

SPECIAL REPORT

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Hospitalists: Weigh the profit potential & risks, understand pros & cons plus the billing implications

By Brett Norman

Edward Volpintesta MD, a family practitioner in Bethel, Conn., used to spend the first 1½ hours of his day commuting to the community hospital in nearby Danbury and rounding a handful of patients. But once Danbury Hospital started a hospitalist program, he handed over his inpatients to the hospitalists, savored his free time and rested a little easier, confident his patients were in good hands.

“It’s a quality of life and a patient-care issue,” he says. “It frees up all that time, frees me up emotionally from all the labs, and X-rays and reports, and lets the guys who are there all the time and who are on top of all the latest hospital procedures handle that part of the care.”

Those are the reasons many of your peers cite for jumping on the hospitalist bandwagon, the fastest growing type of practice in medicine. The majority of hospitalists – 54% – are employed directly by hospitals, while 31% work in hospitalist-only groups and 14% work for multi-specialty practices, according to the Society for Hospital Medicine (SHM).

There are now slightly more hospitalists in the country – 20,000 – than there are gastroenterologists or neurologists. And hospitalist ranks are predicted to swell to 30,000 by 2010, SHM estimates.

The term hospitalist was coined in 1996 and defined as a physician who focuses primarily on the general care of hospitalized patients. Only a few hundred were practicing at the time. Now

about 40% of the country’s 5,000 hospitals employ them, including 71% of hospitals with 500 or more beds and 55% of hospitals with 200-499 beds, according to SHM’s 2005-2006 Survey: *The Authoritative Source on the State of the Hospital Medicine Movement*.

Physician practices are hiring hospitalists, too, or converting one or more of their own doctor(s) into the role of a hospitalist. An unscientific **Part B News** poll shows that about 55% of 60 respondents have at least one physician in their group who functions as a full- or nearly full-time hospitalist.

Of those, 97% call their hospitalist program a success and 93% cite *revenue increases* ranging from 1% to 15% or more. This suggests office-based practices have increased their profits by employing their own hospitalists. And there is broad acknowledgement that when hospitalist programs are running smoothly, they can offer a rare example of a win-win scenario for office-based primary care or multi-specialty practices, hospitals and patients, advocates say.

Nationwide, however, using hospitalists often means abandoning inpatient care altogether, and many physician practices have serious reservations about that. The large majority of hospitalists – about 85% – are employed either by hospitals or hospitalist-only groups, meaning most office-based practices that use hospitalists are outsourcing their inpatient business and losing that revenue, which then has to be recouped some other way, usually by seeing more patients in the office time gained by avoiding rounding.

Despite the rapid rise of hospital medicine, don't expect the traditional mix of office-based and inpatient care to disappear anytime soon. Concerns about lost money, continuity of care, reverence for a long-standing medical tradition – and especially communications problems – mean office-based physicians will continue to scamper around hospital halls for many years to come. “Knowing my docs, they'd sooner die than not see their inpatients,” says Linda Zukin, corporate billing manager for Cardiology and Vascular Associates (31 physicians) in Rochester Hills, Mich., a suburb of Detroit. Her physicians insist on rounding and use nurse practitioners (NPs) to help manage the volume of general inpatient care. She bills the NP services as shared visits under the NP's billing number. “It may be only 85%, but it's still revenue.”

Much of the reluctance that remains boils down to simple economics. “We don't want to give up that revenue stream,” says John Sage MD, a family physician at Metrodocs (six physicians) in Park Ridge, Ill., a suburb of Chicago. The tradition of rounding can be equally important in keeping some from handing over their inpatient business. “I really like going to the hospital. It's busy – you're beating your feet. But you can meet with the families and the specialists are around. It's a great part of the job,” Sage says.

