Transforming Episode Accountability Model (TEAM)
HCC Education

Fall 2025

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Meet the Presenters

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Agenda

1. Welcome and Objectives
2. CMS Value-Based Care Evolution
3. TEAM Model Overview
4. Financial Framework & Target Price Calculation
5. Role of CDI and Coding in TEAM Success
6. Risk Adjustment Analysis
7. Compliance & Operationalization Strategies
8. Q&A and Wrap-Up

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Today’s Learning Objectives

1. Explain the purpose of CMS TEAM and its impact on reimbursement and quality metrics.
2. Describe the role of Hierarchical Condition Categories (HCCs) in risk adjustment and value-based care.
3. Recognize why accurate and specific provider documentation is essential for HCC capture.
4. Identify how CDI and Coding teams support providers in ensuring clinical clarity and accurate code assignment.
5. Apply best practices for documenting chronic conditions, severity, and social determinants of health (SDOH).
6. Avoid common documentation pitfalls that lead to missed diagnoses, incorrect risk scores, and lost reimbursement.

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Transforming Episode Accountability Model (TEAM) Overview

Key Terms and Definitions

TEAM

Transforming Episode Accountability Model

Key Terms:

- Clinical Episode – Surgical procedure + 30-day window beginning with the day of discharge
- Spend – All dollars billed to Medicare for services provided to TEAM beneficiaries during a clinical episode episode
- Target Price – Benchmark price set by CMS for anchor stay + 30 days post-discharge, based on diagnosis, regional benchmark prices and hospital/patient-specific adjustments

Key Acronyms

- LEJR – Lower Extremity Joint Replacement
- SHFFT – Surgical Hip and Femur Fracture Treatment
- CABG – Coronary Artery Bypass Graft
- NPRA – Net payment reconciliation amount
- HHA – Home Health Agency
- SNF – Skilled Nursing Facility
- IRF – Inpatient Rehabilitation Facility
- IP – Inpatient
- OP – Outpatient
- CBSA – Core-Based Statistical Area

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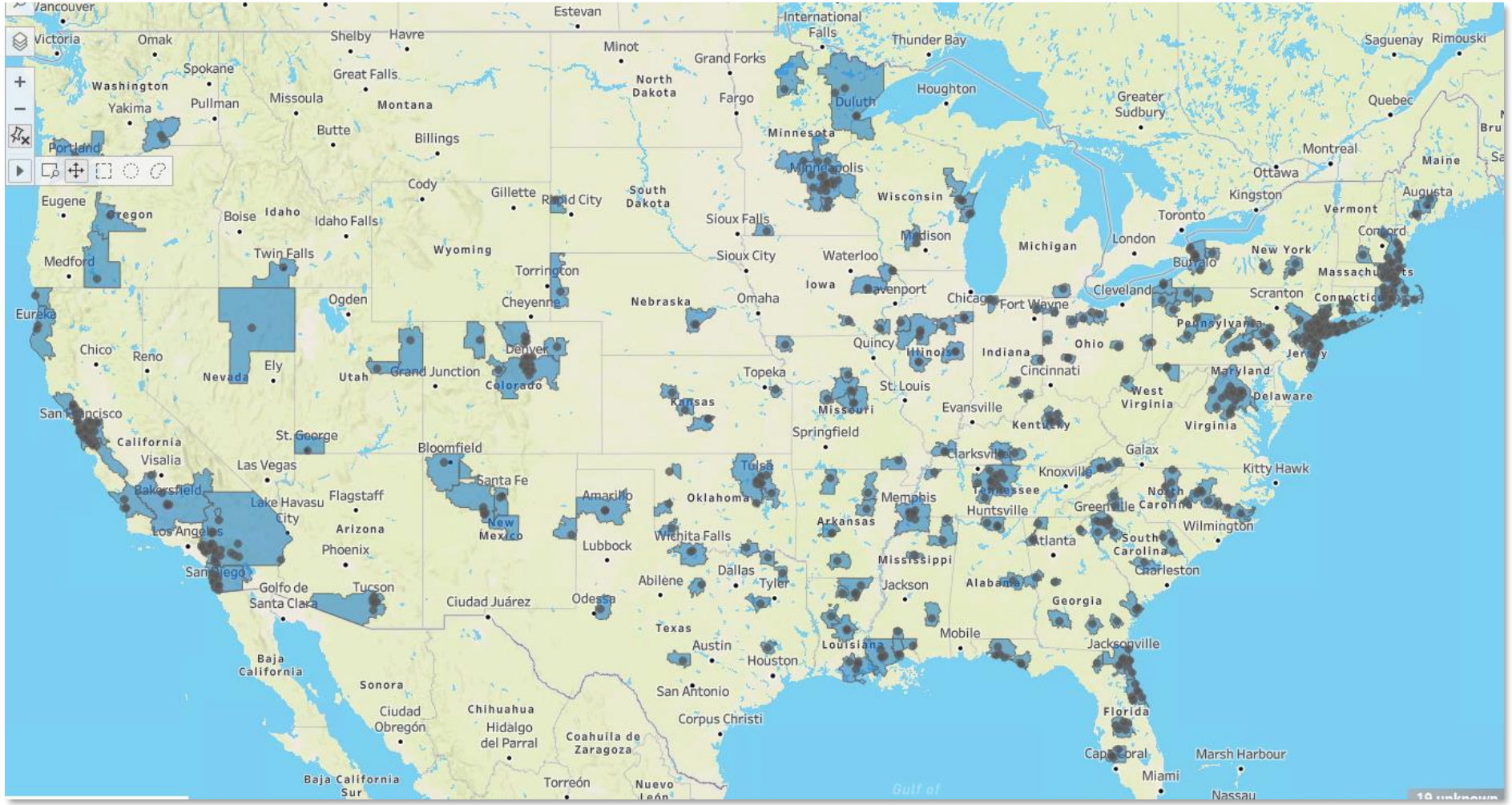
CBSAs Selected for TEAM



