COACHCARE | SERVICE LINE STRATEGY

My Cardiologist

Trading as MyCardiologist · enrolled with Medicare as Cardiovascular Medicine Associates, P.A. — an independent, physician-owned association of 43 clinicians across South Miami, Kendall, West Kendall, Coral Gables, Coconut Grove, Aventura, Miami Lakes, Fort Lauderdale and Boca Raton

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) as a margin-positive standalone P&L billed under the practice's own tax identification number — and as the operating layer beneath heart-failure readmission exposure, the referral relationships that carry it, and the procedural and device book it supports

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the physician and administrative leadership of MyCardiologist. It assembles the practice's public footprint and enrolled structure, its CY2024 Medicare panel, its accountable-care position, the South Florida payer structure, the 2026 payment environment, and a modeled financial forecast into a single argument: this practice already carries one of the richest chronic-care denominators a cardiology group can have — a panel averaging 77.6 years old with heart failure in more than a third of it — and the recurring, monthly, billable layer of care that sits between visits is the largest identified opportunity in the account.

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 33180 — Florida, locality 09102-04) — verify against practice data before budgeting.

One qualifier is large enough to belong on the cover. Miami-Dade County runs at **75.2% Medicare Advantage** — only about one in four local Medicare beneficiaries is in traditional fee-for-service. Every figure in this report is priced at Physician Fee Schedule rates. For the Medicare Advantage majority, what these code families actually pay is a term of the plan contract, not a fee-schedule fact. Sections 3.1 and 8.1 state that in full.

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

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Executive Summary

MyCardiologist is a South Florida cardiology practice founded in 1960 and, since 2007, headquartered in the Medical Arts Building on the South Miami Hospital campus. It does not bill Medicare under that name. **The enrolled organization behind every clinician who practises under the brand is CARDIOVASCULAR MEDICINE ASSOCIATES, P.A.**, CMS organizational PAC identifier **5991609992**, carrying **43 enrolled clinicians — 37 physicians and 6 advanced practice providers** across nine CMS-registered practice addresses in the file dated June 26, 2026.[1] The physician bench resolves as 28 in cardiovascular disease, 4 in interventional cardiology, 3 in cardiac electrophysiology, 1 in internal medicine and **1 in advanced heart failure and transplant cardiology** — a sub-specialty most groups this size do not carry. **This report is written for an independent, physician-owned professional association**. It is not employed by the health system whose campus it sits inside, and Section 1.1 sets out the four independent lines of evidence that establish that.

Four facts define this report.

1. **The chronic-care denominator is unusually rich, and unusually old.** The practice's CY2024 Medicare panel carries a mean beneficiary age of **77.6** with **heart failure at 34.7%, atrial fibrillation at 39.3%, chronic kidney disease at 36.4%, diabetes at 39.4%, ischemic heart disease at 60.0% and hypertension at 75.0%**.[2] Every one of those is a condition that qualifies a patient for remote physiologic monitoring, for principal care management, or for both. A cardiology panel with this composition is not a population that has to be recruited into a chronic-care programme — it is already the programme, seen episodically.
2. **The professional fee accrues to this practice, under this practice's own identifier.** All 43 clinicians reassign their Medicare billing rights to the group's own organizational PAC identifier. Remote monitoring, principal care management and transitional care management are **physician professional services** — they are billed by the practice, under the practice's own tax identification number, and the margin on them lands on the practice's own profit-and-loss statement. Whatever technology sits underneath, that does not change.
3. **Whether a physiologic monitoring programme exists here today is an open question, and this report treats it as one.** The practice's own services page lists “Remote Patient Monitoring Services” as a single line item with **no dedicated page — the expected address returns a not-found error — no described workflow, no conditions, no devices, no vendor and no enrolment path**.[3] That line may describe cardiac device or ambulatory rhythm monitoring rather than physiologic monitoring billed under 99453, 99454 and 99457. **No claim-level screen of the practice's CY2024 service record was run for this account, so no assertion of absence is made anywhere in this report.** Establishing what that line item actually means is the single most valuable question on the first call, and it is listed first in Section 4.3.
4. **Three in four local Medicare beneficiaries are in Medicare Advantage.** Miami-Dade County runs at **75.2% Medicare Advantage** against 56.7% for Florida and 50.9% nationally, with **43.7% of its Medicare population dual-eligible** — the highest of the three counties this practice operates

[1] CMS National Downloadable File (Doctors and Clinicians / PECOS), file modified June 26, 2026; retrieved August 3, 2026. Resolution was by organizational PAC identifier 5991609992 rather than by geography or by brand name, which returns the complete enrolled roster: 43 distinct clinician identifiers, 37 physicians and 6 advanced practice providers, across nine practice addresses. The registry API normally used for taxonomy detail was unreachable from the research environment, so CMS primary-specialty labels are used in place of taxonomy codes.

[2] CMS Medicare Physician & Other Practitioners - by Provider, CY2024 (file MUP_PHY_R26_P05_V10_D24_Prov, dataset modified May 21, 2026, coverage through December 31, 2024). Beneficiary-weighted across the 37 roster identifiers with records; 6 of the 43 enrolled clinicians have no rows in this file. Mean beneficiary age 77.6. These are Medicare fee-for-service figures and therefore describe roughly one quarter of the local Medicare population - see Section 3.1.

[3] The practice's public cardiovascular services page, retrieved August 3, 2026. The phrase appears as a single bullet in a service list. The expected dedicated page returns HTTP 404. No workflow, condition list, device, vendor or enrolment path is described anywhere on the site. No claim-level screen of the practice's CY2024 service record was run for this account, so this report makes no assertion about what is or is not billed today.

in.[4] **This is the single largest qualifier on every financial figure in this report**, and Section 3.1 states it in full rather than in a footnote.

No mandatory model exposure — pure-upside timing, and prepared if selection maps change.

The central argument

1. Standalone value — and here it leads. TCM + RPM + PCM is recurring, subscription-like professional-fee revenue delivered at top-of-license staffing, margin-positive before any value-based upside and dependent on no reconciliation, no shared-savings determination and no model performance year. Modeled at **$9,161,837** of net reimbursement and **$3,880,456** net to the practice over 24 months, a **42.35% practice margin** (net to the practice ÷ net reimbursement), with **month 1 modeled net-positive** at $2,161. Illustrative, modeled — verify against practice data.

2. Connective tissue. One shared engine — enrolment, connected devices, 24/7 alerting and triage, nurse navigation, billing capture and analytics — simultaneously serves heart-failure readmission exposure and the avoided cost that comes with it, the referral relationships with the admitting hospitals that carry that exposure, procedural and device throughput, the practice's position inside a full-downside accountable care organisation, and the standalone P&L. Build once, use everywhere.

The payer structure is the honest constraint on all of it, and it deserves to be stated before the numbers rather than after them. Miami-Dade holds 514,618 Medicare beneficiaries, of whom **386,778 are in Medicare Advantage and only 127,839 remain in traditional fee-for-service**. The favourable consequence is scale: the true Medicare book behind this practice is far larger than any fee-for-service claims file can show. The unfavourable one is pricing. **This report models Physician Fee Schedule rates for MAC locality 09102-04**, and for roughly three quarters of the local Medicare population the applicable rate is not a fee-schedule rate at all. Federal rules require a Medicare Advantage plan to pay a *non-contracted* provider no less than the original Medicare amount; for a *contracted* provider the rate is a term of the contract — and so is the prior question of whether these code families are separately payable at all rather than folded into a capitated, delegated or otherwise bundled arrangement. **That is not a reason to discount the forecast. It is a reason to price the Medicare Advantage book contract by contract before budgeting, and to treat the modeled figures as the fee-for-service case.**

The timing is specific. The CY2026 Physician Fee Schedule expanded remote monitoring in ways that suit this practice's shape precisely. **99445** pays the monthly device-supply amount for 2–15 days of data where 16 or more days were previously required, which makes short post-discharge and post-procedure windows billable for the first time — and this is a practice with a substantial structural-heart, electrophysiology and device-implant book, every case of which opens exactly such a window. **99470** pays for the first 10 minutes of monthly management time where the floor had been 20, which changes the economics of the lighter-touch patient. Principal care management (99424–99427) remains the monthly chassis for single-condition specialty management, and in a cardiology panel the single dominant condition genuinely is the cardiac one.

The companion CoachCare Value Analysis sizes the opportunity on an estimated **28,802-patient in-scope Medicare base across 43 referring providers** — *a discovery-stage estimate to validate against the practice's own chart counts* — with RPM and PCM only. It projects net reimbursement of **$2,251,740** in Year 1 and **$6,910,097** in Year 2 (**$9,161,837** over 24 months — RPM $6,969,591, PCM $2,192,246); **$3,880,456** net to the practice after CoachCare fees; 703,597 physiologic readings; approximately **447 avoided hospitalizations**; and 71,366 care-team hours delivered, about **34.3 full-time equivalents** of clinical labour nobody has to hire. **Month 1 is modeled at $2,161 net-positive — the programme does not carry a loss-making ramp at all**, because CoachCare funds the enrolment engine, the devices and the monitoring staff. *All figures are illustrative, modeled — verify against practice data.*

[4] CMS Medicare Monthly Enrollment, CY2025 annual figures, dataset modified July 23, 2026; retrieved August 3, 2026. Miami-Dade: 514,618 total Medicare beneficiaries, 386,778 in Medicare Advantage and other plans (75.2%), 127,839 in fee-for-service (24.8%), 224,816 dual-eligible (43.7%), 240,411 aged 75 or over (46.7%). Dual-eligible figures here are shares of the beneficiary population; the share of Medicaid claim lines is a different denominator and the two are not interchangeable.

