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DEFINITIONS

Reference these definitions to guide you in pulling Compensation | Payroll | Census Data fields

NOTE: Definitions with an asterisk * are required. Questionnaires with required questions left blank may not be eligible for submission.

PRACTICE DEMOGRAPHICS

***Practice name**
A unique name, ID or tracking code for your practice(s). Only one practice should be identified per row.

***Total # of physician FTE in practice**
The practice's full-time-equivalent (FTE) physician count.

***Total # of advanced practice provider FTE in practice**
The practice's full-time-equivalent (FTE) advanced practice provider count.

***Total # of support staff FTE in practice**
The practice's total support staff FTE including business operations staff, front office support staff, clinical support staff, ancillary support staff, and contracted support staff.

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

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

***Total Patient Care Revenue (Academic Only)**
In general, all revenue received by the department from patient care activities, net of all refunds, returned checks, contractual discounts and allowances, bad debts and write-offs. The sum of total fee-for-service (FFS) revenue, net prepaid (capitation/subcapitation) revenue and net other patient care/medical services revenue equals total patient care revenue.

- **Total FFS Revenue:** A sum of net collections (receipts) from patients who are self-insured, or reimbursements from a third party insurer that compensates the department (practice plan) on a fee-for-service, or discounted fee-for service basis.
- **Net Prepaid (Capitation/Sub-Capitation) Revenue:** Includes all capitation revenue received from Health Maintenance Organizations (HMOs), risk-sharing revenue, hospital/utilization withholds, copayments and revenue received from a benefits coordination and/or reinsurance recovery situation minus professional and medical services purchased from outside providers.
- **Net Other Patient Care/Medical Services Revenue:** Includes all revenue received from the sale of goods and services such as durable medical equipment rental, revenue from medical service contracts with nursing homes or ambulatory care centers, hospital reimbursements for direct patient care, and revenue from providing ancillary services on a fixed fee or percentage contract that are not billed as fee-for-service.

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EMPLOYEE DEMOGRAPHICS AND COMPENSATION

***Employee Name/Identifier**
Unique name, ID, or tracking code for each employee, including providers. This may be the individual's actual name, initials, NPI, or an internal code used. If there are questions on your submission, we will refer to the individual's identifier.

***Provider NPI (Physicians and APPs)**
The provider's National Provider Identifier (NPI), which is 10 digits in length. Providers NPI numbers can be found here.

***Employment Status**

- **New hire:** The provider was hired by the practice during the reported fiscal year.
- **Actively employed:** The provider was employed for the full reported fiscal year. If the provider was hired during the reported fiscal year, but is not expected to begin work until the next fiscal year, do not enter the provider on this survey. NOTE: If you are the owner of the practice and owned the practice for the entire reporting year, you would fall under the "Actively employed" unless you are a new owner and you would be considered a "New hire".
- **Furloughed:** The provider was furloughed during the reported fiscal year. A furlough is a temporary, yet mandatory, leave of absence in which the provider is expected to return to work at a future date.
- **No longer employed:** If the provider left the practice, for any reason during the reported fiscal year.
- **Locum tenens:** The provider was temporary or they were hired to fill a spot for a temporary period of time during the reported fiscal year.
- **Contracted:** The provider was contracted or they were hired to fill a spot for a temporary period of time during the reported fiscal year.

***Date of Hire**
The date each individual becomes contractually bound to work at your organization. This is typically the day the individual signs official paperwork, such as W-3 and I-9 forms.

***Date of Termination**
The date an individual and your organization separate and is the last day the individual worked. For individuals that are actively employed, the date of termination should be blank.

***Provider Specialty/Employee Position**
The specialty or subspecialty where each physician and advanced practice provider (APP) spend more than 50 percent of their time. For employees (non-physician and non-advanced practice provider), the position title that best describes each individual's responsibilities.

