COACHCARE | SERVICE LINE STRATEGY

Aurora Denver Cardiology Associates

A HealthONE Heart Care LLC practice — 48 clinicians, seven Denver-metro offices, credentialed across six HCA HealthONE hospitals

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) as the operating spine for the 30-day post-discharge episode the division's six mandatory TEAM hospitals now carry, for the record seam between an eClinicalWorks ambulatory clinic and a MEDITECH hospital, and for a margin-positive standalone P&L

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the cardiovascular service-line leadership of HCA HealthONE's Denver division. It assembles the group's public footprint and enrolled structure, its CY2024 Medicare service record, its verified position relative to a live mandatory CMS episode model, the Denver-metro payer mix, the 2026 payment environment, and a modeled financial forecast into a single argument: this group already runs a remote cardiac-device operation at scale, and the physiologic layer sitting directly beside it — the one CMS pays for separately, and the one that governs what happens in the 30 days after a hospital discharge — is currently neither staffed nor billed.

All facts are drawn from public sources current to August 2026 and cited in the References section. All financial projections are illustrative and modeled in the CoachCare Value Analysis (MAC locality auto-resolved for ZIP 80012 — Colorado, locality 04112-01) — verify against practice data before budgeting.

Prepared by CoachCare. Contact the CoachCare account team for the underlying model.

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Executive Summary

Aurora Denver Cardiology Associates is a fifty-year-old Denver cardiology brand — its 50th anniversary was marked in March 2025 — and it is no longer a billing entity. **The Medicare-enrolled organization behind every clinician who practises under that brand is HealthONE Heart Care LLC**, CMS organizational PAC ID 9436394467, carrying **48 enrolled members — 25 physicians and 23 advanced practice providers** in the CMS file dated June 26, 2026.[1] No Medicare-enrolled organization named "Aurora Denver Cardiology Associates" exists in the current CMS enrollment file at all; the name survives inside PECOS as a **practice-location address line** under the HealthONE entity. The group's website carries a C-HCA, Inc. copyright notice, serves its pages from HCA's enterprise web platform, and its recruiting runs on HCA's own careers domain.[2] **This report is therefore written for a health-system-owned specialty group, and the economic buyer is HCA HealthONE's Denver division**, not a practice partnership.

Three facts define this report.

1. **The billable care-management layer is empty.** All 44 roster NPIs with CY2024 Medicare claims were screened individually against the full remote physiologic monitoring, chronic care management, principal care management, transitional care management, physiologic-data-review and self-measured blood pressure code sets. **Zero services, on every code, for every provider.**[3] The honest caveat belongs in the same sentence: CMS suppresses any provider / code / place-of-service cell with fewer than 11 beneficiaries, so a very small pilot would be invisible in this file. What the record establishes is that no programme at material scale existed in CY2024.
2. **The remote-monitoring layer beside it is already running.** In the same year the group billed roughly **$171,000 of remote cardiac device monitoring** across 93294–93298 — approximately **1,300 beneficiary-instances** on remote pacemaker, defibrillator, loop-recorder, technical and implantable-hemodynamic interrogation, spread across as many as eleven clinicians on a single code.[4] A group doing that has device technicians, a triage inbox, an alert-review protocol and documented remote-monitoring habits. **It already runs the hardest part of a remote care programme.**
3. **A mandatory CMS episode model is already live around it.** Every HCA HealthONE hospital in which these clinicians hold a practice address is a **mandatory TEAM participant** — including **CCN 060100, HCA HealthONE Aurora**, and **CCN 060112, HCA HealthONE Sky Ridge** — all in **CBSA 19740**, Denver-Aurora-Centennial, with a performance period running **January 1, 2026 to December 31, 2030**.[5] **Coronary artery bypass graft is one of the five TEAM episode families**, and TEAM holds the hospital accountable for the 30 days after discharge, readmissions included. The group itself holds no CCN and is not a TEAM participant; its hospitals are.

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[1] CMS National Downloadable File (Doctors and Clinicians / PECOS), dataset mj5m-pzi6, file modified June 26, 2026. Resolution was by organizational PAC ID 9436394467 rather than by geography, which returns the complete enrolled roster: 48 distinct NPIs, num_org_mem = 48. A separate query of the same file for any facility name matching 'AURORA DENVER CARDIOLOGY', across all states, returned zero rows.

[2] The group's public website, retrieved August 3, 2026: the footer copyright notice naming C-HCA, Inc., the HCA nondiscrimination and surprise-billing legal stack, page assets loading from HCA enterprise web infrastructure, and the .dot URL convention shared with the system's consumer site. The HCA careers page dedicated to the brand was confirmed to exist via search but could not be fetched directly - the careers domain returned an automated-access block.

[3] CMS Medicare Physician & Other Practitioners - by Provider and Service, CY2024 (released May 21, 2026). All 44 roster NPIs with claims were queried individually against 99453, 99454, 99457, 99458; 99091; 99490, 99439, 99487, 99489, 99491; 99424-99427; 99495, 99496; 99473, 99474; and G0511. Zero services on every code, for every provider. CMS suppresses any provider / HCPCS / place-of-service cell with fewer than 11 beneficiaries.

[4] Same file and vintage: CPT 93294, 93295, 93296, 93297, 93298 and 93272. Counts are beneficiary instances per code per provider and contain duplication across providers; they are not unique-patient counts. The 93294 line alone appears for eleven distinct NPIs.

[5] CMS TEAM Participant List, published at cms.gov/team-model-participant-list and served as an XLSX workbook; hospital list as of April 15, 2026, retrieved August 3, 2026. The file carries 720 hospitals - 710 mandatory and 10 voluntary - across 189 distinct CBSA values. CCN 060100 and CCN 060112 are both Mandatory, CBSA 19740, performance period January 1, 2026 to December 31, 2030, as are CCN 060014, 060032, 060034 and 060065.

The central argument

1. Standalone value. TCM + RPM + PCM is recurring, subscription-like professional-fee revenue delivered at top-of-license staffing, margin-positive before any value-based upside — modeled at **$8,939,698** of net reimbursement and **$3,783,655** net to the practice over 24 months, a **42.32% practice margin** (net to the practice ÷ net reimbursement). Illustrative, modeled — verify against practice data.

2. Connective tissue. One shared engine — enrollment, connected devices, 24/7 alerting and triage, nurse navigation, billing capture and analytics — simultaneously serves the hospitals' TEAM episode performance, the post-discharge hand-off across the record seam described below, procedural throughput in structural heart and electrophysiology, the division's readmission and quality position, and the standalone P&L. Build once, use everywhere.

The operational argument is the sharpest one in this account, and it is a verified integration fact rather than a theory. The clinics run **eClinicalWorks** — the patient portal resolves to an eClinicalWorks-hosted instance at **mycw39.eclinicalweb.com**, and telehealth runs on Healow, eClinicalWorks' own patient platform, with a CMS telehealth flag set for 13 of the 48 enrolled clinicians.[6] The hospitals run MEDITECH. **The ambulatory clinical record and the inpatient clinical record are therefore two different systems, and the 30-day TEAM episode runs straight across the boundary between them**. The hospital owns the episode; the cardiology group owns the follow-up; and the two do not share a record. That is precisely the seam post-discharge workflows fall through, and it is the most concrete thing a remote care service line fixes here — a daily discharge feed, an owned two-business-day contact, and monitored days one to fourteen, all of it documented in one place and billed automatically.

The readmission hook is quantified, and it comes from the division's own ACO. HCA's Colorado accountable care organization is **HealthONE Colorado Care Partners ACO LLC (A5328)**, a Colorado BASIC Level A entity that began in January 2024. In its first reconciled performance year it produced a savings rate of **0.12% against a 3.01% minimum savings rate** on 9,906 assigned beneficiaries — it missed by a wide margin — and its hospital-wide 30-day all-cause readmission result of **0.1608 runs worse than the 0.1517 ACO mean**.[7] Two points of discipline on that figure. First, the cardiology group is *not* a participant TIN in A5328; all 34 participant TINs are primary care, family medicine, women's health or pediatrics, so the group carries no shared-savings risk and earns no distribution of its own. Second, a widely used commercial firmographic file attributes this group to MountainStar Care Partners ACO — that is a data error. MountainStar is HCA's Idaho / Utah / Wyoming ACO with no Colorado service area. The relevant point stands anyway: **readmission is the measure that is already underperforming across the division's attributed population, and it is the same measure TEAM reconciles hospitals on.**

The market backdrop cuts both ways and should be stated plainly rather than sold. Arapahoe County holds 108,185 Medicare beneficiaries with **57.6% in Medicare Advantage**; across the six-county Denver metro the figure is **59.4% of 473,415**, against 52.4% for Colorado and 51.2% nationally.[8] The favourable consequence is scale — the true Medicare book behind this group is roughly two and a half times what the fee-for-service claims file shows. The unfavourable one is pricing: **this report models Physician Fee Schedule rates for locality 04112-01, and roughly three in five local Medicare beneficiaries sit in a plan where remote-monitoring reimbursement is contract-dependent rather than fee-schedule-fixed**. Sizing that book plan by plan is a first-order budgeting task (Section 8.1).

[6] The group's patient-portal page links to an eClinicalWorks-hosted portal on the mycw39 instance in eClinicalWorks' region3 cloud at the vendor's standard portal login path; the telehealth page is a Healow virtual-appointments page. Both retrieved August 3, 2026. The CMS National Downloadable File carries a telehealth flag for 13 of the 48 enrolled clinicians. The inpatient platform is not independently verified from public sources and should be confirmed in discovery.

[7] CMS Medicare Shared Savings Program PY2026 Organizations and Participants files (dataset modified February 4, 2026) and the Performance Year Financial and Quality Results file for PY2024 (revised July 17, 2026). HealthONE Colorado Care Partners ACO LLC, ACO ID A5328, Colorado service area, BASIC Level A, one-sided, low revenue, retrospective assignment, start January 1, 2024, Advance Investment Payment. All 34 participant TINs were reviewed in both the CMS participants file and the ACO's own public-reporting document; none is a cardiology entity.

[8] CMS Medicare Monthly Enrollment, April 2026 file, queried on county FIPS codes for Arapahoe, Adams, Jefferson, Denver, Douglas and Elbert, with Colorado and national totals from the same release. Dual-eligible figures are patient counts; note that dual-share denominators differ between claim lines and patients.

The timing is specific. The CY2026 Physician Fee Schedule expanded remote monitoring in ways that suit exactly this group: **99445** pays the monthly device-supply amount for 2–15 days of data where 16 or more were previously required, which makes short post-discharge and post-procedure windows billable for the first time, and **99470** pays for the first 10 minutes of monthly management time where the floor had been 20. TEAM began January 1, 2026. A service line chartered in late 2026 is operating at census inside the first performance year rather than after it.