Where did the money go? How to make up for lost business

Your peers are understandably anxious about forfeiting hospital revenue for more office time, but conclusive data on the trade-off are hard to find. Studies on the bottom line consequences of transitioning to hospitalists not employed by your practice have varied. One estimate is that an average primary care physician (PCP) loses \$25,000 a

Hospitalists by the numbers

- How many: About 20,000. Up to 30,000 expected by the end of the decade.
- Training: 79% internal medicine or internal medicine subspecialty, 14% pediatrics, 3% family medicine, 3% non-physicians or physician assistants.
 - In 2006, 40% of the 5,000 U.S. hospitals employed hospitalists, including 71% of hospitals with 500 beds or more.
 - Pay: \$169,000 plus \$27,000 in benefits (comparable to internists or neurologists); 67% are paid by a mix of salary, productivity and performance, 28% are strictly salaried, 5% are paid for productivity and performance only.
 - Types of patients seen: 79% adults only, 15% pediatrics, 6% both.
 - Average annual gross charges billed by hospitalists: \$324,000.
 - Average annual gross collections received by hospitalists: \$183,000.
 - Average annual number of work RVUs worked by a hospitalist: 3,213.
 - Charges per encounter: \$139.

Source: 2005-2006 SHM Survey: The Authoritative Source on the State of the Hospital Medicine Movement

year by giving up hospital charges; other studies show PCPs can earn up to an additional \$50,000 annually by boosting office visits with their new-found time, according to SHM's Benchmark Committee.

The revenue impact is largely up to how office-based physicians spend the time they would have consumed stuck in traffic commuting to hospitals to round. Volpintesta, who has been in family practice for more than 30 years, just takes the hit and enjoys the free time. He estimates losing \$15,000-\$20,000 a year in inpatient income, but says he's happy with his 5-year-old Toyota Avalon and \$75,000 salary.

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“The quality of life is more than worth it,” he says. Like many doctors who use hospitalists, however, he hasn’t given up his privileges. “I still go when it’s serious – when I feel like I need to be with the patient and the family,” he says. “I call it my ‘priestly function.’”

But many practices aren’t content simply to absorb the blow. **TIP:** If your goal is to maximize revenue, you should consider expanding your office hours to see more patients, as many practices have done.

That’s what Cape Ann Medical Center (8 physicians) in Gloucester, Mass., is trying. The practice surrendered its inpatient business last July, when Addison Gilbert Hospital, the 58-bed facility serving the isolated historic fishing community of about 30,000, recommended its new hospitalist program to the practice, says Christine Allen, office and billing manager for the practice.

The situation in Cape Ann highlights the financial uncertainty involved in going with hospitalists. The practice suffered an immediate dip in revenue; Allen couldn’t say exactly how much. Attempting to make up the shortfall, her physicians have extended their office hours in the past six months, seeing patients from 8 a.m. to 9 a.m. – the hour they used to spend on rounds. Revenue is inching up, but Allen says it hasn’t yet reached the level of the days before the hospitalists came to town. “In another quarter, we’ll have a better idea,” she says.

Are hospitalists being forced on you?

As hospitalists spread across the country over the past decade, some physicians have worried that they will be pressured into giving their hospital business back to the hospital. Forcing hospitalists on private practices doesn’t seem to be a problem in larger markets, however. If physicians have hospitals to choose from, any hospital trying to impose its program would face a massive revolt and loss of business, physicians say. Also, the trend of insurance companies requiring office-

Who employs the hospitalists

There are six basic models for hospital medicine programs.

1. 34% are employed by hospitals
2. 20% by academic hospitals
3. 19% by multi-state hospitalist-only groups or management companies
4. 14% by multi-specialty groups
5. 12% by local hospitalist-only groups and
6. 2% by emergency or critical care groups.

Source: 2005-2006 SHM Survey: The Authoritative Source on the State of the Hospital Medicine Movement

based physicians to refer their inpatients to hospitalists “has fallen by the wayside,” says SHM President Mary Jo Gorman MD, St. Louis.