***Provider Rank (Physicians and APPs)**
Status that most accurately reflects the provider.

- **Non-Academic Provider:** A clinical provider in a non-academic organization.
- **Non-Faculty Academic Provider:** A clinical provider in an academic organization, who isn't faculty/doesn't teach.
- **Instructor:** An academic provider who teaches (a non-tenure-track).
- **Assistant Professor:** An academic provider who assists with teaching, usually immediately below an associate professor.
- **Associate Professor:** An academic provider who teaches, usually a mid-level ranked faculty member.
- **Professor:** An academic provider who teaches, usually the highest-ranking faculty member.
- **Division Chair/Chief:** An academic provider who serves as head of a division.
- **Department Chair:** An academic provider who serves as head of the department.
- **Other:** List any other provider rank if none of the above are applicable.

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Provider Title

Indicate the applicable provider title from the below options:

- **Doctor of Medicine (M.D):** A physician who has earned a degree in medicine and specifically allopathic medicine.
- **Doctor of Osteopathic (D.O):** A physician who has earned a degree in osteopathic medicine or osteopathy.
- **Doctor of Podiatric Medicine (DPM):** is healthcare provider who focuses on treating feet, ankles, and lower legs.
- **Nurse Practitioner (NP):** An advanced practice nurse who has undergone extensive clinical education and training.
- **Physician Assistant (PA):** A healthcare professional who provides medical care, diagnoses, and treats various medical conditions, and offers preventive healthcare services.
- **Other:** Provide the appropriate title if none of the above are applicable.

Gender (Sex)

The gender for which each individual identifies with.

- Male
- Female
- Prefer not to Answer

Date of Birth (DOB)

The exact date each individual was born, including the year.

Years in Specialty/Position Experience

For physicians and advanced practice providers, report the total years of experience the provider has practiced in their specialty. For physicians, the number of years should begin when they completed their residency or fellowship. For employees, report the total years of experience in the individual's current position.

*Physician Had Supervisory Duties (Physicians)

Answer "Yes" if the physician supervised advanced practice provider(s) (APPs) or equivalent, excluding resident(s), for the full reporting period.

Supervisory Duty Compensation

Additional pay provided to the physician for overseeing and managing others alongside their regular responsibilities.

Primary Shift

- **First Shift (or Day Shift):** The provider's primary shift is daytime hours.
- **Second Shift (or Swing Shift):** The provider's primary shift runs from afternoon to evening.
- **Third Shift (or Night Shift):** The provider's primary shift runs from evening to early morning.

Exemption Status

- **Exempt:** Individuals who are exempt from receiving overtime compensation as defined by the Fair Labor Standards Act (FLSA). With some limited exceptions, exempt employees must be paid on a salary basis.
- **Nonexempt:** Individuals who are not exempt from overtime provisions as defined by the FLSA and are therefore entitled to minimum wage and overtime pay for all hours worked beyond 40 in a workweek (as well as any state overtime provisions). Nonexempt employees may be paid on a salary, hourly or other basis.

*Full-Time Equivalent

The full-time equivalent for each individual is considered to be employed by your practice. A 1.0 FTE individual 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 part-time FTE, divide the total hours worked by the individual by the total number of hours that the practice considers to be a normal workweek. For example, an individual working in a clinic or hospital on behalf of the practice for 30 hours compared to a normal workweek of 40 hours would be 0.75 FTE (30 divided by 40 hours).

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*Base Compensation

The amount paid as routine or regular compensation, regardless of the individual's funding sources or productivity. This amount is guaranteed by the hospital, practice, medical school, practice plan, etc.

Do not include:

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

*Total Compensation

The annual total dollar amount reported as direct compensation on the following forms: W2, 1099, or K1 plus all voluntary salary reductions.

Include:

- Total Medicare wages – this includes on-call compensation;
- On-call compensation – included in total Medicare wages;
- Bonus and/or incentive payments;
- Research stipends and honoraria;
- 401(k);
- Life insurance; and
- Any other pre-taxed deductions (Employee contributions).

Do not include:

- Expense reimbursements;
- Fringe benefits paid by the medical practice (such as retirement plan contributions, health insurance, and automobile allowances);
- Flex spending accounts (FSA); or
- Employer contributions.

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

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

Include:

- In box 13: Codes A through W (this includes 401(k))

For S corporations (or LLCs that file as an S corporation): total compensation is the dollar amount reported as direct compensation in Box 5 (Medicare wages and tips) from the provider's W-2 plus Box 1 minus Box 11 minus Box 12 from the provider's K-1 form 1120S (combine amounts from both forms).

