COACHCARE | SERVICE LINE STRATEGY

Florida Cardiovascular Partners

Stuart, Port St. Lucie, Tradition, Vero Beach, Sebastian, Jupiter and Palm Beach Gardens, Florida — a seven-site cardiovascular group across Martin, St. Lucie, Indian River and Palm Beach counties, rebranded from Stuart Cardiology Group in December 2025

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) as depth underneath programmes the practice already runs — sized against two-sided downside risk in an ENHANCED-track accountable care organization, a CY2027 specialty-model designation on a preliminary list, and a margin-positive standalone P&L billed under the practice's own TIN

Purpose of this document

Prepared by CoachCare, August 2026, as a discussion document for the physician leadership of Florida Cardiovascular Partners. It is written from an unusual starting point for a report of this kind: the practice already operates a remote patient monitoring programme and a chronic care management programme, both publicly marketed on their own service pages. This is therefore not a whitespace argument. It is a depth, completeness and scale argument, and it is made without disparaging what is already in place.

The document assembles the practice's public footprint, its verified accountable-care and specialty-model position from CMS primary files, the 2026–2027 payment environment, and a modeled financial forecast into a single question: who owns the month between visits across seven sites and four counties, how completely is that work billed today, and what is the downside exposure if the answer is “partially”.

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 the Stuart headquarters ZIP 34996 — Florida, locality 09102-03) — verify against practice data before budgeting.

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

Table of Contents

Executive Summary

Florida Cardiovascular Partners is a seven-site cardiovascular group headquartered at 1001 SE Monterey Commons Boulevard in Stuart, with offices in Port St. Lucie, Tradition, Vero Beach, Sebastian, Jupiter and Palm Beach Gardens — a footprint spanning **four counties and three core-based statistical areas** along the Treasure Coast and into northern Palm Beach County. Counted from the practice's own provider pages, the group runs **25 physicians — 24 cardiologists and one vascular specialist — alongside 15 advanced practice providers, 40 clinicians in total**, with roughly 190 employees.[1] It bills under its own organizational National Provider Identifier and its own legal entity, **STUART CARDIOLOGY GROUP LLC**, which carries “Florida Cardiovascular Partners” and “FLCVP” as registered doing-business-as names; the practice rebranded on **December 1, 2025** and grew from two sites to its current footprint after a 2023 partnership with an organisation its own materials style “USHP”.[2]

Five facts define this report. Four of them come from public CMS files, and the fifth comes from the practice's own website.

1. **This is not a whitespace account, and the report is written accordingly.** The practice already operates **both a remote patient monitoring programme and a chronic care management programme**, each with its own dedicated public service page. The monitoring programme ships a complimentary cellular blood-pressure monitor direct to the patient's home, preconfigured — its own page states that no smartphone, Wi-Fi connection or mobile application is required — with automatic transmission of readings and access to a dedicated remote nurse. The care-management programme is branded “Connected Care” and runs by phone and text with a dedicated care manager and no app or portal login. The monitoring programme's own frequently-asked-questions page names **congestive heart failure** as a qualifying population.[3] Everything that follows treats those programmes as real and as an asset, and asks a narrower question: how deep, how complete, and how completely billed.
2. **The sharpest economic fact is downside risk, and it is verified.** CMS's Accountable Care Organization Participants file lists the practice's billing entity as a participant taxpayer identification number in **PBACO Holding, LLC (ACO A1001)**, a physician-led Medicare Shared Savings Program organization in its **fourth agreement period** with **822 participant taxpayer identification numbers** — and on the **ENHANCED track, which carries two-sided downside risk**.[4] **A widely used commercial firmographic file records a different, incorrect accountable care organization for this practice**; the CMS file is the authority and Section 3.1 sets out the correction. Downside risk changes the arithmetic of this entire conversation: avoidable admissions, readmissions and emergency department visits land on a shared-savings P&L directly, not merely as foregone upside.
3. **Two of the group's physicians are named on the CMS preliminary CY2027 participant list for the Ambulatory Specialty Model — under the pre-acquisition legal entities of the Vero Beach**

[1] The practice's own website, retrieved August 3, 2026: individual profile pages under its cardiologist, vascular-specialist and advanced-practice-provider sections, counted directly, giving 24 cardiologists plus one vascular specialist (25 physicians) and 15 advanced practice providers. Location addresses and counties are read from each location page's structured data. Employee headcount of 190 is the practice's own figure from its December 1, 2025 rebrand announcement. Organizational National Provider Identifier 1871603332, the STUART CARDIOLOGY GROUP LLC legal name, the two registered doing-business-as names and the December 15, 2025 record update are from the NPPES NPI Registry, queried the same day.

[2] The practice's rebrand announcement, published on its own blog December 1, 2025: the 2023 partnership with the organisation the practice abbreviates USHP, the rebrand date, and growth from two locations and 80 employees to its current footprint. This is the practice's own account of itself and is cited as such.

[3] The practice's dedicated remote patient monitoring and chronic care management service pages, retrieved August 3, 2026. Programme attributes quoted in the Executive Summary and in Section 5.1 are read from those pages. The naming of congestive heart failure as a qualifying population, and the Medicare-coverage and patient cost-share language, appear on the monitoring programme's own frequently-asked-questions section.

[4] CMS Medicare Shared Savings Program Accountable Care Organization Participants public-use file, 15,329 of 15,370 rows retrieved (99.7%), queried August 3, 2026. Exact match on the practice's legal name as a participant taxpayer identification number: ACO A1001, PBACO Holding, LLC; ENHANCED_Track = 1 and BASIC_Track = 0; agreement period 4; 822 participant taxpayer identification numbers on the same organization identifier.

and Sebastian sites, not under the group's own billing entity. Both are in the **Heart Failure** cohort, both flagged as small practice. The group's own entity, STUART CARDIOLOGY GROUP LLC, **returns zero rows in that file**.[5] **The check is complete for 19 of the 25 physicians**; six could not be resolved to a National Provider Identifier and remain open. **This is a preliminary list, and it is a live, checkable question rather than a settled obligation** — Section 3.2 states the caveat in full and Section 7 sets out why it is worth a conversation either way.

4. **The footprint spans four counties and three statistical areas, and the model is priced off one ZIP.** The Value Analysis auto-resolves Medicare Administrative Contractor locality **Florida 09102-03 from the Stuart headquarters ZIP 34996**. Seven active locations sit across Martin, St. Lucie, Indian River and Palm Beach counties and three core-based statistical areas.[6] **Locality assignment should be confirmed site by site before any figure in this report is budgeted**, and enrolment operations should be designed for a geography roughly seventy miles end to end rather than for a single campus.
5. **The standalone P&L is strong, and it is net-positive in month one.** The companion Value Analysis models RPM and PCM only, on an in-scope base of **26,035 patients across 40 referring clinicians**, and projects **$8,352,391 of net reimbursement and $3,532,751 net to the practice over 24 months at a 42.30% practice margin**, with **month 1 modeled at $1,578 of practice profit — the first profitable month is month 1**. *All figures are illustrative, modeled — verify against practice data.*

The central argument

1. Standalone value. TCM + RPM + PCM is recurring, subscription-like professional-fee revenue delivered at top-of-license staffing, margin-positive before any value-based upside — modeled at **$8,352,391** of net reimbursement and **$3,532,751** net to the practice over 24 months, a **42.30% practice margin** (net to the practice ÷ net reimbursement). Illustrative, modeled — verify against practice data.

2. Connective tissue. One shared engine — enrollment, connected devices, 24/7 alerting and triage, nurse navigation, billing capture and analytics — simultaneously serves the group's ENHANCED-track downside exposure, the CY2027 specialty-model question, the post-discharge window across three admitting hospitals, procedural and device throughput, and the standalone P&L. Build once, use everywhere.

The strategic reading of this account is that it is unusually active, and that activity cuts both ways. Since 2023 the practice has grown from two locations to seven, roughly doubled and redoubled its headcount, opened a new ambulatory surgery centre in Port St. Lucie and installed in-office positron-emission-tomography imaging — capital deployed explicitly to bring hospital-level capability into the outpatient setting.[7] An organisation moving that fast has budget, decision-making cadence and appetite. It also has integration debt: two of its sites arrived carrying their own pre-acquisition legal entities, and at least one of those entities is still the identity under which CMS is naming a physician to a specialty model. **A practice that has grown this quickly is exactly the kind that discovers its programme inventory is not uniform across its sites.** That is the discovery question this report is built around, and it is asked in good faith rather than rhetorically.

[5] CMS Ambulatory Specialty Model Participants, CY2027 PRELIMINARY participant file; dataset modified February 4, 2026; retrieved August 3, 2026. Two Heart Failure cohort rows matched the group's physician identifiers, both under pre-acquisition legal entities corresponding to the Vero Beach and Sebastian sites; the group's own billing entity returns zero rows. Nineteen of the group's 25 physicians were resolved to a National Provider Identifier and tested; six could not be resolved. Note 19 sets out the query method in full.

[6] Location addresses and counties from each location page's structured data (retrieved August 3, 2026); statistical-area assignment is this report's mapping from county and should be confirmed. The MAC locality is auto-resolved by the CoachCare Value Analysis from the Stuart headquarters ZIP 34996 to Florida locality 09102-03.

[7] The practice's December 1, 2025 rebrand announcement together with its imaging-technology page (retrieved August 3, 2026), for the growth from two locations to eight claimed, the 80-to-190 employee figure, the new Port St. Lucie ambulatory surgery centre and the positron-emission-tomography installation at the Stuart headquarters. Seven locations are verifiable from the practice's own location pages; eight is the announcement's figure.