2026–2027 Priority Recommendations

1. **Establish what "Remote Patient Monitoring Services" currently means here, before anything else.** The practice advertises the phrase and documents nothing behind it. Cardiac device and ambulatory rhythm monitoring, physiologic monitoring under 99453 / 99454 / 99457, and a network-level platform arrangement are three different things with three different answers. Every other decision in this report depends on which one it is (Section 4.3).
2. **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, atrial fibrillation on rate or rhythm control, chronic kidney disease with cardiac comorbidity, and the post-implant and post-structural-heart windows. Name a physician lead from the cardiology bench — the advanced heart failure sub-specialist is the obvious clinical sponsor — and pair them with the practice's senior administrative leader. Target the first billable enrolment within 90 days.
3. **Price the Medicare Advantage book separately, and do it before any budget is set.** Roughly three quarters of the Miami-Dade Medicare population sits in a plan. Every figure in this report is a fee-for-service figure at locality 09102-04 rates. Pull the plan contracts and answer three questions for each: are the remote-monitoring and care-management code families separately payable; at what rate relative to the fee schedule; and is any part of the panel delegated or capitated such that these services are already inside someone else's risk pool. Until those are answered the Medicare Advantage opportunity is additive and unquantified — which is exactly how this report treats it (Sections 3.1 and 8.1).
4. **Start with the heart-failure cohort the practice can already see.** Heart failure sits in 34.7% of the Medicare panel, the practice carries a dedicated advanced heart failure and transplant sub-specialist, and it already runs cardiac amyloidosis imaging — which means it is actively identifying a heart-failure phenotype that needs monthly weight and blood-pressure management, not annual review. That is the shortest path from today's workflow to a monitored census (Sections 4.1 and 5).
5. **Bill the post-discharge window the practice 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 practice can take on its own merits. It is also the single most visible thing a referring hospital notices (Sections 2.1 and 5).
6. **Confirm the payment locality for every billing address.** The model resolves MAC locality 09102-04 from the Aventura ZIP code, and the practice's operational and billing centre of gravity is South Miami — both in Miami-Dade. But the practice also operates in Broward and Palm Beach counties, and Florida is not a single payment locality. Confirm the locality assignment for each service address before budgeting; a blended realised rate will not equal a single-locality model.
7. **Write the attribution policy before the first enrolment.** Only one practitioner may bill remote physiologic monitoring for a given patient in any 30-day period, and this practice is a participant in an accountable care organisation with 823 participant tax identification numbers whose attributed 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. A duplicate-billing denial here is also a referral-relationship problem (Sections 2.1 and 3.3).
8. **Judge any remote-care arrangement on completeness, not on the platform.** The test that matters is whether the full billing stack is delivered end to end — enrolment labour physically present in the offices, devices logistics, 24/7 triage against thresholds the practice's own physician lead sets, documentation that survives audit, automated claim generation, and structured reporting back to referring physicians. Section 8.3 sets out that test as a checklist that can be applied to any option, including this one.

1. Footprint & Operating Model

1.1 The practice: a brand, a billing entity, and who actually owns it

Three names describe the same organisation, and keeping them straight is not pedantry — it decides which CMS files return results, who signs a contract, and who carries the margin.

Name	What it is	Why it matters
MyCardiologist	The consumer brand and website identity	The name every patient, referring physician and job applicant sees. It is not a Medicare-enrolled entity
Cardiovascular Medicine Associates, P.A.	**The Medicare-enrolled legal name and billing entity** — organizational PAC identifier 5991609992	**The name that must be used for every CMS file check on this account**. Brand-name searches of CMS participant and enrollment files return nothing, which is a naming artifact rather than a finding
South Miami Heart Specialists	A legacy public name	Still visible in older directory listings at the same South Miami address; useful only for reconciling historical records

CMS National Downloadable File (Doctors and Clinicians / PECOS), file modified June 26, 2026; the practice's public website, retrieved August 3, 2026.

Ownership, resolved. The practice is an **independent, physician-owned professional association operating under a management-services network**. It first partnered with a Massachusetts cardiology platform; on **April 18, 2023** that platform merged into a larger private-equity-sponsored cardiovascular network, and contemporaneous trade coverage names this practice explicitly as one of the two Florida groups that became partner groups in the combined network on the day of the merger.[5] The practice self-identifies as a network practice in its own press releases and recruits under the network banner. **What that does not mean is employment by a health system**, and because one publicly listed leadership email address sits on a health system's domain, that question is worth settling on the evidence rather than the inference.

Evidence	What it shows
CMS enrollment — the decisive test	The health system's employed physician organization is separately enrolled, with 661 members, at the same South Miami street address. No clinician on this practice's roster appears under it
Reassignment structure	One of the group's cardiologists reassigns benefits to four organizations — this practice, plus a 40-member diagnostic reading group, a 30-member electrocardiography entity and a 28-member echocardiography entity. Those three are narrow study-interpretation entities, which is the standard structure for an independent cardiologist reading studies at a hospital. They are not an employed medical group
The health system's own directory	It lists clinicians from this practice under its cardiovascular institute brand at **one of this practice's own office addresses** — a co-branding arrangement, not a facility listing. The pages carry no employed-medical-group language
Clinically integrated network membership	Membership of a health system's clinically integrated network is a vehicle *independent* physicians join. Separately, this practice's tax identification number does not appear as a participant in the accountable care organisation that system operates — verified in the same CMS file that confirmed the participation described in Section 3.3

[5] Trade and wire coverage of the April 18, 2023 merger between the practice's original cardiology platform partner and the network it now belongs to, retrieved August 3, 2026. The coverage names this practice explicitly as one of two Florida groups that became partner groups in the combined network on the day of the merger. The practice's own press releases and recruiting materials corroborate the network relationship.

Evidence	What it shows
Geography explains the entanglement	The main office has sat inside the hospital campus since 2007. Deep clinical entanglement with a host system is the expected consequence of that, and it is not evidence of ownership

The conclusion the evidence supports. A leadership email address on a health system's domain is a co-branding and clinically-integrated-network artifact, not an employment signal, and it should not be read as one. **The economic buyer here is the physician partnership together with its management-services network. The health system is the dominant referral and facility partner, and a counterparty — not the owner.** That distinction decides who signs, whose profit-and-loss statement improves, and which conversation this report is written for.

1.2 The operating model: independent, networked, and inside someone else's campus

Nine practice addresses appear in CMS enrollment records; the practice's own website lists ten patient-facing offices plus a walk-in clinic. The reconciliation is unremarkable — CMS enrollment records lag office openings — but the geographic spread matters commercially, because it crosses three counties with materially different payer structures.

Office	County	In CMS records	On the website
South Miami — Medical Arts Building	**Miami-Dade**	**Yes — the primary site, carrying 29 of 50 provider-address rows**	Yes
South Miami — 73rd Street	Miami-Dade	Yes	—
South Miami — Medical Square	Miami-Dade	Yes	Yes
Kendall	Miami-Dade	Yes	Yes
West Kendall	Miami-Dade	Yes	Yes
Coconut Grove	Miami-Dade	Yes	—
Coral Gables	Miami-Dade	Yes	Yes
Aventura	Miami-Dade	Yes	Yes
Boca Raton	Palm Beach	Yes	Yes
Fort Lauderdale	Broward	—	Yes
Miami Lakes	Miami-Dade	—	Yes
Walk-in immediate cardiac care clinic	Miami-Dade	—	Yes — opened September 17, 2025

CMS National Downloadable File, file modified June 26, 2026; the practice's own website, retrieved August 3, 2026. County assignment is by municipality. The practice's operational and billing centre of gravity is South Miami, not the Aventura address carried in commercial firmographic records.

Three operating facts shape everything that follows. First, **the practice has already shown it will operate a supervised remote programme**: its home-based cardiac rehabilitation service is live and documented on its own site — a four-to-eight week course of roughly 36 sessions at three to five per week, on a device that monitors heart rate, electrocardiogram, blood pressure and oxygen saturation, with **live video supervision by a cardiac rehabilitation specialist**.[6] That is not a pilot; it is a running clinical service with remote data, remote supervision and a defined course. The hardest cultural work of a remote care programme is already done here. Second, **34 of the 43 enrolled clinicians carry the CMS telehealth indicator**, so the capability and the credentialing exist even though telehealth is not marketed on the website. Third, the practice has an appetite for new technology and new access models that is unusual for a group of this size: a walk-in immediate cardiac care clinic opened in September 2025, a women's cardiovascular programme runs as a named sub-brand, and in March 2026 the practice announced an artificial-intelligence cardiovascular laboratory initiative.[7]

1.3 Design principles for the 2026 service line

Principle	What it means here
Longitudinal by default	A panel averaging 77.6 years old with heart failure in more than a third of it does not have an episodic disease. Between-visit management is the default state of care for this population, and it should be staffed and billed as such
One P&L, one owner	The service line gets its own profit-and-loss statement, its own physician lead and its own monthly scorecard. Anything run as a side project of the device clinic or the front desk will be measured like one
Billed under the practice's own identifier	Remote monitoring, principal care management and transitional care management are professional services billed by the practice. The margin lands on the practice's statement regardless of what technology sits underneath
Completeness over platform	The variable that decides whether a modeled forecast is realised is not the software. It is whether enrolment labour is physically present, whether every code family in the stack is actually captured, and whether the documentation survives an audit (Section 8.3)
Priced honestly, payer by payer	Fee-for-service and Medicare Advantage are modeled separately, never blended. The figures in this report are the fee-for-service case; the plan book is additive and unpriced until the contracts are read
Multi-site by construction	Nine to twelve offices across three counties means enrolment cannot rely on a single front desk. A rotating on-site pathway plus a telephonic lane is the design, not a fallback

[6] The practice's home-based cardiac rehabilitation page, retrieved August 3, 2026: a four to eight week programme of approximately 36 sessions at three to five sessions per week, on a device monitoring heart rate, electrocardiogram, blood pressure and oxygen saturation, with live video supervision by a cardiac rehabilitation specialist.

[7] The practice's news page, retrieved August 3, 2026: the walk-in immediate cardiac care clinic launched September 17, 2025, and the artificial-intelligence cardiovascular laboratory announcement dated March 26, 2026. The women's cardiovascular programme appears as a named sub-brand on the practice's own service pages.

2. The Remote Care Service Line — The Operating Spine

This section defines the service line precisely, prices its standalone economics against the practice's own Medicare base, and shows how one infrastructure serves every value lever the practice 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 practice
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	The practice's admissions flow overwhelmingly to a small number of nearby hospitals, and the follow-up is ambulatory and belongs to this practice. 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 in a panel where hypertension sits at 75.0%, and — via the short-window code 99445 — for the 2–15 day post-discharge, post-ablation and post-implant windows this practice generates in volume
PCM — Principal Care Management	99424–99427	Monthly management of a single high-risk condition expected to last at least three months	Heart failure, resistant hypertension and rate- or rhythm-controlled atrial fibrillation as the qualifying conditions. In a cardiology panel the single dominant condition genuinely is the cardiac one — the clinical situation this benefit was written for, and the monthly chassis for guideline-directed 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 practice 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** — transitional care management is identified and described 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 remote physiologic monitoring for a given patient in any 30-day period, so the attribution question has to be settled before enrolment 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 practice participates in an accountable care organisation carrying 823 participant tax identification numbers, most of them primary care, whose attributed patients overlap this panel.