Include:

- In box 12: Codes A through S (this includes 401(k))

*Hourly Rate

The amount the individual was paid hourly, if applicable. Do not annualize this number.

*First Year Guaranteed Compensation

The first year guaranteed total contract dollar amount.

Do not include:

- The dollar value of a signing bonus and other dollar amounts received through a bonus system such as production-based bonuses; or
- The dollar value of expense reimbursements, fringe benefits paid by the medical practice such as retirement plan contributions, life and health insurance or automobile allowances or any employer contributions to a 401(k), 403(b) or Keogh Plan.

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***Percent of time, in whole numbers, each provider performed the following efforts and activities (Physicians and APPs)**
The percents can be calculated in a variety of ways. Often, the difference between formulas equals the units of measurement, such as hours per day or sessions per week. In general, it's the effort performing each activity divided by the total effort. The sum of % Billable Clinical, % Administrative, % Teaching, % Research and % Other should equal 100%.

- **% Billable Clinical:** Direct patient care and consultation, individually or in a team-care setting, where a patient bill is generated, or a fee-for-service equivalent charge is recorded. Billable clinical time should include time spent coding and charting.
- **% Administrative:** Medical directorships and any other administrative duties. Do Not Include: time spent coding and charting.
- **% Teaching:** Teaching activities including classroom time, office hours, grading papers, class preparation, tutoring, lecturing, supervision of laboratory course work and residents where patient care is not provided, and any other nonclinical classroom time.
- **% Research:** Research activities including clinical research (funded and nonfunded), research training, and projects that are separately budgeted and accounted for by the medical school.
- **% Other:** Time spent performing any other efforts and activities not reflected above, if applicable.

Actual Hours Worked per Week
The average number of hours each individual worked per week.

Vacation Offered (in Hours)
The number of hours each individual was offered for vacation per year, if vacation and sick time are separate.

Total Sick Time Offered (in Hours)
The number of hours each individual was offered for sick time per year, if vacation and sick time are separate.

Total Paid Time Off (PTO) Offered (in Hours)
The total number of hours each individual was offered for paid time per year, if vacation and sick time cannot be reported separately.

Include:

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

Do not include:

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

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Percentage of total compensation, in whole numbers, each method is used to compensate each provider (Physicians and APPs)

The percentage of each method for the provider's compensation plan utilized in your practice. Provide the whole-number proportion that each method makes up of the entire plan. The sum of % of Total Compensation based on Straight/Base Salary, Productivity, Quality and Patient Experience Metrics, On-Call Compensation and Other Metrics should equal 100%.

- **% of Total Compensation based on Straight/Base Salary:** Compensation is a fixed, guaranteed salary.
- **% of Total Compensation based on Productivity:** Productivity measures volume of physician work RVUs, collections, etc. This also includes equal share of compensation pool. A "compensation pool" is equal to the total practice revenues net of practice overhead expenses. Such plans generally treat practice overhead as a cost of doing business that is borne by the group as a whole and not allocated to individual physicians (with the potential exception of physician-specific direct expenses). Such plans may be referred to as "team" or "group-oriented" compensation methods.
- **% of Total Compensation based on Quality and Patient Experience Metrics:** Examples of quality measures include, but are not limited to, clinical process/effectiveness, patient safety, care coordination, patient and family engagement, efficient use of healthcare resources, population/public health and patient satisfaction.
- **% of Total Compensation based on On-Call Compensation:** Compensation based on "on-call" time.
- **% of Total Compensation based on Other Metrics:** Compensation for metrics not reflected above (e.g., medical directorship stipend, honoraria, etc.), if applicable.

Type of Compensation Tax Form

The form type (W2, K1, 1099) used to report each individuals' wages.

Bonus/Incentive

The annual total dollar amount for any bonus or incentive payments received by each individual. This amount should be included in the "Total Annual Compensation" amount.

Retirement Benefits

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

Do not include:

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

Overtime Compensation

The annual total dollar amount for any overtime payments received by each individual. This amount should be included in the "Total Compensation" amount.

Compensation Included Revenue from Separate Facility Fee (Physicians and APPs)

Report whether the physician received compensation that could be attributed to a separate facility fee. This could include compensation from ownership in an ASC or cath lab, for example.