The companion CoachCare Value Analysis sizes the opportunity on an estimated **16,576-patient in-scope base across 48 referring providers** — *a discovery-stage estimate to validate against the group's own chart counts* — with RPM and PCM only. It projects net reimbursement of **$2,323,938** in Year 1 and **$6,615,761** in Year 2 (**$8,939,698** over 24 months — RPM $6,717,272, PCM $2,222,426); **$3,783,655** net to the practice after CoachCare fees; 691,780 physiologic readings; approximately **439 avoided hospitalizations**; and 71,844 care-team hours delivered, about **34.5 full-time equivalents** of clinical labour nobody has to hire. Month 1 is modeled at −$778 and every month from month 2 onward is net-positive. *All figures are illustrative, modeled — verify against practice data.*

2026–2027 Priority Recommendations

1. **Charter the Remote Care Service Line as a named programme with its own P&L.** TCM at discharge, then RPM, then PCM, across heart failure, uncontrolled and resistant hypertension, post-ablation and post-device-implant windows, and post-structural-heart recovery. Name a physician lead from the cardiology bench and pair them with the division's ambulatory operations lead. Target the first billable enrollment within 90 days.
2. **Start with the patients who already have remote data flowing.** The approximately 1,300 device-remote-monitoring beneficiary-instances in CY2024 are the highest-confidence enrollable cohort in the account: consent exists, a device clinic workflow exists, and the patients are already conditioned to remote review. Physiologic monitoring is a distinct benefit over distinct data (Section 8.3) — this is an attach, not a re-sell.
3. **Bill the post-discharge window the group already generates.** Transitional care management is deliberately excluded from every financial figure in this report so the forecast stays conservative, which makes it a separate and additive decision the division can take on its own merits. The CY2024 record shows initial and subsequent hospital care billed in volume and no TCM billed against any of it (Sections 2.1 and 5).
4. **Take the TEAM conversation to the division, not to one hospital.** Six HCA HealthONE hospitals in CBSA 19740 entered mandatory 30-day episode accountability on January 1, 2026, and CABG is an episode family. The clinicians who determine what happens in those 30 days sit in a different clinical record from the entity carrying the risk. One service line, built once, serves all six CCNs (Section 5).
5. **Make the record seam an explicit design requirement, not an integration afterthought.** The single most common point of failure in a post-discharge programme is not knowing who was discharged yesterday. With an eClinicalWorks ambulatory record and a MEDITECH inpatient record, that feed has to be designed deliberately (Section 6).
6. **Write the attribution policy before the first enrollment.** Only one practitioner may bill RPM for a given patient in any 30-day period, and the division's own accountable care organization has 34 primary-care participant TINs whose patients overlap this panel. Settle in writing which patients the cardiology service line manages and which stay with a primary-care wrapper, with one shared care plan and explicit task ownership (Section 2.1).
7. **Price the Medicare Advantage book separately before budgeting.** Roughly 59% of the metro Medicare population is in Medicare Advantage. Every figure in this report is modeled at fee-schedule rates for the fee-for-service population; the Medicare Advantage opportunity is larger and is priced contract by contract. Treat it as additive and unquantified until the contracts are reviewed.

1. Footprint & Operating Model

1.1 The entity: a brand, a billing organization, and why the difference matters

The distinction between the brand and the enrolled organization is not a technicality; it decides who signs, who budgets and who is accountable for the result. Five independent lines of evidence resolve it the same way.

Evidence	What it shows
CMS enrollment — the strongest	A query of the CMS National Downloadable File for any organization whose facility name matches “Aurora Denver Cardiology”, across all states, returns zero rows. No Medicare-enrolled organization by that name exists in the current file
Reassignment	Every clinician who appears in public directory listings under the brand resolves to HEALTHONE HEART CARE LLC, organizational PAC ID 9436394467, with 48 enrolled members
The PECOS address lines	Practice-location rows read literally “1444 S POTOMAC ST | 300 AURORA DENVER CARDIOLOGY ASSOCIATES | AURORA, CO 80012” and “14100 E ARAPAHOE RD | 130 AURORA DENVER CARDIOLOGY ASSOCIATES | CENTENNIAL, CO 80112” — with the facility name set to HealthONE Heart Care LLC on every one. That is the signature of a brand retained as a trading name after the enrolled entity was replaced
The website	The footer carries a “Copyright 1999-2026 C-HCA, Inc.” notice and HCA's standard legal stack; page assets load from HCA's enterprise web platform. The .dot URL extension is HCA's corporate content-management convention, not a legacy practice site
Recruiting	Hiring for the group runs under HCA's own careers domain, on a page dedicated to the brand

CMS National Downloadable File (Doctors and Clinicians / PECOS), dataset mj5m-pzi6, file modified June 26, 2026; the group's public website, retrieved August 3, 2026. The precise legal instrument — asset purchase, employment, or a professional services agreement with a captive professional corporation — is not established from public sources and is listed as an open item.

Size, counted from CMS rather than from a commercial file. The enrolled roster is **48 clinicians: 25 physicians and 23 advanced practice providers**. The physician bench breaks down as 14 in cardiovascular disease, 7 in interventional cardiology, 3 in internal medicine with cardiology as a secondary specialty, and 1 in cardiac electrophysiology; the advanced practice bench is 14 nurse practitioners, 8 physician assistants and 1 clinical nurse specialist.[9] A widely used commercial firmographic file reports 30 physicians — an overcount of roughly five, consistent with departed or emeritus clinicians still carried in an aggregator record; the same file's group-member count of 49 is essentially correct. Two physicians publicly associated with the brand now enroll under a separate three-member Colorado cardiology organization, which is evidence of ordinary roster churn rather than of anything larger. *Stated as a caveat: enrollment records capture reassignment relationships, so they lag a departure and miss a hire made after the June 2026 snapshot. Confirm the live roster in discovery.*

Footprint. Seven patient-facing offices, not the four a commercial file reports — Aurora (headquarters, 1444 South Potomac Street), Castle Rock, Centennial, Englewood, Greenwood Village, Lakewood and Lone Tree.[10] CMS practice-address records widen the footprint materially beyond those seven: they also place these clinicians on six HCA HealthONE hospital campuses, at rural Colorado outreach sites in Del Norte, Alamosa, Burlington, Wray and Haxtun, and at out-of-state sites in Grant, Sidney and Ogallala,

[9] CMS National Downloadable File, file modified June 26, 2026: the physician and advanced-practice composition by CMS primary specialty descriptor - 14 cardiovascular disease, 7 interventional cardiology, 3 internal medicine with cardiology secondary, 1 cardiac electrophysiology, 14 nurse practitioners, 8 physician assistants and 1 clinical nurse specialist. Enrollment records capture reassignment relationships, so they lag a departure and miss a hire made after the snapshot date.

[10] The group's own location pages, retrieved August 3, 2026, cross-checked against the practice-address rows in the CMS National Downloadable File, which additionally place these clinicians on six HCA HealthONE hospital campuses and at rural Colorado, Nebraska and Kansas outreach sites.

Nebraska, and Wichita, Kansas. **The rural and out-of-state outreach sites are the single most obvious remote-monitoring geography in the account** — they are exactly where an in-person follow-up visit costs the most and happens the least.

Clinical range, from the group's own service pages. Interventional cardiology covers diagnostic and interventional catheterisation, coronary stenting, transcatheter aortic valve replacement, coronary calcium scoring, stress testing and stress echocardiography, myocardial perfusion imaging, vascular and carotid ultrasound, abdominal aortic aneurysm screening, vein ablation and sclerotherapy, and **renal denervation for resistant hypertension**. The structural heart page adds transcatheter mitral valve repair and replacement, surgical aortic valve replacement, left atrial appendage occlusion, and patent foramen ovale and atrial septal defect closure. Electrophysiology covers ablation, cardioversion, pacemaker and defibrillator implantation, event and Holter monitoring, and a named **Protime anticoagulation clinic**.[11] *One absence is worth stating: no dedicated heart failure clinic or disease-management programme is advertised on any page*. That is an absence of evidence rather than evidence of absence, and it is a first-conversation discovery item.

1.2 The operating model: an ambulatory group that practises inside six hospitals

The place-of-service split across the roster's 652 CY2024 service lines is **57.0% office and 43.0% facility by allowed dollars** — $2,968,755 against $2,240,645.[12] The facility side is where the strategic weight sits. Catheterisation, coronary stenting, electrophysiology ablation, device implantation and hospital echocardiography are billed facility-side, which means the clinicians earn the professional component while the technical component flows to an HCA hospital CCN. Add subsequent hospital care at $211,050 and initial hospital care at $91,470 of allowed in the same year, and the operating model is unambiguous: **this is an ambulatory cardiology group whose highest-value work happens inside hospitals in the same enterprise**.

That structure is the reason the division is the right unit of analysis. A remote care service line built here does not have to negotiate across an ownership boundary to reach the hospitals whose episodes it improves. The clinicians already round in them, the technical revenue already lands in them, and the same enterprise carries both sides of the 30-day window. **What does not yet cross that boundary is the clinical record**, and Section 6 is about exactly that.

An external affiliation worth noting. The Aurora cardiology programme is described publicly as affiliated with the Rocky Mountain Heart Rhythm Institute. No practice-level ratings, patient-satisfaction scores or grievance history are reported anywhere in this document, because none were verified from a source worth citing; consumer aggregator listings were used during research only as a lead for names to check against CMS, never as evidence.

1.3 Design principles for the 2026 service line

Principle	What it means for this group
Longitudinal by default	Every heart failure, uncontrolled-hypertension, post-ablation, post-implant and post-discharge patient leaves the encounter enrolled in monitoring or monthly management — not merely scheduled for a return visit a quarter later
Start at the discharge, not at the office visit	The group generates its own highest-value windows inside six mandatory TEAM hospitals. Every cardiac discharge opens a 30-day window, and every ablation, implant and structural case opens a post-procedure window that 99445 now makes billable

[11] The group's interventional cardiology, structural heart and electrophysiology service pages, retrieved August 3, 2026. Imaging capability is separately corroborated by CY2024 billing. No heart failure clinic page exists anywhere in the site's 40-URL sitemap.

[12] CMS Medicare Physician & Other Practitioners - by Provider, CY2024 (released May 21, 2026), queried for all 50 candidate NPIs; 44 returned rows. Total allowed $6,062,840 across 27,559 beneficiary instances. The place-of-service split by allowed dollars across 652 service rows is office $2,968,755 (57.0%) and facility $2,240,645 (43.0%).

Principle	What it means for this group
Design the record seam, do not discover it	The ambulatory record is eClinicalWorks and the inpatient record is MEDITECH. The discharge feed, the enrollment order and the documentation trail have to be specified across that boundary before launch, not after the first missed 30-day window (Section 6)
One front door	A single enrollment, consent and device-logistics workflow; referral to the service line is one order inside the chart clinicians already use, with enrollment status visible in real time
The partner carries the load	The division supplies clinical direction and supervision; the partner supplies enrollment, devices, monitoring, documentation and claims. No care-management headcount has to be created to start
Separate the two remote programmes cleanly	Implanted-device interrogation and patient physiologic monitoring are different benefits over different data. Define the boundary, the data source and the documentation for each before launch, so neither service is at risk (Section 8.3)
Seven offices, six hospitals, and a rural tail	Enrollment scripting and device logistics have to work for a Lone Tree or Greenwood Village patient and for an outreach patient in the San Luis Valley or western Nebraska. The telephonic enrollment pathway is not a fallback here; it is the primary pathway for part of the panel
Single scorecard	Clinical, operational and financial KPIs reviewed monthly by the physician lead and the division's operations lead, and mapped explicitly to the episode and readmission measures the enterprise is already scored on (Sections 3.4 and 8.5)

None of these principles requires new technology and none requires the group to become something it is not. They require one decision — **who owns the layer of care between visits and after discharge** — and a second decision to charter that ownership as a service line with a budget and a scorecard rather than as an initiative. Section 2 prices it. Section 8 staffs it.