- CMS selected 188 of 803 eligible CBSAs for TEAM
- More than 700 hospitals with surgical episodes
- ~200K cases per year
- $481M Expected Savings
- 5 hospitals selected in Kansas

TEAM Overview

Five-year mandatory bundled payment model

- Duration: 1/1/2026-12/31/2030
- Selection based on geographic regions
- Medicare FFS Population Only

Focus on surgical care

- Five inpatient/outpatient surgical episode groups selected
- Site-neutral target prices for spinal fusion and LEJR

30-day episodes

- Participants responsible for total cost of care for the inpatient stay/outpatient procedure plus 30 days post-discharge
- Revenue cycle is not disrupted

Glide path to risk

- Upside only in year one
- 5% - 20% downside risk in subsequent years based on hospital type
- Gains/losses will be tied to quality performance

Relationship to other APMs

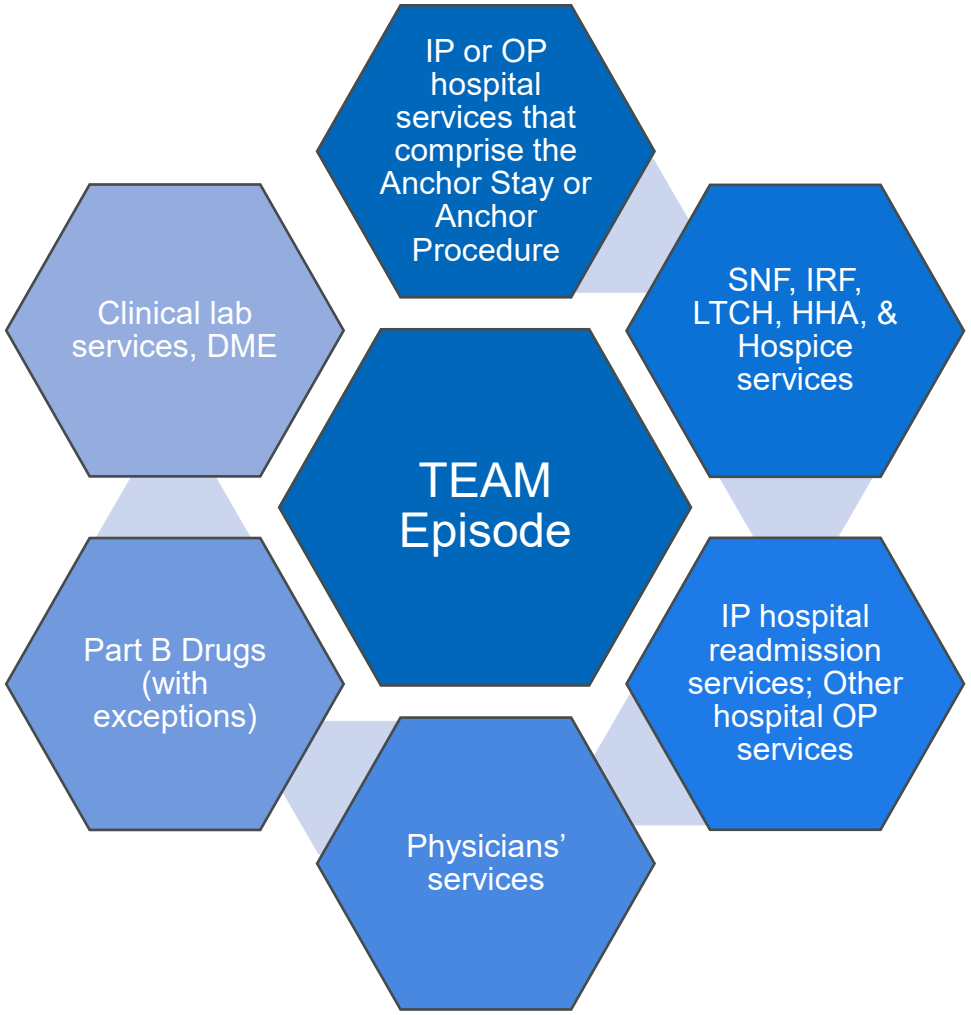
- Medicare ACO beneficiaries can trigger TEAM episodes
  - No Recoupment between models
- Current BPCI-A and CJR participants can opt in to participation if their region was not selected

Key Model Requirements

- Notify beneficiaries of participation in TEAM
- Provide referral to primary care before discharge

What Is Included in a TEAM Episode?

- Total-cost-of-care for episodes during the initial hospitalization (or procedure for OP episodes)
- Almost all expenditures are included; there are some pre-determined exclusions
- Patients may receive services anywhere & all sites of care are included
- Services are prorated if they straddle episode end dates
- Revenue cycle is not disrupted



Target Price Calculation

1 Benchmark price for DRG/HCPCS episode type in census region (three-year baseline)

Census Region: (IA, KS, MI, MN, ND, NE & SD)

2 Site-neutral targets for certain HCPCS/DRG combinations within LEJR and Spinal Fusion episode groups

3 Adjusted for hospital-level variables (hospital bed size, safety net hospital), beneficiary-level variables (age group, HCC count, social risk) and episode-group specific variables (individual HCCs, etc.)

4 1.5% CMS discount applied to Major Bowel Procedure and CABG; 2.0% discount applied to LEJR, SHFFT and Spinal Fusion episodes

Sample Target Price Calculation

$18,975 Regional Price (IA, KS, MI, MN, ND, NE & SD) **x** **1.173** Patient/Hospital Specific Adjustment **x** **0.85** Normalization Factor **x** **1.02** Trend Factor **x** **0.98** CMS Discount **=** **$18,911 Target Price**