One structural caution belongs at the top, because it decides whether this account is winnable at all. The practice describes itself on every page as part of a national clinician network it abbreviates "USHP", and its careers page routes hiring to that organisation rather than to the practice. **The corporate identity behind that abbreviation could not be resolved from any public source** — the obvious domain does not resolve to a working corporate site, and one frequently assumed candidate was tested and ruled out, because this practice does not appear on that company's own published partner-practice list.[8] **No sponsor is named or implied anywhere in this report, because none could be identified.** The commercial consequence is concrete rather than academic: if remote monitoring and care management were standardised above the practice, the buying unit is not the practice. *Establishing where that decision sits is the first qualification question in this account, ahead of any pricing conversation.*

The timing is favourable for a specific and checkable reason. The CY2026 Physician Fee Schedule expanded remote monitoring in ways that suit this practice's shortest and highest-value windows. **99445** pays the monthly device-supply amount for 2–15 days of data where 16 or more were previously required, and **99470** pays for the first 10 minutes of monthly management time where the floor had been 20. Together they convert the days after a cardiac discharge and the days after a device implant from unfunded care into billable events — windows a programme designed around 16-day thresholds would have had no way to bill. The specialty model's first performance year opens **January 1, 2027**. A service line chartered in late 2026 is operating at census before that clock starts.

The companion CoachCare Value Analysis sizes the opportunity on an estimated **26,035-patient in-scope base across 40 referring clinicians** — *a discovery-stage estimate to validate against the practice's own chart counts* — with RPM and PCM only. It projects net reimbursement of **$2,052,080** in Year 1 and **$6,300,311** in Year 2 (**$8,352,391** over 24 months — RPM $6,346,757, PCM $2,005,635); **$3,532,751** net to the practice after CoachCare fees; 662,476 physiologic readings; approximately **421 avoided hospitalizations**; and 67,354 care-team hours delivered, about **32.4 full-time equivalents** of clinical labour the practice does not have to hire. **Month 1 is modeled at $1,578 of practice profit and every month thereafter is larger**. *All figures are illustrative, modeled — verify against practice data.*

2026–2027 Priority Recommendations

1. **Establish where the remote-care decision sits before anything else.** The practice, or the organisation above it. If monitoring and care management were standardised at network level, the practice may not be the buying unit and every subsequent step changes. This is a single question and it can be answered in one conversation (Sections 1.2 and 5.3).
2. **Audit the existing programmes for billing completeness, not for existence.** Enrolled census, code mix, and specifically whether the time-tier and add-on rungs — 99457, 99458, 99470 and the PCM 99424–99427 family — are being captured, or only the device-supply base. The classic failure mode in a nurse-delivered monitoring programme is billing the base rungs and leaving the management-time rungs on the table (Section 5.2).
3. **Treat the ENHANCED-track position as the primary business case.** Two-sided downside risk means avoidable utilization is a direct charge against the shared-savings P&L. Quantify the practice's own attributed population inside the accountable care organization, and size the readmission and avoidable-admission exposure before sizing anything else (Section 6).
4. **Resolve the specialty-model TIN question, in writing.** Two physicians are named on a **preliminary** CY2027 list under the pre-acquisition legal entities of two sites. Establish which taxpayer identification number each is billing under today, whether the legacy entities remain

[8] The practice's site footer and careers page (retrieved August 3, 2026) carry the parent abbreviation on every page; the site never spells it out beyond the rebrand announcement and carries no outbound link to a parent site. The obvious corporate domain fails certificate validation, its certificate covering an unrelated hostname. A well-known cardiovascular platform company with a similar abbreviation publishes a partner-practice list of 16 practices, none in Florida and none of them this one - a decisive negative test, and the reason no sponsor is named anywhere in this report.

active, and diarise a re-check against the final CMS list. Both possible answers carry work (Section 7).

5. **Close the coverage gap on the six unresolved physicians.** Nineteen of 25 physicians were resolved to a National Provider Identifier and checked; six were not. That is a thirty-minute internal exercise for the practice and it either closes the specialty-model question or opens it wider (Section 3.2).
6. **Confirm MAC locality site by site.** The model prices off the Stuart headquarters ZIP. Seven sites across four counties and three statistical areas may not all price identically, and the difference is real money at this census (Section 3.4).
7. **Write the attribution policy before the next enrollment, not after the next denial.** Only one practitioner may bill remote physiologic monitoring for a given patient in any 30-day period. With an existing programme already enrolling patients and referring primary-care physicians managing the same people, this is a live operational risk today, independent of anything in this report (Section 2.1).
8. **Separate device interrogation from physiologic monitoring explicitly.** The group implants pacemakers, generators and loop recorders and runs an electrophysiology service, so remote device interrogation is near-certain in practice — but it is a different benefit over different data than patient physiologic monitoring, and the boundary has to be documented rather than assumed (Sections 9 and 11.3).

1. Footprint & Operating Model

1.1 The practice

The legal entity is **STUART CARDIOLOGY GROUP LLC**, enumerated under organizational National Provider Identifier 1871603332 with a primary taxonomy of internal medicine, cardiovascular disease. The registry carries two doing-business-as names — **"Florida Cardiovascular Partners" and "FLCVP"** — and the record was last updated on December 15, 2025, two weeks after the public rebrand.[9] That gap between legal name and trade name matters more than it sounds: an account like this is findable in CMS model and accountable-care files only under the legal name, and a search run on the brand returns nothing. Every CMS determination in this report was run against the legal name, and Section 3.2 shows what happens when a practice's own sites still carry other legal names entirely.

A note on entity form, stated as an open item rather than glossed over. The practice's patient-portal tenant slug and at least one state corporate-registry result reference a **professional association** form of the Stuart Cardiology Group name, while both the CMS provider registry and the CMS accountable-care file carry the **limited liability company** form. A conversion, or parallel entities, is the likely explanation and it is **unverified** — the state registry was gated behind an automated-access challenge that was not bypassed during research. It is listed among the open items rather than asserted.

Location	County	Statistical area	Note
Stuart — Monterey Commons (headquarters)	**Martin**	**Port St. Lucie**	**1001 SE Monterey Commons Blvd, Suite 300 — the address the model's MAC locality resolves from, and the address a commercial firmographic file matches exactly**
Tradition	St. Lucie	Port St. Lucie	11380 SW Village Parkway, Suite 300
Port St. Lucie	St. Lucie	Port St. Lucie	370 SE Veranda Falls Way, Suite 202
Vero Beach	**Indian River**	**Sebastian–Vero Beach**	**1355 37th Street, Suite 303 — one of the two sites carrying a pre-acquisition legal entity in the CMS specialty-model file (Section 3.2)**
Sebastian	**Indian River**	**Sebastian–Vero Beach**	**13885 US Highway 1 — the second such site**
Jupiter	Palm Beach	Miami–Fort Lauderdale–West Palm Beach	500 University Blvd, Suite 116
Palm Beach Gardens	Palm Beach	Miami–Fort Lauderdale–West Palm Beach	4750 East Park Drive, Suite 100
Stuart — Ocean Blvd	*Martin*	*Port St. Lucie*	*Relocated into the Monterey Commons headquarters in July 2026 per a site-wide banner, but still hyperlinked from the monitoring programme page — treat "eight locations" as marketing carryover and seven as the verifiable active count*

Addresses and counties read from each location page's structured data, retrieved August 3, 2026. A commercial firmographic file reports six locations and a single county; both are stale. Statistical-area assignment is this report's mapping from county, and should be confirmed before any locality-sensitive figure is budgeted.

Roster, counted from the practice's own pages. Individual profile pages resolve to **24 cardiologists and one vascular specialist — 25 physicians** — alongside **15 advanced practice providers** holding nurse-practitioner, physician-assistant and doctor-of-nursing-practice credentials, for **40 clinicians in**

[9] NPPES NPI Registry, queried August 3, 2026: organizational National Provider Identifier 1871603332, legal name STUART CARDIOLOGY GROUP LLC, an internal-medicine cardiovascular-disease primary taxonomy, two other-name records of type Doing Business As carrying the trade name and its abbreviation, and a record last updated December 15, 2025 with the same certification date.

total. That count is the referral engine the financial model is built on. A commercial firmographic file reports 24 physicians and 29 group-practice members; the physician figure is close, the member figure understates the advanced-practice layer materially.[10] Confirmed sub-specialty depth includes **interventional cardiology and clinical cardiac electrophysiology**, with the remainder in general cardiovascular disease. **No heart-failure-specific taxonomy appears on any resolved identifier**, and heart failure is not a named service line on the practice's website — which is worth holding in mind against Section 3.2.

What is visibly absent from the leadership picture, stated as a gap rather than a criticism. No non-physician executive function — chief operating, chief financial or chief administrative — is identifiable in any public source for this practice. The documented senior roles are physician roles: a divisional medical director who is also the authorized official of the billing entity, and a site medical director at Vero Beach. A commercial firmographic file records a chief executive title that no primary source supports.[11] **The phrase "Florida Division" in the documented title is itself informative**: it implies a parent with divisional structure, and it implies that this practice is not where an enterprise chief executive sits. For a programme that needs an operational owner, that is a real design constraint and Section 11.2 answers it directly.

1.2 The operating model: sponsor-backed, multi-county, and still its own billing entity

Two things are true at once here, and neither cancels the other. **The practice bills as itself**: its own organizational identifier, its own legal entity, its own taxpayer identification number listed independently in the CMS accountable-care file, and referral relationships across three competing hospitals rather than employment by any one of them. At the same time, **it is not an independent practice in the ownership sense and has not been since 2023**. Its own rebrand announcement describes a 2023 partnership with an organisation it abbreviates "USHP"; that organisation's name appears in the site footer on every page and on the careers page header, and hiring is routed to it rather than run locally.[12]

[10] Counted from the practice's own provider profile pages, retrieved August 3, 2026: 24 cardiologist pages, one vascular-specialist page and 15 advanced-practice-provider pages. Sub-specialty depth is taken from the primary taxonomies on the 19 resolved physician identifiers in the NPPES registry, queried the same day. The comparison figures of 24 physicians and 29 group-practice members are from a caller-supplied commercial firmographic export of unknown vintage. Directory aggregators were not used as evidence for practice size or staffing anywhere in this report.

[11] The practice's rebrand announcement and provider biography pages (retrieved August 3, 2026) for the documented divisional-medical-director and site-medical-director roles, and the NPPES record for the authorized-official title on the billing entity. A commercial firmographic export records a chief-executive title that no primary source supports. No individual is named anywhere in this report; roles are described in the aggregate.

[12] The practice's rebrand announcement (December 1, 2025), its site footer, which carries the parent abbreviation on every page, and its careers page, whose header routes hiring to that organisation rather than to the practice and which contains no job listings and no applicant-tracking embed. Retrieved August 3, 2026.