2. The Remote Care Service Line — The Operating Spine

This section defines the service line precisely, prices its standalone economics against the group's own Medicare base, and shows how one infrastructure serves every value lever the division faces in 2026–2027.

2.1 What it is: the cardiology clinical & billing stack

The Remote Care Service Line is not a device programme and not an app. It is a managed clinical service built on Medicare's transitional-care, remote-monitoring and care-management benefits, configured for a cardiology group:

Programme	Core codes	What it does	Where it lands at this group
TCM — Transitional Care Management *(identified, not modeled)*	99495 / 99496	The 30-day post-discharge transition: interactive contact within two business days, face-to-face visit within 14 or 7 days depending on complexity	Initial and subsequent hospital care billed in volume in CY2024, and no TCM billed against any of it. The single largest identified gap — and deliberately excluded from every financial figure in this report
RPM — Remote Physiologic Monitoring	99453; 99454 / 99445; 99457 / 99470; 99458	Cellular blood-pressure cuffs, weight scales and pulse oximeters; daily physiologic data; 24/7 review and alert triage; monthly clinical management time	The between-visit layer for heart failure (weight and blood pressure), for uncontrolled and resistant hypertension, and — via the new short-window code 99445 — for the 2–15 day post-discharge, post-ablation, post-implant and post-structural-heart windows
PCM — Principal Care Management	99424–99427	Monthly management of a single high-risk condition expected to last at least three months	Heart failure and resistant hypertension as the qualifying conditions. In a cardiology panel the single dominant condition genuinely is the cardiac one — the clinical situation PCM was written for, and the monthly chassis for titration

Chronic Care Management is not in the modeled stack, and that is a deliberate design choice rather than an oversight. It is the multi-condition instrument of primary care, and this is a specialty group with no primary-care panel of its own to bill it against; the model therefore carries it at zero eligibility. **The stack modeled in this report is RPM plus PCM, and nothing else** — TCM is identified and quantified but excluded from every financial figure.

The one coordination rule

RPM and PCM stack. They may be billed for the same patient in the same month with discrete time and discrete documentation — that pairing is the core of this programme. What does not stack: only one practitioner may bill RPM for a given patient in any 30-day period, so the attribution question has to be settled before enrollment rather than after a denial.

The practical rule here: the cardiology service line owns the transitional-care window at discharge and owns RPM plus PCM on the cardiac condition; the patient's primary-care physician owns any longitudinal primary-care wrapper; both work from **one shared care plan** with explicit task ownership. This is not hypothetical housekeeping in this account — the division's own accountable care organization has 34 primary-care participant TINs whose attributed patients overlap this panel, and a duplicate-billing denial there is also a referral-relationship problem.

And a boundary specific to this group: implanted-device interrogation (93294–93298) and patient physiologic monitoring (99453 onward) are different benefits over different data — the device's own telemetry versus patient-generated physiologic readings from a separate connected device. The rule to design around is that the same data stream is not billed twice. *Confirm the specific pairings with the payer and with billing counsel before launch.*

2.2 Standalone value: a margin-positive service line

Before any value-based upside, the service line stands on four layers of value:

1. **Direct professional-fee revenue.** Recurring monthly billing on a population the group already manages clinically, delivered at top-of-license staffing under general-supervision rules. Modeled at $8,939,698 of net reimbursement over 24 months, $3,783,655 of it net to the practice.
2. **Avoided cost and readmission exposure.** Modeled at approximately 439 avoided hospitalizations over 24 months — on the order of $6.6 million at an illustrative $15,000 per admission. In an enterprise where six hospitals now carry 30-day episode accountability and the division's accountable care organization already reports a readmission result worse than its peer mean, that value is visible to the hospital side of the house as well as to the group.
3. **Procedural throughput.** A monitored discharge pathway is what converts a structural heart or ablation case from a bed-day into a same-or-next-day discharge. Freed bed-days are the constraint on procedural volume, and in this enterprise the freed bed-day accrues to the same balance sheet as the additional case (Section 7).
4. **Strategic position and model readiness.** A built, billable, hospital-facing post-discharge capability is an asset the division can point at when TEAM reconciles, when a payer asks what changed, and when the next episode model arrives. Building it once, centrally, is cheaper than assembling a separate response to each.

The CY2026 billing stack

Service / code	Type	~CY2026 magnitude	Notes
TCM — 99495 / 99496 *(not modeled)*	Per discharge	~$200 / ~$280	Moderate / high complexity. Interactive contact within two business days; face-to-face within 14 or 7 days — upside beyond every financial figure in this report
RPM — 99453	One-time setup	~$20	Device setup and patient education; requires qualifying data days
RPM — 99454 / 99445	Monthly	~$52	99454 = 16–30 days of data; 99445 = new 2026 short-window code (2–15 days) at the same magnitude — post-discharge and post-procedure windows now billable
RPM — 99457 / 99470	Monthly	~$52 / ~$26	First 20 minutes of management time / new 2026 first-10-minute code
RPM — 99458	Monthly	~$41	Each additional 20 minutes
PCM — 99424 / 99425	Monthly	~$79 / ~$57	Physician or qualified health professional: first 30 minutes / each additional 30
PCM — 99426 / 99427	Monthly	~$60 + ~$50 addl	Clinical staff under supervision: first 30 minutes / each additional 30 — the workhorse codes for a full-service care team

Rates are illustrative — and one local factor cuts the other way

The figures above are illustrative national non-facility magnitudes for CY2026. Actual payment is locality-adjusted. The financial model in this report uses MAC-locality rates auto-resolved for ZIP 80012 in the CoachCare Value Analysis — Colorado, locality 04112-01. Verify against the current CY2026 Physician Fee Schedule and the applicable Colorado locality files before budgeting, and note that CMS rulemaking for CY2027 is in progress: remote-monitoring code values are subject to change inside the 24-month window modeled here.

The Medicare Advantage caveat belongs here, not in a footnote. Roughly 59% of the six-county Denver metro Medicare population is enrolled in Medicare Advantage. Fee-schedule rates govern the fee-for-service share; for the majority in a plan, remote-monitoring and care-management reimbursement is set by plan contract and may be paid differently, bundled, or not separately paid at all. **Every modeled figure in this report is a fee-for-service figure. The Medicare Advantage book is larger and is priced contract by contract — treat it as additive and unquantified until reviewed.**

Modeled economics

The companion Value Analysis prices an RPM + PCM programme on the group's Medicare base. The modeled population is an estimated **16,576-patient in-scope base across 48 referring providers**, all of it in scope in Year 1. *This is a discovery-stage estimate and should be validated against the group's own chart counts before budgeting.* It is derived from the CY2024 claims record rather than assumed: office and outpatient evaluation-and-management services covered 10,834 beneficiary-instances across the roster, complete transthoracic echocardiography 5,279, and the sum of per-provider beneficiary counts across all 44 NPIs with claims was 27,559 — a figure that contains substantial duplication, because a patient seen by two clinicians in the group is counted twice.[13] Deduplicating the ambulatory anchor gives a fee-for-service ambulatory panel on the order of 6,500–8,500, and because fee-for-service is only about 41% of the local Medicare population, the all-payer Medicare ambulatory panel plausibly runs 16,000–21,000. **The modeled 16,576 sits at the conservative end of that range.**

Enrollment builds bottom-up from **48 referring providers at eight referrals per provider per month with 80% patient acceptance**, supported by **one on-site enrollment specialist** at approximately 80 enrollments per month — **staffed at CoachCare's expense: embedded value, never deducted from the practice's margin**. Programme eligibility is modeled at 75% of the in-scope population for RPM (12,432 patients) and 85% for PCM (14,090), with acceptance of 35% and 30% respectively, and monthly attrition of 1.5%. Revenue is reported as **net** reimbursement — gross allowed amounts less a 13% realization discount for payer mix and collection, as configured in the model.

Modeled result	Year 1	Year 2	24-month
Net reimbursement	$2,323,938	$6,615,761	**$8,939,698**
CoachCare fees (incl. setup & integration)	—	—	$5,156,043
Net to the practice	**$975,662**	**$2,807,993**	**$3,783,655**
Practice margin	**41.98%**	—	**42.32%**
Net reimbursement by programme	RPM $1,786,299 · PCM $537,639	RPM $4,930,973 · PCM $1,684,788	RPM $6,717,272 · PCM $2,222,426
Claims / billed units	—	—	159,571
Physiologic readings collected	—	—	691,780
Hospitalizations avoided (modeled)	—	—	~439 (≈$6.6M at an illustrative $15,000 each)

[13] Same files. The unique-patient estimate applies a stated intra-group duplication factor to the office and outpatient evaluation-and-management anchor; it is an analyst estimate derived from a disclosed method, not a CMS-published figure, and should be replaced with the group's own chart counts before budgeting.

Modeled result	Year 1	Year 2	24-month
Care-team hours delivered	—	—	71,844 (≈34.5 FTE)
Active programme enrollments at month 24	—	—	6,270 (RPM 4,351 · PCM 1,919)
Unique patients (de-duplicated)	3,190 at month 12	4,927 at month 24	—

CoachCare Value Analysis, MAC locality CO 04112-01 (ZIP 80012), RPM and PCM only. Chronic care management is carried at zero eligibility. Transitional care management is excluded entirely. Fee-for-service rates only; Medicare Advantage volume is additive and unpriced. Illustrative, modeled — verify against practice data.

The margin, and how it is defined

24-month practice margin: 42.32% — net to the practice ÷ net reimbursement. Year 1 is **41.98%**, on $8,939,698 of net reimbursement and $3,783,655 net to the practice over the full 24 months.

Month 1 is modeled at **−$778** because one-time implementation lands there, and **every month from month 2 onward is net-positive**. By month 24 the programme is modeled at $617,469 of monthly net reimbursement and $262,978 of monthly net to the practice. The more useful way to describe the timing is this: no capital is at risk while the census builds, because CoachCare funds the enrollment engine, the devices and the monitoring staff.

The two arms behave differently, and it matters for planning. **RPM is ceiling-pinned**: it reaches its modeled ceiling of 4,351 enrolled patients at month 18 and holds there, so the back half of Year 2 adds RPM revenue only through retention, not through growth. **PCM is not** — it stands at 1,919 patients at month 24 against a modeled ceiling of 4,227, still climbing, limited by enrollment pace rather than by eligibility. **Year 2 is therefore a growth year rather than a steady state, and the census at month 24 is not the programme's terminal size**. Raising referral throughput or opening a second enrollment pathway moves the PCM arm materially; it does very little for RPM once the ceiling is reached. Given 48 referring providers across seven offices and a rural outreach tail, the telephonic pathway is the obvious second lane.

Recurring-revenue mechanics

Each month's enrolled census re-bills, so revenue is a function of census and capture rate rather than of visit volume. Year 2 net reimbursement ($6,615,761) is 2.8× Year 1 ($2,323,938) on the same referral engine, purely from census accumulation. Unit economics are modeled at approximately $101.96 of net reimbursement per RPM patient-month and $93.71 per PCM patient-month, across 65,884 RPM and 23,716 PCM patient-months over 24 months.

