and cost of dieticians/nutritionists.

Other nonphysician providers

PRIMARY CARE PRACTICES ONLY

FTE and cost of other nonphysician providers.

Nonphysician provider compensation (8310-8360, 8380)⁹⁹ / [8410-8416, 8419, 8510-8516, 8519]¹¹

Nonphysician providers are specially trained and licensed providers who can provide medical care and billable services. Examples of nonphysician providers include audiologists, certified registered nurse anesthetists (CRNAs), dieticians/nutritionists, midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physician assistants, psychologists, and surgeon assistants. Report the total compensation paid to nonphysician providers who comprise the count of "Total nonphysician provider," Cost column.

Include:

- Compensation for both employed and contracted nonphysician providers;
- Compensation for full-time and part-time nonphysician providers;
- Provider wages reported as direct compensation in Box on a W2, 1099 or K1 (for partnerships);
- 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.

Do not include:

- Amounts included in "Nonphysician 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.



Nonphysician provider benefit cost (8410-8495)⁹⁹ / [8417-8418, 8420-8480, 8517-8518, 8520-8580]¹¹

Include:

- 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.

Do not include:

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

*Total nonphysician providers

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

To compute "Total nonphysician provider," Cost column, add "Nonphysician provider compensation" and "Nonphysician provider benefit cost," Cost column.



Primary care physicians

Include:

- Family medicine: sports medicine
- Family medicine: urgent care
- Family medicine: with obstetrics
- Family medicine: without obstetrics
- Geriatrics
- Internal medicine: general
- Pediatrics: adolescent medicine
- Pediatrics: general
- Pediatrics: internal medicine
- Pediatrics: sports medicine
- Urgent care

OB/GYN: maternal & fetal medicine physicians

OB/GYN PRACTICES ONLY

FTE of OB/GYN maternal & fetal medicine physicians.

OB/GYN: reproductive endocrinology physicians

OB/GYN PRACTICES ONLY

FTE of OB/GYN reproductive endocrinology physicians.



Nonsurgical specialty physicians

Include:

- Allergy/immunology
- Cardiology: electrophysiology
- Cardiology: invasive
- Cardiology: invasive/interventional
- Cardiology: noninvasive
- Critical Care: intensivist
- Dentistry
- Dermatology
- Emergency medicine
- Endocrinology/metabolism
- Gastroenterology
- Gastroenterology: hepatology
- Genetics
- Hematology/oncology
- Hematology/oncology: oncology (only)
- Hospitalist: internal medicine
- Infectious disease
- Nephrology
- Neurology
- OB/GYN: maternal and fetal medicine
- OB/GYN: reproductive endocrinology
- Occupational medicine
- Orthopedics: nonsurgical
- Pathology: anatomic
- Pathology: anatomic and clinical
- Pathology: clinical
- Pediatrics: allergy/immunology
- Pediatrics: cardiology
- Pediatrics: child development
- Pediatrics: clinical and lab immunology
- Pediatrics: critical care intensivist
- Pediatrics: emergency medicine
- Pediatrics: endocrinology
- Pediatrics: gastroenterology
- Pediatrics: genetics
- Pediatrics: hematology/oncology
- Pediatrics: hospitalist
- Pediatrics: infectious disease
- Pediatrics: neonatal medicine
- Pediatrics: nephrology
- Pediatrics: neurology
- Pediatrics: pulmonology
- Pediatrics: rheumatology
- Physiatry (physical medicine and rehabilitation)
- Podiatry: general
- Psychiatry: addiction medicine
- Psychiatry: chemical dependency
- Psychiatry: child and adolescent
- Psychiatry: forensic
- Psychiatry: general
- Psychiatry: geriatric
- Pulmonary medicine: general
- Pulmonary medicine: critical care
- Radiation oncology
- Radiology: diagnostic-invasive
- Radiology: diagnostic-noninvasive
- Radiology: nuclear medicine
- Rheumatology
- Sleep medicine



OB/GYN: general physicians

OB/GYN PRACTICES ONLY

FTE of OB/GYN general physicians.

OB/GYN: gynecology only physicians

OB/GYN PRACTICES ONLY

FTE of OB/GYN gynecology only physicians.