And a boundary specific to a practice with this device book: 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 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: the lead layer, and a margin-positive P&L

On this account the standalone economics are not the supporting argument. **They are the argument**, and the other layers compound on top of them rather than carrying them. The service line stands on four layers of value, in this order:

1. **Direct professional-fee revenue — the lead layer.** Recurring monthly billing on a population the practice already manages clinically, delivered at top-of-license staffing under general-supervision rules and billed under the practice's own tax identification number. Modeled at $9,161,837 of net reimbursement over 24 months, $3,880,456 of it net to the practice. It depends on no reconciliation, no shared-savings determination and no performance year.
2. **Avoided cost and readmission exposure.** Modeled at approximately 447 avoided hospitalizations over 24 months — on the order of $6.7 million at an illustrative $15,000 per admission, accruing to whoever carries the risk. In a panel with heart failure at 34.7% and a referral pattern concentrated on a small number of hospitals, that value is visible to the practice's referral partners as well as to the practice (Section 5).
3. **Procedural and device throughput.** A monitored discharge pathway is what converts a structural-heart, ablation or device-implant case from a bed-day into a same-or-next-day discharge, and a managed census is what keeps a candidate pipeline identified rather than incidental (Section 6).
4. **Strategic position.** A built, billable, hospital-facing post-discharge capability is an asset the practice can point at when a referral partner asks what changed, when a plan asks what the practice does between visits, and when the next payment programme arrives. Building it once 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

Service / code	Type	~CY2026 magnitude	Notes
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 in this market one qualifier dominates all the others

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 33180 in the CoachCare Value Analysis — Florida, locality 09102-04. Verify against the current CY2026 Physician Fee Schedule and the applicable Florida locality files before budgeting, confirm the locality assignment for the Broward and Palm Beach service addresses separately, 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, in the largest type on the page, not in a footnote. Miami-Dade County runs at **75.2% Medicare Advantage** — the highest of the three counties this practice operates in, and roughly 24 points above the national figure. **Only about one in four local Medicare beneficiaries is in traditional fee-for-service, and every modeled figure in this report prices the whole in-scope panel at the Physician Fee Schedule locality rate.** Federal rules require a plan to pay a non-contracted provider no less than the original Medicare amount. That is a floor for the non-contracted case; it is *not* a guarantee that a given plan contract pays these particular code families on the same terms, at the same rate, or as separately payable services at all. **Treat the Medicare Advantage book as additive, unpriced, and answerable only by reading the contracts.**

Modeled economics

The companion Value Analysis prices an RPM + PCM programme on the practice's Medicare base. The modeled population is an estimated **28,802-patient in-scope base across 43 referring providers**, all of it in scope in Year 1. *This is a discovery-stage estimate and should be validated against the practice's own chart counts before budgeting.* The reasoning behind it is worth showing, because in a market like this one it is easy to size an account wrongly in either direction. The CY2024 CMS file reports **21,159 beneficiary-provider pairs** across the 37 roster identifiers with records — a duplicated count, because a patient seen by two clinicians in the group is counted twice.[8] At a plausible 1.8 to 2.4 clinicians per patient, the deduplicated fee-for-service ambulatory panel is on the order of 8,800 to 11,800. Fee-for-service is only 24.8% of the Miami-Dade Medicare population, so scaling that panel at the county's full payer mix would imply an all-payer Medicare panel of roughly 35,000 to 47,000. **The modeled 28,802 sits below the bottom of that scaled range**, which is the conservative assumption: it presumes the practice carries materially less than the county's full Medicare Advantage share.

Enrolment builds bottom-up from **43 referring providers at eight referrals per provider per month with 80% patient acceptance**, supported by **one on-site enrolment specialist** at approximately 80 enrolments 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 (21,602 patients) and 85% for PCM (24,482), with acceptance of 35% and 30% respectively, and monthly

[8] CMS Medicare Physician & Other Practitioners - by Provider, CY2024. The 21,159 figure is the sum of per-provider beneficiary counts across the 37 roster identifiers with records. It is a beneficiary-provider pair count and contains substantial duplication, because a patient seen by two clinicians in the group is counted twice. A true unique-patient denominator cannot be derived from this file.

attrition of 1.5%. Revenue is reported as **net** reimbursement — gross allowed amounts less an 11% realization discount for payer mix and collection, as configured in the model.

Modeled result	Year 1	Year 2	24-month
Net reimbursement	$2,251,740	$6,910,097	**$9,161,837**
CoachCare fees (incl. setup & integration)	—	—	$5,281,381
Net to the practice	**$949,049**	**$2,931,407**	**$3,880,456**
Practice margin	**42.15%**	—	**42.35%**
Net reimbursement by programme	RPM $1,720,602 · PCM $531,138	RPM $5,248,989 · PCM $1,661,108	RPM $6,969,591 · PCM $2,192,246
Claims / billed units	—	—	160,714
Physiologic readings collected	—	—	703,597
Hospitalizations avoided (modeled)	—	—	~447 (≈$6.7M at an illustrative $15,000 each)
Care-team hours delivered	—	—	71,366 (≈34.3 FTE)
Active programme enrolments at month 24	—	—	7,236 (RPM 5,417 · PCM 1,819)
Unique patients (de-duplicated)	3,016 at month 12	5,962 at month 24	—

CoachCare Value Analysis, MAC locality FL 09102-04 (ZIP 33180), 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, the timing, and how both are defined

24-month practice margin: 42.35% — net to the practice ÷ net reimbursement. Year 1 is **42.15%**, on $9,161,837 of net reimbursement and $3,880,456 net to the practice over the full 24 months.

Month 1 is modeled net-positive, at $2,161 — this forecast carries no loss-making ramp at all, which is unusual and is worth checking rather than assuming. It is a consequence of how the programme is resourced: CoachCare funds the enrolment engine, the connected devices and the monitoring staff, so no practice capital is at risk while the census builds. By month 24 the programme is modeled at $735,637 of monthly net reimbursement and $312,178 of monthly net to the practice.

Both arms are pace-limited, and that is the single most useful planning fact in the model. Neither programme reaches its modeled eligibility ceiling inside 24 months. RPM stands at **5,417 enrolled patients at month 24 against a modeled ceiling of 7,561**; PCM stands at **1,819 against a ceiling of 7,345**. Together that is 7,236 active enrolments against a combined ceiling of 14,906 — **less than half**. The constraint is enrolment throughput, not eligibility. **Month 24 is therefore not the programme's terminal size for either arm**, and the levers that move it are the ones that add enrolment capacity: a second enrolment specialist, a telephonic lane run at scale across the nine-to-twelve office footprint, or higher referral throughput from the bench. Given the geographic spread across three counties, the telephonic pathway is the obvious second lane rather than the fallback.

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 ($6,910,097) is 3.1× Year 1 ($2,251,740) on the same referral engine, purely from census accumulation. Unit economics are modeled at approximately $104.01 of net reimbursement per RPM patient-month and $97.45 per PCM patient-month, across 67,009 RPM and 22,497 PCM patient-months over 24 months.

The professional fee depends on no reconciliation and no shared-savings determination — while the same monitored census is what moves the readmission, avoided-cost and total-cost-of-care results described in Sections 3.3 and 5. The two compound rather than compete. *All figures are illustrative, modeled — verify against practice data.*

2.3 Connective tissue: one infrastructure, every lever

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

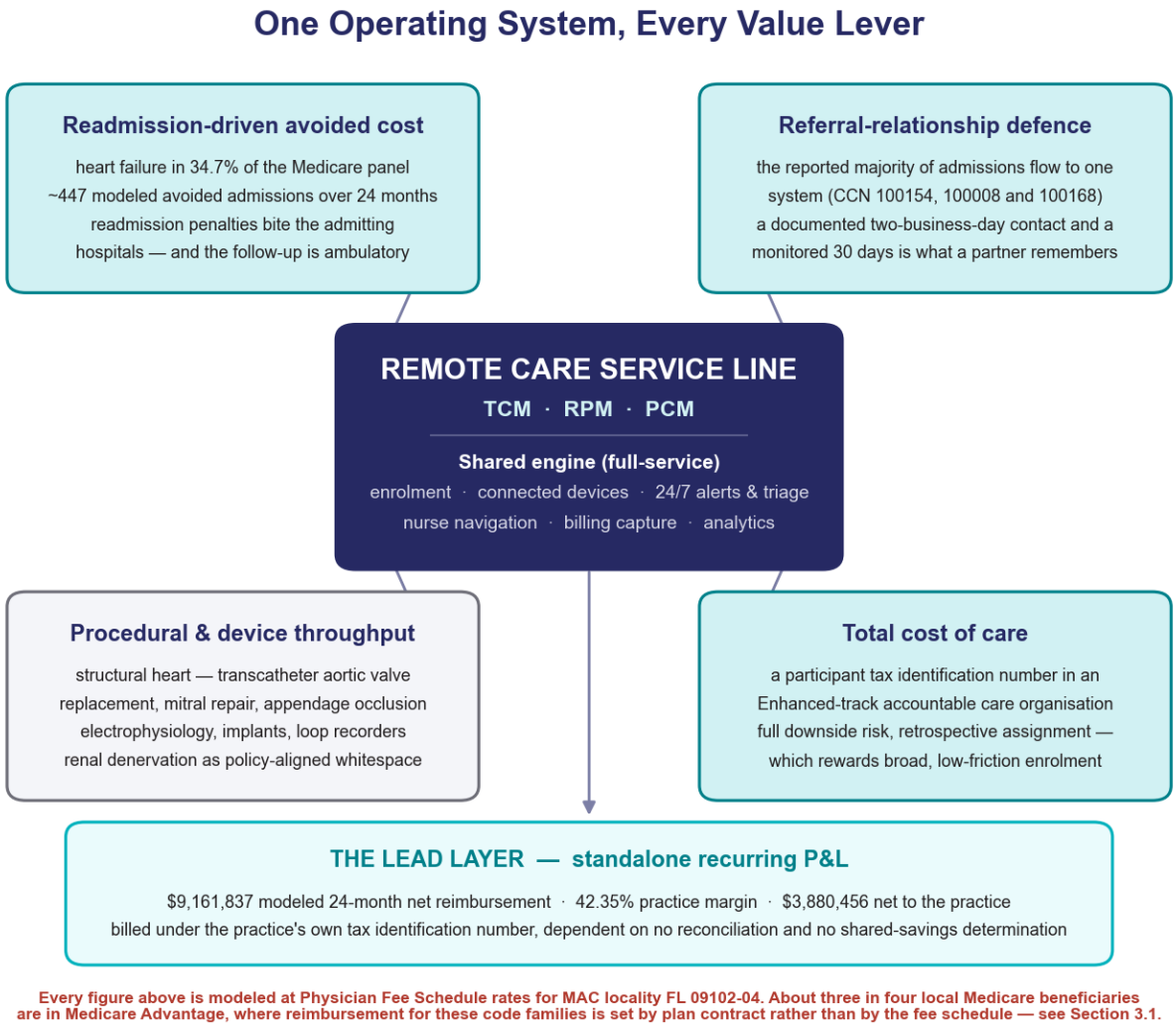

Figure 1. The Remote Care Service Line as connective tissue — on this account the standalone recurring P&L is the lead layer, and the other levers compound on top of it. Modeled at fee-for-service rates.