What could not be identified, and why it matters commercially

The sponsor is unidentified, and this report names none. The practice never spells the abbreviation out beyond its own announcement, carries no outbound link to a parent site, and the obvious corporate domain does not resolve to a working site — its certificate covers an unrelated hostname entirely. The only independent corroboration that the abbreviation is real branding rather than a typo is the practice's own content-management host, whose name encodes the abbreviation alongside the practice's initials.[13]

One frequently assumed candidate was tested and ruled out. A well-known cardiovascular platform company with a similar-sounding abbreviation publishes its own partner-practice list. **This practice does not appear on it**, and none of the practices on it are in Florida. That is a decisive negative test on the one check that could be run, and it is why no private-equity sponsor, no parent company and no capital source is named or implied anywhere in this document.

Why this is the first qualification question rather than a footnote. If remote monitoring and care management were selected and standardised at network level, the practice is not the buying unit — and the correct next conversation is with a different organisation entirely. If they were selected locally, the practice is the buying unit and everything in this report applies as written. *Both outcomes are workable; being wrong about which one is true is not.*

The growth record is the strongest signal in the account, and it is the practice's own account of itself. From 2023 to the December 2025 rebrand: **two locations to eight claimed** (seven verifiable), **80 employees to 190**, expansion into two additional counties, a new ambulatory surgery centre in Port St. Lucie, and a new in-office positron-emission-tomography scanner at the Stuart headquarters.[14] Read that as an operating posture rather than as a fact sheet: this is an organisation that deploys capital into ancillary and outpatient capacity, consolidates sites, and rebrands around geographic scope. **A recurring, margin-positive professional-fee line that requires no capital and no hiring is aligned with that posture rather than orthogonal to it** — and unlike an imaging or surgical investment, it produces revenue in month one.

The integration debt is the other side of the same record, and it is the report's central operational thesis. Two of the seven sites — Vero Beach and Sebastian, both in Indian River County, both added during the expansion — still surface in a CMS specialty-model file under **pre-acquisition legal entities**, not under the group's own. A third address the practice says it vacated in July 2026 is the registered address of a separate legacy cardiology entity whose registry record has not been touched since 2018.[15] None of that is unusual for a group that has grown this fast, and none of it is a criticism. It is simply strong circumstantial evidence that **programme inventory, billing configuration and vendor coverage are unlikely to be uniform across all seven sites** — which is the specific thing Section 5 asks about.

1.3 Design principles for the 2026 service line

Principle	What it means at this practice
Extend, do not replace	A monitoring programme and a care-management programme already exist and are publicly marketed. The design question is depth, completeness and coverage across all seven sites — not whether to start one

[13] Certificate inspection of the obvious corporate domain, August 3, 2026: the presented certificate covers an unrelated hostname and its wildcard, not the domain requested, so the host is not a working corporate site. The practice's own content-management and staging host, whose name encodes the parent abbreviation alongside the practice's initials, is embedded in the page markup of the practice's site and is the only independent corroboration found that the abbreviation is genuine branding.

[14] The practice's December 1, 2025 rebrand announcement, which states the two-to-eight location and 80-to-190 employee growth, the expansion into two additional counties, the new Port St. Lucie ambulatory surgery centre and the enhanced cardiac imaging programme. Seven locations are verifiable from the practice's own location pages as of August 3, 2026; the eighth is a site the practice's own banner says was relocated into the headquarters in July 2026.

[15] NPPES NPI Registry, queried August 3, 2026: a legacy Stuart-area cardiology organization enumerated at the address the practice's own site banner says it vacated in July 2026, with a registry record last updated in 2018. The address match and the timing are circumstantial evidence of an absorbed practice; the transaction itself is not documented in any public source found and is listed among the unverified items.

Principle	What it means at this practice
Longitudinal by default	Every heart failure, uncontrolled-hypertension, post-implant and post-discharge patient leaves the encounter enrolled in monitoring or monthly management, at every site — not merely scheduled for a return visit a quarter later
One front door across four counties	A single enrollment, consent and device-logistics workflow that behaves identically in Stuart and in Sebastian. A seven-site, seventy-mile footprint is the single most common reason a programme's census concentrates at headquarters and thins at the edges
Bill the whole ladder	Device supply is the base rung. Management time, additional time, and the monthly single-condition chassis are where the yield is. The service line is designed so that documented time is a by-product of care rather than a separate abstraction task
The partner carries the load	With no identifiable non-physician executive function and no population-health department, the practice supplies clinical direction and supervision while the partner supplies enrollment, devices, monitoring, documentation and claims
Separate the two remote programmes cleanly	Implanted-device interrogation and patient physiologic monitoring are different benefits over different data. With an electrophysiology service, pacemakers and loop recorders in the mix, define the boundary, the data source and the documentation for each before launch (Sections 9 and 11.3)
Single scorecard, mapped to the risk	Clinical, operational and financial KPIs reviewed monthly, and mapped explicitly to the avoidable-utilization exposure the group already carries on the ENHANCED track (Sections 6 and 11.5)

None of these principles requires new technology, and none of them asks the practice to undo anything it has built. They require one decision — **who owns the month between visits, at every site, and how completely that work is billed** — and a second decision to charter that ownership as a service line with a budget and a scorecard rather than as a marketing page. Section 2 prices it. Section 5 addresses the programmes already running. Section 11 staffs it.

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 base, and shows how one infrastructure serves every value lever the group 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 cardiovascular 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	A group performing catheterisation, valve procedures, device implants and vascular surgery across three admitting hospitals generates this window constantly. 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 programme that already exists — extended to weight-based heart failure monitoring, to the 2–15 day post-discharge and post-implant windows via 99445, and to the management-time rungs that carry most of the yield
PCM — Principal Care Management	99424–99427	Monthly management of a single high-risk condition expected to last at least three months	Heart failure or resistant hypertension as the qualifying condition. In a cardiology panel the single dominant condition genuinely is the cardiac one — the clinical situation PCM was written for, and the monthly chassis underneath a heart-failure cohort

Chronic Care Management is carried at zero eligibility in the model, and that is a design choice worth explaining rather than hiding. It is the multi-condition instrument of primary care, and the modeled stack is the specialty stack. The practice's existing “Connected Care” programme is explicitly multi-condition — its own page names high blood pressure, heart disease, diabetes, arthritis and chronic pain — so it occupies precisely that primary-care-shaped space. **The two are complements rather than competitors**: PCM bills the cardiac condition monthly at specialty depth; the existing programme handles the multi-condition wrapper. **What they cannot be is billed for the same patient in the same month**, which is exactly why the attribution policy below has to be written down. **The stack modeled in this report is RPM plus PCM, and nothing else** — TCM is identified and quantified but excluded from every financial figure.

The one coordination rule

RPM and PCM stack. They may be billed for the same patient in the same month with discrete time and discrete documentation — that pairing is the core of this programme. What does not stack: **only one practitioner may bill remote physiologic monitoring for a given patient in any 30-day period**, and the monthly care-management instruments cannot be doubled up on the same patient in the same month.

Why this is a live operational risk at this practice today, not a future one: a monitoring programme is already enrolling patients, a care-management programme is already running, and referring primary-care physicians are managing many of the same people. **That 30-day exclusivity rule is being tested right now, whether or not anyone has written the policy down.** The practical rule to adopt: the practice owns the transitional-care window at discharge and owns RPM plus PCM on the cardiac condition; the referring primary-care physician owns any longitudinal primary-care wrapper; both work from **one shared care plan** with explicit task ownership.

And a boundary this group will care about more than most: 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 group implants pacemakers, generators and loop recorders and runs an electrophysiology service, so this boundary is not academic here. The rule to design around is that the same data stream is not billed twice. *Confirm the specific pairings with the payer and with billing counsel before launch.*

2.2 Standalone value: a margin-positive service line

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

1. **Direct professional-fee revenue.** Recurring monthly billing on a population the practice already manages clinically, delivered at top-of-license staffing under general-supervision rules. Modeled at $8,352,391 of net reimbursement over 24 months, $3,532,751 of it net to the practice.
2. **Avoided cost and downside-risk exposure.** Modeled at approximately 421 avoided hospitalizations over 24 months — on the order of $6.3 million at an illustrative $15,000 per admission. **In an ENHANCED-track accountable care organization that value is not theoretical upside; avoidable utilization is a direct charge against a shared-savings P&L the practice's taxpayer identification number is already inside** (Section 6).
3. **Procedural and referral throughput.** A monitored pathway is what keeps a post-implant, post-valve or post-discharge patient attached to this practice rather than transferring the relationship with the referral — particularly relevant for a group moving volume into its own ambulatory surgery centre and in-office imaging (Section 9).
4. **Strategic position and model readiness.** The practice keeps its own taxpayer identification number, its own data and its own patient relationships while adding an infrastructure layer at depth it would otherwise have to build or buy. Under a preliminary CY2027 specialty-model designation at two of its sites, that infrastructure is also its negotiating position.

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-implant 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. **These are the rungs most often left uncaptured in a programme built around device supply — worth auditing against the existing programme specifically**
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

The figures above are illustrative national non-facility magnitudes for CY2026. Actual payment is locality-adjusted and set by the Medicare Administrative Contractor for Florida. The financial model in this report uses MAC-locality rates auto-resolved for ZIP 34996 in the CoachCare Value Analysis — Florida, locality 09102-03. Verify against the current CY2026 Physician Fee Schedule and the applicable Florida locality files before budgeting, and note that CMS rulemaking for CY2027 is in progress: remote-monitoring code values are subject to change inside the 24-month window modeled here.

One geography factor deserves explicit attention here rather than a footnote. **The model resolves a single locality from the headquarters ZIP, and the practice operates across four counties and three statistical areas**. Florida's locality structure is not uniform statewide, so the Indian River and Palm Beach sites should be confirmed against the applicable locality file rather than assumed to match Stuart. This is a verification task, not a modelling flaw — but it should be completed before any figure in this report is used for budgeting.