Established hospitalists interviewed by **Part B News** insist it is bad business to force anything on a local physician community. They also insist another early concern – that hospitalists would treat patients in the hospital and then funnel them into the hospitalist’s outpatient practice – is unwarranted. It would be commercial suicide, they say.

“The whole point is to serve,” says Glenn Appelbaum, an executive director with IPC – The Hospitalist Company, based in North Hollywood, Calif., which employs more than 600 hospitalists in 14 states, according to the company’s website. It’s the largest hospitalist operation in the country. “We design our programs very much around the private practice model, no different from a cardiologist trying to build a practice one referral at a time. We spend a lot of time meeting with primary doctors, specialists, telling them what we do and earning their business. If we do a good job, they’ll send us another patient. If we don’t, they won’t.”

At Baptist Health Care in Pensacola, Fla., there’s no way the hospitalist program could siphon off patients from office-based practices. Baptist won’t hire hospitalists who practice outside the BHC system out of concern for the appearance of conflict of interest, says Scott Pippin, director of physician relations, who runs the program.

But in smaller markets with a monopoly hospital, for instance, practices may have fewer options, and hospitals, wanting to capture more of the inpatient revenue, have leverage. When Cape Ann Medical Center gave over its inpatient business to Addison Gilbert Hospital, “it was a mutual agreement,” Allen says, but some political considerations were involved. “We’re trying to work with the hospital. They’ve talked about closing it, which would be terrible.” Her practice treats many older patients who would be severely burdened by having to make the trip to a neighboring hospital. “We’re a little community ‘at the end of the world.’ A lot of our patients don’t ever cross the bridge,” she says.

By contrast, Sage, the primary care physician in suburban Chicago, says he has felt no pressure from the two hospitals he uses. He respects the hospitals’ hospitalists. “All of our arrangements are amicable,” he says. They’re good doctors who were in private practice before they became hospitalists, he says, and he doesn’t doubt the quality of care they provide, but his practice decided to hang onto most of its inpatient business, anyway.

An alternative to hospitalists

Sage’s practice, Metrodocs, has adopted “a compromise” between traditional rounding and using hospitalists. He and four of his partners have become “part-time hospitalists” themselves. Instead of each doctor visiting his own inpatients, the doctors rotate one week at a time to round for the entire practice. “When you’re rounding, it’s busy. You get an early start, you’re taking calls from nurses, working with residents, but you block off the morning and you can do it,” he says.

On the sixth week, the doctors do it the old fashioned way, rounding their own patients, except for one of their partners who does not have privileges at one hospital. He relies on hospitalists. “It works well,” Sage says. “We realized we had an inefficient model with all of us going to the hospitals all the time, so this allows us to gain some of the business efficiencies without giving

Coding and billing for hospitalists

If you are a primary care practice that has decided to refer all of your hospital business to independent or hospital-based hospitalists, you can essentially wash your hands of inpatient billing entirely, which has simplified some coders’ lives.

If, however, you have a hospitalist in the group and are handling the billing yourself instead of outsourcing it to a billing company or contracting with the hospital’s billing department, you will need to become intimately familiar with a relatively small set of codes. Because of the limited coding involved, some hospitalists, such as the 600+ that work for IPC – The Hospitalist Company, North Hollywood, Calif., do their own coding.

Whoever has the duty, the following are the codes to master:

- Initial hospital care: **99221-99223**
- Subsequent hospital care: **99231-99233**
- Discharge: **99238-99239**
- Consults: mainly **99251-99255**.
- Observation: **99234-99236**
- Critical care: **99291-99292**.
- Prolonged service: **99356-99357**.

Remember, a PCP may visit an inpatient as a courtesy, but once the inpatient care has been transferred to the hospitalist, the PCP may not bill for the hospital visit, unless the hospitalist transfers the care back. **Within a given specialty, only one physician can bill one E/M code per patient per day**, which complicates billing for hospitalists, who often work in shifts around the clock. It’s not uncommon for more than one hospitalist to visit the same patient in the same day, but the hospitalist group practice must select one E&M code for the entire day of care. This means the care each provides (time spent, exams performed, medical decisions made, etc.) must be combined and billed under one of the provider’s identifier numbers.