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
Standalone P&L — the lead layer	CY2026 code expansion (99445, 99470); revenue durability that does not depend on any reconciliation, performance year or savings determination	$9,161,837 of modeled 24-month net reimbursement at a 42.35% practice margin, $3,880,456 net to the practice — recurring professional-fee revenue billed under the practice's own tax identification number
Readmission-driven avoided cost	Heart failure in 34.7% of the Medicare panel, in a population averaging 77.6 years old; hospital partners carry readmission consequences on exactly this cohort	Daily physiologic signal with 24/7 triage turns deterioration into a same-week outpatient intervention instead of an emergency-department visit. Approximately 447 modeled avoided admissions over 24 months
Referral-relationship defence	Admissions are reported to concentrate heavily on three nearby hospitals, and the practice's main office sits inside one of their campuses. Independent groups keep referral relationships by being operationally better, not by being closer	A documented two-business-day post-discharge contact, monitored days one to fourteen, and a structured monthly report back to the referring physician — the artifacts a partner actually notices (Section 5)
Procedural and device throughput	Structural heart, electrophysiology, device implants and loop recorders, plus renal denervation as policy-aligned whitespace	A monitored discharge pathway converts a post-procedure bed-day into a same-or-next-day discharge, and a managed census keeps the candidate pipeline identified rather than incidental (Section 6)
Total cost of care	A participant tax identification number in an Enhanced-track accountable care organisation — two-sided, full downside risk, retrospective assignment	Retrospective assignment means the attributed panel cannot be pre-identified, which raises the value of broad, low-friction chronic-care enrolment across the whole panel rather than a targeted subset (Section 3.3)
Transitional care *(identified, not modeled)*	A 30-day post-discharge window the practice already generates and does not bill in any figure in this report	The same enrolment and monitoring engine covers the window; short-window RPM is billable today via 99445, and transitional care management remains a separate decision the practice can take on its own merits

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 practice already owns the hardest inputs: a chronic-care denominator most groups would have to build, a demonstrated willingness to run supervised remote care, and a clinical bench that includes a dedicated advanced heart failure sub-specialist. What it does not yet demonstrably own is the physiologic data layer, the enrolment engine and the billing capture that turn all of that into a service line.

3. 2026 Policy & Payment Environment

Three things in the environment bear on this account: the payer structure, which is unusually extreme; the fee schedule, which moved in this practice's favour; and the accountable-care arrangement the practice already participates in.

3.1 The market: three in four local beneficiaries are in Medicare Advantage

This is the most important section in the report, and it is the one that most reports like this one would put in an appendix. **Miami-Dade County is one of the most Medicare Advantage-saturated markets in the United States**, and the practice's home county, its billing centre of gravity and the large majority of its offices are all in it.

County / benchmark	Total Medicare	Fee-for-service	Medicare Advantage & other	MA penetration	Dual-eligible
Miami-Dade — the practice's home county	**514,618**	**127,839**	**386,778**	**75.2%**	**43.7%**
Broward — Fort Lauderdale office	371,601	131,299	240,302	64.7%	22.3%
Palm Beach — Boca Raton office	365,926	190,966	174,961	47.8%	12.9%
Florida	5,241,793	—	—	56.7%	—
National	69,462,038	—	—	50.9%	—

CMS Medicare Monthly Enrollment, CY2025 annual figures, dataset modified July 23, 2026; retrieved August 3, 2026. Dual-eligible figures are shares of the beneficiary population, not shares of claim lines — the two denominators are different and are not interchangeable. 46.7% of Miami-Dade Medicare beneficiaries are aged 75 or over.

Three consequences follow, and the second is the uncomfortable one. First, **the account is materially larger than any fee-for-service claims file can show**: only 127,839 Miami-Dade beneficiaries remain in traditional fee-for-service, roughly a quarter of the county's Medicare population, so a value analysis built purely on fee-for-service claims understates the covered lives behind this practice by a wide margin. That is why the in-scope base modeled in Section 2.2 is derived by scaling rather than taken from the claims file directly. Second, and this is the qualifier that has to be said plainly: **the model prices the whole in-scope panel at the Physician Fee Schedule locality rate, and for the Medicare Advantage majority the actual reimbursement is contract-dependent**. Third, the **dual-eligible share is 43.7% and it changes the operational design**, because a dual-eligible population has different cost-sharing exposure, different engagement barriers and a different device-logistics problem than a commercially supplemented one.

The Medicare Advantage question, stated precisely enough to act on

What is true: federal rules require a Medicare Advantage plan to pay a *non-contracted* provider no less than the amount the provider would have received under original Medicare. That is a genuine statutory floor, and it is the reason a Medicare Advantage panel should never be assumed to be worth less than a fee-for-service one.

What is not true: that the floor settles what a *contracted* provider is paid for these particular services. For a contracted provider the rate is a term of the negotiated agreement, and so is the logically prior question — **whether remote monitoring and care management are separately payable at all**, or whether they are folded into a capitated, delegated or otherwise bundled arrangement in which someone else is already at risk for the same work.

What that means for this forecast: every figure in this report is a fee-for-service figure at locality 09102-04 rates. The Medicare Advantage book is larger and is priced contract by contract. **It is treated here as additive and unquantified, and it should stay that way until the contracts are read.** Reading them is a first-order budgeting task and it belongs in the first 30 days (Section 8.6).

And one market-specific complication worth naming: the practice's management-services network has publicly announced a value-based cardiac care collaboration with a national Medicare Advantage carrier. Whether that arrangement covers this practice, this market, or these code families is not established from any public source, and it should be asked directly rather than assumed in either direction.

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 practice 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, which changes the economics of the lighter-touch patient and makes a larger share of the panel worth enrolling. Together they convert the two windows this practice generates most of — the 30 days after a cardiac discharge, and the days after an ablation, device implant or structural procedure — from unfunded care into billable events. Principal care management (99424–99427) remains the monthly chassis for single-condition specialty management, and RPM and PCM stack in the same month with discrete documentation.

One forward-looking caveat. CMS rulemaking for CY2027 is in progress. Remote-monitoring and care-management code values are subject to change inside the 24-month window this report models, and the modeled figures should be re-run against the final CY2027 rates when they publish.

3.3 The accountable-care position: Enhanced track, full downside

The practice's Medicare-enrolled legal name appears as a participant tax identification number in a Medicare Shared Savings Program accountable care organisation for performance year 2026. The match was made by full-text scan of the participant legal-name field across all 15,370 participant rows in the CMS file; exactly one match was returned.[9] The characteristics of that organisation change how a chronic-care programme should be designed here.

Characteristic	Value	Why it matters for the service line
Initial start date	July 1, 2012	One of the original programme entrants — fourteen continuous years. Mature infrastructure and a real appetite for tools that move total cost of care

[9] CMS Medicare Shared Savings Program PY2026 Participants file (dataset modified February 4, 2026; retrieved August 3, 2026). A full-text scan of the participant legal-name field across all 15,370 participant rows returned exactly one match for the practice's Medicare-enrolled legal name. Organization-level characteristics are taken from the companion PY2026 Organizations file (dataset modified April 16, 2026). Performance-year financial and quality results for this organisation were not pulled for this report.

Characteristic	Value	Why it matters for the service line
Track	**Enhanced — two-sided, maximum risk**	**Full downside exposure**. Avoided admissions are not a soft benefit in an Enhanced-track entity; they are the difference between a distribution and an assessment
Assignment	**Retrospective**	**The single most design-relevant fact here**. A retrospectively assigned organisation cannot pre-identify its attributed panel, which raises the value of broad, low-friction enrolment across the whole eligible population rather than a narrow targeted subset
Revenue classification	Low-revenue	Consistent with a physician-led rather than hospital-led structure
Participant tax identification numbers	823	A large, mostly primary-care participant base whose attributed patients overlap this panel — which is why the attribution policy in Section 2.1 is not optional
Skilled nursing facility three-day rule waiver	Held	Post-acute flexibility that pairs naturally with a monitored discharge pathway
Service area	District of Columbia, Florida, Georgia, North Carolina, South Carolina, Texas	A multi-state entity; this practice is one participant among many

CMS Medicare Shared Savings Program PY2026 Participants and Organizations files, dataset modified February 4, 2026 / April 16, 2026; retrieved August 3, 2026. Performance-year financial and quality results for this organisation were not pulled for this report and no shared-savings outcome should be inferred.

Two disciplines on this section. First, nothing in this report should be sold as accountable-care upside. The practice is one participant tax identification number among 823 in a multi-state organisation; how any savings distribution reaches an individual participant is a matter of that organisation's internal arrangements, which are not public and are not modeled anywhere here. Second, the practice is *not* a participant in the accountable care organisation operated by the health system on whose campus its main office sits — that was checked in the same file and returned no match. The relationship with that system is clinical, referral-based and, at the level of its clinically integrated network, individual. It is not a shared-savings alignment.

4. Performance Snapshot: The Starting Position

4.1 The panel: 77.6 years old, and heart-failure heavy

The clinical case for this account needs no exaggeration, and it is best made with the practice's own Medicare data rather than with market averages. Across the 37 roster identifiers with CY2024 records, the beneficiary-weighted chronic-condition profile is as follows.