OB/GYN: gynecological oncology physicians

OB/GYN PRACTICES ONLY

FTE of OB/GYN gynecology oncology physicians.

Surgical specialty physicians

Include:

Anesthesiology	Pediatrics: otorhinolaryngology
Anesthesiology: pain management	Pediatrics: plastic and reconstructive surgery
Dermatology: Mohs surgery	Pediatrics: surgery
OB/GYN: gynecology (only)	Pediatrics: urology
OB/GYN: gynecological oncology	Podiatry: surgical - foot and ankle
Obstetrics/gynecology: general	Podiatry: surgical - forefoot only
Ophthalmology	Surgery: cardiovascular
Ophthalmology: retina	Surgery: colon and rectal
Orthopedic surgery: general	Surgery: endovascular (primary)
Orthopedic surgery: foot and ankle	Surgery: general
Orthopedic surgery: hand	Surgery: neurological
Orthopedic surgery: hip and joint	Surgery: oncology
Orthopedic surgery: oncology	Surgery: oral
Orthopedic surgery: spine	Surgery: plastic and reconstruction
Orthopedic surgery: sports medicine	Surgery: plastic and reconstruction - hand
Orthopedic surgery: trauma	Surgery: thoracic (primary)
Otorhinolaryngology	Surgery: transplant
Pediatrics: anesthesiology	Surgery: trauma
Pediatrics: cardiovascular surgery	Surgery: trauma - burn
Pediatrics: ophthalmology	Surgery: vascular (primary)
Pediatrics: orthopedic surgery	Urology



Total physician compensation (8110-8160, 8180)⁹⁹ / [8110-8116, 8119, 8210-8216, 8219, 8310-8316, 8319, 8610-8616, 8619]¹¹

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

Include:

- 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 125 plans; and
- Compensation attributable to activities related to revenue in “Nonmedical revenue.”

Do not include:

- 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 (8210-8295)⁹⁹ / [8117-8118, 8120-8180, 8217-8218, 8220-8280, 8317-8318, 8320-8380, 8413, 8617-8618, 8620-8680]¹¹

The total benefits paid to physicians who comprise “Total physicians,” FTE column.

Include:

- 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.

Do not include:

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

*Total physicians

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

*Total providers

For “Total providers” FTE, add “Total nonphysician providers” and “Total physicians,” FTE column. For “Total providers” cost, add “Total nonphysician providers” and “Total physicians,” Cost column.

*Did your practice have a dedicated staffing model?

PRIMARY CARE PRACTICES ONLY

Please indicate “yes” if your practice has a dedicated staff model. An example of a medical practice with a dedicated staffing model is one in which each physician has an individual nurse that he/she works with on a daily basis.

Faculty anesthesiologists

ANESTHESIOLOGY PRACTICES ONLY

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

*Nonfaculty anesthesiologists

ANESTHESIOLOGY PRACTICES ONLY

Report the FTE and cost for all nonfaculty anesthesiologists.

Employed versus contracted:

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



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

Contracted anesthesiologists

ANESTHESIOLOGY PRACTICES ONLY

Report the FTE and cost for all contracted anesthesiologists.

Employed versus contracted:

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

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

Employed CRNAs

ANESTHESIOLOGY PRACTICES ONLY

Report the FTE and cost for all employed CRNAs.

Contracted CRNAs

ANESTHESIOLOGY PRACTICES ONLY

Report the FTE and cost for all contracted CRNAs.

SRNAs

ANESTHESIOLOGY PRACTICES ONLY

Report the FTE and cost for all SRNAs.

Anesthesiology assistants

ANESTHESIOLOGY PRACTICES ONLY

Report the FTE and cost for all anesthesiology assistants.



Residents/fellows

ANESTHESIOLOGY PRACTICES ONLY

Report the FTE and cost for all residents/fellows.



NET INCOME

*Total medical revenue after operating cost

Subtract "Total operating cost" from "Total medical revenue."

*Net practice income or loss

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



PERFORMANCE

Accounts Receivable

Provide the information regarding the age of your practice's accounts receivable (to the nearest whole dollar). Do not include accounts that have been assigned to collection agencies.