The two value streams compound rather than compete. The professional fee depends on no reconciliation and no shared-savings determination — while the same monitored census is what moves the readmission, cost and quality results that the hospitals' TEAM episodes are reconciled on from 2026. *All figures are illustrative, modeled — verify against practice data.*

2.3 Connective tissue: one infrastructure, every lever

The same enrollment engine, connected-device logistics, 24/7 monitoring, nurse triage, billing-grade documentation, record integration and analytics serve every strategic lever the division faces. That is the argument for building the service line once, centrally, rather than assembling a separate response to each problem as it arrives.

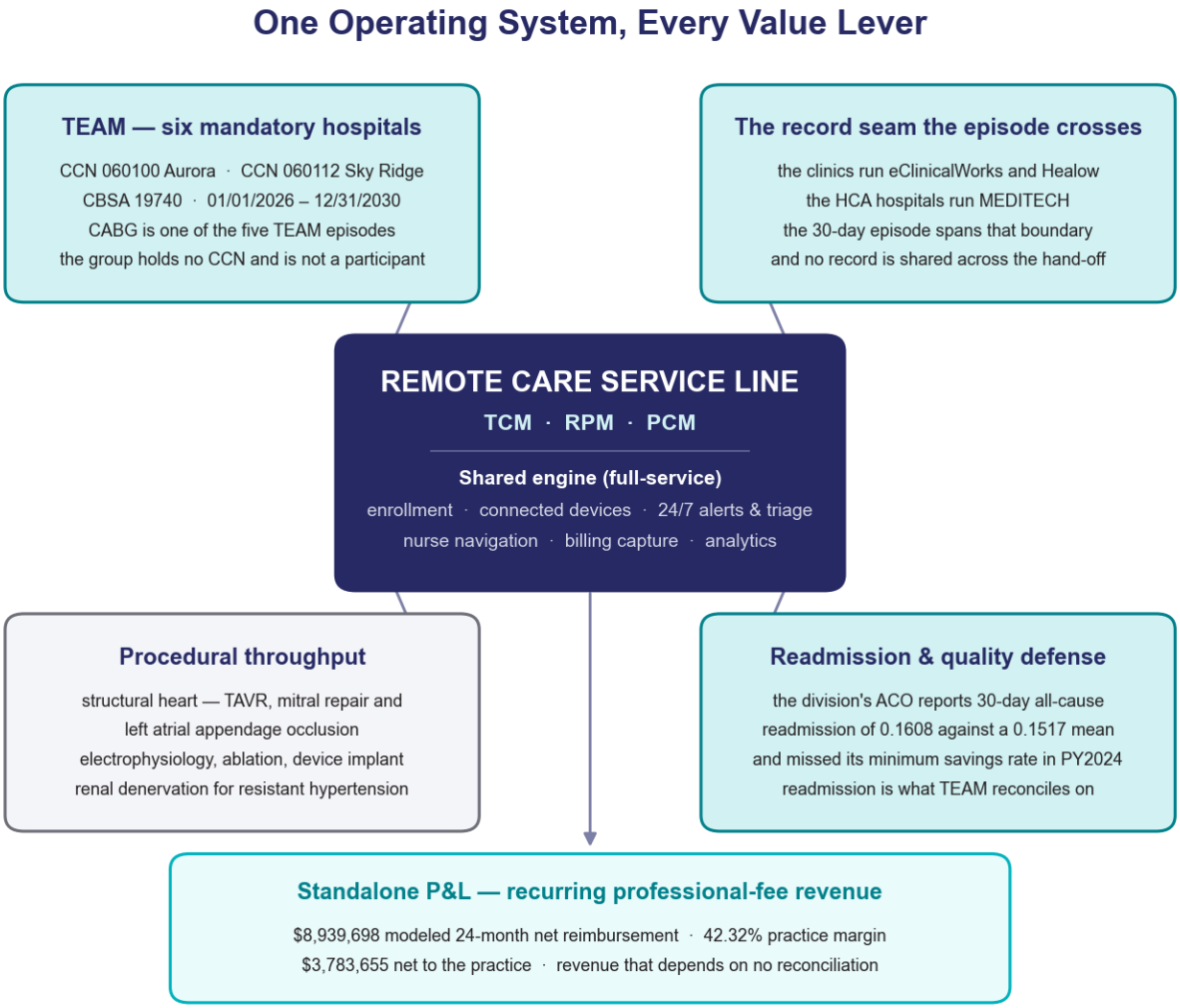

Figure 1. The Remote Care Service Line as connective tissue: one operating system powering the six mandatory TEAM hospitals' episode performance, the hand-off across the eClinicalWorks–MEDITECH record seam, procedural throughput in structural heart and electrophysiology, readmission and quality defense, and the standalone P&L.

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
TEAM — six mandatory hospitals	CCN 060100 and CCN 060112 among six HCA HealthONE CCNs in CBSA 19740, all mandatory from January 1, 2026 through December 31, 2030; CABG is an episode family; the group holds no CCN and is not itself a participant	TCM at discharge plus short-window RPM via 99445 covers exactly the 30 days the hospital is accountable for. The cardiology bench is the instrument by which the enterprise defends episode performance, and it sits inside the same enterprise
The record seam	An eClinicalWorks ambulatory record and a MEDITECH inpatient record, with the 30-day episode running across the boundary and no shared chart	A daily discharge feed, one enrollment order, and a documentation trail that closes the loop back to the clinicians who own the follow-up. This is the concrete deliverable, not a slogan (Section 6)
Readmission and quality defense	The division's accountable care organization reports a hospital-wide 30-day all-cause readmission result of 0.1608 against a 0.1517 ACO mean, and missed its minimum savings rate in PY2024	Daily physiologic signal with 24/7 triage turns deterioration into a same-week outpatient intervention instead of an emergency-department visit. It is the same measure on both sides of the enterprise

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
Procedural throughput	Structural heart, electrophysiology and an advertised renal denervation programme, all performed inside hospitals in the same enterprise	A monitored discharge pathway converts a post-procedure bed-day into a same-or-next-day discharge. Freed bed-days are capacity, and capacity is procedural volume
Transitional care *(identified, not modeled)*	Initial and subsequent hospital care billed in volume in CY2024, and no TCM billed against any of it	The same enrollment and monitoring engine covers the 30-day window; short-window RPM is billable today via 99445, and TCM remains a separate decision the division can take on its own merits
Standalone P&L	CY2026 code expansion (99445, 99470); revenue durability regardless of how any episode performance year reconciles	$8,939,698 of modeled 24-month net reimbursement at a 42.32% practice margin — recurring professional-fee revenue that depends on no reconciliation

Read that table one way and it is six separate problems, each with its own project plan, its own budget line and its own reason to be deferred. Read it the other way and it is **one asset, built once and paid for once, that answers all six**. The group already owns the hardest input to that asset — a working remote-monitoring habit operating at scale, with staff who already triage device alerts for a living. What it does not yet own is the physiologic data layer, the enrollment engine and the billing capture that turn a habit into a service line.

3. 2026 Policy & Payment Environment

One mandatory CMS model bears on this account, and it bears on it through the hospitals rather than through the group. It is not optional, it is not far away, and it started seven months ago.

3.1 TEAM: six mandatory hospitals, and a group that holds no CCN

The **Transforming Episode Accountability Model** is mandatory and episode-based, running **January 1, 2026 through December 31, 2030** across selected core-based statistical areas. It covers five surgical episode categories including **coronary artery bypass graft**, and reconciles a hospital's 30-day episode spending against a CMS target price with a quality adjustment. **Participation attaches to a hospital CCN.**

Hospital	CCN	TEAM status	CBSA	Performance period
HCA HealthONE Aurora	**060100**	**Mandatory**	**19740**	01/01/2026 – 12/31/2030
HCA HealthONE Sky Ridge	**060112**	**Mandatory**	**19740**	01/01/2026 – 12/31/2030
HCA HealthONE Presbyterian St. Luke's	060014	Mandatory	19740	01/01/2026 – 12/31/2030
HCA HealthONE Rose	060032	Mandatory	19740	01/01/2026 – 12/31/2030
HCA HealthONE Swedish	060034	Mandatory	19740	01/01/2026 – 12/31/2030
HCA HealthONE Mountain Ridge	060065	Mandatory	19740	01/01/2026 – 12/31/2030

CMS TEAM Participant List, hospital list as of April 15, 2026 (CMS updates it periodically): 720 hospitals, 710 of them mandatory. All six HCA HealthONE hospitals in which the group's clinicians hold a CMS practice address are mandatory participants in CBSA 19740, Denver-Aurora-Centennial, CO. Re-check at the next update.

Stated plainly, so it is not overstated

The group holds no CCN. It is not a TEAM participant and cannot be one — TEAM participation attaches to a hospital CCN, and this is an ambulatory physician organization. Its exposure to the model is entirely indirect.

What is direct is the operational dependency, and here it runs inside one enterprise. Six HCA HealthONE hospitals carry 30-day post-discharge episode accountability, readmissions included, from January 1, 2026 — and the cardiology bench that determines what happens in those 30 days is the same enterprise's ambulatory group, working in a different clinical record. **There is no negotiation to have across an ownership boundary here; there is a design decision to take inside one**.

For context on the competitive set: CBSA 19740 contains 21 TEAM hospitals in total and Colorado 27 statewide. HCA HealthONE is the largest acute-care operator in the CBSA by hospital count, ahead of AdventHealth at four, and CommonSpirit, UCHealth and Intermountain Health at three each.

3.2 The CY2026 fee schedule: remote care gets more billable

The CY2026 Physician Fee Schedule expanded the remote-monitoring toolkit in ways that suit a cardiology group whose highest-value windows are short. **99445** pays the monthly device-supply amount for 2–15 days of data, where 16 or more days were previously required — which had made short post-discharge and post-procedure windows effectively unbillable. **99470** pays for the first 10 minutes of monthly management time, where the floor had been 20. Together they convert the two windows this group generates most of — the 30 days after a cardiac discharge from an HCA HealthONE hospital, and the days after an ablation, device implant or structural procedure — from unfunded care into billable events. PCM (99424–99427) remains the monthly chassis for single-condition specialty management, and RPM and PCM stack in the same month with discrete documentation.

3.3 The market: a Medicare Advantage metro, and what that does to the model

County	Medicare beneficiaries	Original Medicare	MA & other	MA penetration
Arapahoe — the group's home county	108,185	45,872	62,313	**57.6%**
Adams	71,765	25,383	46,382	64.6%
Jefferson	124,114	47,133	76,981	62.0%
Denver	97,512	38,916	58,596	60.1%
Douglas	65,800	32,070	33,730	51.3%
Elbert	6,039	3,031	3,008	49.8%
Six-county Denver metro	**473,415**	192,405	281,010	**59.4%**
Colorado	1,084,047	516,371	567,676	52.4%
National	70,330,194	34,314,772	36,015,422	51.2%

CMS Medicare Monthly Enrollment, April 2026 file. "MA & other" is the file's non-Original-Medicare category. Dual-eligible share is low across the core service area — 12.2% in Arapahoe and 4.4% in Douglas against 17.1% nationally — with Denver County the outlier at 19.4%. Those are patient counts, not claim-line shares.