Can be adjusted by up to 3% retrospectively

For illustrative purposes only

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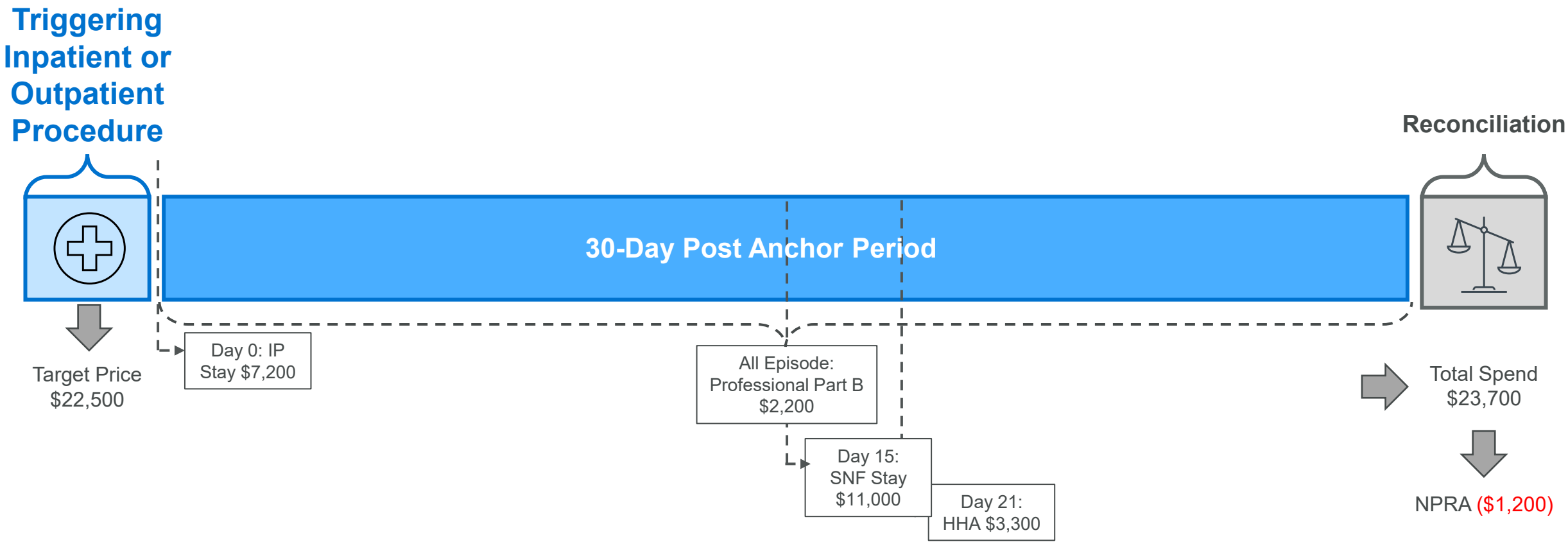
How a TEAM Episode Works



- Reconciliation: Target Price – Spend = NPRA (Net Payment Reconciliation Amount)
  - $22,500 - $23,700 = **($1,200)**; therefore, for this specific Episode, Participant owes **($1,200)**

Episode Groups & Definitions

Episode Category	Billing Codes
Lower Extremity Joint Replacement (Inpatient & Outpatient)	MS-DRG 469, 470, 521, 522 HCPCS 27447, 27130, 27702
Surgical Hip & Femur Fracture Treatment (Inpatient)	MS-DRG 480, 481, 482
Coronary Artery Bypass Graft ("CABG") Surgery (Inpatient)	MS-DRG 231, 232, 233, 234, 235, 236
Spinal Fusion (Inpatient & Outpatient)	MS-DRG 402, 426, 427, 428, 429, 430, 447, 448, 450, 451, 471, 472, 473 HCPCS 22551, 22554, 22612, 22630, 22633
Major Bowel Procedure (Inpatient)	MS-DRG 329, 330, 331

Risk Adjustment

Target Price Calculation

HCCs documented by any provider in the 180 days preceding the episode count toward the target price

1 Benchmark price for DRG/HCPCS episode type in census region (three-year baseline)

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Sample Target Price Calculation

$18,975 Regional Price
Census Region: IA, KS, MI, MN, ND, NE & SD

x

1.173 Patient/Hospital Specific Adjustment

x

0.85 Normalization Factor

x

1.02 Trend Factor

x

0.98 CMS Discount

=

$18,911 Target Price

Can be adjusted by up to 3% retrospectively

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Risk Adjustment // All Episode Groups- EXAMPLE