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PRODUCTIVITY

***Does this provider's productivity include any that was not their own?**
State if the productivity measures (collections, charges, encounters, E/M procedures, RVUs, ASA units) include productivity attributed to an advanced practice provider working under a physician's supervision by selecting "Yes" or "No."

***Can APP Bill Under Themself? (APP Only)**
For advanced practice providers only, indicate if they can or cannot bill the procedures they perform under themselves, as opposed to under a physician within the practice.

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

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

***Total RVUs**
The total RVUs reported in the data set will only reflect those performed by the physician or advanced practice provider in the practice.

Include:

- RVUs for the "physician work RVUs," "practice expense," and "malpractice RVUs," including any adjustments made because of modifier usage;
- RVUs for all professional medical and surgical services performed by providers;
- RVUs for the professional component of laboratory, radiology, medical diagnostic and surgical procedures;
- RVUs for procedures for both fee-for-service and capitation patients; and
- RVUs for all payers, not just Medicare. 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.
- RVUs attributed to advanced practice providers or any other external provider within the physician RVU data; or
- RVUs where the Geographic Practice Cost Index (GPCI) equals any value other than one. The GPCI must be set to 1.000 (neutral).

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*Work RVUs

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

Include:

- RVUs for the "physician work RVUs" only, including any adjustments made because of modifier usage;
- Physician work RVUs for all professional medical and surgical services performed by providers;
- Physician work RVUs for the professional component of laboratory, radiology, medical diagnostic, and surgical procedures;
- Physician work RVUs for procedures for both fee-for-service and capitation patients;
- Physician work RVUs for all payers, not just Medicare;
- Physician work RVUs for purchased procedures from external providers on behalf of the practice's fee-for-service patients;
- Anesthesia practices should provide the physician work component of the RVU for flat fee procedures only such as lines, blocks, critical care visits, intubations, and postoperative management care; and
- All RVUs associated with professional charges, including both medically necessary and cosmetic RVUs.

Do not include:

- RVUs for "malpractice RVUs" or "practice expense RVUs";
- RVUs attributed to advanced practice providers or any other external provider within the physician RVU data;
- RVUs for other scales such as McGraw-Hill or California;
- RVUs for purchased procedures from external providers on behalf of the practice's capitation patients;
- RVUs where the Geographic Practice Cost Index (GPCI) equals any value other than one.
- The GPCI must be set to 1.000 (neutral); or
- Anesthesiology departments. The departments reported ASA units.

ASA UNITS

American Society of Anesthesiologists (ASA) units. The ASA units for a given procedure consist of three components: Base unit, time in 15-minute increments, and risk factors.

Please note

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

Collections for Professional Charges

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

Include:

- Fee-for-service collections;
- Allocated capitation payments;
- Personally performed administration of chemotherapy drugs; and
- Personally performed administration of immunizations.

Do not include:

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

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Professional Gross Charges

Gross patient charges are the full dollar value, at the practice's established undiscounted rates*, of services provided to all patients before reduction by charitable adjustments, professional courtesy adjustments, contractual adjustments, employee discounts, and bad debts. For both Medicare participating and nonparticipating providers, gross charges include the practice's full, undiscounted charge and not the Medicare limiting charge.

Include:

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

Do not include:

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

Encounters

A documented interaction, regardless of setting (including tele-visits and e-visits), between a patient and healthcare provider(s) for the purpose of providing medical services, assessing illness or injury, and determining the patient's health status. If a patient sees two different providers on the same day for one diagnosis, it is one encounter. However, if a patient sees two different providers from two different specialties/practices for the same diagnosis on the same day, it is considered two encounters. If a patient sees two different providers on the same day for two unrelated issues, then it is considered two encounters. Encounters are procedures from the evaluation and management chapter (CPT codes 99202-99499) or the medicine chapter (CPT codes 90281-99607) of the Physicians' Current Procedural Terminology, Fourth Edition, copyrighted by the American Medical Association (AMA).