Three consequences follow, and the second is the uncomfortable one. First, **the account is materially larger than the fee-for-service claims file shows**: fee-for-service is only about 41% of the metro Medicare population, so the true Medicare-funded professional book behind this group is on the order of two and a half times the $6.06 million of CY2024 allowed charges the public file reports. Second, **every financial figure in this report is a fee-for-service figure**. Remote monitoring and care management are Physician Fee Schedule benefits; inside a Medicare Advantage plan they are paid according to the plan contract, which may pay them at fee-schedule parity, bundle them into a capitated arrangement, or not pay them separately at all. The model does not assume any Medicare Advantage revenue, and it should not be read as excluding it either. Third, the **85-and-over segment is unusually large in absolute terms** — 11,348 beneficiaries in Arapahoe County, 13,798 in Jefferson and 10,513 in Denver — and that is the highest-acuity, highest-yield remote monitoring population there is.

3.4 The division's ACO: a quantified readmission gap

HCA's Colorado accountable care organization is **HealthONE Colorado Care Partners ACO LLC, ACO ID A5328** — a Colorado-service-area BASIC Level A, one-sided, low-revenue entity that started January 1, 2024 and takes an Advance Investment Payment. **The cardiology group is not a participant TIN in it**: all 34 participant TINs are primary care, family medicine, women's health or pediatrics, which is unsurprising because accountable-care assignment is driven by primary care. The commercial consequence is worth being precise about — the group carries no shared-savings risk of its own and earns no distribution of its own, so nothing in this report should be sold as ACO upside.[14]

Correcting a widely repeated data error

A commercial firmographic record attributes this group to **MountainStar Care Partners ACO**. That is wrong. MountainStar Care Partners (ACO ID A5181) is HCA's **Idaho, Utah and Wyoming** accountable care organization, headquartered in Salt Lake City, on BASIC Level E with prospective assignment. It has no Colorado service area. The correct Colorado entity is HealthONE Colorado Care Partners ACO LLC (A5328), headquartered in Denver. The two are separate HCA divisional ACOs and the confusion is a brand-name artifact.

[14] CMS Medicare Shared Savings Program PY2026 Participants file and the Performance Year Financial and Quality Results file for PY2024 (revised July 17, 2026). The 34 participant TINs of ACO A5328 were reviewed individually; all are primary care, family medicine, women's health or pediatrics. Readmission and admission measures are reported as rates where lower is better; the remaining measures are percentages where higher is better.

The PY2024 results are the reason this section exists at all. On 9,906 assigned beneficiaries, A5328 recorded expenditures of $112,290,994 against a $112,425,833 benchmark — a **savings rate of 0.12% against a 3.01% minimum savings rate**, generating $134,839 of savings and $26,429 of earned shared savings, at a quality score of 63.25. It missed the threshold by a wide margin in its first reconciled year. The quality detail is where the remote-care relevance is:

PY2024 measure	A5328	ACO mean	Read
Hospital-wide 30-day all-cause readmission	**0.1608**	**0.1517**	**Worse than peers — the direct TCM and RPM lever**
Depression screening and follow-up	20.95	53.18	Notably worse
Risk-standardized admissions, multiple chronic conditions	33.94	37.00	Better
Controlling high blood pressure	79.26	72.43	Better — and the group already advertises renal denervation for resistant hypertension
Diabetes HbA1c poor control	9.1	23.88	Better
CAHPS — care coordination	86.56	85.89	At par

CMS Medicare Shared Savings Program Performance Year Financial and Quality Results, PY2024, revised July 17, 2026. Readmission and admission measures are reported as rates where lower is better; the remaining measures are reported as percentages where higher is better.

Read that table carefully, because it argues against the lazy version of this pitch. This is not a population failing on chronic-disease control — blood pressure control, diabetes control and risk-standardized admissions are all *better* than the peer mean. It is a population failing on **transitions**: readmissions worse than peers, follow-up after screening worse than peers, and a savings rate that did not clear its threshold. **A patient population that is well controlled in clinic and readmitted more often than its peers after discharge is describing a hand-off problem, not a disease-burden problem** — and a hand-off problem is what transitional care management, remote physiologic monitoring and principal care management exist to close. It is also, precisely, what Section 6 shows is structurally hard here.

4. Performance Snapshot: The Starting Position

4.1 The service record: device monitoring at scale, care management at zero

Every HCPCS line billed by all 44 roster NPIs with CY2024 Medicare claims was screened against the full remote-monitoring and care-management code set — remote physiologic monitoring, physiologic data collection and review, chronic care management, principal care management, transitional care management, self-measured blood pressure and the general care-management code. **Not one code from that set appears, for any provider.**[15] In the same file, the group's remote *device* monitoring is a real, staffed operation:

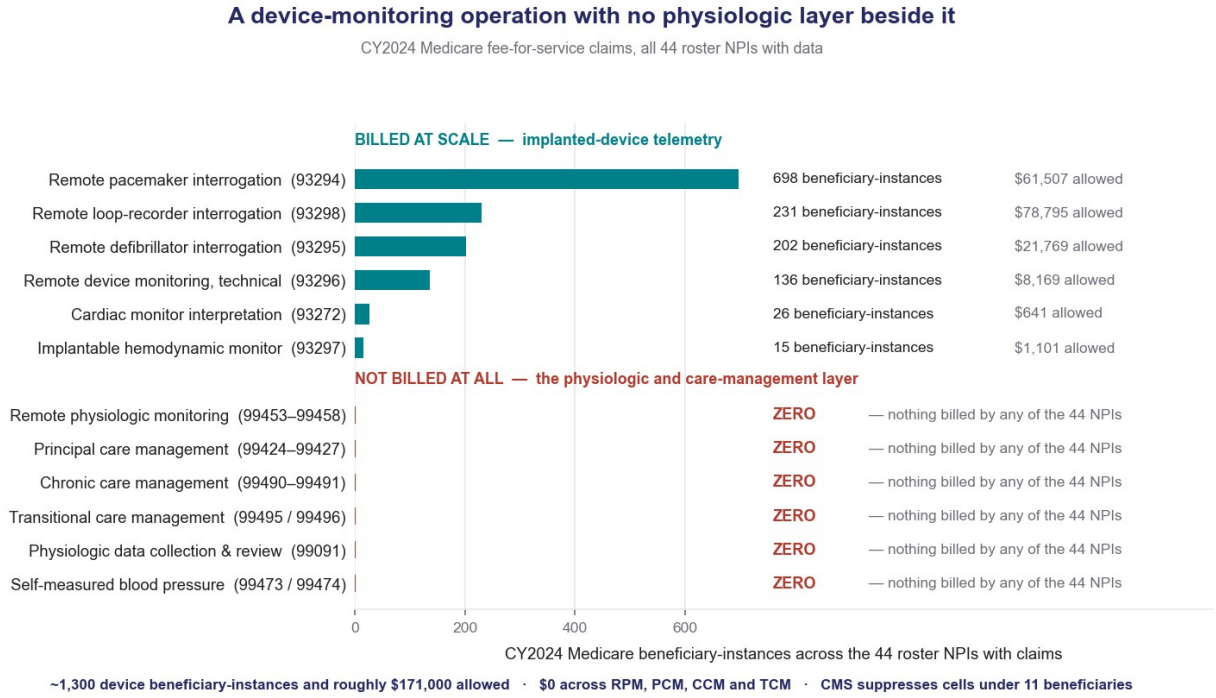

Figure 2. The group's CY2024 Medicare service record, remote-monitoring and care-management codes only. Implanted-device telemetry runs at scale across as many as eleven clinicians on a single code; every physiologic-monitoring and care-management family is at zero. CMS suppresses any provider / code / place-of-service cell with fewer than 11 beneficiaries, so a very small pilot would not appear here.

HCPCS	What it is	Beneficiary-instances	Services	Allowed	NPIs
93294	Remote pacemaker interrogation, up to 90 days	698	2,075	$61,507	11
93298	Remote loop-recorder interrogation, 30 days	231	1,502	$78,795	6
93295	Remote defibrillator interrogation, up to 90 days	202	589	$21,769	5
93296	Remote device monitoring, technical component	136	350	$8,169	1
93272	Cardiac monitor, interpretation and report	26	27	$641	1

[15] CMS Medicare Physician & Other Practitioners - by Provider and Service, CY2024 (released May 21, 2026), screened for all 44 roster NPIs with claims against the full remote physiologic monitoring, physiologic-data-review, chronic care management, principal care management, transitional care management, self-measured-blood-pressure and general care-management code sets. No line from that set appears for any provider.

HCPCS	What it is	Beneficiary-instances	Services	Allowed	NPIs
93297	**Remote implantable hemodynamic monitor**	**15**	**45**	**$1,101**	**1**
Total	**Implanted-device remote monitoring, 93294–93298**	**~1,282**	—	**$171,341**	—

CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024 (released May 21, 2026), across all 44 roster NPIs with claims. Counts are beneficiary instances per code per provider and contain duplication across providers; they are not unique-patient counts.

Three things follow, and they matter more than anything else in this report. First, **this group already runs a remote-monitoring workflow**. Roughly 700 beneficiary-instances of remote pacemaker interrogation across eleven clinicians, with loop-recorder and defibrillator monitoring alongside, means device technicians, a triage inbox, an alert-review protocol and documented remote-monitoring habits. The usual first objection to a remote care programme — that the nurses could not run one — is pre-answered by the group's own claims data. Second, **the physiologic layer beside it is genuinely empty**, and that is unusual for a 48-clinician group with a renal denervation programme, a named anticoagulation clinic and $436,532 of buy-and-bill inclisiran in a single year. Third, **only 15 beneficiary-instances appear on the implantable hemodynamic monitor code, billed by a single clinician**. Pulmonary-artery pressure sensors are placed in advanced heart failure patients; 15 is a nascent programme, not an established one. Combined with the absence of any advertised heart failure clinic, the honest reading is that **advanced heart failure population management is the least built part of an otherwise very capable cardiology service line**.

What the CY2024 data proves, stated precisely

CMS suppresses any provider / HCPCS / place-of-service line with fewer than 11 beneficiaries, so a pilot-scale programme would not appear in this file. What the record therefore establishes is that **no remote physiologic monitoring or care-management programme at meaningful scale existed in CY2024**. It does not establish that literally zero patients were ever monitored, and it cannot speak to a programme launched in 2025 or 2026 — the next CMS release covering data year 2025 is not expected until roughly mid-2027. It also covers Medicare fee-for-service only, which in this market is about 41% of the Medicare population; commercial or Medicare Advantage remote monitoring would not appear at all. *Confirm current-state programmes directly in discovery — this is the single most important question to ask.*

One related finding worth recording: no evidence was found that HCA HealthONE operates a centralised care-management service extended to specialty groups. The division's clinically integrated network provides value-based support to its member practices, but its entire membership is primary care and pediatrics. *That is an unverified gap, not a confirmed absence.*

4.2 The revenue picture, and why the public figure understates the enterprise

A commercial firmographic file reports about $5.85 million of Medicare allowed charges for this group, and that figure is often read as evidence of a small account. It is neither small nor stale. Querying the CY2024 provider-level file for all 50 candidate NPIs returned 44 with rows, totalling **$6,062,840 of allowed charges across 27,559 beneficiary-instances** — corroborating the commercial figure within about 3.6%.[16] The number is accurate. It is also structurally incomplete, for three specific reasons.