Episode Group	Episode Volume	Target Price	Regionally Efficient Target Price	Diff. from Regionally Efficient	% MCC			Patient-Specific Adjustment		
					% MCC	Region % MCC	Regionally Efficient % MCC	PSA	Region PSA	Regionally Efficient PSA
LEJR-fracture	94	$37,714	$38,958	-$1,244	17.0%	22.7%	22.2%	1.27	1.30	1.30
LEJR-no fract	1,144	$18,085	$18,337	-$251	0.3%	1.1%	0.9%	1.13	1.13	1.13
SHFFT	167	$38,154	$38,915	-$761	17.5%	21.8%	22.3%	1.22	1.23	1.22
CABG	87	$50,275	$51,978	-$1,702	29.1%	42.1%	40.3%	1.07	1.09	1.09
Spinal Fusion	185	$37,791	$40,833	-$3,042	2.7%	6.7%	5.3%	1.12	1.13	1.13
Major Bowel	213	$29,638	$31,019	-$1,381	32.1%	38.1%	37.1%	1.09	1.10	1.10

How do target price elements compare to benchmarks?

$XX,XXX Regional DRG Price

x

1.XXX Patient/Hospital Specific Adjustment

Note: Table includes 2024 episodes only.

Category	Variable Description	Variable Coefficient	Major Bowel	
			Regionally Efficient	Diff. from Regionally Efficient
Patient Specific Adjustment			1.10	-0.01
HCC Count			2.68	0.25
Demographics	Average Age		74.6	-0.1
	% Age 85+	1.13	11.3%	0.4%
	% Age 75-84	1.05	38.2%	4.5%
	% Age 65-74	1.01	45.2%	-6.7%
	% Under Age 65	1.00	5.3%	1.7%
Prior PAC Use	% w/ Prior Pac Use	0.00	0.0%	0.0%
HCC Capture	% HCC 253-Hemiplegia/Hemiparesis	1.09	1.4%	-1.4%
	% HCC 151-Schizophrenia	1.08	0.8%	-0.8%
	% HCC 199-Parkinson Disease	1.08	1.8%	-1.3%
	% HCC 126-Dementia, Moderate	1.08	0.5%	-0.5%
	% HCC 17-Metastatic Cancer	1.06	4.6%	0.5%
	% HCC 383-Chronic Skin Ulcer	1.05	1.6%	-0.7%
	% HCC 127-Dementia, Mild	1.05	4.0%	0.7%
	% HCC 211-Respirator Dependence	1.04	0.3%	0.2%
	% HCC 125-Dementia, Severe	1.05	0.2%	-0.2%
	% HCC 267-DVT and Pulmonary Embolism	1.03	5.0%	-0.3%
	% HCC 326-Chronic Kidney Disease Stage 5	1.03	0.5%	-0.5%
	% HCC 201-Seizure Disorders	1.03	2.7%	-0.8%
	% HCC 213-Cardio-Respiratory Failure	1.03	5.5%	1.0%
	% HCC 224-Acute or Chronic HF	1.03	2.2%	2.1%
	% HCC 327-Chronic Kidney Disease Stage 4	1.03	1.8%	0.0%
	% HCC 48-Morbid Obesity	1.02	7.9%	0.5%
	% HCC 37-Diabetes w/CC	1.02	14.4%	2.5%
	% HCC 155-Major Depression	1.02	4.7%	1.4%
	% HCC 238-Unspec Heart Arrhythmias	1.01	18.9%	4.1%
	% HCC 226-Heart Failure	1.01	11.6%	4.3%
	% HCC 280-COPD and other Lung Disorders	1.00	15.7%	-0.6%
	% HCC 78-Intestinal Obstruction	0.98	30.2%	2.6%
	% HCC 22-Colorectal Cancer	0.96	23.4%	6.7%
	% HCC 463-Artificial Openings	0.96	14.3%	7.7%

HCC Capture

Why Clinical Documentation Integrity and Coding Teams Are Critical for Provider Documentation and HCC Capture

1. CDI ensures clinical clarity and specificity

- CDI specialists review documentation to confirm it accurately reflects the patient's clinical picture.
- They help providers use precise terms (e.g., "Chronic systolic heart failure" instead of "CHF") to capture severity and acuity.