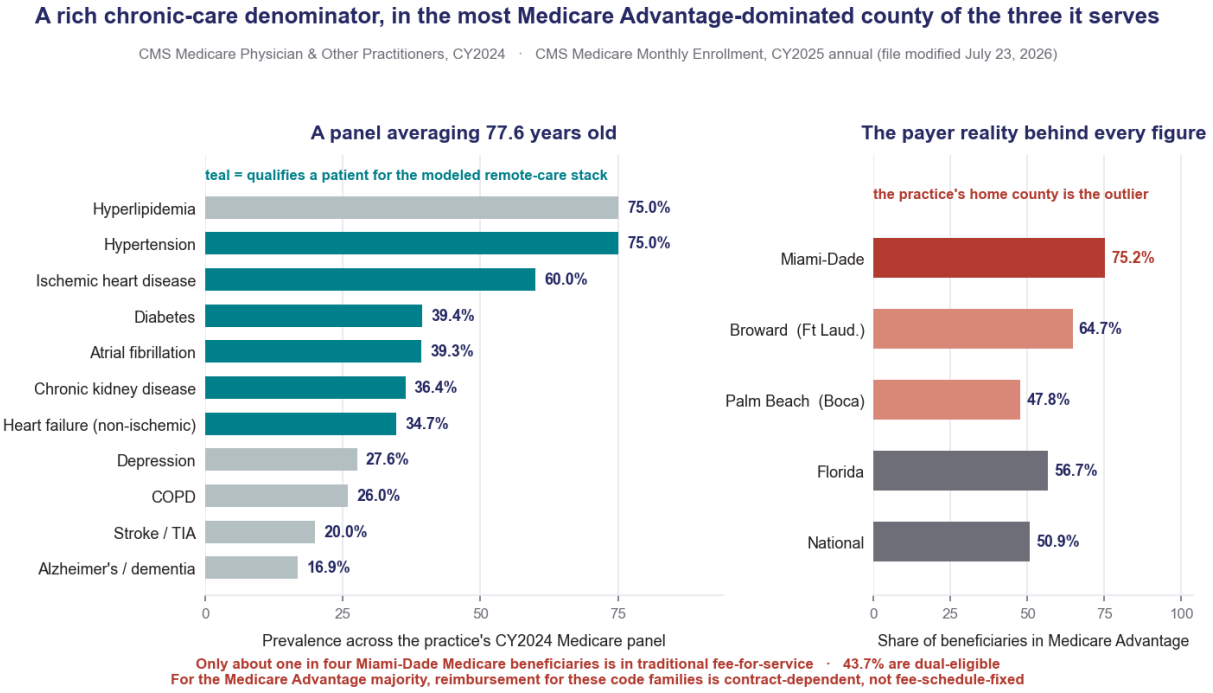

Figure 2. Left: chronic-condition prevalence across the practice's own CY2024 Medicare panel; conditions shown in teal qualify a patient for remote physiologic monitoring, for principal care management, or for both. Right: Medicare Advantage penetration in the three counties the practice operates in, against Florida and national benchmarks. The left panel is the opportunity; the right panel is the qualifier on it.

Condition	Prevalence in the practice's Medicare panel	Relevance to the modeled stack
Hypertension	75.0%	The largest single monitoring population. Blood-pressure RPM with protocolised titration is the highest-volume pathway in the model
Hyperlipidemia	75.0%	Not itself a monitoring indication; relevant to adherence programmes and to the lipid-management pathway
Ischemic heart disease	60.0%	The secondary-prevention population — blood-pressure and symptom monitoring after revascularisation
Diabetes	39.4%	Co-morbid burden that raises both the acuity and the monitoring value of the hypertension and heart-failure cohorts
Atrial fibrillation	39.3%	Rate and rhythm control, anticoagulation follow-up, and a natural principal care management population
Chronic kidney disease	36.4%	The cardio-renal overlap. Blood-pressure control and volume status are the levers, and both are physiologic-monitoring questions

Condition	Prevalence in the practice's Medicare panel	Relevance to the modeled stack
Heart failure (non-ischemic)	**34.7%**	**The anchor cohort**. Daily weight and blood pressure with 24/7 triage is the canonical remote-monitoring use case, and guideline-directed titration is what principal care management pays for monthly
Anxiety / mood disorders / depression	31.9% / 30.9% / 27.6%	Relevant to engagement and adherence design rather than to billing; a monitored census with regular human contact is the mitigation
COPD	26.0%	Pulse-oximetry monitoring overlaps the cardiac population and complicates dyspnoea triage — a reason to protocolise escalation carefully
Stroke / transient ischemic attack	20.0%	Secondary prevention with blood-pressure control as the primary lever
Alzheimer's disease and related dementias	16.9%	A caregiver-enrolment design question, not an exclusion. Device selection and consent workflow have to account for it

CMS Medicare Physician & Other Practitioners — by Provider, CY2024 (file MUP_PHY_R26_P05_V10_D24_Prov, dataset modified May 21, 2026; coverage through December 31, 2024; retrieved August 3, 2026). Beneficiary-weighted across the 37 roster identifiers with records. Mean beneficiary age 77.6. Note the approximately 18-month claims lag inherent in this file, and note that these are fee-for-service figures in a market where fee-for-service is the minority payer.

The composition is the argument. A cardiology panel where hypertension sits at three quarters, ischemic heart disease at three fifths, and heart failure, atrial fibrillation, chronic kidney disease and diabetes each between a third and two fifths, at a mean age of 77.6, is not a population that has to be recruited into chronic-care management. **It is a chronic-care population that is currently seen episodically**. The practice also carries a dedicated advanced heart failure and transplant cardiologist on its enrolled roster and offers cardiac amyloidosis imaging among its diagnostic services, which means it is actively identifying a heart-failure phenotype that requires monthly management rather than annual review.

4.2 The revenue picture, and the two figures that disagree

Two credible figures exist for this practice's Medicare revenue, they differ by about 37%, and both belong in this report because they measure different things.

Figure	Value	What it actually measures
Practice-level Medicare allowed amount, commercial firmographic file	$9,173,444	Almost certainly scoped to the practice's own tax identification number — only claims billed under this entity. Use this as the **conservative practice-attributable anchor**
Sum of Medicare allowed amount across the roster identifiers, CMS	$12,573,399	All Part B allowed for these physicians, including work billed through their other reassignments — the diagnostic reading, electrocardiography and echocardiography entities described in Section 1.1. Use this as the **physician-total ceiling**
Total Medicare payment amount, CMS	$9,633,444	The paid rather than allowed figure across the same roster identifiers
Beneficiary-provider pairs, CMS	21,159	A duplicated count, not unique patients — a patient seen by two clinicians in the group appears twice. The true unique-patient denominator cannot be derived from this file

CMS Medicare Physician & Other Practitioners — by Provider, CY2024 (dataset modified May 21, 2026), summed across the 37 roster identifiers with records; and a caller-provided commercial firmographic export of unknown vintage. Neither figure is wrong; they have different scopes.

State which is which, every time either is used. The $9,173,444 figure is the **conservative practice-attributable anchor**; the $12,573,399 figure is the **physician-total ceiling**. And weigh both against Section 3.1: these are fee-for-service figures in a county where fee-for-service covers roughly one beneficiary in four. **The Medicare Advantage book is the larger and entirely unmeasured part of this practice's Medicare revenue**, and no public file will size it.

One more reconciliation worth recording. A commercial firmographic file reports 34 physicians for this practice. CMS enrollment resolves **43 enrolled clinicians — 37 physicians and 6 advanced practice providers** under the group's own organizational identifier. CMS is the better source, and the commercial figure appears either stale or physician-only. The two sources agree exactly on the nine CMS-registered locations.

4.3 What is — and is not — established about remote care here today

This section exists because the honest answer is “partly unknown,” and a report that pretended otherwise would be wrong in a way the first meeting would immediately expose.

Capability	Status	Evidence
Physiologic remote patient monitoring	**NOT ESTABLISHED — the first discovery question**	The practice's services page lists “Remote Patient Monitoring Services” as a bare line item. The expected dedicated page returns a not-found error, and no workflow, condition list, device, vendor or enrolment path is described anywhere on the site. That line may describe cardiac device or ambulatory rhythm monitoring rather than physiologic monitoring billed under 99453, 99454 and 99457. **No claim-level screen of the practice's CY2024 service record was run for this account, so nothing here asserts an absence.**
Home-based cardiac rehabilitation	**LIVE and documented**	A four-to-eight week programme of roughly 36 sessions at three to five per week, on a device monitoring heart rate, electrocardiogram, blood pressure and oxygen saturation, with live video supervision by a cardiac rehabilitation specialist. Described in detail on the practice's own site
Cardiac device clinic	Implied, not confirmed as remote	The practice implants pacemakers and defibrillators, performs defibrillator checks and offers implantable loop recorders — all of which generate remote device-monitoring volume. But the site never uses the phrase “remote device monitoring” and names no vendor
Ambulatory rhythm monitoring	Offered; vendor not named	Holter and event monitors appear in the published service list
Patient portal / ambulatory record	**athenahealth — CONFIRMED**	A live, practice-branded athenahealth patient portal instance, verified August 3, 2026 (Section 7.1)
Telehealth	Capability exists; not marketed	34 of the 43 enrolled clinicians carry the CMS telehealth indicator, but telehealth is not promoted anywhere on the practice's website
Chronic care management	No evidence either way	Nothing published, and no claim-level screen was run
Named care-coordinator or monitoring staff roles	Not determined	Job-posting research was not completed within the research budget for this account

Stated as absence of evidence, not as proof of absence

No page, posting or press release was found describing a physiologic remote monitoring programme — blood-pressure cuffs, weight scales, pulse oximetry — with an enrolment workflow at this practice. **That is a statement about what public sources show, and nothing more.** A programme running today would be entirely consistent with the public record, and it would change the conversation from a build to an extension — which is a better conversation, not a worse one.

The distinction that has to be established on the first call: cardiac device and ambulatory rhythm monitoring, physiologic monitoring under the 99453 family, and a network-level platform arrangement are three different things. They have different code sets, different eligible populations, different staffing and different economics. Section 8.3 sets out the test that distinguishes a platform from a delivered, fully-billed service line, and it applies to whatever is already in place as much as to anything new.

The three possible answers, and what each one changes

If the answer is…	What it means	What changes in this report
Cardiac device or ambulatory rhythm monitoring	The line item describes implanted-device telemetry or a rhythm-monitor service, not patient-generated physiologic data	Nothing in the modeled economics changes. Physiologic monitoring is a distinct benefit over distinct data (Section 2.1), and the already-monitored population becomes the highest-confidence enrolment cohort in the account — consent, device logistics and a review habit already exist
A physiologic monitoring programme already running	The practice is further along than the public record shows, which is a better starting position than this report assumes	This becomes an extension rather than a build. The questions move to Section 8.3 — code-level capture across the whole stack, enrolment throughput, documentation quality and payer segmentation — and the distance between a partial programme and the modeled figures is the opportunity
A platform arrangement without a fully delivered service line	A technology decision has been taken and the operating layer beneath it — enrolment labour, complete code capture, clinical governance — is partly or wholly unbuilt	The completeness checklist in Section 8.3 is the right instrument, applied row by row. The professional fee accrues to this practice under any arrangement; what varies is how much of the billable stack is actually captured

The useful thing about that table is that the modeled stack is the same in all three cases. What the answer changes is the starting point and the shape of the work, not the size of the opportunity or the codes it is built on. That is why this report does not guess: it prices the opportunity, states the qualifier, and puts the question first.