If your practice does not have any accounts receivable for a certain range, enter "0."

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. "Accounts payable to patients and payers" are subtracted from "Accounts receivable" before reporting "Accounts receivable."



This is the net amount owed after patient refunds.

Do not include:

- Capitation payments owed to the practice by HMOs.

Use the same definition given for "31 to 60 days."

Use the same definition given for "61 to 90 days."

Use the same definition given for "91 to 120 days."

Use the same definition given for "Over 120 days."

Total accounts receivable

Add "Current to 30 days," "31 to 60 days," "61 to 90 days," "91 to 120 days," and "Over 120 days."

Did your practice re-age accounts receivable when a balance was transferred to a secondary carrier or the patient's private account?

Answer "Yes" 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.

Payer Mix

Please estimate the percentage of your practice's "Total gross charges" by type of payer. The sum of the percentages must add to 100 percent. If not applicable, please enter "0."

Managed care: Managed healthcare is a system in which the provider of care is incentivized to establish mechanisms to contain costs, control utilization, and deliver services in the most appropriate settings.

There are three key factors:

- Controlling the utilization of medical services;
- Shifting financial risk to the provider; and
- Reducing the use of resources in rendering treatments to patients.

Capitation: Capitation is when a provider organization receives a fixed, previously negotiated periodic payment per member covered by the health plan in exchange for delivering specified healthcare services to the members for a specified length of time regardless of how many or how few services are actually required or rendered. Per member per month (PMPM) is the commonplace calculation unit for such capitation payments.

Medicare

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



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

Do not include:

- Fee-for-service equivalent gross charges for services provided to Medicare/TEFRA (Tax Equity and Fiscal Responsibility Act) patients under capitated, prepaid or other "at-risk" arrangements.

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

Include:

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

Do not include:

- Fee-for-service equivalent gross charges for services provided to Medicare/TEFRA (Tax Equity and Fiscal Responsibility Act) patients under capitated, prepaid arrangements.

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

Do not include:

- Charges for fee-for-service patients; or
- Charges for patients covered under discounted fee-for-service contract arrangements.

Medicaid

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

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

Do not include:

- Fee-for-service equivalent gross charges for services provided to Medicaid or other state healthcare program patients under capitated, prepaid or other "at-risk" arrangements; or
- Charges for patients covered under discounted fee-for-service contract arrangements.

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

Include:

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

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

**Do not include:**

- Charges for fee-for-service patients; or
- Charges for patients covered under discounted fee-for-service contract arrangements.

Commercial

Include all fee-for-service, managed care fee-for-service and capitated charges for all services provided patients under a commercial capitated contract.

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

Do not include:

- Charges for Medicare patients;
- Charges for Medicaid patients;
- Charges for capitation patients;
- Charges for patients covered by a managed care plan;
- Charges for workers' compensation patients;
- Charges for charity or professional courtesy patients; or
- Charges for self-pay patients.

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

Include:

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

Do not include:

- Charges for Medicare patients;
- Charges for Medicaid patients;
- Charges for capitation patients;
- Charges for workers' compensation patients;
- Charges for charity or professional courtesy patients; or
- Charges for self-pay patients.

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

Do not include:

- Charges for fee-for-service patients; or
- Charges for patients covered under discounted fee-for-service contract arrangements.



Workers' compensation

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

Do not include:

- 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.

Include:

- 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.

Include:

- Charges for TRICARE patients.

Do not include:

- Charges for Medicare and Medicaid patients.

*Total payer mix gross charges

The sum of the percentages for Medicare, Medicaid, Commercial "Workers' compensation," "Charity care," "Self-pay" and "Other federal government payers" should equal 100%.



*Specify the number of trauma centers serviced at each level

ANESTHESIOLOGY PRACTICES ONLY

If your group provides services to a level one, two, or three trauma center, specify the number of trauma centers serviced at each level in the boxes provided.

*Number of facilities staffed

ANESTHESIOLOGY PRACTICES ONLY

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

*Number of anesthetizing locations

ANESTHESIOLOGY PRACTICES ONLY

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

What was the average utilization percentage for the operating rooms that you covered at your largest hospital?