2. Coding translates documentation into accurate ICD-10 and HCC codes

- Coders convert provider documentation into standardized codes that drive reimbursement, quality metrics, and risk adjustment.
- Without accurate coding, even well-documented conditions may not count toward HCC risk scores.

3. Collaboration prevents costly gaps

- **Missed diagnoses:** Conditions not documented or coded correctly reduce risk scores.
- **Incorrect risk scores:** Impacts CMS TEAM benchmarks and reimbursement.
- **Lost reimbursement:** Under-documentation can lead to significant financial loss and compliance risk.

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HCC Capture

CDI & Coding Readiness for TEAM

• TEAM depends on complete and accurate risk-adjusted documentation.

• CDI and Coding teams must align for precision, timeliness, and completeness.

• Goal: Ensure chronic and acute conditions are captured to drive fair reimbursement.

HCC Capture
CDI & Coding Readiness for TEAM

Audit Current-State HCC Capture Rate

- Review inpatient and outpatient charts for completeness.
- Calculate current HCC capture % versus expected benchmarks.
- Identify missed conditions and documentation gaps.
- Prioritize high-volume surgical and chronic disease categories.

Audit Workflow and Methodology

1. Identify target DRGs and service lines (LEJR, CABG, Spine, etc.).
2. Sample charts for risk completeness and coding specificity.
3. Validate documentation supports coded HCCs.
4. Document patterns and share with medical staff for correction.

Validate Chronic Condition Lists and Problem Lists

- Ensure all active conditions appear in the EHR problem list.
- Retire inactive or resolved diagnoses.
- Map chronic problems to ICD-10-CM and HCC categories.
- Engage physicians in quarterly list maintenance.

Problem List Optimization Strategies

- Set policy for required updates pre-op and at discharge.
- Use EHR alerts for unspecified or inactive conditions.
- Integrate CDI review prompts into pre-admission workflows.
- Standardize terminology for chronic conditions.

Review Documentation Templates and EHR Prompts

- Evaluate templates for completeness of comorbidity fields.
- Add required prompts for chronic diseases and SDOH Z-codes.
- Embed SmartPhrases for CHF, CKD, COPD, obesity, and diabetes.
- Reinforce linkage between diagnoses and treatment plans.

HCC Capture

CDI & Coding Readiness for TEAM

Develop Physician Feedback Loops and Education

- Provide monthly HCC and query response dashboards.
- Conduct case-based CDI education.
- Compare provider-level performance against benchmarks.
- Recognize accurate and timely documenters.

CDI & Coding Readiness for TEAM

Cross-Functional Collaboration Framework

- Establish joint CDI–Coding–Physician rounds.
- Share query outcomes and denial root causes.
- Train teams on TEAM episode structure and target logic.
- Escalate complex documentation issues via review committee.

HCC Capture

CDI & Coding Readiness for TEAM

TEAM	TEAM HCC CDI & Coding Readiness – Action Plan
Complete	Complete baseline HCC audit and close documentation gaps.
Update	Update templates and problem lists.
Launch	Launch physician feedback dashboard.
Form	Form multidisciplinary TEAM readiness task force.

HCC Documentation Strategies

HCC Documentation Strategies

Lower Extremity Joint Replacement

Key Risk Drivers:

- Diabetes with complications (E11.22, E11.65)
- Obesity (E66.9) and BMI Z-codes (Z68.xx)
- Chronic kidney disease (N18.xx)
- COPD (J44.xx)
- Heart failure (I50.xx)

Documentation Focus:

- Capture all active chronic conditions at pre-op clearance.
- Ensure specificity (e.g., 'Chronic systolic CHF', not 'CHF').
- Include SDOH Z-codes for home environment or mobility limitations.

HCC Documentation Strategies: Lower Extremity Joint Replacement
Example Documentation for Pre-Op Clearance

Patient: 72-year-old scheduled for left total knee arthroplasty.