Modeled economics

The companion Value Analysis prices an RPM + PCM programme on the practice's base. The modeled population is an estimated **26,035-patient in-scope base across 40 referring clinicians**, 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 40 referring clinicians are the 25 physicians and the 15 advanced practice providers counted from the practice's own pages. Programme eligibility is modeled at **75% of the in-scope population for RPM (19,526 patients) and 85% for PCM (22,130)**, with acceptance of 35% and 30% respectively. Revenue is reported as **net** reimbursement — gross allowed amounts less a **14% realization discount** for payer mix and collection, as configured in the model.

Modeled result	Year 1	Year 2	24-month
Net reimbursement	$2,052,080	$6,300,311	**$8,352,391**
CoachCare fees (incl. setup & integration)	$1,189,500	$3,630,141	$4,819,641
Net to the practice	**$862,580**	**$2,670,171**	**$3,532,751**
Practice margin	**42.03%**	—	**42.30%**
Net reimbursement by programme	RPM $1,566,230 · PCM $485,850	RPM $4,780,527 · PCM $1,519,784	RPM $6,346,757 · PCM $2,005,635
Claims / billed units	—	—	151,561
Physiologic readings collected	—	—	662,476

Modeled result	Year 1	Year 2	24-month
Hospitalizations avoided (modeled)	—	—	~421 (≈$6.3M at an illustrative $15,000 each)
Care-team hours delivered	—	—	67,354 (≈32.4 FTE)
Active programme enrollments at month 24	—	—	6,826 (RPM 5,100 · PCM 1,725)
Unique patients (de-duplicated)	2,842 at month 12	5,618 at month 24	—

CoachCare Value Analysis, MAC locality FL 09102-03 (ZIP 34996), RPM and PCM only. Chronic care management and the primary-care bundle are carried at zero eligibility. Transitional care management is excluded entirely. Illustrative, modeled — verify against practice data.

The margin, and how it is defined

24-month practice margin: 42.30% — net to the practice ÷ net reimbursement. Year 1 is **42.03%**, on $8,352,391 of net reimbursement and $3,532,751 net to the practice over the full 24 months.

Month 1 is modeled at $1,578 of practice profit, which makes month 1 the first profitable month. That is unusual and it is worth stating plainly: there is no J-curve here and no month in which the programme is a net cost. By month 24 the programme is modeled at $670,760 of monthly net reimbursement and $284,424 of monthly net to the practice. No practice capital is at risk while the census builds, because CoachCare funds the enrollment engine, the devices and the monitoring staff.

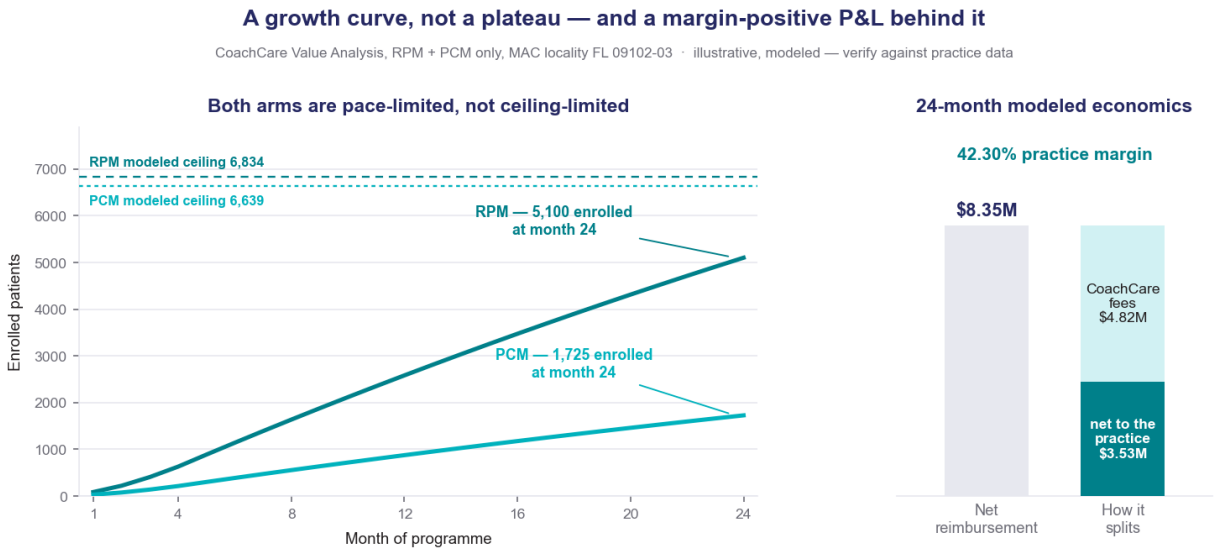

Figure 1. The modeled enrolment curve against its ceilings, and the 24-month economics. Neither arm reaches its modeled ceiling inside the window, so month 24 is not a steady state. CoachCare Value Analysis — illustrative, modeled; verify against practice data.

Both arms are enrollment-limited rather than eligibility-limited, and that is the single most important planning fact in this table. RPM stands at 5,100 enrolled patients at month 24 against a modeled ceiling of 6,834, still climbing; PCM stands at 1,725 against a ceiling of 6,639, with the great majority of its eligible pool untouched. **Neither arm reaches its ceiling inside the modeled window**, which means Year 2 is a growth year rather than a steady state and the census at month 24 is nowhere near the programme's terminal size. The practical consequence is direct: **referral throughput, not eligibility, is the binding constraint**. Raising referrals per clinician, or opening a second enrollment pathway — a second on-site enrolment specialist, or a telephonic lane for the Indian River and Palm

Beach sites — moves both arms materially. For a seven-site group across four counties that is not a theoretical lever; it is the design question for the first twelve months.

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 ($6,300,311) is 3.1× Year 1 ($2,052,080) on the same referral engine, purely from census accumulation. Unit economics are modeled at approximately $100.59 of net reimbursement per RPM patient-month and $94.01 per PCM patient-month, across 63,093 RPM and 21,334 PCM patient-months over the 24 months.

The two value streams compound rather than compete. The professional fee is the practice's revenue and depends on no reconciliation, no shared-savings determination and no hospital agreement — while the same monitored census is what moves the avoidable-utilization result that the group's ENHANCED-track position is settled on annually. *All figures are illustrative, modeled — verify against practice data.*

2.3 Connective tissue: one infrastructure, every lever

The same enrollment engine, connected-device logistics, 24/7 monitoring, nurse triage, billing-grade documentation, EMR integration and analytics serve every strategic lever the practice faces. That is the argument for building the service line once, centrally, rather than assembling a separate response to each problem as it arrives — and for a seven-site group it is also the argument for one operating standard rather than seven local habits.

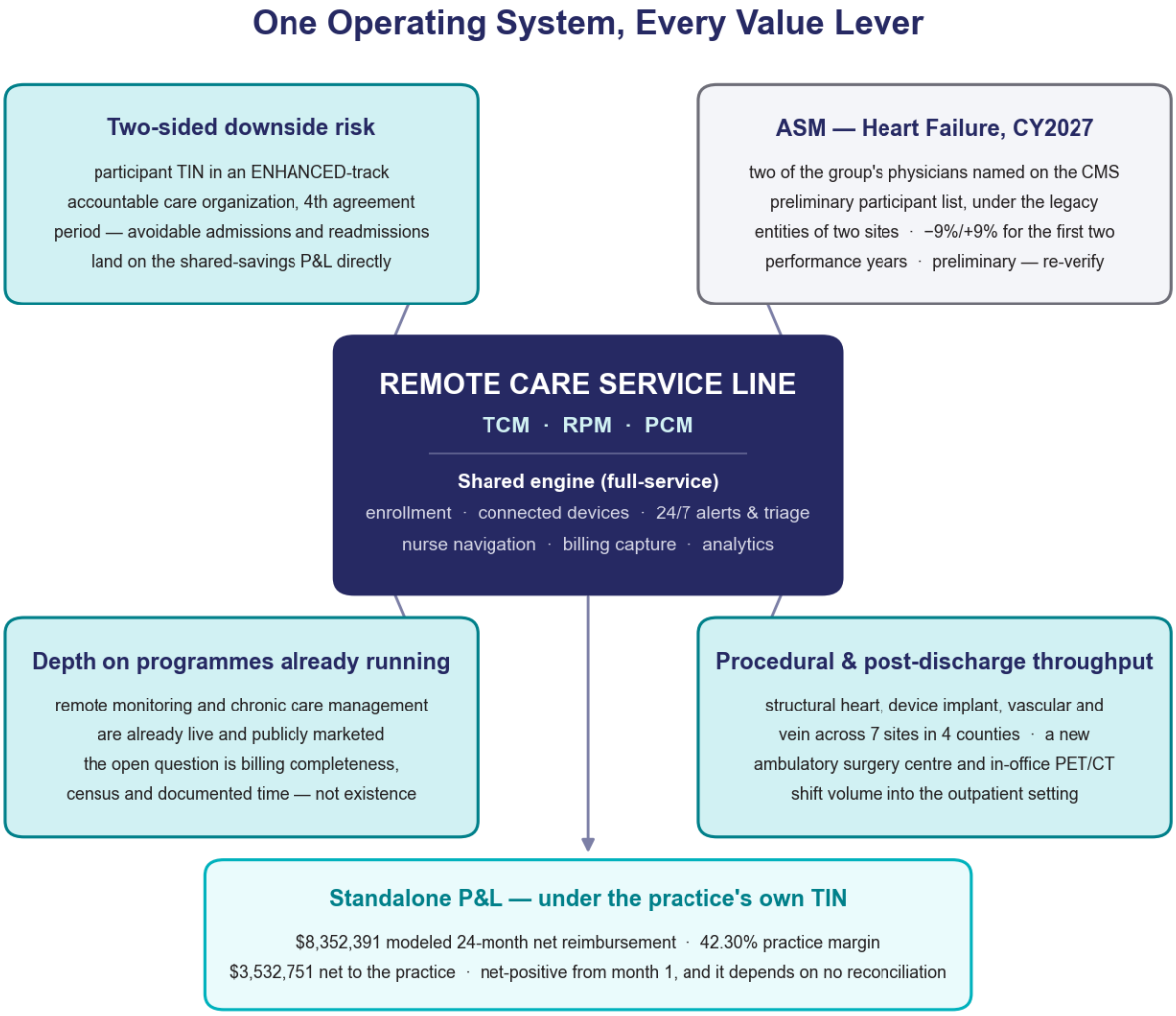

Figure 2. The Remote Care Service Line as connective tissue: one operating system serving the group's ENHANCED-track downside exposure, the CY2027 specialty-model question on a preliminary participant list, depth underneath programmes already running, procedural and post-discharge throughput, and the standalone P&L.