It also means that if a hospitalist tries to bill for treating a patient that a PCP is caring for in the hospital, both physicians could run into denials based on concurrent care or duplicated services grounds.

up seeing our patients.” Sometimes the patients are surprised not to see their primary care physician (PCP), but most have gotten used to it and are

more comfortable having someone from the same practice, says Sage. There is another important role hospitalists play for his practice and many others. They cover on-call emergency room duties, says Sage, who has been practicing for more than 20 years and describes his practice as “maturing.” On-call relief helps in two ways. It means:

1. fewer midnight runs to the ER and
2. fewer high-risk, unassigned, uninsured patients to treat.

Some say this is the best benefit office-based physicians receive from hospitalists.

“When you’re on call, you get these people you’ve never seen before, everything’s wrong with them, and they just hand you a chart and you’ve got to treat them,” says Dianne Wilkinson, compliance officer and quality manager at Med-South Healthcare (11 physicians) in Dyersburg, Tenn. “It’s incredibly stressful and there’s some liability.”

Wilkinson’s doctors have handed over all of their inpatient business to hospitalists and love it. The only problem: the patients often don’t. “No matter what you tell them and how well you explain it or how smart or good the hospitalist is, they still want to see the same face they’re used to.”

Making the transition to hospitalists

Honalee Lincoln, coding supervisor and educator for Regina Medical Center, was recently charged with looking into implementing a hospitalist program for a hospital-based group of 10 PCPs at the 54-bed facility in Hastings, Minn., a suburb of Minneapolis. Like other practices, “we want to free up our docs for more clinic visits,” she says. She hopes to have the program up and running this summer, but the group has not decided what form it will take. Will they convert one of their own doctors, hire a new one, or contract with an independent hospitalist? Lincoln hopes they hire a doctor into the group. “It’s easier for everyone to stay in touch and be on the same page

Info to expect from hospitalist

A discharge summary – or at least a substantive discharge note – should be sent to a patient’s primary care physician on the day of discharge, even though the Joint Commission (JCAHO) allows up to 30 days, according to recommendations in a story about hospitalist communications problems in the Feb. 28 edition of the *Journal of the American Medical Association*. The note should include diagnoses, discharge medications, results of procedures, follow-up needs, and pending test results.

The article advises that complete discharge summaries should include:

- Primary and secondary diagnoses
- Pertinent history and physical findings
- Dates of hospitalization, treatment provided
- Results of procedures and abnormal laboratory test results
- Information given to patient and family
- Patient’s condition at discharge
- Discharge medication regimen with reasons for any changes, indications for new prescriptions
- Specific follow-up needs, including appointments and procedures or pending test results and
- Name and contact info of the hospitalist.

with coding and documentation,” she says.

Lincoln’s concerns highlight perhaps **the main obstacle to effective hospitalist programs: Timely and relevant communication with PCPs or referring specialists.** “The whole key, the vital function of a good hospitalist program, is communication,” says Pippin, who runs Baptist Health Care’s hospitalist program. His program employs eight physicians to cover two hospitals 24/7.

His hospitalists notify PCPs of any admission (through the emergency room and not a referral, for instance), change of condition, change of unit and provide a discharge note, including the prescribed medication regimen and follow up appointments, usually within 48 hours of a patient going home, says Pippin. He estimates 45-50 doctors – the majority of those on staff at Baptist – are in the program, and more have expressed interest. He believes staying in constant touch with them is a crucial part of the program’s success.

Hospitalist-practice communications key

Communication breakdowns between hospitalists and PCPs or specialists, particularly right after discharge, “may have substantial implications for continuity of care, patient safety, patient and clinician satisfaction, and resource use,” according to a Feb. 28 article in the *Journal of the American Medical Association* (JAMA).