Include:

- Pre- and post-operative visits and other visits associated with a global charge;
- Visits that resulted in a coded procedure;
- The total number of procedures or reads for diagnostic radiologists and pathologists, regardless of place of service;
- For obstetrics care, where a single CPT-4 code is used for a global service, each is counted as a separate ambulatory encounter (e.g., each prenatal visit and postnatal visit is one encounter). The delivery is counted as a single encounter; and
- Encounters that include procedures from the surgery chapter (CPT codes 10021-69979) or anesthesia chapter (CPT codes 00100-01999).

Do not include:

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

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Number of Outpatient E/M Codes

Include:

- 90791, 99202-99499, Psychiatric diagnostic evaluation;
- 90792, 99202-99499, Psychiatric diagnostic evaluation with medical services;
- 99202-99205, 99211-99215, office or other outpatient services;
- 99217, 99220-99226, 99234-99236, hospital observation services;
- 99241-99245, office consultations;
- 99281-99288, emergency department services;
- 99304-99310, 99315-99316, 99318, nursing facility services;
- 99324-99328, 99334-99337, domiciliary, rest home or custodial care services;
- 99339-99340, domiciliary, rest home, or home care plan overnight services;
- 99341-99345, 99347-99350, home services;
- 99354-99355, prolonged physician service in the office or outpatient setting;
- 99366-99368, medical team conference;
- 99374-99375, 99377-99380, care plan oversight services;
- 99381-99387, 99391-99397, 99401-99404, 99406-99409, 99411-99412, 99420, 99429, preventive medicine services;
- 99441-99444, non-face-to-face physician services;
- 99446-99449, interprofessional telephone/internet consultations;
- 99450, 99455-99456, special evaluation and management services;
- 99461, normal newborn care in other than hospital or birthing room setting;
- 99483, cognitive assessment and care plan services; and
- 99492-99494, psychiatric collaborative care management services.

Do not include:

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

Number of Inpatient E/M Codes

Include:

- 99221-99223, 99231-99233, 99238-99239, hospital inpatient services;
- 99251-99255, inpatient consultations;
- 99291-99292, 99471-99472, 99468-99469, critical care services;
- 99356-99359, prolonged physician service in the inpatient setting;
- 99360, physician standby services;
- 99366-99368, medical team conference;
- 99460, 99462-99465, newborn care;
- 99466-99467, pediatric patient transport;
- 99468-99476, inpatient neonatal and pediatric critical care;
- 99477, initial hospital care, neonatal intensive care services;
- 99478-99480, subsequent hospital care, neonatal intensive care services;
- 99487-99490, complex chronic care coordination;
- 99495-99496, transitional care management services; and
- 99497-99498, advance care planning.

Do not include:

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

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ON CALL FOLLOW-UP QUESTIONS (PHYSICIANS AND APPS)

For physicians and advanced practice providers that received payments for being on call, you will be prompted to answer the following questions.

Type of On-Call Coverage Provided

Indicate the type of call that most closely describes what was provided by each provider.

- **No Call Provided:** If the provider does not take call, indicate "No Call Provided"
- **Restricted:** A type of on-call coverage in which the provider must be present at the facility throughout the additional block.
- **Unrestricted:** A type of on-call coverage in which the provider must be available to respond to pages as necessary. Also referred to as "beeper only" coverage.
- **Both Restricted/Unrestricted:** A type of on-call coverage in which the provider must be present at the facility for part of the additional block and is available to respond to pages, as necessary, for the other part of his or her coverage.
- **Trauma Call – Level 1:** The provider must only be available for emergency trauma call while providing on-call coverage.
- **Trauma Call – Level 2:** The provider must only be available for emergency trauma call while providing on-call coverage.
- **Trauma Call – Level 3**: The provider must only be available for emergency trauma call while providing on-call coverage.
- **Trauma Call – Level 4:** The provider must only be available for emergency trauma call while providing on-call coverage.
- **General ED Call:** The provider must only be available for general emergency department call while providing on-call coverage.
- **Other:** List any other type of coverage if none of the above are applicable.

Method by which the Provider was Compensated for On-Call Coverage

Indicate the period for which the on-call compensation amount was paid for each provider.