ANESTHESIOLOGY PRACTICES ONLY

Indicate the percentage for operating rooms that you covered at your largest hospital.

Utilization percentage reflects the percentage of time that billable cases are occurring in the operating room(s). List the utilization percentage between the peak hours of 7:00 a.m.-3:00 p.m., Monday-Friday.

To calculate utilization, take the total number of billable minutes and divide by the possible number of minutes in the time period. For example, if operating room three had cases going from 7:30 a.m. until 1:00 p.m., with a 30 minute break for turnover, that room would have been utilized for 300 minutes out of a possible 480 minutes (7:00 a.m.-3:00 p.m.), or 62.5 percent of the time. To calculate this statistic in the aggregate, take the total number of minutes billed between these hours at the facility in question and divide by the available minutes in the month (480 minutes x 23 days x number of operating rooms staffed).



If possible, use data that represents a twelve month period (for example, January 1, 2017 to December 31, 2017). List what you would consider a reasonable utilization for opening an operating room without requesting subsidies from a facility.

If you require assistance in calculating the utilization percentage, you may want to refer to the American Society of Anesthesiologists Web site at <http://www.asahq.org>.

What was the average utilization percentage for the operating rooms you covered at your largest surgery center?

ANESTHESIOLOGY PRACTICES ONLY

Indicate the percentage for operating rooms that you covered at your largest surgery center.

What would your group consider a reasonable utilization percentage to expect for a new operating room?

ANESTHESIOLOGY PRACTICES ONLY

Indicate the percentage for new operating rooms.

What was the total number of hospitals covered that paid a stipend?

ANESTHESIOLOGY PRACTICES ONLY

Report the total number of hospitals staffed by the practice's physicians and nonphysician providers that received a stipend.

*Total stipend amount

ANESTHESIOLOGY PRACTICES ONLY

List up to three entities' stipends. If you receive stipends from more than three entities, provide data for your three entities that have been allotted the largest stipends.

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

Entity 1 Amount

Indicate the net stipend amount for the entity with the largest total stipends.

Entity 2 Amount

Indicate the net stipend amount for the entity with the second largest total stipends.

Entity 3 Amount

Indicate the net stipend amount for the entity with the third largest total stipends.



Number of Beds

ANESTHESIOLOGY PRACTICES ONLY

Provide the number of licensed beds for the entity listed in "Total stipend amount," columns Entity 1, Entity 2, Entity 3, and total.

Entity 1 Amount

Provide the number of licensed beds for the entity with the largest total stipends, using the same entity reported in "Total stipend amount."

Entity 2 Amount

Provide the number of licensed beds for the entity with the second largest total stipends, using the same entity reported in "Total stipend amount."

Entity 3 Amount

Provide the number of licensed beds for the entity with the third largest total stipends, using the same entity reported in "Total stipend amount."

What was the medical practice's legal tax status?

HOSPITAL/IDS PRACTICES ONLY

Indicate how the Internal Revenue Service (IRS) classified the medical practice for filing federal income taxes. The medical practice may have had the same tax status of its parent, or it may have had a different legal tax status.

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

For-profit: Classified as for-profit for IRS purposes.

Were your physician offices required to comply with Joint Commission Accreditation standards?

HOSPITAL/IDS PRACTICES ONLY

Joint Commission Accreditation standards address the organization's level of performance in key functional areas, such as patient rights, patient treatment, medication safety, and infection control. They carry a CMS designation, which means that organizations accredited by The Joint Commission may choose to be "deemed" as meeting Medicare and Medicaid certification requirements. Answer 'Yes' if your offices had to comply with Joint Commission Accreditation standards.

How does the system cover malpractice/liability?

HOSPITAL/IDS PRACTICES ONLY

Indicate how the system covers malpractice/ liability costs.

Commercial Market: Coverage purchased through a commercial entity that protects the system's assets and reputation against claims of negligent acts or omissions that result in injury or harm to your patients.

Self Funded: Self-funded coverage is the establishment and professional operation of a proactive mechanism for the funding, investigation, management, defense, and payment of claims with the purpose of minimizing the system's exposure to loss of assets.