[16] CMS Medicare Physician & Other Practitioners - by Provider, CY2024 (released May 21, 2026). Fifty candidate NPIs were queried and 44 returned rows, totalling $6,062,840 of allowed charges across 27,559 beneficiary instances. The commercial firmographic record reports $5,852,774 of Medicare allowed for the same group - a difference of about 3.6%.

Why the public number is low	The mechanism	Order of magnitude
Medicare Advantage takes most of the market	The fee-for-service claims file — and therefore any commercial record built on it — sees only the Original Medicare share. In the six-county Denver metro that is 192,405 of 473,415 beneficiaries	About 41% visibility. Grossing up naively puts Medicare-funded professional revenue on the order of $14–15M and the true Medicare panel at roughly 2.4× the fee-for-service panel
The technical component bills under hospital CCNs	43.0% of allowed dollars are billed at facility place of service. There the clinicians earn the professional component only; the cath lab, electrophysiology lab, hospital echocardiography and nuclear technical components flow to an HCA hospital CCN	$2,240,645 of the $5.21M office-plus-facility split sits on the facility side. The technical revenue is real; it simply lands on a different line of the same enterprise
The billing organization is an enterprise organization	All billing runs through HealthONE Heart Care LLC. There is no separate practice enrollment whose revenue could be measured on its own	Any comparison against an independent group of similar size is not like-for-like

The right conclusion is a framing one. The public fee-for-service figure is not a measure of this group's clinical or economic weight; it is a measure of one visible slice of it. For a remote care service line that matters in two directions at once. The modeled revenue in Section 2.2 is built on the fee-for-service slice, so it is conservative against the full book. And the value that shows up on the hospital side — episode performance, freed bed-days, avoided readmissions — accrues to the same enterprise, which is why the decision belongs at division level rather than at a single site.

One line in the CY2024 record deserves separate mention. Inclisiran (J1306) accounts for **$436,532 of allowed charges on 74 beneficiaries** — an office-administered, twice-yearly injectable for lipid lowering.[17] It is the clearest existing example in the file of a therapy whose value depends entirely on the patient coming back on schedule. A monitored, contacted, actively managed census is the natural companion to a buy-and-bill adherence programme, and the same enrollment engine serves both.

4.3 The panel, and the highest-confidence enrollable cohort

A unique-patient denominator cannot be derived from the public CMS files, which report beneficiary instances per code per provider and count a patient seen by two clinicians twice. The anchors below are stated with that limitation attached rather than rounded into a single confident number.

Anchor, CY2024	Beneficiary-instances	How to read it
Sum across all 44 NPIs with claims	27,559	A ceiling, not a panel — heavily duplicated across clinicians
Cardiologist-typed NPIs only	19,450	Still duplicated; excludes the APP bench
Office and outpatient E/M (99204/05, 99213/14/15)	**10,834**	**The most defensible single anchor — these are ambulatory encounters, the population a remote care programme actually enrolls from**
Complete transthoracic echocardiography (93306)	5,279	A cardiology-specific cross-check on the ambulatory denominator
Electrocardiogram interpretation (93010)	9,827	Includes inpatient interpretation; a weaker ambulatory proxy

[17] CMS Medicare Physician & Other Practitioners - by Provider and Service, CY2024: HCPCS J1306, $436,532 of allowed charges on 36,874 billed units across 74 beneficiaries, office place of service.

Anchor, CY2024	Beneficiary-instances	How to read it
Implanted-device remote monitoring (93294–93298)	**~1,282**	**The highest-confidence enrollable cohort in the account — consent, device logistics and a review workflow already exist**

CMS Medicare Physician & Other Practitioners — by Provider and by Provider and Service, CY2024 (released May 21, 2026). Beneficiary instances are per code per provider and contain duplication.

Applying a typical intra-group cardiology duplication factor to the ambulatory anchor gives a fee-for-service ambulatory panel on the order of **6,500–8,500 unique patients** — *an estimate from a stated method, not a CMS-published figure*. Because fee-for-service is about 41% of the local Medicare population, the all-payer Medicare ambulatory panel plausibly runs **16,000–21,000**, with commercial and Medicaid volume on top of that and not measurable from these sources. The modeled in-scope base of 16,576 used in Section 2.2 sits at the conservative end of that range.

Where to start, and why

The approximately **1,282 implanted-device remote-monitoring beneficiary-instances** are the shortest path to a first billable enrollment in this account. These patients already have remote data flowing to the practice, already consented to remote review, and already sit inside a device-clinic workflow with named owners. Adding a connected blood-pressure cuff or weight scale to a patient who is already remotely monitored is a conversation about one more device, not a conversation about a new kind of care.

The programmes are distinct benefits over distinct data and must be documented as such (Section 8.3). But the enrollment friction — consent, education, logistics, trust — is already paid for on this cohort, and enrollment friction is what determines how fast a census builds.

5. Powering TEAM: The 30-Day Post-Discharge Episode

The correct statement first. This group holds no CCN. **It is not a TEAM participant and cannot become one** — participation attaches to a hospital CCN. All six HCA HealthONE hospitals in which its clinicians hold a CMS practice address are mandatory participants (CCN 060100 and CCN 060112 among them, CBSA 19740, January 1, 2026 through December 31, 2030). The group's exposure to the model is indirect. Its *operational centrality to it* is not.

TEAM holds the hospital financially accountable for a 30-day post-discharge episode, readmissions included, reconciled against a CMS target price with a quality adjustment. **Coronary artery bypass graft is one of the five episode families**, alongside lower-extremity joint replacement, surgical hip and femur fracture, spinal fusion and major bowel procedures. The model also requires participant hospitals to refer patients to primary care to support continuity after discharge. This group does not perform cardiac surgery, but it is the diagnostic and referral bench that feeds those cases, it rounds on those patients, and it owns the ambulatory cardiology relationship after they leave. **The clinicians who determine what happens in the 30 days after a cardiac discharge therefore sit in a different clinical record from the entity carrying the risk** — inside the same enterprise, which is what makes this a design problem rather than a negotiation.

The episode bundle, in billing terms

Window	What the service line does	Billing
Day 0 — discharge	Discharge captured from the inpatient record and surfaced to the ambulatory team the same day; patient enrolled before they leave or within 48 hours; device shipped or handed over; interactive contact inside two business days	TCM 99495 / 99496 (identified, not modeled)
Days 1–14	Daily weight, blood pressure and symptom data with 24/7 triage — the window in which a readmission is still preventable	**Short-window RPM: 99445 + 99470** — newly billable in CY2026 for 2–15 days of data and the first 10 minutes of management time
Days 15–30	Face-to-face visit inside the TCM window; continued monitoring; medication titration against measured response	RPM 99454 / 99457 / 99458 once the data threshold is met
Month 2 onward	The patient transitions from an episode to a managed census — heart failure, hypertension, post-procedure recovery	Longitudinal RPM + PCM (99424–99427)

Everything in that table depends on the first cell. Knowing which patients were discharged yesterday, from which hospital, is the single most common point of failure in a post-discharge programme — and it is harder here than it looks, because the discharge happens in one clinical system and the follow-up happens in another. Section 6 is about that specific gap. It is not an integration footnote; it is the operational core of the TEAM argument.

TEAM-readiness checklist

- A daily feed or process that tells the ambulatory team which of its patients were discharged yesterday, from which of the six CCNs, with the discharge summary attached.
- A standing two-business-day interactive contact protocol with named ownership and an escalation path, documented to survive audit.
- Device logistics that work at discharge rather than at the next office visit — the first 14 days are the window that matters, and 99445 now pays for them.
- A shared readmission dashboard between the ambulatory group and the participating hospitals, so the service line's contribution to episode performance is measured rather than asserted.

- An agreed definition of the cardiac episode population per CCN, and clarity on which post-discharge activity is the ambulatory group's and which is the hospital's.
- A written attribution policy with the division's primary-care network, because only one practitioner may bill RPM for a patient in any 30-day period (Section 2.1).

Why this is the same build as everything else in this report. Nothing in the episode table is a TEAM-specific asset. It is the same enrollment engine, the same devices, the same triage protocol, the same documentation and the same billing capture that the standalone P&L runs on from month one, that the procedural pathways in Section 7 depend on, and that moves the readmission measure in Section 3.4. **Build once, reuse everywhere** is not a slogan here; it is the reason one service line can answer a mandatory episode obligation across six CCNs without six separate projects.

> **One condition on any cross-entity arrangement**
>
> Where a hospital supports, subsidises or co-invests in physician-practice services — even inside a single enterprise, and even where both sides are commonly owned — the arrangement must be structured to comply with the physician self-referral and anti-kickback rules, and with the applicable state corporate-practice-of-medicine framework. *Take the structure to healthcare counsel before it is proposed, not after.*

6. The Record Seam: eClinicalWorks Ambulatory, MEDITECH Inpatient

6.1 What is verified about the platform

This section is unusually concrete for an integration section, because the platform is not a matter of inference here. It is confirmed three ways.

Evidence	What it establishes
The patient portal	The portal page links to an eClinicalWorks-hosted patient portal on the mycw39 instance in eClinicalWorks' region3 cloud, at the vendor's standard portal login path. eclinicalweb.com is eClinicalWorks' own hosting domain
Telehealth	The telehealth page is a Healow virtual-appointments page with eClinicalWorks-specific patient instructions. Healow is eClinicalWorks' patient-engagement and telehealth product
The CMS telehealth flag	Set for 13 of the 48 enrolled clinicians in the CMS file, consistent with an active Healow deployment rather than an unused licence
What the .dot URLs are *not* evidence of	The .dot extension across the group's public site is HCA's corporate web content-management convention — the same platform serving the system's consumer site, with assets loading from HCA's enterprise web infrastructure. It is evidence about who owns the marketing site, not about the clinical system

Group website, retrieved August 3, 2026, and the CMS National Downloadable File, file modified June 26, 2026. The eClinicalWorks version or edition, and whether any ambulatory EHR consolidation is planned, are not established from public sources.

6.2 The seam the episode falls through

The single most concrete operational finding in this account

The ambulatory clinics run eClinicalWorks. The hospitals run MEDITECH. Those are two different clinical records, maintained by two different parts of the same enterprise, and the **30-day TEAM episode runs straight across the boundary between them**.

The hospital owns the episode and is reconciled on it. The cardiology group owns the follow-up that determines how the episode ends. And the record of what happened on one side is not the record the other side works in. **That is the seam post-discharge workflows fall through** — not because anyone designed it badly, but because nobody designed it at all: it is the residue of an ambulatory group that kept its own system when the enterprise around it changed.

The practical failures are specific and familiar. The ambulatory team learns about a discharge from the patient rather than from the record. The two-business-day contact clock starts late or not at all. The discharge medication list and the clinic medication list diverge. The 14-day window — the one in which a readmission is still preventable, and the one 99445 now pays for — is half gone before anyone has the patient's weight.

This is a solvable problem, and solving it is the deliverable. A daily discharge feed into the ambulatory workflow, one enrollment order inside eClinicalWorks, monitoring from day one, and a documentation trail that closes back into the chart the clinicians actually use. *Confirm the hospital-side record, its interface surface and any planned ambulatory consolidation in discovery before scoping.*

Why the seam is worth more attention than a typical integration line item. In most accounts the electronic health record is a scoping question: which connector, which version, how long. Here it is the argument. Six hospitals took on mandatory 30-day episode accountability on January 1, 2026; the group whose clinicians manage those 30 days works in a different system; and the division's own accountable care organization already reports a readmission result worse than its peer mean. **Those three facts describe one problem, and the remote care service line is the only one of them that is a thing you can buy**.