- **Hourly Rate:** The provider is paid a defined amount for each hour spent providing on-call coverage.
- **Daily Stipend:** The provider is paid a defined amount for each day spent providing on-call coverage.
- **Weekly Stipend:** The provider is paid a defined amount for each week spent providing on-call coverage.
- **Monthly Stipend:** The provider is paid a defined amount for each month spent providing on-call coverage.
- **Annual Stipend:** The provider is paid a defined amount for the entire year for all time spent providing on-call coverage.
- **Per Work RVU:** The provider is paid a defined amount for each work RVU generated while providing on-call coverage.
- **Per Procedure:** The provider is paid a defined amount for each procedure completed while providing on-call coverage.
- **Other Compensation Method:** List any other compensation method if none of the above are applicable.
- **No Additional Compensation:** The provider is not paid additional compensation for providing on-call coverage.
- **Not Applicable:** The options provided do not pertain to the provider for type of compensation for on-call coverage.

Amount Compensated per On-Call Compensation Method

The amount each provider is compensated, per the method indicated in the "Method by which the Provider is Compensated for On-Call Coverage" question. If different rates are paid at the practice, hospitals, or for different days, excluding holiday or weekend pay, perform a blend. For example, if the provider is compensated $600 per day at the practice and $700 per day at the hospital, report $650 as the on-call compensation amount.

Number of Hours per On-Call Compensation Method

The number of hours each provider spent on-call, per the method indicated in the "Method by which the Provider is Compensated for On-Call Coverage" question. If the on-call coverage method was "No Additional Compensation", provide the number of hours per week.

Holiday On-Call Compensation Amount (per day)

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

Weekend On-Call Compensation Amount (per day)

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

On Call Compensation (Physicians and APPs)

The annual total dollar amount each provider received for taking call. This amount should be included in the "Total Compensation" amount.

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MEDICAL DIRECTORSHIP FOLLOW-UP QUESTIONS (PHYSICIANS)

For physicians that received payments for medical directorship duties, you will be prompted to answer the following questions.

Method by which the Medical Directorship was Compensated

Indicate the period for which the medical directorship amount was paid.

- **Hourly Rate:** The provider is paid a defined amount for each hour spent performing medical directorship duties.
- **Daily Stipend:** The provider is paid a defined amount for each day spent performing medical directorship duties.
- **Weekly Stipend:** The provider is paid a defined amount for each week spent performing medical directorship duties.
- **Monthly Stipend:** The provider is paid a defined amount for each month spent performing medical directorship duties.
- **Quarterly Stipend:** The provider is paid a defined amount for each quarter spent performing medical directorship duties.
- **Annual Stipend:** The provider is paid a defined amount for the entire year for all time spent performing medical directorship duties.
- **Deferred Compensation:** The provider receives some type of deferred compensation, which is paid after the regular pay period, such as an annuity or pension plan, for time spent performing medical directorship duties.
- **Other Compensation Method:** List any other compensation method if none of the above are applicable.
- **No Additional Compensation:** The provider is not paid additional compensation for performing medical directorship duties.
- **Not Applicable:** The options provided do not pertain to the provider for additional compensation for performing medical directorship duties.

Directorship Compensation per Method

The amount the provider is compensated, per method indicated in the "Method by which the Medical Directorship is Compensated" question.

Total Annualized Directorship Compensation (Physicians)

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

Directorship Hours per Week

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

Internal or External Directorship

If the same federal tax ID is used, the directorship is internal. If a different federal tax ID is used, the directorship is external. For example, if the provider is employed by his/her medical practice for his/her medical directorship duties, indicate "Internal." If the provider is a medical director for an organization other than the one he/she practices at, indicate "External."

NEW HIRE FOLLOW-UP QUESTIONS (PHYSICIANS AND APPS)

For physicians and advanced practice providers hired within the last year, you will be prompted to answer the following questions.

State Provider Relocated From

The state from which the provider relocated. If the provider was relocated from outside of the continental United States, indicate "Out of Country" or from a "US Territory." If the provider did not relocate, indicate "Provider did not relocate."

Hired Out of Residency or Fellowship

Indicate "Yes" if the provider was hired out of residency or fellowship. Indicate "No" if the provider was not hired out of residency or fellowship.

- **Residency:** A period of advanced medical training and education that normally follows graduation from medical school and licensing to practice medicine. This process consists of supervised practice of a specialty in a hospital and in its outpatient department and instruction from specialists on the hospital staff.
- **Fellow:** A provider who has completed training as a resident and has been granted a position allowing him/her to do further study or research in a specialty.