Occurrence: Occurrence policy protects you from any incident occurring while the policy is in force. Any incident that occurred while the policy was in force will be covered forever.



Claims Made: The claims made policy will only respond when the claim is made, as long as the policy continues to be in effect.

Other: If the means by which you cover malpractice/liability is other than the options provided, describe in the “Other” box.

Are all clinics on the same practice management system?

HOSPITAL/IDS PRACTICES ONLY

Indicate "Yes" if all your clinics were online with the same practice management system.

Are all clinics on an EHR?

HOSPITAL/IDS PRACTICES ONLY

Indicate "Yes" if your clinics utilized an EHR.

Is the practice's EHR integrated with the practice management system?

HOSPITAL/IDS PRACTICES ONLY

Indicate "Yes" if your group's EHR is integrated with your practice management system.

Is the practice EHR the same as the hospital's acute EHR referenced previously?

HOSPITAL/IDS PRACTICES ONLY

Indicate "Yes" if the group's EHR is the same as the hospital's EHR.

Bone densitometry (DEXA)

OB/GYN PRACTICES ONLY

Noninvasive technology that is used to measure bone mass using Dual Energy X-Ray Absorptiometry (DEXA). Indicate the number of machines, total gross charges, total medical revenue, direct operating cost and number of procedures for each ancillary service.

Ultrasound (Sonography)

OB/GYN PRACTICES ONLY

Technology that uses sound waves to obtain images of organs and tissues in the body. Indicate the number of machines, total gross charges, total medical revenue, direct operating cost and number of procedures for each ancillary service.

Total ancillary services

OB/GYN PRACTICES ONLY

Add bone densitometry (DEXA) and ultrasound (sonography). Indicate the total number of machines, total gross charges, total medical revenue, total direct operating cost and total number of procedures for bone densitometry (DEXA) and ultrasound (sonography).



*Magnetic resonance imaging (MRI) service provided

ORTHOPEDIC PRACTICES ONLY

Noninvasive radiology technique that uses magnetism, radio waves, and a computer to produce images of body structures.

*Bone densitometry (DEXA) service provided

ORTHOPEDIC PRACTICES ONLY

Noninvasive technology that is used to measure bone mass using Dual Energy X-Ray Absorptiometry (DEXA).

*Diagnostic radiology (X-ray) service provided

ORTHOPEDIC PRACTICES ONLY

Total for Diagnostic radiology (Film, Digital CR, Digital DR and C-arm).

*Electromyography service provided

ORTHOPEDIC PRACTICES ONLY

A test that measures the response of muscle fibers to electrical activity.

*Occupational therapy service provided

ORTHOPEDIC PRACTICES ONLY

A therapy based on engagement in meaningful activities of daily life especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning.

*Physical therapy service provided

ORTHOPEDIC PRACTICES ONLY

The treatment of disease by physical and mechanical means.

*Other ancillary services service provided

ORTHOPEDIC PRACTICES ONLY

Provide the name and information requested for any other ancillary services not listed above.

*Indicate whether your practice charged for the following services and the average fee attributed to each

PRIMARY CARE PRACTICES ONLY

Answer “yes” if your practice charged for any of the services listed. Provide the average payment collected for the service provided.

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

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



Online evaluation: Non face-to-face consultations.

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



PRODUCTION

Medical procedures conducted inside the practice's facilities

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

Include:

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

Do not include:

- Purchased procedures from external providers and facilities on behalf of the practice's capitation patients for which costs are reported as "Purchased services for capitation patients."

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

The five digit numbers in the following lists are the Current Procedural Terminology (CPT) codes published in *Current Procedural Terminology CPT 2016* (American Medical Association, 2015).



Medical procedures conducted inside the practice's facilities

Include:

Evaluation and Management Services (given an appropriate location code)

- 99201-99215, office or other outpatient services;
- 99241-99245, office or other outpatient consultations;
- 99354-99360, prolonged and standby services;
- 99363-99364, 99366-99368, 99441-99449, case management services;
- 99374-99375, 99377-99380, care plan oversight services;
- 99381-99387, 99391-99397, 99401-99404, 99406-99409, 99411-99412, 99420, 99429, preventive medicine services;
- 99450, 99455-99456, special evaluation and management services; and
- 99460-99465 newborn care.