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
Two-sided downside risk	A participant taxpayer identification number in an ENHANCED-track accountable care organization in its fourth agreement period, with 822 participant taxpayer identification numbers — avoidable admissions, readmissions and emergency department visits charge against the shared-savings result directly	A monitored census with 24/7 alert triage converts deterioration into a same-week outpatient intervention rather than an admission. Modeled at ~421 avoided hospitalizations over 24 months — illustrative, modeled
ASM — Heart Failure cohort, CY2027	Two of the group's physicians are named on the CMS preliminary CY2027 participant list, under the pre-acquisition legal entities of the Vero Beach and Sebastian sites; a −9% to +9% Part B adjustment applies in the first two performance years, rising toward −12% to +12% by the final performance year	A monitored heart failure census produces the between-visit intervention that moves cost and utilization, and produces the documentation the quality measures are scored from. The shared care plan is also the substrate for the required collaborative care arrangement with primary care

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
Depth underneath programmes already running	A remote monitoring programme and a chronic care management programme are already live and publicly marketed; enrolled census, code mix and time capture are unknown	The same engine adds weight-based heart failure monitoring, the short-window post-discharge codes, documented management time on the add-on rungs, and uniform coverage across all seven sites rather than concentration at headquarters
The post-discharge window *(identified, not modeled)*	Catheterisation, valve procedures, device implants, carotid and vascular surgery performed across three admitting hospitals, and no public evidence of a transitional care management workflow	The same enrollment and monitoring engine covers the 30 days after discharge; short-window RPM is billable today via 99445 and 99470, and TCM remains a separate decision the practice can take on its own merits
Procedural and device throughput	Structural heart is live, an electrophysiology service implants pacemakers, generators and loop recorders, and a new ambulatory surgery centre and in-office positron-emission-tomography scanner are shifting volume into the outpatient setting	The physiologic layer sits alongside — not inside — device interrogation, and keeps post-procedure patients attached to this practice rather than transferring the relationship with the referral
Standalone P&L	CY2026 code expansion (99445, 99470); revenue durability regardless of how any shared-savings year reconciles	$8,352,391 of modeled 24-month net reimbursement at a 42.30% practice margin — billed under the practice's own taxpayer identification number and dependent on no reconciliation

Read that table one way and it is six separate problems, each with its own project plan, its own budget line and its own reason to be deferred. Read it the other way and it is **one asset, built once and paid for once, that answers all six**. This practice already owns two of the hardest inputs to that asset: a working device-and-nurse remote workflow, and a patient population conditioned to receive care between visits. What is not established from any public source is how deep that workflow runs, how completely it bills, and whether it reaches all seven sites.

3. 2026–2027 Policy & Payment Environment

Two CMS positions bear directly on this practice. One is live today and carries two-sided risk. The other begins in five months and is currently recorded against legal entities the practice acquired. This section states what is verified about each, what is not, and what else in the payment environment changes the arithmetic.

3.1 Two-sided risk: an ENHANCED-track accountable care position

The practice's billing entity appears in CMS's **Accountable Care Organization Participants** public-use file as a participant taxpayer identification number in **PBACO Holding, LLC — ACO A1001**, a Medicare Shared Savings Program organization headquartered in Palm Springs, Florida with a service area spanning six states. The record carries an initial start date of July 1, 2012, a current agreement start of January 1, 2025, a **fourth agreement period**, low-revenue status, retrospective assignment, the skilled-nursing three-day-rule waiver, and — the operative field — **ENHANCED_Track = 1**.[16]

What ENHANCED track means, and why it is the strongest fact in this report

Two-sided risk. The ENHANCED track is the Shared Savings Program's highest risk-and-reward option. An organization on it shares in savings at the highest rate **and owes CMS money when spending exceeds the benchmark**. That is categorically different from an upside-only arrangement, where a bad year simply produces no bonus. Here a bad year produces an invoice.

Fourth agreement period, 822 participant taxpayer identification numbers. This is a large, mature, physician-led organization that has been operating since 2012 and has chosen to keep escalating its risk. It is not a first-time participant feeling its way in, and it is unlikely to be relaxed about avoidable utilization among its participants.

What this does to the business case. Remote monitoring and care management stop being a fee-for-service add-on and become **margin defence**. Every avoided admission, avoided readmission and avoided emergency department visit among attributed beneficiaries improves a result the practice's own taxpayer identification number is measured inside. **The practice's own monitoring programme page already makes this argument** — it claims reduced risk of unnecessary hospitalizations and emergency room visits. The programme and the risk position are already pointed at the same target.

The caveat, stated honestly. Shared Savings Program participation covers **Original Medicare fee-for-service only**. It says nothing about Medicare Advantage, and the practice's Medicare Advantage exposure was not publicly discoverable. How the accountable care organization allocates savings and losses among 822 participants is a contractual matter this report cannot see. *What each participant's actual exposure looks like is a question for the practice's own participation agreement.*

[16] CMS Medicare Shared Savings Program Accountable Care Organization Participants public-use file, queried August 3, 2026, for the full participant record: ACO A1001, PBACO Holding, LLC; service area spanning six states; agreement period 4; initial start July 1, 2012; current start January 1, 2025; low-revenue flag set; retrospective assignment; skilled-nursing three-day-rule waiver; ENHANCED_Track = 1 with BASIC_Track = 0; and 822 participant taxpayer identification numbers on the same organization identifier.

A correction worth making in the practice's own records

A widely used commercial firmographic file records this practice's accountable care organization as a health-system-affiliated organization in Florida. **The CMS file does not support that**. That organization is real — it holds its own identifier and a Florida service area — but its participant list contains exactly four entities, all belonging to the same health system, and this practice is not among them. The most likely origin of the error is an affiliation-based inference: the group's dominant admitting hospital does belong to that system's organization, and a hospital affiliation appears to have been recorded as an accountable-care membership.[17]

The distinction is strategically substantive rather than clerical. **The practice takes risk inside a competing, independent physician-led organization while admitting the majority of its patients into a hospital that belongs to a different organization entirely**. The physician arm of the group's second admitting hospital is also a participant in the same physician-led organization. Any conversation about shared-savings performance, data sharing or care-coordination investment has to start from the correct affiliation.

3.2 ASM: a CY2027 designation on a preliminary list, under legacy entities

The **Ambulatory Specialty Model** begins **January 1, 2027** and runs five performance years through 2031, with payment years running 2029 through 2033 — so performance in calendar 2027 lands as a payment adjustment in **2029**. It covers two conditions, with cardiology accountable for **heart failure**. It is a clinician-level model: participants are identified by taxpayer identification number and National Provider Identifier, are scored individually on quality and cost and at the group level on care improvement activities and interoperability, and receive a Part B payment adjustment of **−9% to +9% in the first two performance years, rising toward −12% to +12% by the final performance year**. The design is **budget-neutral**: total positive adjustments cannot exceed total negative adjustments, which makes it a tournament scored against peers treating the same condition. It also requires an electronic **collaborative care arrangement with primary care**. Participation is mandatory for attributed clinicians — there is no opting in and no opting out.[18]

[17] CMS Medicare Shared Savings Program Accountable Care Organization Participants public-use file, queried August 3, 2026. The health-system-affiliated Florida organization recorded by a commercial firmographic export holds its own organization identifier and a Florida service area, and its participant list contains exactly four entities, all belonging to that health system. The practice's legal name is not among them. The physician arm of the practice's second admitting hospital is a participant in the same physician-led organization the practice belongs to.

[18] CMS Ambulatory Specialty Model overview and participant readiness materials, and the CMS model landing page (retrieved August 3, 2026), for the January 1, 2027 start, the five performance years 2027 through 2031 and payment years 2029 through 2033, the payment adjustment of -9% to +9% in the first two performance years rising toward -12% to +12% by the final performance year, budget neutrality, participant identity by taxpayer identification number and National Provider Identifier, the four scored categories and their individual versus group-level assessment, and the required electronic collaborative care arrangement with primary care.

What the verification actually found — read this carefully

The precise finding. Two of the group's physicians are named on the CMS preliminary participant list for the Ambulatory Specialty Model, under the pre-acquisition legal entities of the Vero Beach and Sebastian sites — not under the group's own billing entity. Both are in the **Heart Failure** cohort and both carry the CY2027 participant flag set to Yes and the CY2027 small-practice flag set to Yes.[19]

The Vero Beach listing sits under **TREASURE COAST CARDIOVASCULAR INSTITUTE INC**. The Sebastian listing sits under a solo-physician professional association carrying that physician's own name, which this report does not reproduce. **The group's own billing entity, STUART CARDIOLOGY GROUP LLC, returns zero rows in the file** — as do searches on the trade name, the abbreviation, the legacy Stuart cardiology entity, and every plausible parent-company string, across all states.

Coverage, stated honestly. Nineteen of the 25 physicians were resolved to a National Provider Identifier and tested individually against all 6,637 rows of the file, with no filter on the file's state column. **Six could not be resolved and remain open.** A surname scan of the full file found no plausible Florida match for any of the six, but that is weak negative evidence rather than a clean result. **The correct statement is that the check is complete for 19 of 25 physicians.**

The caveat, stated plainly. The file is the **CY2027 preliminary participant list** (dataset modified February 4, 2026, retrieved August 3, 2026), and CY2028 through CY2031 flags are null — CMS has published determinations for CY2027 only. *Preliminary lists can be revised. Re-verify against the final CY2027 file before acting on anything in Section 7*. The phrasing this report holds to throughout is that these clinicians are **named on the CMS preliminary participant list** — never that the practice itself is a model participant, which the file does not support.

Why this is worth a conversation rather than a compliance memo. The finding is genuinely ambiguous, and it cuts both ways. **If those physicians now bill under the group's own taxpayer identification number**, their CY2027 attribution may not follow them — and the practice may be carrying model obligations it cannot see, or may have quietly shed them. **If the legacy entities are still active**, the group is running two separately-identified specialty-model participant entities inside one brand, with the reporting burden that implies and no single owner of it. **Either way, the answer is knowable inside the practice in an afternoon and is not knowable from outside it at all**. That is what makes it a good opening question rather than a claim.

