# Hospital Medicine Has a Specialty Code. Is the Memo Still in the Mail?

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The Centers for Medicare and Medicaid Services awarded Hospital Medicine a Medicare specialty code, "C6", in 2016. We examined the early uptake of C6 code using the 2017 Medicare Part B utilization data. We also compared the actual C6 specialty code usage against estimated rates of overall hospitalist billing using threshold-based hospitalist rates of Evaluation and Management codes to assess the integration of the newly introduced code. Billing activity associated with the C6 code was approximately one-tenth of expected rates. *Journal of Hospital Medicine* 2020;15:91-93. © 2020 Society of Hospital Medicine

In recognizing the importance of Hospital Medicine (HM) and its practitioners, the Centers for Medicare and Medicaid Services (CMS) awarded the field a specialty designation in 2016. The code is self-selected by hospitalists and used by the CMS for programmatic and claims processing purposes. The HM code ("C6"), submitted to the CMS by the provider or their designee through the Provider Enrollment Chain and Ownership System (PECOS), in turn links to the National Provider Identification provider data.

The Society of Hospital Medicine® sought the designation given the growth of hospitalists practicing nationally, their impact on the practice of medicine in the inpatient setting,[1] and their secondary effects on global care.[2] In fact, early efforts by the CMS to transition physician payments to the value-based payment used specialty designations to create benchmarks in cost metrics, heightening the importance for hospitalists to be able to assess their performance. The need to identify any shifts in resource utilization and workforce mix in the broader context of health reforms necessitated action. Essentially, to understand the "why's" of hospital medicine, the field required an accounting of the "who's" and "where's."

The CMS granted the C6 designation in 2016, and it went live in April 2017. Despite the code's brief two-year tenure, calls for its creation long predated its existence. As such, the new modifier requires an initial look to help steer the role of HM in any future CMS and managed care organization (MCO) quality, payment, or practice improvement activities.

## METHODS

We analyzed publicly available 2017 Medicare Part B utilization data[3] to explore the rates of Evaluation & Management (E&M) codes used across specialties, using the C6 designation to identify hospitalists.

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To try to estimate the percentage of hospitalists who were likely billing under the C6 designation, we then compared the rates of C6 billing to expected rates of hospitalist E&M billing based on an analysis of hospitalist prevalence in the 2012 Medicare physician payment data. Prior work to identify hospitalists before the implementation of the C6 designation relied on thresholds of inpatient codes for various inpatient E&M services.[4,5] We used our previously published approach of a threshold of 60% of inpatient E&M hospital services to differentiate hospitalists from their parent specialties.[6] We also calculated the expected rates of E&M billing for other select specialty services by applying the 2012 E&M coding trends to the 2017 data.

## RESULTS

Table 1 shows the distribution of inpatient E&M codes billed by hospitalists using the C6 identification, as well as the use of those codes by other specialists. Hospitalists identified by the C6 designation billed only 2%-5% of inpatient and 6% of observation codes. As an example, in 2017, discharge CPT codes 99238 and 99239 were used 7,872,323 times. However, C6-identified hospitalists accounted for only 441,420 of these codes.

Table 2 compares the observed billing rates by specialty using the C6 designation to identify hospitalists with what would be the expected rates with the 2012 threshold-based specialty billing designation applied to the 2017 data. This comparison demonstrates that hospitalist billing based on the C6 modifier use is approximately one-tenth of what would have been their expected volume of E&M services.

## DISCUSSION

We examined the patterns of hospitalist billing using the C6 hospital medicine specialty modifier, comparing billing patterns with what we would expect hospitalist activity to be if we had used a threshold-based approach. The difference between the C6 and the threshold-based approaches to assessing hospitalist activity suggests that as few as 10% of hospitalists have adopted the C6 code.

TABLE 1. **2017 Proportion Use of Hospitalization-Associated E&M Code Clusters, by Specialty**

| | Hospitalists | Internal Medicine | Family Medicine | Cardiology | Emergency Medicine | Pulmonology |
|---|---|---|---|---|---|---|
| Initial Hospital | 2.34% | 28.11% | 5.74% | 9.49% | 0.44% | 4.66% |
| Subspecialty Hospital | 2.57% | 33.1% | 5.98% | 7.49% | 0.4% | 6.35% |
| Hospital Discharge | 5.6% | 58.38% | 12.56% | 2.4% | 0.73% | 1.12% |
| Initial Observation | 6.26% | 53.05% | 11.44% | 4.63% | 5.88% | 0.57% |
| Subspecialty Observation | 6.5% | 54.81% | 10.63% | 6.57% | 1.05% | 0.86% |
| Observation Discharge | 6.41% | 55.54% | 12.63% | 4.38% | 4.09% | 0.36% |

E&M Code clusters around severity of E/M services. Initial Hospital: 99221-99223; Subspecialty Hospital: 99231-99233; Hospital Discharge: 99238-99239; Initial Observation: 99218-99220; Subspecialty Observation: 99224-99226; Observation Discharge: 99217
Abbreviation: E&M, evaluation and management.