5. Readmission Economics & Referral-Relationship Defence

In a health-system-owned group the readmission argument is an internal transfer: the avoided admission and the ambulatory follow-up land on the same balance sheet. **This practice is independent, so the argument is different and, commercially, more interesting**. The readmission consequence lands on the hospital. The 30 days that determine it are controlled by this practice. That asymmetry is not a problem to be managed — it is the clearest referral-relationship asset an independent cardiology group can build.

Where the admissions go

Admitting hospital	CCN	Reported share of the practice's admissions
South Miami Hospital — the campus the practice's main office sits inside	100154	39%
Baptist Hospital of Miami	100008	30%
Boca Raton Regional Hospital	100168	9%

CCNs verified against CMS Hospital General Information, dataset modified April 28, 2026 — all three are acute-care hospitals, voluntary non-profit, private. ⚠ The share percentages are drawn from a caller-provided commercial firmographic export of unknown vintage and were NOT independently verified. They are directionally corroborated by the practice's physical location inside the first hospital's campus and by the reassignment structure described in Section 1.1, but the specific figures should be confirmed with the practice before they are relied on.

The policy backdrop, stated carefully. Under the Hospital Readmissions Reduction Program, acute-care hospitals face a payment adjustment based on excess 30-day readmissions in a defined set of conditions, **heart failure among them**. That programme is permanent statute, not a time-limited demonstration, and heart failure is precisely the cohort this practice's panel is heaviest in. **The specific penalty status of each of the three hospitals above was not verified for this report and must not be assumed** — the general mechanism is what matters commercially, and the general mechanism is that a hospital's exposure on heart-failure readmissions is determined largely by ambulatory care it does not control.

The mechanism, in one paragraph

A heart-failure patient is discharged. Over the following fourteen days, weight rises two kilograms, blood pressure drifts, and the patient's symptoms change in a way that nobody sees because the next appointment is in three weeks. On day nineteen the patient returns through the emergency department. **Everything that determined that outcome happened in ambulatory space, and none of it was visible to anyone**. A monitored discharge pathway makes days one to fourteen visible: daily weight and blood pressure, 24/7 triage against thresholds the practice's physician lead sets rather than vendor defaults, and a defined escalation path from alert to nurse contact to a same-week outpatient intervention. That is where the approximately 447 modeled avoided admissions come from — not from a coefficient, but from a workflow.

What the service line delivers	Who sees the value	Why it defends the relationship
Interactive contact within two business days of discharge, documented	The hospital's case-management and quality teams	It is the single most visible post-discharge artifact, and it is measurable per hospital. A referring partner can see it happening
Monitored days one to fourteen, billable today via 99445	The hospital carries the readmission consequence; the practice carries the monitoring	It converts the highest-risk window from an unobserved gap into a managed service, and it is billable to the practice at the same time

What the service line delivers	Who sees the value	Why it defends the relationship
Structured monthly reporting back to the referring physician	Referring primary-care and hospital-based physicians	Good practice, a referral-retention mechanism, and the artifact that keeps the attribution policy in Section 2.1 honest
A named escalation path with a human on the other end	Patients, and the emergency departments that would otherwise see them	Same-week outpatient intervention instead of an emergency-department visit is the operational definition of an avoided admission
An avoided-admission count the practice can report	The practice, its accountable care organisation, and its plan counterparties	Approximately 447 modeled avoided admissions over 24 months — on the order of $6.7 million at an illustrative $15,000 per admission. Illustrative, modeled — verify against practice data

Two honest limits on this section. First, **the avoided-cost figure does not accrue to the practice's own profit-and-loss statement** in a fee-for-service arrangement — it accrues to whoever carries the risk, which is the hospital, the plan, or the accountable care organisation in which this practice participates. It is presented here as a relationship and total-cost-of-care argument, not as practice revenue, and none of it is included in the $9,161,837 in Section 2.2. Second, the $15,000 per-admission figure is an illustrative round number for sizing, not a local cost estimate. *All figures are illustrative, modeled — verify against practice data.*

6. Procedural, Device and Structural-Heart Throughput

Remote care is usually sold as a chronic-disease programme. In a practice with this procedural profile it is also a throughput and pipeline argument, and the mechanisms are 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**, and a managed census is what keeps a candidate pipeline identified rather than incidental. Everything in the table below is drawn from the practice's own published service list — nothing is inferred, and no volumes are asserted, because no procedural volume data was verified for this account.

Procedural line	What the practice publishes	What the service line adds
Structural heart	Transcatheter aortic valve replacement, transcatheter mitral repair, atrial septal defect and patent foramen ovale closure, left atrial appendage occlusion, cardiac catheterisation and complex coronary intervention	Post-procedure rhythm and blood-pressure monitoring in the 2–15 day window, now billable via 99445; earlier discharge; and structured anticoagulation follow-up after appendage occlusion, which is a scheduled-contact problem more than a clinical one
Electrophysiology and device implant	Pacemaker and defibrillator implantation, defibrillator and pacemaker checks, electrophysiology studies, cardioversion, tilt-table testing, and implantable loop recorders	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)
Advanced cardiac imaging	Cardiac positron emission tomography, cardiac computed tomography, calcium scoring, fractional-flow modelling, transoesophageal echocardiography, multigated acquisition scanning, and **cardiac amyloidosis scanning**	**The amyloidosis pathway is the one that matters here.** A practice that runs it is deliberately identifying a heart-failure phenotype with a specific natural history and a heavy monthly management burden. Finding those patients is the hard part; what follows is exactly what the modeled stack pays for
Ambulatory rhythm monitoring	Holter monitors, event monitors and implantable loop recorders	The patients who wear a rhythm monitor are, by definition, patients someone is worried about. They are a high-yield enrolment pool for physiologic monitoring on the haemodynamic side of the same problem
Vascular and vein	Carotid duplex, peripheral vascular studies, peripheral angiography and intervention, varicose vein treatment and sclerotherapy	Blood-pressure control is the shared lever across the peripheral arterial population, and post-intervention monitoring uses the same infrastructure
Renal denervation	**NOT published as a current capability** — the practice's own interventional and service pages do not list it. Treat it as whitespace and confirm intent directly	**If the practice ever builds toward it, blood-pressure RPM is intrinsic to the pathway** — for candidate identification, for pre-procedure documentation of uncontrolled pressure on maximal therapy, for titration afterwards, and for the evidence CMS national coverage determination 20.40 requires under Coverage with Evidence Development, effective October 28, 2025. In a panel with hypertension at 75.0%, the monitoring infrastructure is worth building whether or not the procedure ever follows
Home-based cardiac rehabilitation	Live: a four-to-eight week course of roughly 36 sessions with live video supervision, monitoring heart rate, electrocardiogram, blood pressure and oxygen saturation	The graduation cliff is the opportunity. A patient finishes rehabilitation in eight weeks and returns to unobserved care; remote physiologic monitoring plus principal care management is the longitudinal layer that catches them

Procedural line	What the practice publishes	What the service line adds
Walk-in immediate cardiac care	A same-day access clinic opened September 17, 2025	A same-day front door generates exactly the acute-symptom encounters a monitored census should be preventing or routing. It is also the most natural enrolment point in the practice for a patient who has just had a scare

The pattern running through that table is worth naming explicitly. In every row, the practice has already done the expensive, difficult part — implanting the device, performing the procedure, running the scan, supervising the rehabilitation course — and the cheap, recurring, monthly layer that follows it is the part that is not yet built. The amyloidosis scan finds the patient; monthly weight, blood pressure, symptom burden, titration and escalation is what happens next. The loop recorder identifies a patient somebody is worried about; physiologic monitoring is the haemodynamic half of the same question. The rehabilitation course monitors a patient intensively for eight weeks and then stops. **Each of those is a handoff from a capital-intensive service the practice already owns into a recurring service it does not yet bill.**

7. athenahealth Integration & Technology Architecture

7.1 What is verified about the platform

Evidence	Finding
Live patient portal	**A practice-branded athenahealth patient portal instance responds successfully, carries the page title "Patient Portal", and contains the practice's brand name in the page body. Verified August 3, 2026**
Portal linked from the practice site	Patient-portal links appear in the global navigation of every page of the practice's website
Practice context identifier	The portal subdomain carries the athenaNet practice identifier, which is how a practice-specific instance is addressed
Telehealth capability	34 of the 43 enrolled clinicians carry the CMS telehealth indicator, though telehealth is not marketed on the website
Technology posture	A named artificial-intelligence cardiovascular laboratory initiative announced in March 2026, and a walk-in immediate cardiac care clinic opened in September 2025 — both evidence of an organisation that adopts rather than defers
Open item — network EHR standardisation	Whether the practice's management-services network plans an enterprise-wide record standardisation is **not established from any public source**. No such programme is published, and the network's stated posture emphasises partner clinical and operational autonomy. An in-flight record migration would be a first-order integration risk for any monitoring deployment and should be asked about directly

The practice's live patient portal and public website, retrieved August 3, 2026; CMS National Downloadable File, file modified June 26, 2026. The caller-provided ambulatory record system is CONFIRMED by direct observation of a live, branded, practice-specific portal instance — this is direct evidence rather than directory inference.

7.2 What the integration does

A confirmed, mainstream ambulatory platform is the easy case, and it should be treated as such rather than as a project. What the integration has to deliver is four things:

1. **One enrolment action inside the record the clinicians already use.** An order placed in the ambulatory chart, not a second system a clinician has to remember to open. Enrolment friction is the largest single determinant of whether the modeled census is reached, and it is almost entirely a design problem rather than a technology one.
2. **Physiologic data written back to the chart.** Readings, trends and alert history visible where the clinician documents, so the monitoring record and the clinical record are one record at the point of decision.
3. **A discharge and encounter feed that triggers the pathway.** The most common failure in a post-discharge programme is not knowing who was discharged yesterday. Across a nine-to-twelve office footprint with admissions concentrated on three hospitals, that feed has to be designed deliberately rather than assumed.
4. **Automated claim generation from the monitoring record.** Time, readings and interventions captured as a by-product of care, converted into claims without a separate manual step (Section 7.3).