And the clinical alignment is the part that makes it commercially interesting. The cohort is **heart failure** — and the practice's own monitoring programme page names congestive heart failure as a qualifying population. Whatever the taxpayer-identification-number answer turns out to be, **the model would score exactly the population the practice's existing programme already targets**, at two sites that joined the group most recently and are furthest from its headquarters. Section 7 develops that.

3.3 The CY2026 fee schedule: remote care gets more billable

The CY2026 Physician Fee Schedule expanded the remote-monitoring toolkit in ways that suit a cardiovascular group whose highest-value windows are short. **99445** pays the monthly device-supply amount for 2–15 days of data, where 16 or more days were previously required — which had made short post-discharge and post-procedure windows effectively unbillable. **99470** pays for the first 10 minutes of monthly management time, where the floor had been 20. Together they convert the two windows this practice generates most of — the days after a cardiac discharge, and the days after a device or valve procedure — from unfunded care into billable events. PCM (99424–99427) remains the monthly chassis

[19] CMS Ambulatory Specialty Model Participants, CY2027 PRELIMINARY participant file; dataset modified February 4, 2026; retrieved August 3, 2026. The full file of 6,637 rows was retrieved in paginated form and de-duplicated. Nineteen confirmed physician identifiers were intersected against all rows; the organization legal-name column was scanned by substring for the group's legal name, trade name, abbreviation, the legacy Stuart cardiology entity and every plausible parent-company string; and physician surnames were scanned across all rows. The file's state column was never used as a filter, because it is known to be miscoded for some participants. Two Heart Failure cohort rows matched, both with ASM_CY27_PARTICIPANT = Yes and ASM_CY27_SMALLPRACTICE = Yes, both under pre-acquisition legal entities corresponding to the Vero Beach and Sebastian sites. The group's own billing entity returns zero rows. CY2028 through CY2031 flags are null for both. Six of the 25 physicians could not be resolved to a National Provider Identifier, so the check is complete for 19 of 25.

for single-condition specialty management, and RPM and PCM stack in the same month with discrete documentation.

There is an account-specific reason to raise this early. A monitoring programme designed before 2026 was necessarily built around a 16-day data threshold and a 20-minute time floor, because nothing else was payable. **A programme built to those thresholds has no mechanism to bill the two-week window after a discharge or a device implant** — the window in which a readmission is still preventable and, for a group carrying two-sided risk, the window with the most avoidable cost in it. That is not a criticism of any existing programme; it is a policy change that arrived in 2026, and it is worth asking whether the current configuration has been revisited since.

3.4 Locality, geography, and what this model does not yet know

Three limits on this report's sizing belong on the record, stated before anyone budgets from it.

Limit	What is known	What has to be resolved
MAC locality	The Value Analysis auto-resolves Florida locality 09102-03 from the Stuart headquarters ZIP 34996, and every modeled dollar in this report uses that locality	**Seven sites across four counties and three statistical areas may not all price at the same locality.** Confirm site by site against the current Florida locality files before budgeting
County demographics and senior share	Not retrieved. The research pass that produced this account's dossier exhausted its search budget before demographic sources could be queried, and	**no Census, senior-share or county-population figure is asserted anywhere in this report**. The Treasure Coast is a well-known Florida retirement corridor, but that is context, not a statistic
Medicare Advantage penetration	Not retrieved, and material. Shared Savings Program participation covers Original Medicare fee-for-service only, and the specialty model applies to Original Medicare	**Medicare Advantage share directly sizes the population sitting outside both**. The same infrastructure serves it, on plan-specific terms that have to be confirmed contract by contract. Pull county-level enrollment before the forecast is finalised
Panel size	The 26,035-patient in-scope base is a discovery-stage modelling estimate, not a counted chart population. A commercial file reports a practice-level Medicare allowed amount that was not independently verified	Validate against the practice's own active-patient counts. Every figure in Section 2.2 scales with this input

Why the gaps are listed rather than filled with estimates. A forecast that quietly substitutes a plausible number for a missing one is worse than a forecast that says which numbers are missing, because the reader cannot tell which is which. All four items above are resolvable in a first working session with the practice, and three of the four are resolvable from public data in under an hour. **None of them changes the structure of the argument; all of them change its size.**

4. Performance Snapshot: The Starting Position

4.1 The panel and the modeled base

This account differs from most in this series in one respect that has to be stated up front: **no practice-level Medicare claims analysis was performed**. No per-provider service record, no risk-score profile, no condition-prevalence read and no code-level utilization screen appears in this report, because none was retrieved during research. What exists instead is a modelling estimate of the in-scope population and a verified clinician count.

Model input	Value	Basis and confidence
In-scope base	**26,035**	**Discovery-stage modelling estimate.** Not counted from charts and not derived from a CMS claims file. Validate before budgeting
Referring clinicians	**40**	**High confidence.** 25 physicians and 15 advanced practice providers, counted individually from the practice's own profile pages, August 3, 2026
RPM eligibility / acceptance	75% (19,526) / 35%	Modeled ceiling 6,834 patients; at 5,100 at month 24 and still climbing
PCM eligibility / acceptance	85% (22,130) / 30%	Modeled ceiling 6,639; at 1,725 at month 24 — the arm with by far the most headroom
Referrals per clinician per month	8	With 80% patient acceptance
On-site enrolment specialist	1 (≈80 enrollments / month)	**CoachCare's expense — embedded value, never deducted from practice margin**
Revenue basis	Net of a 14% realization discount	Payer mix and collection, as configured in the model
MAC locality	FL 09102-03 (ZIP 34996)	Auto-resolved in the Value Analysis; confirm per site (Section 3.4)

CoachCare Value Analysis inputs. Illustrative, modeled — verify against practice data.

What can be said about acuity is directional and is labelled as such. A cardiovascular group of 25 physicians on Florida's Treasure Coast, performing catheterisation, valve procedures, device implants and vascular surgery, and carrying a practice-level Medicare allowed amount reported in the high eight figures by a commercial file, is self-evidently working a heavily Medicare-weighted, high-acuity panel. **That is an inference from structure, not a measured statistic, and this report does not convert it into a number.** The panel figures that would normally anchor this section — risk score, heart-failure prevalence, chronic kidney disease and diabetes rates — are listed among the open items and should be pulled before the forecast is presented as final.

4.2 Capabilities confirmed, and capabilities absent

The practice's own service navigation and hospital-services page establish a clear capability picture. Everything in the left column below is stated by the practice; everything in the right column is either absent from every public source or explicitly disclaimed.

Confirmed on the practice's own pages	Absent, unverified, or explicitly disclaimed
General cardiology, interventional cardiology, electrophysiology (branded as heart rhythm disorders), and cardio-oncology	**Heart failure is not a named service line** anywhere on the site — notable against the CY2027 heart-failure finding in Section 3.2, and against the monitoring programme's own naming of congestive heart failure as a qualifying population

Confirmed on the practice's own pages	Absent, unverified, or explicitly disclaimed
Diagnostic imaging including a newly opened positron-emission-tomography scanner at the Stuart headquarters, plus calcium scoring promoted in the practice's own content	**Cardiac rehabilitation: no evidence found** — no page, no mention. Absence of evidence rather than proof of absence
Vascular: peripheral arterial disease, carotid artery disease, aortic aneurysm, renal artery stenosis, and vascular surgery. Vein: varicose and spider veins, chronic venous insufficiency	**Telehealth or virtual visits: no evidence found** — no page appears in the practice's sitemap
Hospital-based procedures performed by the group: cardiac catheterisation; pacemaker placement, generator replacement and implantable loop recorders; transcatheter aortic valve replacement; carotid endarterectomy; transcarotid artery revascularization	**A patient application is actively disclaimed**. Both programme pages emphasise that no app is required and no portal login is needed — a deliberate low-technology design, and a real constraint on documentation rigour
Structural heart is live — transcatheter aortic valve replacement is on the hospital-services list, and the practice published its own structural-heart explainer in April 2026	**Remote device interrogation: near-certain in practice, unverified in public.** The group implants pacemakers, generators and loop recorders and runs an electrophysiology service, but no device-clinic or remote-interrogation page exists. Treat as a discovery question, not a finding (Sections 9 and 11.3)
A new ambulatory surgery centre in Port St. Lucie, framed by the practice as bringing hospital-level capability into the outpatient setting	**No job postings for monitoring or care-management staff were found**, but the careers page is a marketing stub with no applicant-tracking system and hiring appears to run above the practice. Treat as untested rather than searched-and-empty

Read from the practice's own website — service navigation, hospital-services page, imaging page, blog and sitemap — retrieved August 3, 2026. Nothing in either column is inferred from a directory aggregator.

4.3 Position in the market

The group refers into three hospitals across its footprint. CMS publishes an overall star rating for each, and the spread is wide:

Hospital	CCN	City / county	Ownership	CMS overall star
Cleveland Clinic Martin North Hospital	**100044**	**Stuart / Martin**	**Voluntary non-profit**	**3**
Jupiter Medical Center	100253	Jupiter / Palm Beach	Voluntary non-profit	4
St. Lucie Medical Center	100260	Port St. Lucie / St. Lucie	Proprietary (for-profit)	1

CMS Provider Data Catalog, Hospital General Information, retrieved August 3, 2026. Star ratings are CMS's own published overall ratings, not a directory aggregator's. Admitting mix quoted below is from a commercial firmographic file, is undated, and is directional only — it was not independently verified.

The competitive geometry here is genuinely unusual and it should be handled carefully. A commercial file puts roughly **69% of the group's admissions at the Stuart hospital and 7% at the Jupiter hospital** — directional figures, undated, unverified. Taken at face value they describe a practice sending most of its inpatient volume into a hospital belonging to a health system whose own accountable care organization the practice is *not* part of, while carrying two-sided risk inside a competing physician-led organization. The physician arm of the second admitting hospital is a participant in that same physician-led organization. **This is a reason for the practice to want capability it owns outright, not a reason to attack a referral partner**, and every piece of external material for this account should read that way.