Active Chronic Conditions:
- Type 2 diabetes mellitus with diabetic neuropathy (E11.40)
- Obesity, BMI 36.2 kg/m² (E66.9; Z68.36)
- Chronic kidney disease, stage 3 (N18.32)
- Chronic obstructive pulmonary disease (J44.9)
- Chronic systolic heart failure (I50.22)

Social Determinants of Health:
- Lives alone, limited mobility (Z60.2)
- Requires home health support post-discharge (Z74.01)

Documentation Notes:
- Ensure specificity: “Chronic systolic CHF” rather than “CHF.”
- Confirm all conditions are active and clinically relevant for surgical risk.
- Include SDOH Z-codes for care planning and risk adjustment.

HCC Documentation Strategies: Lower Extremity Joint Replacement

Example Documentation for LEJR Case

Patient Summary:

•70-year-old patient scheduled for right total knee arthroplasty due to severe osteoarthritis.

•Past medical history includes:

- Type 2 diabetes mellitus with diabetic nephropathy (E11.22)
- Obesity, BMI 34.8 kg/m² (E66.9; Z68.34)
- Chronic kidney disease, stage 3 (N18.32)
- Chronic obstructive pulmonary disease (J44.9)
- Chronic systolic heart failure (I50.22)

Key Documentation Points:

•**Capture all active chronic conditions at pre-op clearance:**

“Patient with chronic systolic CHF, stable on medication; COPD managed with inhalers.”

•**Ensure specificity:**

Use “Chronic systolic CHF” instead of “CHF.”

Document BMI and obesity explicitly.

•**Include SDOH Z-codes:**

“Patient lives alone with limited mobility; requires home health support post-discharge (Z74.01).”

HCC Documentation Strategies

Coronary Artery Bypass Graft

Key Risk Drivers:

- Atherosclerotic heart disease (I25.xx)
- Chronic heart failure, type and acuity (I50.2x)
- Chronic kidney disease (N18.xx)
- Diabetes with cardiovascular complications (E11.59)
- Peripheral vascular disease (I73.xx)

Documentation Focus:

- Capture pre-existing CAD severity, not just procedural indication.
- Document all cardiac devices and ischemic cardiomyopathy.
- Avoid 'history of' phrasing for chronic conditions still active.

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HCC Documentation Strategies: Coronary Artery Bypass Graft

Example Documentation for CABG Case

Patient Summary:

•68-year-old patient admitted for elective CABG due to severe multivessel CAD.

•Past medical history includes:

- Atherosclerotic heart disease (I25.10)
- Chronic systolic heart failure (I50.22)
- Chronic kidney disease, stage 3 (N18.32)
- Type 2 diabetes mellitus with cardiovascular complications (E11.59)
- Peripheral vascular disease (I73.9)

Key Documentation Points:

•**Pre-existing CAD severity:**

“Patient with severe multivessel coronary artery disease involving LAD, RCA, and LCx confirmed by angiography.”

•**Cardiac devices and ischemic cardiomyopathy:**

“History of ischemic cardiomyopathy with EF 30%, ICD in place.”

•**Avoid ‘history of’ phrasing:**

Instead of “history of CHF,” document as “Chronic systolic heart failure, stable on medical therapy.”

HCC Documentation Strategies

Surgical Hip and Femur Fracture Treatment

Key Risk Drivers:

- Osteoporosis with current pathological fracture (M80.xx)
- Chronic anemia (D63.1)
- Dementia (F03.xx) or cognitive impairment (R41.81)
- Malnutrition (E46)
- CKD, CHF, COPD as secondary comorbidities

Documentation Focus:

- Capture all pre-fracture chronic conditions.
- Include functional limitations, malnutrition, and cognitive state.
- Code concurrent infections (UTI, pneumonia) accurately.

HCC Documentation Strategies: Surgical Hip and Femur Fracture Treatment

Example Documentation for Hip Fracture Case

Patient Summary:

•82-year-old patient admitted for surgical repair of left femur fracture following a fall.

•Past medical history includes:

- Osteoporosis with current pathological fracture (M80.052A)
- Chronic anemia (D63.1)
- Dementia without behavioral disturbance (F03.90)
- Malnutrition (E46)
- Chronic kidney disease, stage 4 (N18.4)
- Congestive heart failure (I50.32)
- COPD (J44.9)

Key Documentation Points:

•**Pre-fracture chronic conditions:**

“Patient with severe osteoporosis and chronic anemia contributing to fracture risk.”