7.3 Why automated claim generation matters here specifically

Capture rate — billed divided by eligible — is the metric that quietly decides whether the modeled profit-and-loss statement in Section 2.2 is realised, and it is the metric most often lost. Three features of this account make it especially load-bearing.

Feature of this account	Why it stresses billing capture
43 clinicians across nine to twelve offices in three counties	Manual capture degrades with distribution. Every additional site is another set of local habits, and a code family billed monthly per patient does not survive local habits
Codes with day-count and minute-count conditions	99454 requires 16–30 days of data and 99445 requires 2–15; 99457, 99470 and 99458 are time-threshold codes. Eligibility is a computed property of the monitoring record, not a clinical judgement made at month end
Multiple payment localities across the footprint	Miami-Dade, Broward and Palm Beach service addresses may not price identically. Locality has to be resolved per billing address rather than per practice
A retrospectively assigned accountable care organisation and an overlapping primary-care participant base	The attribution rule — only one practitioner may bill remote physiologic monitoring per patient per 30-day period — has to be enforced at the point of enrolment, not discovered at the point of denial
A Medicare Advantage majority	Different plans may require different documentation, different authorisation, or may not separately pay these codes at all. The system has to be able to segment the census by payer and report on it

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 profit-and-loss statement, its own physician lead, a defined target population, and a first billable enrolment inside 90 days. The modeled funnel is deliberately conservative and bottom-up:

Model input	Value	Note
In-scope Medicare base	28,802	Discovery-stage estimate, derived by scaling a deduplicated fee-for-service panel of roughly 8,800–11,800 for the local payer mix — and set below the bottom of the scaled range. Validate against chart counts
Referring providers	43	The full enrolled roster as of June 26, 2026
Referrals per provider per month	8	With 80% patient acceptance
On-site enrolment specialist	1 (≈80 enrolments / month)	**CoachCare's expense — embedded value, never deducted from practice margin**
RPM eligibility / acceptance	75% (21,602) / 35%	Modeled ceiling 7,561 patients; census 5,417 at month 24 and still climbing
PCM eligibility / acceptance	85% (24,482) / 30%	Modeled ceiling 7,345; census 1,819 at month 24 and still climbing
Monthly attrition	1.5%	Discharge from programme
Revenue basis	Net of an 11% realization discount	Payer mix and collection, as configured in the model
Payer scope	**Medicare fee-for-service only**	**Miami-Dade is 75.2% Medicare Advantage. Every figure in this report prices the whole in-scope panel at the fee schedule locality rate; for the plan majority the actual reimbursement is a contract term, not a fee-schedule fact. Additive, unmodeled, and the first budgeting task (Sections 3.1 and 8.6)**
Payment locality	FL 09102-04, resolved from ZIP 33180	Confirm separately for the Broward and Palm Beach service addresses — Florida is not a single payment locality
Programmes modeled	RPM + PCM only	Chronic care management carried at zero eligibility; transitional care management excluded from every financial figure

Target populations and clinical pathways

Population	Why it is first	Pathway
Heart failure	34.7% of the Medicare panel, a dedicated advanced heart failure sub-specialist on the roster, and cardiac amyloidosis imaging already identifying a phenotype that needs monthly management	Daily weight and blood-pressure monitoring with 24/7 triage; principal care management as the monthly chassis; guideline-directed titration against measured response
Uncontrolled and resistant hypertension	The largest cohort in the panel at 75.0%, and the highest-volume pathway in the model	Blood-pressure monitoring with protocolised titration; candidate identification for any future procedural hypertension pathway (Section 6)

Population	Why it is first	Pathway
Cardiac rehabilitation graduates	A live programme with a defined end date. Every graduate is a patient who has just spent eight weeks being monitored and then stops	Convert the rehabilitation course into a longitudinal monitored census at graduation — the lowest-friction enrolment conversation in the practice
Post-discharge cardiac	Admissions concentrated on three nearby hospitals, and a post-discharge window the practice already owns clinically and does not bill in any figure here	Transitional care management (not modeled) plus short-window RPM via 99445 and 99470, triggered by the discharge feed in Section 7.2
Atrial fibrillation on rate or rhythm control	39.3% of the panel, with anticoagulation follow-up and titration already part of the workflow	Blood-pressure and symptom monitoring; principal care management on the arrhythmia as the single dominant condition
Post-implant, post-ablation and post-structural-heart	A substantial device and structural book, every case of which opens a short window that is now billable	Short-window RPM via 99445, kept explicitly distinct from device interrogation
The rhythm-monitor population	Patients wearing a Holter, event monitor or loop recorder are patients somebody is already worried about — consent and monitoring habits already exist	Attach a connected cuff or scale to an already-monitored patient; physiologic monitoring documented as a distinct benefit over distinct data
The multi-site and Broward / Palm Beach panel	Offices across three counties where an in-person enrolment conversation is least likely to happen on any given day	Telephonic enrolment as a primary pathway rather than a fallback; shipped devices; monthly management without a drive

8.2 Staffing: nobody has to be hired

The model delivers **71,366 care-team hours over 24 months — approximately 34.3 full-time equivalents** — supplied by the partner under the practice's protocols and clinical supervision, alongside 321,429 care-management tasks, 80,357 chart updates, 48,214 patient conversations and 2,679 hours of call time. **The on-site enrolment specialist is funded by CoachCare: embedded value, never deducted from the practice's margin, and never a practice cost line.** That matters more in this account than the raw number suggests, because the practice operates across nine to twelve offices in three counties, and an enrolment engine that depends on existing front-desk capacity at each of them would not reach the modeled census.

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

8.3 The completeness test: what turns a platform into a billed service line

Selecting a technology platform and operating a fully-billed service line are different achievements, and the gap between them is where most remote-care programmes underperform their business case. The test below is written to be applied to *any* option — an existing arrangement, a network-level arrangement, or this one. It is a checklist rather than a comparison, and the right way to use it is to walk it row by row against whatever is in place today.

Requirement	Why it decides the outcome	How to test it
Enrolment labour physically present	Census is revenue, and census is built by a human having a conversation. A portal invitation, a mailer or a clinic-staff task added to an existing workload does not produce the modeled enrolment rate	Ask how many enrolments per month, by whom, physically located where, across how many of the offices — and who pays for that person

Requirement	Why it decides the outcome	How to test it
The complete billing stack, not one code family	A programme that bills 99454 and stops leaves 99453, 99445, 99457, 99470, 99458 and the whole of 99424–99427 on the table. The modeled economics in Section 2.2 assume the full stack is captured	Ask for a code-level capture report: billed units by code, by month, against eligible patient-months
Clinical governance owned by this practice	Alert thresholds set by vendor defaults rather than by the practice's own physician lead produce either alarm fatigue or missed deterioration. Escalation has to end with a named clinician in this practice	Ask who sets the thresholds, who receives the escalation, what the response-time standard is, and what happens at 2 a.m. on a Sunday
Documentation that survives an audit	These are time-based and day-count-based codes. Documentation that cannot evidence the minutes and the days is a recoupment risk, not a revenue line	Ask to see a de-identified example of the record generated for a single billed patient-month
Automated claim generation	Manual capture degrades across 43 clinicians and a dozen sites, and it degrades silently (Section 7.3)	Ask whether claims are generated from the monitoring record or assembled by a person at month end
Structured reporting back to referring physicians	It is the referral-retention artifact and the attribution-policy enforcement mechanism at the same time (Sections 2.1 and 5)	Ask what the referring physician receives, in what format, and how often
Payer segmentation and reporting	In a 75.2% Medicare Advantage county, a census that cannot be segmented by payer cannot be managed or forecast	Ask for the census and capture report broken out by payer type
The professional fee lands on this practice's statement	**This one is true under any arrangement** — remote monitoring, principal care management and transitional care management are physician professional services billed under the practice's own tax identification number. It is worth confirming explicitly nonetheless, because it is the row that determines whose profit-and-loss statement the programme improves	Confirm the billing entity, the supervising-physician arrangement and the revenue flow in writing

The reason to run this test rather than a feature comparison is that every row of it is an operational commitment rather than a software capability. Software is not usually the reason a remote-care forecast is missed; enrolment throughput, incomplete code capture and documentation quality are. A practice that walks this checklist before committing will get a better programme regardless of which way the decision goes.

8.4 Clinical workflow

1. **Identify.** Heart failure, uncontrolled and resistant hypertension, atrial fibrillation on rate or rhythm control, cardiac rehabilitation graduates, post-discharge and post-procedure. Seeded by the rhythm-monitor and rehabilitation populations and by the discharge feed from the three principal admitting hospitals.
2. **Enroll.** One order in the ambulatory record. Consent, device selection and logistics handled by the partner; the on-site enrolment specialist covers the offices in rotation, with a telephonic pathway carrying the Broward and Palm Beach panel.
3. **Monitor.** Daily physiologic data with 24/7 review and alert triage against thresholds the practice's 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. The walk-in immediate care clinic

is a natural same-day landing point for escalations that need to be seen. This is where the 447 modeled avoided admissions actually come from.

5. **Titrate.** Guideline-directed therapy adjusted against measured response on a schedule, with principal care management 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 7.3).
7. **Report back.** Structured monthly reporting to the referring physician and, where relevant, to the discharging hospital — good practice, a referral-retention mechanism, and the artifact that keeps the attribution policy honest where the accountable care organisation's primary-care participants share 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 practice's hospital partners carry consequences on and the one that most directly demonstrates the value of the programme to them
Operational	Enrolled census by programme; enrolment conversion rate; device compliance (days with data); alert-to-contact time; enrolments per office	Census is revenue. Days-with-data is what makes 99454 and 99445 billable in the first place. Enrolments per office is the metric that catches a multi-site programme drifting into a single-site one
Transitions	Post-discharge reach rate within two business days, reported by hospital; time from discharge to first physiologic reading	The measure that tells you whether the discharge feed in Section 7.2 was actually closed, reported per hospital so it can be acted on with each referral partner
Financial	Time to first billable enrolment; capture rate (billed ÷ eligible), by code; net reimbursement per patient per month; net to practice; census by payer type	Modeled at ~$104.01 per RPM patient-month and ~$97.45 per PCM patient-month. Capture rate is the metric that quietly decides whether the modeled profit-and-loss statement is realised, and payer segmentation is what makes the Medicare Advantage question answerable

Expected impact over 24 months, as modeled: $9,161,837 of net reimbursement and $3,880,456 net to the practice at a 42.35% margin; 5,962 unique patients and 7,236 active programme enrolments at month 24; 703,597 physiologic readings; 160,714 billed units; approximately 447 avoided hospitalizations; and 71,366 care-team hours delivered. *All figures are illustrative, modeled — verify against practice data.*