TABLE 2. **Observed Versus Expected (2017 Data Versus Estimated Proportion Using 2012 Pay Data Identifier)**

| | Hospitalists Observed | Hospitalists Expected | IM/FM[a] Observed | IM/FM[a] Expected | Cardiology Observed | Cardiology Expected |
|---|---|---|---|---|---|---|
| Initial Hospital | 2.34% | 25.55% | 33.85% | 15.23% | 9.49% | 12.50% |
| Subspecialty Hospital | 2.57% | 27.41% | 39.08% | 16.30% | 7.49% | 9.78% |
| Hospital Discharge | 5.60% | 51.76% | 70.94% | 29.24% | 2.40% | 5.73% |
| Initial Observation | 6.26% | 57.65% | 64.49% | 22.35% | 4.63% | 9.23% |
| Subspecialty Observation | 6.50% | 64.51% | 65.44% | 17.00% | 6.57% | 12.73% |
| Observation Discharge | 6.41% | 58.58% | 68.17% | 19.92% | 4.38% | 8.63% |

[a]IM/FM was used combined as a single unit in Lapps et al.[6] To make comparisons to our analysis of 2012 Medicare physician pay data, we added 2017 E/M usage rates for IM and FM together.
Abbreviations: E&M, evaluation and management; FM, family medicine; IM, internal medicine..

Why is the adoption of the C6 modifier so low? Although administrative data do not allow us to identify the reasons why providers chose to disregard the C6 designation, we can speculate on causes. There are, to date, low direct risks and recognized benefits with using the code. We hypothesize that several factors could be impeding whether providers use the modifier to bring about potential gains. The first may be knowledge-related; ie, hospitalists might not be familiar with the specialty code or unaware of the importance of accurately capturing hospitalist practice patterns. They may also wrongly assume that their practices are aware of the revision or have submitted the appropriate paperwork. Similarly, practice personnel may lack knowledge regarding the code or the importance of its use. The second factor may be logistical; ie, administrative barriers such as difficulty accessing the Provider Enrollment, Chain and Ownership System (PECOS) and out-of-date paper registration forms impede fast uptake. The final reason might be related to professionals whose tenures as hospitalists will be brief, and their unease of carrying an identifier into their next non-HM position prompts hesitation. Providers may have a misperception that using the C6 code may somehow impact or limit their future scope of practice, when, in fact, they may change their Medicare specialty designation at any time.

Changes in reimbursement models, including the Bundled Payments for Care Improvement Advanced (BPCI-A) and other value-based initiatives, heighten the need for a more accurate identification of the specialty. Classifying individual providers and groups to make valid performance comparisons is relevant for the same reasons. The CMS continues to advance cost and efficiency measures in its publicly accessible physician-compare.gov website.[7] Without an improved ability to identify services provided by hospitalists—by both CMS and commercial entities—the potential benefits delivered by hospitalists in terms of improved care quality, safety, or efficiency could go undetected by payers and policymakers. Moreover, C6 may be used in other ways by the CMS throughout its payment systems and programmatic efforts that use specialty to differentiate between Medicare providers.[8] Finally, the C6 is an identifier for the Medicare fee-for-service system; state programs and MCOs may not identify hospitalists in the same manner, or at all. Therefore, it may make it more difficult for those groups and HM researchers to study the trends in care delivery changes. The specialty needs to engage with these other payers to

assist in revising their information systems to better account for how hospitalists care for their insured populations.

Although we would expect a natural increase in C6 adoption over time, optimally meeting stakeholders' data needs requires more rapid uptake. Our analysis is limited by our assumption that specialty patterns of code use remain similar from 2012 to 2017. Regardless, the magnitude of the difference between the estimate of hospitalists using the C6 versus billing thresholds strongly suggests underuse of the C6 designation. The CMS and MCOs have an increasing need for valid and representative data, and C6 can be used to assess "HM-adjusted" resource utilization, relative value units (RVUs), and performance evaluations. Therefore, hospitalists may see more incentives to use the C6 specialty code in a manner consistent with other recognized subspecialties.

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