•**Functional limitations and cognitive state:**

“Patient requires assistance with ADLs due to dementia and limited mobility.”

•**Concurrent infections:**

“Urinary tract infection present on admission; treated with antibiotics.”

•**Avoid vague phrasing:**

Instead of “history of CKD,” document as “Chronic kidney disease, stage 4, stable.”

Spinal Fusion

Key Risk Drivers:

- Obesity and BMI (E66.xx, Z68.xx)
- Chronic pain and long-term opioid dependence (F11.2x)
- Diabetes and neuropathic complications (E11.42)
- Depression or anxiety (F32.xx, F41.xx)
- CKD and hypertension (I12.xx, N18.xx)

Documentation Focus:

- Link chronic pain, functional impairment, and comorbidities.
- Clarify fusion indication (degenerative disc vs. trauma vs. deformity).
- Ensure post-op complications are clearly defined (acute blood loss anemia, infection).

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HCC Documentation Strategies: Spinal Fusion

Example Documentation for Spinal Fusion Case

Patient Summary:

•62-year-old patient admitted for lumbar spinal fusion due to degenerative disc disease with severe functional impairment.

•Past medical history includes:

- Obesity (BMI 38.2) – E66.9, Z68.38
- Chronic pain syndrome with long-term opioid therapy – F11.20
- Type 2 diabetes mellitus with neuropathic complications – E11.42
- Depression – F32.9
- Chronic kidney disease, stage 3 – N18.32
- Hypertension – I12.9

Key Documentation Points:

•**Link chronic pain and functional impairment:**

“Patient with chronic lumbar pain causing significant mobility limitations; requires assistance with ADLs.”

•**Clarify fusion indication:**

“Fusion performed for degenerative disc disease with instability, not trauma or deformity.”

•**Post-op complications:**

“Acute blood loss anemia noted post-operatively; transfusion administered.”

HCC Documentation Strategies

Major Bowel Procedures

Key Risk Drivers:

- Malignancy (C18.xx–C20.xx) with metastasis (C78.xx)
- Malnutrition (E43–E46)
- Chronic inflammatory bowel disease (K50.xx, K51.xx)
- Sepsis risk factors (A41.xx)
- Diabetes and obesity (E11.xx, E66.xx)

Documentation Focus:

- Specify cancer stage and metastatic sites.
- Document nutritional status (albumin <3.0 g/dL → E46).
- Include ostomy status, dehydration, and infection diagnoses.
- Capture SDOH barriers impacting recovery (Z60–Z65).

HCC Documentation Strategies: Major Bowel Procedures

Example Documentation for Major Bowel Procedure Case

Patient Summary:

•72-year-old patient admitted for colectomy due to metastatic colon cancer.

•Past medical history includes:

- Malignant neoplasm of sigmoid colon with liver metastasis (C18.7, C78.7)
- Severe protein-calorie malnutrition (E43)
- Chronic ulcerative colitis (K51.90)
- Type 2 diabetes mellitus (E11.9)
- Obesity (E66.9)

Key Documentation Points:

•**Specify cancer stage and metastatic sites:**

“Stage IV colon cancer with metastasis to liver and peritoneum.”

•**Document nutritional status:**

“Albumin 2.8 g/dL indicating severe malnutrition.”

•**Include ostomy status and infection risk:**

“Patient has ileostomy post-op; monitoring for dehydration and infection.”

•**Capture SDOH barriers:**

“Limited access to transportation and home health support impacting recovery (Z60.2).”

Key Takeaways

Key Takeaways

Protecting TEAM Revenue Through HCC Accuracy

01

HCCs drive target prices, reconciliation, and revenue.

02

Documentation precision = financial protection.

03

CDI + Coding + Physician alignment = TEAM readiness.

04

Every missed HCC is a lost opportunity for fair reimbursement

05

TEAM success depends on risk-adjusted integrity

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Q&A

Contact

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Thank You

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