Radiology Services (given an appropriate location code)

- 77261-77799, radiation oncology; and
- 79005-79999, therapeutic nuclear medicine.

Medicine Services (given an appropriate location code)

- 90281-99091; and
- 99170-99199, other services/procedures.

Do not include:

- 10021-69990, surgery procedures. These procedures are reported as "Surgery and anesthesia procedures";
- 70010-76499, diagnostic radiology. These procedures are reported as "Diagnostic radiology and imaging procedures";
- 76506-76999, diagnostic ultrasound. Report in "Diagnostic radiology and imaging procedures";
- 78012-78999, diagnostic nuclear medicine. Report in "Diagnostic radiology and imaging procedures"; or
- 80047-89398, clinical laboratory and pathology. These procedures are reported as "Clinical laboratory and pathology procedures."

Medical procedures conducted outside the practice's facilities

Include:

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

- 99217-99226, hospital observation services;
- 99221-99223, 99231-99236, 99238-99239, hospital inpatient and observation services;
- 99251-99255, inpatient consultations;



- 99281-99285, 99288, emergency services;
- 99291-99292, critical care services;
- 99466-99467, 99471-99472, 99475-99476, pediatric critical care services;
- 99468-99469, 99477-99480, neonatal critical and intensive care services;
- 99304-99310, 99315-99316, 99318, nursing facility services;
- 99324-99328, 99334-99337, domiciliary, rest home, or custodial care services;
- 99354-99360, prolonged and standby services;
- 99341-99345, 99347-99350, home services;
- 99460-99465, newborn care; and
- 99500-99602, home health services.

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

Include:

- 00100-01999, anesthesia procedures;
- 10021-36410, 36420-69990, surgery procedures;
- 99100-99140, anesthesia procedures; and
- Surgery and anesthesia procedures performed in the practice's own ambulatory surgery unit.

Do not include:

- 36415 and 36416, venous and capillary blood collection.

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

Include:

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

Do not include:

- 36415 and 36416, venous and capillary blood collection.

Clinical laboratory and pathology procedures (CPT codes 80047-89356, 36415-36416)

Include:

- 36415 and 36416, venous and capillary blood collection;
- 80047-89398, a panel of tests represented by a single CPT code is considered to be one procedure;
- HCPCS P codes;



- All clinical laboratory and pathology procedures conducted by laboratories outside of the practice's facilities as long as the practice pays the outside laboratory directly for the procedures and the procedures are only for the practice's fee-for-service patients. The cost for these purchased laboratory services should be reported as a subset of "Clinical laboratory;" and
- All procedures done either at the practice (where the practice bills at a global rate for both the technical and professional components) or procedures done at an outside facility (where the practice bills at a professional rate only).

Do not include:

- Purchased laboratory services from external providers and facilities on behalf of the practice's capitation patients for which costs are reported as "Purchased services for capitation patients."

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

Include:

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

Do not include:

- 77261-77799, radiation oncology;
- 79005-79999, therapeutic nuclear medicine. Radiation oncology and therapeutic nuclear medicine activity is included in "Medical procedures," depending on location code; or
- Purchased radiology services from external providers and facilities on behalf of the practice's capitation patients for which costs are reported as "Purchased services for capitation patients."

Total procedures and procedural gross charges

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

Nonprocedural gross charges (include chemotherapy drug charges)

Other charges not reported in "Medical procedures conducted inside the practice's facilities" through "Diagnostic radiology and imaging procedures" in the Gross Charges column.

**Include:**

- Facility fee charges for the operation of an ambulatory surgery unit;
- Facility fee charges in a hospital-affiliated practice that utilizes a split billing system where both facility fees and professional charges are billed;
- Charges for drugs and medications, administered inside the practice's facilities, such as chemotherapy drugs; and
- Charges for HCPCS A, J, R, and V codes.

Do not include:

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

Total gross charges

Add "Total procedures and procedural gross charges" and "Nonprocedural gross charges."