6.3 What the integration does

The integration pattern against eClinicalWorks is well-trodden. What it delivers here:

- **Enrollment inside the chart.** Referral to the service line is one order in eClinicalWorks — not a separate system, a separate login or a paper form.
- **Enrollment status visible in real time.** Whether a patient is enrolled, which programmes they are on, and which device they hold — visible to the clinician at the point of the next decision rather than in a monthly report.
- **Structured clinical exchange.** Health history out; vitals, evidence of care and care plans back into the chart on a monthly cadence, so the record the group is audited on is the record it already keeps.
- **The discharge trigger.** The one piece that has to be designed rather than configured: a process or feed that surfaces yesterday's inpatient discharges to the ambulatory team on the day they happen, and starts the two-business-day clock automatically.
- **Automated claim generation.** The monthly per-patient claim is generated by the billing engine rather than assembled by hand.

Scope note: integration capabilities are CoachCare-provided; confirm the connector, the product version and the delivery timeline in contracting, and confirm the hospital-side interface path separately.

6.4 Why automated claim generation matters here specifically

This is not a general benefit; it is the specific difference between a programme that runs at this scale and one that does not. At a modeled census of **6,270 active programme enrollments at month 24**, across seven offices, a rural outreach tail and 48 billing providers, the monthly billing task is thousands of per-patient, per-code, time-documented claims — each one dependent on evidence that the monitoring days and the management minutes were actually met. **The model projects 159,571 billed units over 24 months.** No administrative layer assembles that by hand, and the failure mode is not a rejected claim; it is a programme that quietly stops billing what it delivers. Automated generation from the monitoring record is what makes the capture rate in Section 8.5 a real operating metric rather than an aspiration.

7. Powering Procedural Growth: Structural Heart, EP and Resistant Hypertension

Remote care is usually sold as a chronic-disease programme. In a group with this procedural profile it is also a throughput multiplier, and the mechanism is specific: **a monitored discharge pathway is what lets a post-procedure patient go home on the same or next day instead of occupying a bed overnight**. In an enterprise where the freed bed-day and the additional case land on the same balance sheet, and where six hospitals now have an episode-cost reason to care about the 30 days afterwards, that mechanism is worth more than it usually is.

Procedural line	What the record shows	What the service line adds
Structural heart	Transcatheter aortic valve replacement, transcatheter mitral valve repair and replacement, surgical aortic valve replacement, left atrial appendage occlusion, and patent foramen ovale and atrial septal defect closure, all on the group's own structural heart page	Post-procedure rhythm and blood-pressure monitoring in the 2–15 day window, now billable via 99445; earlier discharge; structured anticoagulation follow-up in a group that already runs a named Protime clinic
Electrophysiology and device implant	Comprehensive electrophysiologic evaluation with ablation at $120,406 of allowed charges on 128 beneficiaries in CY2024, pacemaker insertion at $46,566, and dual-lead pacemaker programming at $76,398 — alongside the remote device-monitoring book in Section 4.1	Post-ablation and post-implant physiologic monitoring sits alongside — not inside — device interrogation. Blood pressure, weight and symptom data are patient-generated and distinct from the device's own telemetry (see the boundary rule in Section 2.1)
Interventional cardiology	Coronary stent placement at $103,961 on 154 beneficiaries and left-heart catheterisation with coronary angiography at $58,972 on 257, all billed facility-side inside enterprise hospitals	A monitored discharge pathway after percutaneous intervention, and a managed census afterwards. The freed bed-day accrues to the same enterprise that carries the episode
Resistant hypertension and renal denervation	**Advertised as a current capability** on the group's interventional cardiology page — this is not whitespace here, it is an existing programme. The division's accountable care organization also reports better-than-peer blood-pressure control (79.26 against 72.43), so the underlying hypertension management is working	**Blood-pressure RPM is intrinsic to the renal denervation pathway** — for candidate identification, for pre-procedure documentation of uncontrolled pressure on maximal therapy, for titration, and for the evidence CMS national coverage determination 20.40 requires under Coverage with Evidence Development, effective October 28, 2025. A programme that already does the procedure and does not yet run the monitoring is doing the harder half
Lipid management	$436,532 of inclisiran (J1306) allowed charges on 74 beneficiaries in CY2024 — an office-administered, twice-yearly injectable	Adherence to a twice-yearly injection is a scheduling and contact problem. A managed census with monthly structured contact is the mechanism that keeps a buy-and-bill adherence programme on schedule

The renal denervation row is the one to read twice. In most cardiology accounts renal denervation is policy-aligned whitespace — a procedure the group might build toward. Here it is advertised as a current service, which inverts the argument: the group has already committed to the procedure and has not yet built the blood-pressure monitoring infrastructure that identifies candidates, documents the coverage conditions and manages titration afterwards. *Confirm current renal denervation volume directly* — it does not appear as a distinct, unsuppressed line in the CY2024 public file, which is consistent with either a small programme or a programme that grew after 2024.

8. Implementation Playbook: Building the Remote Care Service Line

8.1 Goals, scope, and the modeled funnel

The goal for the first twelve months is a named service line with its own P&L, its own physician lead, a defined target population, and a first billable enrollment inside 90 days. The modeled funnel is deliberately conservative and bottom-up:

Model input	Value	Note
In-scope Medicare base	16,576	Discovery-stage estimate at the conservative end of a 16,000–21,000 range — validate against chart counts
Referring providers	48	The full enrolled roster as of June 26, 2026
Referrals per provider per month	8	With 80% patient acceptance
On-site enrollment specialist	1 (≈80 enrollments / month)	**CoachCare's expense — embedded value, never deducted from practice margin**
RPM eligibility / acceptance	75% (12,432) / 35%	Modeled ceiling 4,351 patients; reached at month 18
PCM eligibility / acceptance	85% (14,090) / 30%	Modeled ceiling 4,227; at 1,919 at month 24 and still climbing
Monthly attrition	1.5%	Discharge from programme
Revenue basis	Net of a 13% realization discount	Payer mix and collection, as configured in the model
Payer scope	Medicare fee-for-service only	**Medicare Advantage is roughly 59% of the metro Medicare population and is priced contract by contract — additive and unmodeled**

Target populations and clinical pathways

Population	Why it is first	Pathway
The device-monitored cohort	Approximately 1,282 implanted-device beneficiary-instances in CY2024 — consent, device logistics and a review workflow already exist, so enrollment friction is already paid	Add a connected cuff or scale to an already-monitored patient; RPM plus PCM on the cardiac condition, documented as a distinct benefit over distinct data
Post-discharge cardiac	Six mandatory TEAM hospitals, a 30-day episode that includes readmissions, and no TCM billed against any hospital care in CY2024	TCM 99495 / 99496 (not modeled) + short-window RPM via 99445 / 99470, triggered by the daily discharge feed in Section 6.3
Uncontrolled and resistant hypertension	An advertised renal denervation programme with no blood-pressure monitoring infrastructure beneath it, and better-than-peer blood-pressure control to build on	Blood-pressure RPM; protocolised titration; candidate identification and coverage documentation for the procedure pathway (Section 7)
Heart failure	The least built part of the service line — 15 beneficiary-instances on implantable hemodynamic monitoring and no advertised heart failure clinic	Weight and blood-pressure RPM with 24/7 triage; PCM as the monthly chassis; titration against measured response
Post-ablation, post-implant and post-structural-heart	A substantial ablation, implant and structural book, every case of which opens a short window that is now billable	Short-window RPM (99445), kept explicitly distinct from device interrogation

Population	Why it is first	Pathway
The rural and outreach panel	Outreach sites across southern and eastern Colorado, western Nebraska and Kansas, where an in-person follow-up visit is most expensive and least likely to happen	Telephonic enrollment as the primary pathway rather than the fallback; shipped devices; monthly management without a drive

8.2 Staffing: nobody has to be hired

The model delivers **71,844 care-team hours over 24 months — approximately 34.5 full-time equivalents** — supplied by the partner under the group's protocols and clinical supervision, alongside 319,141 care-management tasks, 79,785 chart updates, 47,871 patient conversations and 2,660 hours of call time. **The on-site enrollment specialist is funded by CoachCare: embedded value, never deducted from the practice's margin, and never a practice cost line.** That matters more here than the raw number suggests, because no evidence was found that the division operates a centralised care-management capability that could be extended to a specialty group — its clinically integrated network's entire membership is primary care and pediatrics.

What the group supplies is clinical direction, general supervision, and the physician lead who owns the escalation protocol. What it does not supply is headcount.

8.3 “We already do remote monitoring” — the answer

This objection is going to come up in the first meeting, and it should — the group does already do remote monitoring, across eleven clinicians on a single code. The answer is not to argue with it. It is to be precise about what is and is not already covered.

	Remote cardiac device monitoring (93294–93298)	Remote physiologic monitoring (99453 onward)
What is measured	The implanted device's own telemetry — lead integrity, arrhythmia episodes, device diagnostics	Patient-generated physiologic data from a separate connected device — blood pressure, weight, pulse oximetry
Who it covers	Patients with an implanted pacemaker, defibrillator, loop recorder or hemodynamic sensor	Any patient with a qualifying condition — the great majority of this group's heart failure and hypertension panel has no implanted device at all
What clinical question it answers	Is the device working, and has an arrhythmia occurred	Is this patient decompensating, is the blood pressure controlled, is the titration working
Status at this group	Running — roughly $171,000 and ~1,282 beneficiary-instances in CY2024	**Zero in CY2024**

The two are different benefits over different data, and they answer different questions. The design rule is that the same data stream is not billed twice: a distinct device generating distinct physiologic data supports a distinct service, and the documentation has to make that distinction obvious on its face. *Confirm the specific code pairings with the payer and with billing counsel before launch.* The larger point is the encouraging one: this group has already proved it will operate a remote-data workflow. It simply has not monetised the physiologic side of it — and the physiologic side is the one that moves readmissions.

8.4 Clinical workflow

1. **Identify.** Heart failure, uncontrolled and resistant hypertension, post-discharge, post-procedure. Seeded by the device-monitored cohort and by the daily discharge list from the six participating hospitals.

2. **Enroll.** One order in eClinicalWorks. Consent, device selection and logistics handled by the partner; the on-site enrollment specialist covers the metro offices in rotation, with a telephonic pathway carrying the outreach panel.
3. **Monitor.** Daily physiologic data with 24/7 review and alert triage against thresholds the physician lead sets — not vendor defaults.
4. **Escalate.** A defined path from alert to nurse contact to same-week outpatient intervention, with the emergency department as the exception rather than the default. This is where the 439 modeled avoided admissions actually come from.
5. **Titrate.** Guideline-directed therapy adjusted against measured response on a schedule, with PCM as the monthly billing chassis for the work.
6. **Document and bill.** Time, readings and interventions captured as a by-product of care; claims generated automatically from the monitoring record (Section 6.4).
7. **Report back.** Structured monthly reporting to the referring primary-care physician — good practice, a referral-retention mechanism, and the artifact that keeps the attribution policy honest where the division's own primary-care network shares the patient.