The second dynamic is the one the practice is creating itself. A new ambulatory surgery centre and an in-office positron-emission-tomography scanner both move volume out of the hospital setting and into the practice's own. That is a deliberate strategy and it is working; it also means the group's relationship with its dominant admitting hospital is changing rather than static. **A practice that arrives at that conversation with its own measured post-discharge and readmission data is negotiating from a materially different position than one arriving with a proposal**. The service line is the mechanism that produces that data as a by-product of care.

What this report deliberately does not claim about the market. No local competitor survey was performed, no market-share figure is asserted, and no other area cardiology group is characterised. A handful of neighbouring entities surfaced incidentally in the CMS accountable-care and specialty-model files, but that is a by-product of a participant-list query rather than a market study, and it would be misleading to present it as one.

5. Build vs. Partner: The Programmes Already Running

This is the section that makes this account different, and it is placed before the "powering" sections deliberately. Most reports in this series open a whitespace: a practice with no monitoring programme, no care-management programme and no between-visit workflow. **That is not the situation here, and pretending otherwise would be falsified in the first meeting**. Both programmes exist. Both are publicly marketed. Both appear to be billed rather than given away. The honest question is not whether to start — it is depth, completeness, and coverage.

5.1 What is verifiably in place

Programme	What the practice's own page states	What that establishes
Remote patient monitoring	Tracks key health data between appointments — blood pressure readings, body weight measurements, or other cardiovascular indicators. A complimentary blood-pressure monitor based on the patient's condition. Direct delivery of the device to the home. Automatic transmission of readings to the care team. Access to a dedicated remote nurse. Devices arrive preconfigured, with no smartphone, Wi-Fi connection or mobile application required	**Cellular devices, not application-paired.** "Preconfigured, no smartphone or Wi-Fi" is the signature of a cellular cuff. **Drop-shipped logistics implies a fulfilment partner** — practices rarely build direct-to-home device fulfilment themselves. And the programme's own frequently-asked-questions page discusses Medicare coverage and patient cost-share ahead of enrollment, which means **it is billed, not a free perk**
Chronic care management, branded "Connected Care"	Additional access to the healthcare team between appointments. A personalised care plan and a dedicated care manager. Scheduling, symptom monitoring, medication questions, prescription refills, referral coordination and lab results. Contact by phone or text; no application to download and no website to log into. Supports high blood pressure, heart disease, diabetes, arthritis, chronic pain and other long-term concerns	**A real, staffed, multi-condition care-management service.** The cost disclosure — insurance coverage varies, some patients may have a cost-sharing responsibility — is consistent with billed chronic care management. **The deliberate absence of any portal or application is a defensible service-design choice**, and it is also a constraint on documentation rigour and time capture

Read verbatim from the practice's two dedicated public service pages, retrieved August 3, 2026. Characterisations in the right-hand column are this report's inference from those descriptions and are labelled as such.

No vendor is named in this report, because none could be identified

A full inspection of both programme pages found **no remote-monitoring vendor script, pixel, iframe or asset** of any kind. The only third-party hosts referenced anywhere are the practice's electronic-record patient portal, a patient intake and payments platform, and the practice's own content-management host.[20]

That absence is itself informative rather than merely inconclusive: it is exactly what a fully telephonic, nurse-delivered service with no patient-facing web application looks like — which is precisely what both pages describe. **Whether the nurse is the practice's own employee or a partner's staff, and whether one platform or two sit behind the programmes, is not publicly discoverable.** No vendor is named or implied anywhere in this report, and no assumption should be made in any conversation about the account.

[20] Page-source inspection of both programme pages and of the home, patient-support, prepare-for-visit, insurance, referral and careers pages, August 3, 2026. The only third-party hosts referenced anywhere are the practice's NextGen patient portal, a patient intake and payments platform, and the practice's own content-management host. No monitoring-vendor script, pixel, iframe or asset appears. No competing electronic-record fingerprint appears either.

5.2 Where a partnered model adds depth rather than duplication

The credible argument here is not novelty. It is **scale, completeness and uniformity**, and it rests on things the public pages describe and things they do not.

Dimension	What the public description covers	Where the depth question sits
Billing ladder	Device supply and nurse review are described. Nothing on the pages speaks to escalation workflow, documented management minutes, or the time-tier rungs	**The classic failure mode of a device-led monitoring programme is billing the device-supply base and leaving 99457, 99470, 99458 and the PCM family uncaptured.** That is not an accusation — it is the single most common finding in this kind of audit, and it is checkable in one report from the practice's own billing system
Modality	Blood pressure is named explicitly and body weight is named as an option	**Weight is the heart-failure signal**. A blood-pressure-first programme is built for hypertension; a heart-failure cohort needs daily weight with threshold alerting as the primary stream. Given the CY2027 heart-failure finding, that is a specific and answerable question
Short windows	Nothing on either page addresses the post-discharge or post-procedure window	**99445 and 99470 only became billable in CY2026**. A programme configured before then had no reason to build a two-week pathway, and the two-week window after a discharge is where avoidable readmission cost concentrates
Coverage across seven sites	The pages describe the programmes at brand level; nothing establishes per-site coverage	**Two sites still surface in a CMS file under their pre-acquisition legal entities**. Uniform programme coverage across a four-county, seven-site footprint is a reasonable thing to verify rather than assume
Documentation and time capture	Phone and text, with no portal and no application, by design	Time-based codes are audited on documented time. A low-technology contact model is clinically defensible and operationally sound; it makes automated, billing-grade time capture harder, and that is where an integrated engine contributes most
Census and yield	Unknown. Marketing a programme establishes nothing about enrolled penetration	**This is the first number to ask for**, and it reframes the entire conversation. A programme at 200 enrolled patients across 40 clinicians and a 26,035-patient base is a pilot; a programme at 2,000 is an operation. The strategy differs completely between those two answers

Stated as plainly as it can be: the practice has already answered the build-versus-buy question, and it answered it in the right direction. It runs cellular devices, drop-shipped logistics, a dedicated remote nurse and a dedicated care manager — the components most groups spend a year assembling. **The remaining question is a yield question, and it is arithmetic rather than philosophy**: across a 26,035-patient base and 40 referring clinicians, what census is enrolled today, what code mix is captured, and what does the gap between that and the modeled 6,826 active enrollments at month 24 represent? *All figures are illustrative, modeled — verify against practice data.* If the answer is that the existing programme is at scale and billing the full ladder, this report's Section 2.2 figures largely describe revenue the practice is already earning, and the conversation moves to coverage and to the specialty-model question. **That would be a good outcome to discover, and it is worth saying so.**

5.3 The questions that decide displace, co-exist, or walk away

1. **Where does the decision sit — the practice or the network above it?** If monitoring and care management were standardised at network level, the practice is not the buying unit. Everything downstream depends on this answer and it is a single question.

2. **What is the enrolled census today, by programme and by site?** The number that separates a pilot from an operation, and the number that sizes every gap in Section 5.2.
3. **Which codes are actually being billed?** Specifically: is management time captured beyond device supply, are the add-on rungs used, and is anything billed in the 2–15 day window since CY2026 made it payable?
4. **Is the programme uniform across all seven sites, including Vero Beach and Sebastian?** The two sites that arrived with their own legal entities are also the two sites carrying the CY2027 heart-failure designation. If programme coverage is thinnest exactly there, that is the single highest-value thing this report can surface.
5. **Does monitoring data flow into the electronic record discretely, or does it sit in a separate system?** Both programme pages emphasise no portal and no application. That strongly suggests device and nurse data may not be flowing into NextGen as discrete, reportable elements — which matters for audit, for quality reporting, and for the collaborative care arrangement the specialty model requires (Section 10).
6. **Is remote device interrogation billed separately, and by whom?** A distinct benefit over distinct data, near-certain given the electrophysiology service, and invisible in every public source (Sections 9 and 11.3).

The three honest outcomes, named in advance. Co-exist — the existing programme keeps the population it serves well and the service line adds the heart-failure weight stream, the short post-discharge windows, the under-served sites and the billing completeness. **Displace** — the existing arrangement is a thin pilot and a full-service model replaces it with more census, more codes and more coverage. **Walk away** — the programme is at scale, billing the full ladder, uniform across seven sites, and the decision sits above the practice anyway. **All three are legitimate, and the questions above distinguish them in one conversation. That is a better use of a first meeting than a pitch.**

6. Powering Two-Sided Risk: The Accountable Care Position

Start with what is verified, because it is unusually clean. The practice's billing entity is a participant taxpayer identification number in an **ENHANCED-track** Medicare Shared Savings Program organization — the programme's highest risk-and-reward option, carrying **two-sided risk** — in its **fourth agreement period**, with **822 participant taxpayer identification numbers** and a current agreement that began January 1, 2025.[21] That single field changes the shape of the business case more than anything else in this report.

Why downside risk is a different argument from shared savings

Under an upside-only arrangement, a poor year produces no bonus and the conversation about care management is a conversation about opportunity cost. **Under two-sided risk, spending above the benchmark produces a repayment obligation**. Avoidable admissions, readmissions and emergency department visits stop being missed upside and become a charge. That reframes remote monitoring and care management from a revenue programme with a quality halo into **margin defence with a revenue programme attached**.

The practice's own monitoring programme page already argues the clinical half of this: it claims reduced risk of unnecessary hospitalizations and emergency room visits. **The programme and the risk position are pointed at the same target** — which means the question is not whether the strategy is right, but whether it is running at the census and completeness the risk position warrants.