How many Resource Based Relative Value Scale (RBRVS) total and physician work relative value units (RVUs) units did your practice produce?

If you are an MGMA member and would like assistance in calculating your RVUs, please visit <http://data.mgma.com/DataTools/rdPage.aspx> to use the RVU calculator.

Report the relative value units (RVUs), as measured by the Resource Based Relative Value Scale (RBRVS), not weighted by a conversion factor, attributed to all professional services. An RVU is a nonmonetary standard unit of measure that indicates the value of services provided by physicians, nonphysician providers, and other healthcare professionals. The RVU system is explained in detail in the November 15, 2016 Federal Register, pages 80170-80562. Addendum D: Relative Value Units (RVUs) and Related Information presents a table of RVUs by CPT code. Your billing system vendor should be able to load these RVUs into your system if you are not yet using RVUs for management analysis. When answering this question, note the following:

- The RVUs published in the November 15, 2016 Federal Register, effective for calendar year 2017, should be used; and
- The total RVUs for a given procedure consist of three components:
 - Physician work RVUs;
 - Practice expense (PE) RVUs; and
 - Malpractice RVUs.

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

- For 2017, there were two different types of practice expense RVUs
 - Fully implemented nonfacility practice expense RVUs; and
 - Fully implemented facility practice expense RVUs.
- **"Nonfacility"** refers to RVUs associated with a medical practice that is not affiliated with a hospital and does not utilize a split billing system that itemizes facility (hospital) charges and professional charges. "Nonfacility" also applies to services performed in settings other than a hospital, skilled nursing facility, or ambulatory surgery center. You should report total RVUs that are a function of "nonfacility" practice expense RVUs.



- **“Facility”** refers to RVUs associated with a hospital affiliated medical practice that utilizes a split billing fee schedule where facility (hospital) charges and professional charges are billed separately. “Facility” also refers to services performed in a hospital, skilled nursing facility, or ambulatory surgery center. Do not report total RVUs that are a function of “facility” practice expense RVUs. If you are a hospital affiliated medical practice that utilizes a split billing fee schedule, you should report your total RVUs as if you were a medical practice not affiliated with a hospital.
- To summarize, there are two different types of total RVUs:
 - Fully implemented nonfacility total RVUs; and
 - Fully implemented facility total RVUs.
- The Federal Register Addendum D presents six columns of RVU data. The column labeled “Physician work RVUs” is what you should report as work RVUs. Any adjustments to RVU values through periodic adjustments and updates made by CMS should be included.

*Work RVUs

Include:

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

Do not include:

- RVUs for “malpractice RVUs”;
- 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

Include:

- 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, nonphysician 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.

Do not include:

- RVUs for other scales such as McGraw-Hill, California;
- The technical component (TC) associated with any medical diagnostic, laboratory, radiology, or surgical procedure. If your practice cannot break this out, report RVUs and select the appropriate response to the question regarding technical component. If you can report total RVUs without technical component, answer 0% for the technical component question; or
- RVUs where the Geographic Practice Cost Index (GPCI) equals any value other than one. The GPCI must be set to 1.000 (neutral).

ASA units

Include:

- If your practice recorded ASA units, write the total number of ASA units based on the 2017 American Society of Anesthesiology Relative Guide Report, in “ASA units.”

Do not include:

- Duplicate services.

*Number of individual patients

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

Include:

- 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 2016, but did not receive any services at all during 2017, that person would not be counted as a patient for 2017. A patient is not the same as a covered life. The number of capitated patients, for example, could be less than the number of capitated covered lives if a subset of the covered lives did not utilize any services during the 12-month reporting period.



Number of patient encounters

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

Include:

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

Do not include:

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

Practice panel size for the past 18 months

CARDIOLOGY AND PRIMARY CARE PRACTICES ONLY

Answer the panel size or 'set of patients cared for by a physician' as the number of individual unique patients that have been seen by any provider within the practice over the past 18 months. To determine the panel size per physician, use the following methodologies:

- 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.

*How many exam/treatment rooms did your practice have?