8.6 Twelve-month roadmap

Phase	Months	What happens
Establish the facts	0–1	Answer the first discovery question — what “Remote Patient Monitoring Services” currently means at this practice (Section 4.3). Commission the Medicare Advantage contract review. Confirm the payment locality for every service address. Run the completeness checklist in Section 8.3 against whatever is in place today
Charter	1–2	Physician lead named; service line chartered with its own profit-and-loss statement; target populations agreed; attribution policy written before the first enrolment

Phase	Months	What happens
Stand up	1–3	Ambulatory record integration built; the discharge feed from the three principal admitting hospitals designed and tested — this is the long pole, not the connector; alert thresholds and escalation protocol set by the physician lead; on-site enrolment specialist placed and the office rotation set
First census	2–6	Heart failure, hypertension and cardiac rehabilitation graduates enrolled first; first billable enrolment inside 90 days; the model shows the programme net-positive from month 1
Extend	6–9	Atrial fibrillation, post-discharge, post-implant and post-structural-heart pathways added; telephonic enrolment opened across the Broward and Palm Beach panel. Both arms are pace-limited rather than eligibility-limited, so added enrolment capacity converts directly into census (Section 2.2)
Institutionalise	9–12	Monthly scorecard running; capture rate reported by code and by payer type; post-discharge reach rate reported by hospital and shared with each referral partner; readmission delta against the unenrolled panel measured; the transitional care management decision taken on its own merits

References & Data Sources

- **CMS National Downloadable File — Doctors and Clinicians / PECOS** (file modified June 26, 2026; retrieved August 3, 2026): the enrolled organization CARDIOVASCULAR MEDICINE ASSOCIATES, P.A., organizational PAC identifier 5991609992, 43 enrolled members, the 37-physician / 6-advanced-practice composition, the specialty mix including one advanced heart failure and transplant cardiologist, the nine practice addresses, the telehealth indicator on 34 of 43 clinicians, the reassignment structure described in Section 1.1, and the separate 661-member health-system physician organization enrolled at the same street address under which no clinician from this practice appears.
- **CMS Medicare Physician & Other Practitioners — by Provider, CY2024** (file MUP_PHY_R26_P05_V10_D24_Prov, dataset modified May 21, 2026, coverage through December 31, 2024; retrieved August 3, 2026): total Medicare allowed amount of $12,573,399 and total payment of $9,633,444 summed across the 37 roster identifiers with records; 21,159 beneficiary-provider pairs; mean beneficiary age 77.6; and the beneficiary-weighted chronic-condition prevalences in Section 4.1. Note the approximately 18-month claims lag.
- **CMS Medicare Monthly Enrollment** (CY2025 annual figures, dataset modified July 23, 2026; retrieved August 3, 2026): total, fee-for-service, Medicare Advantage and dual-eligible counts for Miami-Dade, Broward and Palm Beach counties, and the Florida and national benchmarks in Section 3.1.
- **CMS Medicare Shared Savings Program — PY2026 Participants and Organizations files** (datasets modified February 4, 2026 and April 16, 2026; retrieved August 3, 2026): the single participant-legal-name match across all 15,370 participant rows; the accountable care organisation's July 1, 2012 start date, Enhanced track, low-revenue classification, retrospective assignment, skilled nursing facility three-day rule waiver, 823 participant tax identification numbers and six-state service area; and the confirmation that this practice is not a participant in the accountable care organisation operated by the health system on whose campus its main office sits.
- **CMS Hospital General Information** (dataset modified April 28, 2026): CCN 100154, CCN 100008 and CCN 100168, all confirmed as acute-care, voluntary non-profit, private hospitals.
- **The CMS mandatory-model participant files** — the clinician-level specialty file and the hospital-level file, both retrieved August 3, 2026. Each was queried in full for this account: by exact identifier across all 43 roster identifiers, by organization-name regular expression across every row without any state filter, and by core-based statistical area. **Neither returned any match attributable to this practice, to its enrolled organization or to its principal admitting hospitals**, so no mandatory CMS model applies to this account and none is discussed anywhere in this report. Both files are refreshed periodically and both queries should be re-run at each refresh.
- **The practice's own website** (retrieved August 3, 2026): the office list, the published cardiovascular service list used in Section 6 — structural heart, electrophysiology, advanced imaging including cardiac amyloidosis scanning, ambulatory rhythm monitoring, and vascular and vein services — the home-based cardiac rehabilitation programme description, the women's cardiovascular sub-brand, the walk-in immediate cardiac care clinic opened September 17, 2025, the artificial-intelligence cardiovascular laboratory announcement of March 26, 2026, the practice history from 1960 and the 2007 relocation, and the single unelaborated “Remote Patient Monitoring Services” line item whose dedicated page returns a not-found error.
- **The practice's live patient portal** (retrieved August 3, 2026): a practice-branded athenahealth portal instance responding successfully with the practice's brand name in the page body — direct confirmation of the ambulatory record platform.
- **Trade coverage of the April 18, 2023 network transaction** and the management-services network's own published materials (retrieved August 3, 2026): the merger that brought this practice

into its current network, the practice's own self-identification as a network practice, network-level partnerships in prior authorisation automation, value-based care operations tooling and home-based cardiac rehabilitation, and the announced Medicare Advantage value-based cardiac care collaboration referenced in Section 3.1. Two different network scale figures are published in different places; neither is cited as fact anywhere in this report.

- **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 practice is modeled under Florida locality 09102-04. CY2027 rulemaking is in progress.
- **CMS national coverage determination 20.40,** renal denervation for uncontrolled hypertension, effective October 28, 2025 under Coverage with Evidence Development — referenced in Section 6 only in relation to a capability this practice does not currently publish.
- **CoachCare Value Analysis companion model —** all modeled economics, clinical and operational forecasts in Sections 2.2, 5 and 8, including the 28,802-patient in-scope base, 75% / 85% RPM / PCM eligibility, 35% / 30% acceptance, 1.5% monthly attrition, an 11% realization discount, the 43-provider referral engine at eight referrals per provider per month with 80% acceptance, one on-site enrolment specialist at CoachCare's expense, and MAC-locality rates auto-resolved for ZIP 33180 (Florida, locality 09102-04).

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.

- **What “Remote Patient Monitoring Services” currently means at this practice.** The phrase appears on the practice's own services page with no dedicated page, no workflow, no conditions, no devices, no vendor and no enrolment path behind it, and no claim-level screen of the practice's CY2024 service record was run for this account. Cardiac device monitoring, ambulatory rhythm monitoring and physiologic monitoring under the 99453 family are three different services. *This is the single most important thing to ask directly, and every other conclusion in this report is downstream of the answer.*
- **Medicare Advantage contracting.** With roughly three quarters of the Miami-Dade Medicare population in a plan, the plan book is the larger opportunity and it is entirely undocumented publicly — which plans, at what rates relative to the fee schedule, whether remote monitoring and care management are separately payable at all, and whether any part of the panel is delegated or capitated such that these services are already inside someone else's risk arrangement. **Every financial figure in this report is a fee-for-service figure and should be read as the fee-for-service case only.**
- **Whether the announced network-level Medicare Advantage collaboration covers this practice.** The practice's management-services network has published a value-based cardiac care collaboration with a national carrier. The states in scope are described only as “multiple”, this market is not explicitly named, and the risk structure is not disclosed. Whether this practice is in scope is not established either way.
- **Where the remote-care decision right sits.** Practice leadership, the management-services network, or both jointly — this is not determinable from public sources and it determines the engagement model. The network has made enterprise-level technology decisions in other domains, and the practice has a documented history of operating network programmes locally, which is consistent with either answer.
- **Chronic care management activity today.** No evidence either way was found in any public source, and no claim-level screen was run.

- **Cardiac device clinic volume and remote-monitoring vendor.** The practice implants pacemakers and defibrillators and offers implantable loop recorders, so remote device-monitoring volume necessarily exists, but no vendor, workflow or volume is documented publicly. This matters because it determines the boundary rule in Section 2.1.
- **Procedural volumes.** The structural heart, electrophysiology, imaging and vascular capabilities in Section 6 are taken from the practice's own published service list. **No procedural volume of any kind is asserted anywhere in this report, because none was verified.**
- **Care-coordinator and monitoring staffing.** Job-posting research was not completed within the research budget for this account. Absence of a found posting is not evidence of absence.
- **The referral-share percentages.** The 39% / 30% / 9% split across the three admitting hospitals comes from a caller-provided commercial firmographic export of unknown vintage and was not independently verified. The hospitals and their CCNs are verified; the shares are not.
- **The specific readmission-penalty status of each admitting hospital.** The Hospital Readmissions Reduction Program mechanism described in Section 5 is general policy. No hospital-specific penalty status was pulled for this report and none should be assumed.
- **True unique-patient panel size and payer mix.** A unique-patient denominator cannot be derived from the public CMS files, which report beneficiary-provider pairs and contain duplication. The modeled 28,802 is a discovery-stage estimate built by scaling a deduplicated fee-for-service panel for the local payer mix, and it is set below the bottom of the scaled range. Commercial and Medicaid volume is additive to every figure in this report.
- **Payment locality for the Broward and Palm Beach service addresses.** The model resolves a single Miami-Dade locality from the ZIP code supplied. Florida is not a single payment locality and the assignment should be confirmed per billing address.
- **Whether a network-wide ambulatory record standardisation is planned.** The practice's own platform is confirmed live and branded as of August 3, 2026. No enterprise standardisation programme is published, but an in-flight migration would be a first-order integration risk and should be asked about directly.
- **The corporate register record.** The Florida corporate register blocked automated retrieval, so officers, registered agent, entity status, formation date and any name-change filings were not read from the primary record. Nothing in this report depends on them.
- **Litigation and regulatory history.** No docket or court-records search was performed. Absence of evidence only.
- **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 facts to check against CMS.

Global verification caveat

Facts in this report reflect public sources current to August 2026 and are cited above. Items flagged “estimate,” “reported,” “not established,” “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 Florida locality files, and note that CY2027 rulemaking is in progress. **Every modeled figure in this report is a Medicare fee-for-service figure priced at MAC locality 09102-04. Miami-Dade County is 75.2% Medicare Advantage, and for that majority the reimbursement for these code families is set by plan contract rather than by the fee schedule; Medicare Advantage, commercial and Medicaid volume is additive and unpriced.** No procedural volume, rating, patient-satisfaction score or programme-performance result is asserted anywhere in this document. All Value Analysis outputs are illustrative, modeled — verify against practice data.

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