The article reviewed recent academic studies on hospitalist communications and found them wanting. For example, one week after discharge, a median of 53% of discharge letters had reached PCPs, providing the information necessary for follow up care. The article reported that 11% of discharge letters – brief treatment reviews and follow up information provided by hospitalists – and 25% of discharge summaries – more complete reports sent by the hospitals – never reached PCPs. Patients treated by physicians who don’t receive a discharge summary are at greater risk for being rehospitalized, the article notes.

The discharge summaries that did reach the physicians were often missing crucial information. **Most notably:** 65% failed to mention test results that were pending at discharge and 91% were missing an account of counseling provided to patients or their families, according to the JAMA review.

TIP: If you are using hospitalists, insist on prompt and complete patient updates from them, especially discharge letters and summaries (see table, p. 5).

Some hospitalist groups have attacked this problem with automatically generated reports that keep the patient’s relevant physicians apprised of what they need to know. “One of our strongest points is that we have a fully integrated, interoperable proprietary computer management system,” says IPC’s Appelbaum. “Day to day, physicians enter basic clinical data on a patient. For an admit and discharge, it creates an automatic fax to the physicians involved, including medication

changes and follow up instructions.”

Appelbaum says the system has three major benefits.

1. It facilitates prompt communication
2. helps with daily billing and
3. tracks length-of-stay data and business development, including referral patterns.

“I get a discharge summary on the day of release that has all the essential info, and the hospital follows up by sending me X-rays or test results,” says Corinna Warren MD, an internist with Compas (7 physicians) in Alton, Ill. She refers her patients to IPC hospitalists at Saint Anthony’s Health Center, also in Alton. She began using the hospitalists two years ago “for lifestyle reasons” after her second child was born. The only drawback she sees is that some of her patients are disappointed in not seeing her.

Hospitalists work well for some larger practices: One multi-specialty group’s story

The Watson Clinic, a multi-specialty practice with about 190 doctors representing 39 specialties at 12 sites around Lakeland, Fla., is a good example of the many ways physician offices are putting hospitalists to use. The practice has been at the forefront of the hospitalist movement, hiring its first one in 1996, says Medical Director Jorge Gonzalez MD, a cardiologist. The clinic now employs eight full-time hospitalists and plans to bring on more this summer.

For the business efficiencies that come with the separation of hospital- and office-based care, and for overall accessibility and acute care expertise hospitalists bring to inpatient treatment, Gonzalez believes the clinic’s hospitalists play an invaluable role in the practice. But that role varies. The following breakdown illustrates the different ways in which Watson’s 49 PCPs use the group’s hospitalists.

Nine are traditionalists, handling all of their own inpatient admissions and care, but the rest use

hospitalists to varying degrees. Eleven use hospitalists during office hours – 7 a.m. to 5 p.m. – Monday-Friday, which frees up clinic office time. But those physicians handle hospital admissions and subsequent care for their own patients who come into the hospital after business hours and on the weekends. About 10 physicians provide inpatient care on the weekends but use hospitalists during the week. And 19 physicians, who work in urgent or priority care settings or in outlying communities, use hospitalists for all of their patients who go to Lakeland Regional Medical Center (850 beds).

The clinic has partnered with the hospital to hire a total of 12 new hospitalists – Watson will have six and the hospital will have six – largely to handle the “unassigned” emergency room patients – those who have no PCP and often no insurance.

By providing some relief for the office-based physicians at Watson, the hospitalist program has helped minimize turnover, Gonzalez says. “There have been a few docs who would have left us, maybe left medicine, if this arrangement weren’t available,” he says, adding in particular those who are practicing medicine and raising children at the same time.

But using hospitalists does have some drawbacks, primarily in continuity of care. Sometimes PCPs don’t get all of the information they might want about a patient’s hospital care, Gonzalez

says. “We try to solve that by providing a nice discharge summary and a phone call, and we do a pretty good job, I think.”