PRIMARY CARE PRACTICES ONLY

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



*Surgical anesthesia

ANESTHESIOLOGY PRACTICES ONLY

Include:

- 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.
- List base units and minutes for surgical anesthesia cases only.
 - For base units and time minutes, list one set of base units and time minutes per case only. Do not double-count medically directed cases. The best way for most practices to do this is to list physician base units and physician minutes only.
 - Academic practices should beware not to double count resident units and should only count units for the supervising attending.
 - If you have a significant number of cases which involve unsupervised CRNAs (QZ modifier), the base units and minutes for these cases should be added.

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

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

Labor epidurals (CPT codes 59409, 01960, 01967)

ANESTHESIOLOGY PRACTICES ONLY

Include:

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

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

ANESTHESIOLOGY PRACTICES ONLY

Include:

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



Epidurals (CPT codes 62318, 62319)

ANESTHESIOLOGY PRACTICES ONLY

Include:

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

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

ANESTHESIOLOGY PRACTICES ONLY

Include:

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

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

ANESTHESIOLOGY PRACTICES ONLY

Include:

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

Critical care services (CPT codes 99291, 99292)

ANESTHESIOLOGY PRACTICES ONLY

Include:

- 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

Include:

- 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 is counted 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, do not double count here.



*Total for anesthesiology procedures

ANESTHESIOLOGY PRACTICES ONLY

Add “Surgical anesthesia,” “Labor epidurals,” “C-Sections,” “Epidurals,” “Follow-up visits,” “Nerve blocks for post op pain,” “Other acute pain services,” “Critical care services,” and “Other flat fees” for total number of cases, total gross charges and total revenue.

Claims processed per biller

ANESTHESIOLOGY PRACTICES ONLY

To calculate, take the total number of claims processed by your group, divide by the total number of FTE who processed anesthesiology billing. For example, if your group processed 30,000 anesthesiology claims in 2017 and had 5.5 FTE working on anesthesia billing, you would enter 5454.54 (30,000/5.5) for “Number of claims processed per biller for anesthesia claims.”

Magnetic resonance imaging (MRI)

ORTHOPEDIC PRACTICES ONLY

Noninvasive radiology technique that uses magnetism, radio waves, and a computer to produce images of body structures. Indicate the number of machines, total gross charges, total medical revenue, direct operating cost and number of procedures for each ancillary service.

Bone densitometry (DEXA)

ORTHOPEDIC PRACTICES ONLY

Noninvasive technology that is used to measure bone mass using Dual Energy X-Ray Absorptiometry (DEXA). Indicate the number of machines, total gross charges, total medical revenue, direct operating cost and number of procedures for each ancillary service.

Diagnostic radiology (X-ray)

ORTHOPEDIC PRACTICES ONLY

Total for Diagnostic radiology (Film, Digital CR, Digital DR and C-arm). Indicate the number of machines, total gross charges, total medical revenue, direct operating cost and number of procedures for each ancillary service.

Electromyography

ORTHOPEDIC PRACTICES ONLY

A test that measures the response of muscle fibers to electrical activity. Indicate the total gross charges, total medical revenue, direct operating cost and number of procedures for each ancillary service.



Occupational therapy

ORTHOPEDIC PRACTICES ONLY

A therapy based on engagement in meaningful activities of daily life especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning. Indicate the total gross charges, total medical revenue, direct operating cost and number of procedures for each ancillary service.

Physical therapy

ORTHOPEDIC PRACTICES ONLY

The treatment of disease by physical and mechanical means. Indicate the total gross charges, total medical revenue, direct operating cost and number of procedures for each ancillary service.

Other ancillary services

ORTHOPEDIC PRACTICES ONLY

Provide the name and information requested for any other ancillary services not listed above. Indicate the total gross charges, total medical revenue, direct operating cost and number of procedures for each ancillary service.

Total ancillary services

ORTHOPEDIC PRACTICES ONLY

Add corresponding total lines from MRI, DEXA, diagnostic radiology (film, digital CR, digital DR, C-arm), diagnostic radiology (X-ray), electromyography, occupational therapy, physical therapy, physical and occupation therapy (combined) and other ancillary services. Indicate the total gross charges, total medical revenue, total direct operating cost and total number of procedures for all ancillary services.