Signing Bonus Offered

A financial award offered by the practice to a new employee as an incentive to sign a contract and join the organization. Indicate "Yes" if the provider was offered a signing bonus as part of the contract offer or negotiation.

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Signing Bonus Amount Offered
The dollar value the provider received as a signing bonus in his/her contract. If no signing bonus was offered by the practice, enter $0.

Signing Bonus Payback Required
If the provider is offered a signing bonus as part of a contract offer or negotiation but does not start employment with the practice after accepting,

- **Full Payback:** Full payback of the signing bonus from the provider to the practice is required.
- **Prorated Payback:** A prorated amount of the signing bonus is required.
- **Not Required:** The provider is not required to pay back the signing bonus.

Starting Bonus Offered
A financial award offered by the practice to a new employee as an incentive at the start of his/her employment with the organization. Indicate "Yes" if the provider was offered a starting bonus as part of the contract offer or negotiation.

Starting Bonus Amount Offered
The dollar value the provider received as a starting bonus in his/her contract. If no starting bonus was offered by the practice, enter $0.

Do not include:

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

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

Loan Forgiveness Amount
Indicate the dollar value the provider received as loan forgiveness in his/her contract. If loan forgiveness was not offered by the practice, enter $0.

First Year CME Paid Time Off (in Weeks)
The number of weeks the provider was given for continuing medical education (CME) in his/her first year of placement. CME is educational activities that serve to maintain, develop, or increase the knowledge, skills and professional performance and relationships a provider uses to provide services for patients, the public or the profession. The content of CME is the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine and the provision of healthcare to the public.

STAFF QUESTIONS (STAFF ONLY)

Certified in Position
Answer "Yes" if the individual is certified in their position. For example, report "Yes" for a Certified Medical Assistant.

Lead in Position
Answer "Yes" if the individual is considered the lead of a team.

ACMPE Status
The ACMPE (American College of Medical Practice Executives) status that best represents each individual.

- Not Certified
- Certified (CMPE)
- Fellow (FACMPE)

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Formal Education

Indicate the formal education level that best represents each individual.

- High school diploma or the equivalent
- Associate degree or other two-year degree
- Bachelors degree or other four-year degree
- Masters degree
- PhD, JD, EdD
- MD or DO (with masters degree)
- Other: List any other formal education level if none of the above are applicable.

Compensation Method

Indicate the compensation plan/financial funds flow model that best represents the compensation plan for the individual listed.

- Hourly
- Straight salary only (no bonus)
- Base salary PLUS discretionary bonus (e.g., end-of-year bonus)
- Base salary PLUS percentage of practice productivity and/or physician income (formula bonus)
- Base salary PLUS percentage of practices net profit (formula bonus)
- Base salary PLUS other formula bonus (e.g., number of patient visits, patient satisfaction, etc.)
- Base salary PLUS deferred compensation (e.g., trusts, stock options, etc.)
- Base salary PLUS combination of discretionary and formula bonuses PLUS deferred compensation
- Other Compensation Method: List any other method if none of the above are applicable.

Total Paid Time Off for Continuing Education (in Hours)

The total number of hours each individual was offered for continuing education (CE).

Continuing Education Amount Offered (in Dollars)

The total dollar value allocated to each individual for continuing education (CE). For physicians, report the dollar value the physician received in his/her contract for CME. If CME expenses were not offered by the practice, enter $0.

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SUPPORT

Use the following, helpful resources any time you get stuck or have a question.

MGMA DataDive Resources
Within MGMA DataDive, select “Help” in the left navigation. This area links to a variety of resources including helpful guides, glossaries, survey demographics, best practices and FAQs.

Visit mgma.com/datadiveresources

Online Help Community
Join an online support community of fellow MGMA DataDivers! Post questions, discuss insights, search archives and learn something new.

Visit community.mgma.com/home

Contact
We are here to make sure you get the most out of your investment. Your account manager is available to help answer your questions and accept feedback.

If you have questions about the MGMA benchmarks, please contact the MGMA Data Solutions department.

Call 877.275.6462, ext. 1895, or email survey@mgma.com

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