TIP: Having a hospitalist on staff can bypass or at least alleviate the communication problem, although that’s not necessarily an option for smaller practices. “One advantage from our experience has been that having hospitalist positions within the group facilitates expectations and communications. I don’t know that they have problems in other situations, but I know it helps us,” says Lynne Kirk MD, president of the American College of Physicians and an internist at Southwestern Medical Center, an academic hospital in Dallas.

Gonzalez says his hospitalist program has a solution for another complaint by some physicians: that hospitalists sometimes step in to provide treatment for a new patient against the wishes of that patient’s PCP.

One of Sage’s partners at Metrodocs ran into this problem in March. An ER physician mistakenly thought a patient had a PCP who used hospitalists and referred the patient for admission accordingly. The next day, the hospitalist recognized the error, called Sage’s partner in, and transferred the care. The miscue did not create a duplicate billing problem, which is a possibility for similar situations if both the hospitalist and the PCP try to bill for an E/M visit for the same patient on the

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same day. “I think (the hospitalist) billed for the first day and then we billed for the rest,” Sage says.

Gonzalez says that type of confusion has been a nonissue for his hospitalist program, which handles many of the Watson Clinic’s patients and also those of four independent physicians. “One of the first questions you ask the patient at intake is, ‘Who is your primary care physician?’” Gonzalez says. The hospital maintains an updated list of physicians with their hospitalist preferences that can be easily cross-referenced, he says.

Billing issues – duplicate services

But not everyone has perfected the system, some physicians and consultants say. Sometimes PCPs do find hospitalists treating patients against the PCP’s wishes, and sometimes they find themselves billing for the same services, says Diane Zucker, an independent coding and compliance officer based in Rocky River, Ohio, who works with hospitalist groups.

The blame can go both ways, she says.

TIP: PCPs should clearly communicate to hospitals and hospitalists exactly what services the hospitalist should provide. If a referring physician just wants the hospitalist to admit the patient during clinic office hours, for instance, but then take over the care of that patient at night or on the weekends, she should be specific about that.

One hospitalist group Zucker works with has a “Rolodex” full of questionnaires filled out by every physician practicing at the hospital that include detailed instructions about the extent of work – or lack of – that hospitalists should do for a given PCP’s patient. “That seems to work well,” she says.

It’s also important for hospitalists to keep track of PCP’s specialist preferences. “We always try to honor a physician’s preferences for referrals and consults,” says Kathy Loya, VP of health services, compliance and privacy officer, for IPC –

The Hospitalist Company. IPC’s software allows hospitalists to make a note, say, that a given PCP wants his patients referred to a certain cardiologist for heart problems, Loya adds.

One situation that can be particularly confusing is when a surgeon refers a patient to a hospitalist for peripheral surgery-related care, which is a surgeon’s right, but the patient’s PCP wants to continue to manage the general inpatient care, Zucker says. In that case, the surgeon “really has to decide, because as a rule only one internist can provide the general medical care for a patient,” Loya says.

Remember, a PCP may visit an inpatient as a courtesy, but once the inpatient care has been transferred to the hospitalist, the PCP may not bill for the hospital visit, unless the hospitalist transfers the care back. **Within a given specialty, only one physician can bill one E/M code per patient per day.**

That raises the question of what happens when both a hospitalist and a PCP visit a patient and bill for an E/M service on the same day. It’s a losing scenario for the PCP for two reasons.

1. “Generally, the first claim filed is the one that gets paid,” Zucker says. That favors hospitalists, who often have faster hospital billing operations than office-based physicians, she says.

2. In the case where a carrier is weighing competing claims, payment will go to whoever has better documentation, a standard that also tends to favor hospitalists, Zucker says. “I’m not saying visiting PCPs don’t do good documentation, but hospitalists have some advantage, being based at the hospital, maybe having notes from multiple visits throughout the day,” she says.

The lesson: Communicate your expectations explicitly to avoid these potential billing problems. “You have to be clear: who’s referring to what doctor and under what set of guidelines,” Zucker says.