8.5 KPI dashboard and expected impact

Domain	Metric	Why it is on the dashboard
Clinical	Blood-pressure control rate; weight-alert response time; heart failure admissions and 30-day readmissions among the enrolled census	Readmission is the measure the hospitals' TEAM episodes are reconciled on and the one the division's accountable care organization is already behind its peers on
Operational	Enrolled census by programme; enrollment conversion rate; device compliance (days with data); alert-to-contact time;	Census is revenue. Days-with-data is what makes 99454 and 99445 billable in the first place
Transitions	Post-discharge reach rate within two business days, by CCN; time from discharge to first physiologic reading	The measure that tells you whether the record seam in Section 6 was actually closed, reported per hospital so it can be acted on
Financial	Time to first billable enrollment; capture rate (billed ÷ eligible); net reimbursement per patient per month; net to practice	Modeled at ~$101.96 per RPM patient-month and ~$93.71 per PCM patient-month. Capture rate is the metric that quietly decides whether the modeled P&L is realised

Expected impact over 24 months, as modeled: $8,939,698 of net reimbursement and $3,783,655 net to the practice at a 42.32% margin; 4,927 unique patients and 6,270 active programme enrollments at month 24; 691,780 physiologic readings; 159,571 billed units; approximately 439 avoided hospitalizations; and 71,844 care-team hours delivered. *All figures are illustrative, modeled — verify against practice data.*

8.6 Twelve-month roadmap

Phase	Months	What happens
Charter	0–1	Physician lead named; service line chartered with its own P&L at division level; target populations agreed; attribution policy written with the primary-care network before the first enrollment; Medicare Advantage contract review commissioned
Stand up	1–3	eClinicalWorks integration built; the daily discharge feed from the participating hospitals designed and tested — this is the long pole, not the connector; alert thresholds and escalation protocol set by the physician lead; on-site enrollment specialist placed

Phase	Months	What happens
First census	2–6	The device-monitored cohort and the post-discharge cohort enrolled first; first billable enrollment inside 90 days; month 2 is the first net-positive month in the model
Extend	6–9	Hypertension, heart failure, post-ablation, post-implant and post-structural-heart pathways added; telephonic enrollment opened to the rural and outreach panel to move the PCM arm, which is enrollment-limited rather than eligibility-limited
Institutionalise	9–12	Monthly scorecard running; capture rate and post-discharge reach rate reported by CCN; readmission delta against the unenrolled panel measured; the TCM decision taken on its own merits

References & Data Sources

- **CMS National Downloadable File — Doctors and Clinicians / PECOS** (dataset mj5m-pzi6, file modified June 26, 2026; 3,387,942 rows): the enrolled organization HEALTHONE HEART CARE LLC, organizational PAC ID 9436394467, 48 members, the 25-physician / 23-APP composition, the practice-location address lines, and the telehealth flag. The zero-row result for any organization whose facility name matches “Aurora Denver Cardiology”, across all states, comes from the same file.
- **CMS Medicare Physician & Other Practitioners — by Provider, CY2024** (released May 21, 2026): total allowed charges of $6,062,840 and 27,559 beneficiary instances across the 44 roster NPIs with rows, the place-of-service split, and the per-provider beneficiary anchors.
- **CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024** (released May 21, 2026): the 652 service rows for the roster, the remote cardiac device monitoring lines (93294, 93295, 93296, 93297, 93298 and 93272), the top billed HCPCS including inclisiran (J1306), and the negative screen across the full remote physiologic monitoring, chronic care management, principal care management, transitional care management, physiologic-data-review, self-measured-blood-pressure and general care-management code sets for all 44 NPIs. CMS suppresses lines with fewer than 11 beneficiaries.
- **CMS TEAM Participant List** (published at cms.gov/team-model-participant-list; hospital list as of April 15, 2026; retrieved August 3, 2026; 720 hospitals, 710 mandatory, across 189 distinct CBSA values): CCN 060014, 060032, 060034, 060065, 060100 and 060112, all mandatory, CBSA 19740 Denver-Aurora-Centennial CO, performance period January 1, 2026 to December 31, 2030; and the 21-hospital census of CBSA 19740 used for the competitive comparison.
- **CMS Medicare Shared Savings Program** — PY2026 Organizations and Participants files (dataset modified February 4, 2026) and the Performance Year Financial and Quality Results file for PY2024 (revised July 17, 2026): HealthONE Colorado Care Partners ACO LLC (A5328), its 34 primary-care participant TINs, its PY2024 financial and quality results, and the separate record for MountainStar Care Partners ACO (A5181, ID/UT/WY) that establishes the commercial-record error.
- **CMS Medicare Monthly Enrollment** (April 2026 file): total, Original Medicare, Medicare Advantage and dual-eligible counts for Arapahoe, Adams, Jefferson, Denver, Douglas and Elbert counties, for Colorado and for the nation, and the age-85-and-over segment counts.
- **CMS specialty-model participant files, CY2027 preliminary** (catalog modified February 4, 2026; 6,637 rows; retrieved August 3, 2026): searched in full, by exact NPI across all 50 candidate NPIs and by organization-name regular expression across every row, in both cohorts and without any state filter. **Zero matches attributable to this group or to its enrolled organization**, so no clinician-level specialty model applies to this account and none is discussed anywhere in this report. The only mandatory model with a verified bearing here is TEAM, through the hospitals.
- **The group's own website** (adcacardiology.com — locations, interventional cardiology, structural heart, electrophysiology, patient portal, telehealth and newsroom pages; retrieved August 3, 2026): the seven patient-facing offices, the published procedure range, the named Protime anticoagulation clinic, the eClinicalWorks patient-portal target, the Healow telehealth deployment, the C-HCA, Inc. copyright notice and the HCA enterprise web assets.
- **CMS — CY2026 Medicare Physician Fee Schedule:** TCM 99495 and 99496; RPM 99453, 99454, 99445, 99457, 99470 and 99458; PCM 99424–99427; and the concurrency rules under which RPM and PCM stack. Locality-adjusted payment for this group is set under Colorado locality 04112-01.
- **CMS policy references:** the Transforming Episode Accountability Model (mandatory, January 1, 2026 – December 31, 2030; five episode categories including coronary artery bypass graft; participation by hospital CCN; a requirement that participant hospitals refer patients to primary care

to support continuity); and national coverage determination 20.40, renal denervation for uncontrolled hypertension, effective October 28, 2025 under Coverage with Evidence Development.

- **CoachCare Value Analysis companion model —** all modeled economics, clinical and operational forecasts in Sections 2.2, 5, 6.4 and 8, including the 16,576-patient in-scope base, 75% / 85% RPM / PCM eligibility, 35% / 30% acceptance, 1.5% monthly attrition, a 13% realization discount, the 48-provider referral engine at eight referrals per provider per month with 80% acceptance, one on-site enrollment specialist at CoachCare's expense, and MAC-locality rates auto-resolved for ZIP 80012 (Colorado, locality 04112-01).

Items not independently verified

The following were searched for and could not be confirmed from public sources. They are listed so that nothing in this report is mistaken for a verified fact, and together they are the right discovery agenda for a first conversation.

- **Whether any remote monitoring, chronic care or principal care management programme exists today.** CY2024 Medicare shows zero across all 44 NPIs with claims, but CMS suppresses cells under 11 beneficiaries, so a very small pilot would be invisible; a programme launched in 2025 or 2026 would not yet appear in any released file; and Medicare Advantage or commercial activity would not appear at all. *This is the single most important thing to ask directly.*
- **Where the buying decision sits.** Practice leadership, the HCA HealthONE Denver division, HCA's physician services organization, or corporate supply chain — this is not determinable from public sources and it determines the entire engagement model.
- **Whether HCA HealthONE operates a centralised care-management capability** that could be extended to specialty groups, or whether an incumbent vendor already holds a national agreement. No evidence of either was found; the division's clinically integrated network serves primary care and pediatrics only. A national agreement would change this from a practice engagement into a channel one.
- **Whether the hospitals have stood up post-discharge episode management** for their six mandatory TEAM CCNs, and whether cardiology and CABG episodes are in scope. This is the live, dated, mandatory obligation and the second most valuable discovery question after current-state programmes.
- **The hospital-side clinical record and its interface surface.** The ambulatory platform is confirmed as eClinicalWorks. The inpatient platform, its interface path, and whether any ambulatory EHR consolidation is planned were not independently verified from public sources and must be confirmed before integration scoping.
- **Medicare Advantage contracts.** With roughly 59% of the metro Medicare population in Medicare Advantage, the plan book is the larger opportunity and is entirely undocumented publicly — which plans, what risk arrangements, and whether remote monitoring and care management are separately reimbursed, bundled or capitated.
- **The legal form and date of the HCA relationship.** No acquisition or affiliation announcement was located in any source reached during research. Asset purchase, employment, or a professional services agreement with a captive professional corporation are indistinguishable in CMS enrollment data and differ commercially. The Colorado corporate register blocked automated retrieval.
- **The live roster.** Forty-eight enrolled clinicians as of June 26, 2026, but enrollment records lag departures and miss recent hires, and at least two physicians publicly associated with the brand now enroll elsewhere. Confirm the current roster before any outreach that depends on it.

- **Whether a heart failure clinic or disease-management pathway exists.** None is advertised on any page, and only 15 beneficiary-instances appear on implantable hemodynamic monitoring, billed by one clinician. That is consistent with a nascent programme or with none at all.
- **Current renal denervation volume.** The procedure is advertised as a current capability but does not appear as a distinct, unsuppressed line in the CY2024 public file. Confirm volume, the referral pathway, and whether the Coverage with Evidence Development requirements are being met today.
- **Hiring signals.** The enterprise careers site returned an automated-access block to every attempt, so no care-coordinator, remote-monitoring-nurse or population-health posting could be confirmed or ruled out. Absence of a found posting is not evidence of absence.
- **True unique-patient panel size and payer mix.** A unique-patient denominator cannot be derived from the public CMS files, which report beneficiary instances per code per provider and contain duplication. The modeled 16,576 is a discovery-stage estimate. Commercial and Medicaid volume is additive to every figure in this report.
- **Competitive cardiology census.** Only partially mapped. One Colorado cardiology organization of comparable enrolled size was identified in CMS enrollment data; a full competitor profile was not completed and no market share figure should be inferred.
- **Ratings, patient-satisfaction scores and grievance history.** None are reported anywhere in this document because none were verified from a citable source. Consumer aggregator listings were used during research only as a lead for names to check against CMS.

Global verification caveat

Facts in this report reflect public sources current to August 2026 and are cited above. Items flagged “CoachCare-provided,” “stated assumption,” “estimate,” “plausibly” or “confirm” were not independently verifiable from public sources. Reimbursement figures are illustrative national or modeled locality magnitudes — verify against the current CY2026 Physician Fee Schedule and the applicable Colorado locality files, and note that CY2027 rulemaking is in progress. Every modeled figure is a Medicare fee-for-service figure; Medicare Advantage, commercial and Medicaid volume is additive and unpriced. The TEAM hospital list is current as of April 15, 2026 and CMS updates it periodically; the group itself holds no CCN and is not a TEAM participant. All Value Analysis outputs are illustrative, modeled — verify against practice data.

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