What the service line contributes to that result, mechanically. Avoidable utilization is not reduced by intent; it is reduced by a specific operational chain — a monitored census, a threshold that fires, a nurse who reaches the patient the same day, and an outpatient intervention that happens inside the week. Every link in that chain is labour, and labour is what the practice does not currently have a department for. The model supplies **67,354 care-team hours over 24 months, approximately 32.4 full-time equivalents**, alongside 303,122 care-management tasks, 75,780 chart updates and 45,468 patient conversations, and projects approximately **421 avoided hospitalizations** over the same period. *All figures are illustrative, modeled — verify against practice data.*

What the risk position rewards	What the service line supplies
Fewer avoidable admissions among attributed beneficiaries	A monitored census with 24/7 alert triage converts deterioration into a same-week outpatient intervention rather than an admission — modeled at ~421 avoided hospitalizations over 24 months
Fewer readmissions in the 30 days after discharge	Enrollment at discharge rather than at the next office visit, with short-window monitoring now billable in the first two weeks via 99445 and 99470 — the window in which a readmission is still preventable (Section 8)
Fewer emergency department visits as the default escalation path	A defined path from alert to nurse contact to same-week clinic slot, with the emergency department as the exception rather than the reflex. This is an operating protocol, not a technology feature
Quality reporting the organization is scored on	Monthly structured contact generates documented blood-pressure readings, weight trends and medication-tolerance notes as a by-product of care rather than as a separate abstraction project
Coordination across 822 participant entities	Structured monthly reporting back to referring primary-care physicians — good practice, a referral-retention mechanism, and the same artifact the specialty model's collaborative care arrangement will require (Section 7)

[21] CMS Medicare Shared Savings Program Accountable Care Organization Participants public-use file, queried August 3, 2026: ENHANCED_Track = 1, agreement period 4, current agreement start January 1, 2025, and 822 participant taxpayer identification numbers on the same organization identifier. How savings and losses are allocated among those participants is governed by the accountable care organization's own participation agreement and is not public; no shared-savings figure for this practice is asserted anywhere in this report.

What this report cannot see, and will not guess

How savings and losses are allocated among 822 participant taxpayer identification numbers is a contractual matter inside the accountable care organization's participation agreement, and it is not public. **This report therefore quantifies no shared-savings dollar figure for this practice, and none should be inferred**. What is verified is the track, the agreement period, the participant count and the practice's membership. What each participant actually bears is a question for the agreement itself.

Two further limits belong here. The organization's assignment is **retrospective**, so the attributed population is determined after the fact rather than known in advance — which argues for managing the whole clinically eligible panel rather than a list. And Shared Savings Program participation covers **Original Medicare only**, so the Medicare Advantage population sits entirely outside it and has to be sized separately (Section 3.4).

7. Powering ASM: The Heart Failure Cohort and the TIN Question

Reminder of the constraint on everything in this section. Two of the group's physicians are named on the CMS preliminary participant list for the Ambulatory Specialty Model, under the pre-acquisition legal entities of the Vero Beach and Sebastian sites, Heart Failure cohort. The group's own billing entity returns zero rows. That is a **preliminary** list; CY2028 through CY2031 flags are null; and the check is complete for 19 of the group's 25 physicians. **Re-verify against the final CMS file before acting on this section.** Everything below is written as readiness planning and as a discovery agenda, not as a compliance instruction.

Why a two-physician finding is worth a section

A cohort of two is small, and this report will not inflate it. What makes it worth attention is not the count — it is **where the two sit and what entity they sit under**.

What is unusual about this finding	Why it matters operationally
Both listings are attributed to legal entities the practice acquired, not to the practice's own billing entity	Model obligations follow the taxpayer identification number and the identifier. If those physicians now bill under the group's entity, attribution may not follow them — and nobody inside the practice may currently own the question either way
Both are at the two Indian River County sites — Vero Beach and Sebastian	These are the two most recently added, geographically furthest sites. They are the ones most likely to have inherited a different programme configuration, a different workflow and a different level of monitoring coverage
Both carry the small-practice flag set to Yes	The flag reflects the entity's size as CMS sees it. That an entity inside a 40-clinician group is still flagged as a small practice is a direct signal that CMS is not yet seeing these sites as part of the group
The cohort is heart failure, and heart failure is not a named service line on the practice's website	The practice's monitoring programme names congestive heart failure as a qualifying population, so the clinical population exists. What does not appear anywhere publicly is a named heart-failure pathway, clinic or programme wrapper around it

What the model would score, and what the service line supplies

What the model scores	What the service line supplies
Cost of care across the heart failure year	A monitored census with 24/7 alert triage converts deterioration into a same-week outpatient intervention rather than an admission. Modeled at ~421 avoided hospitalizations over 24 months — illustrative, modeled, verify against practice data
Clinician-level quality measures	Monthly structured contact generates the documented blood-pressure readings, weight trends, symptom assessments and medication-tolerance notes the measures are scored from — as a by-product of care rather than as a separate abstraction project
Guideline-directed medical therapy titration	Titration is a production process, not an event. Home blood pressure and daily weight between visits give the clinical team the data to move doses on a schedule instead of waiting for the next quarterly visit — and PCM (99424–99427) is the monthly billing chassis for exactly that work
Group-level care improvement and interoperability	One enrollment workflow, one shared care plan and one analytics view across seven offices is the group-level artifact this component asks for — and it is precisely what a seven-site group that grew by acquisition is least likely to have today

What the model scores	What the service line supplies
The electronic collaborative care arrangement with primary care	This group has no primary-care panel of its own, so the arrangement is a collaboration with **external referring primary-care physicians**: a shared care plan, structured monthly reporting back to the referring physician, and explicit task ownership. The attribution policy in Section 2.1 is the substrate — write it once and it serves both purposes
Health information exchange data sharing	The contribution here is putting structured monitoring data, care plans and evidence of care back into the electronic record on a monthly cadence rather than leaving them in a vendor portal or a nurse's call log (Section 10)

Design decisions to take before the first performance year, not during it

Resolve the taxpayer identification number question first. Which entity is each of the two physicians billing under today, and are the legacy entities still active? Both answers carry work, and neither is knowable from outside the practice.

Close the coverage gap. Six of 25 physicians could not be resolved to an identifier from public sources. The practice can close that in an afternoon, and it either settles the question or widens it.

Start where the population already is. The monitoring programme already names congestive heart failure as a qualifying population. The shortest path to a heart-failure census is to extend an enrollment habit that exists rather than to introduce a foreign one — and to add daily weight as the primary stream.

Prioritise Vero Beach and Sebastian. Both named listings sit there. If programme coverage is thinner at the northern sites than at headquarters — a reasonable hypothesis for sites added during a rapid expansion, and an easy one to test — that is where the first census should be built.

One shared care plan. The collaborative care arrangement is an electronic artifact, not a handshake. Build it as the same care plan the service line already maintains, inside the practice's own record.

Diarise the re-verification. Check against the final CY2027 participant list the week CMS publishes it, and re-run the identifier match including the six unresolved physicians. Preliminary lists get revised.

The honest summary of this section. The specialty-model finding here is real, small, partial, and attributed to entities other than the group's own. It is not a reason to buy a service line on its own, and this report does not present it as one. **What it is, is the sharpest available proof that this group's programme inventory and billing identity are not yet uniform across its seven sites** — and that is a question worth a conversation regardless of what the final CY2027 file says. The economic case in this account rests on Section 6 and Section 2.2. This section is the credibility test.

8. The Post-Discharge Window: The Largest Unbilled Asset

The correct statement first, because it is easy to overstate. This practice holds no CMS Certification Number and is not a hospital; its exposure to what happens inside a hospital is indirect. **Its exposure to what happens in the 30 days after a patient leaves one is entirely direct**, because those 30 days are outpatient cardiology, they belong to this group, and — under an ENHANCED-track arrangement — a readmission inside them lands on a shared-savings result the practice is a participant in.

What is established, and what is not. Established: the group performs cardiac catheterisation, transcatheter aortic valve replacement, pacemaker and generator implantation, implantable loop recorder placement, carotid endarterectomy and transcarotid artery revascularization in hospital settings across three admitting facilities.[22] Those procedures generate a continuous stream of discharges belonging to this practice. **Not established: whether any transitional care management is billed today**. No practice-level Medicare claims analysis was performed for this account, and the practice's website says nothing about a post-discharge programme. *This report therefore makes no claim about current transitional-care billing, and none should be inferred — it is a discovery question, and one of the more valuable ones.*

Why this window is worth asking about before anything else

Three facts converge on the same fourteen days. The group carries **two-sided downside risk**, where a readmission is a direct charge. Its own monitoring programme is built around blood pressure rather than the **daily weight** signal that predicts heart-failure decompensation. And **the short-window codes that make those fourteen days billable only arrived in CY2026** — 99445 for 2–15 days of data, and 99470 for the first 10 minutes of management time.

A programme designed before 2026 had no billable mechanism for that window, because none existed. That is not a failure of design; it is a policy change that has not necessarily been acted on yet. **It is also the single cheapest addition to an existing programme, because the enrollment relationship, the device logistics and the nurse are already there.**

The post-discharge window, in billing terms

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

[22] The practice's hospital-services page, retrieved August 3, 2026, which names cardiac catheterisation, pacemaker placement and generator replacement, implantable loop recorders, transcatheter aortic valve replacement, carotid endarterectomy and transcarotid artery revascularization as procedures performed by the group in hospital settings. No procedure volume figure of any kind is asserted in this report; no practice-level Medicare claims analysis was performed for this account.

Post-discharge readiness checklist

- A daily feed or process that tells the practice which of its patients were discharged yesterday, from which of the three hospitals — the single most common point of failure in a transitional care programme, and harder here than at a single-hospital practice because there are three sources and no shared electronic record with any of them.
- A standing two-business-day interactive contact protocol with named ownership and an escalation path, documented to survive audit.
- Device logistics that work at discharge rather than at the next office visit. The practice already drop-ships devices to homes, so the capability exists — the question is whether the trigger is a discharge or a clinic visit.
- Daily weight as the primary stream for heart-failure discharges, not blood pressure alone.
- A readmission view the practice can show its accountable care organization and its hospital partners, so the group's contribution is measured rather than asserted.
- An agreed definition of which post-discharge activity is the practice's and which belongs to a referring primary-care physician, written before the next enrollment.

One point on sequencing, because it determines who has to say yes. None of this requires a hospital's agreement to begin. The transitional-care and short-window remote-monitoring revenue is the practice's own, billed under its own taxpayer identification number, whether or not any hospital or accountable care organization ever co-invests a dollar. **The partner conversation is what the capability makes possible — not what it depends on**. And where a hospital or network does support, subsidise or co-invest in physician-practice services, the arrangement must be structured to comply with the physician self-referral and anti-kickback rules. *Take that structure to healthcare counsel before it is proposed, not after.*

9. Powering Procedural Throughput: Structural Heart, Device and Hypertension

Remote care is usually sold as a chronic-disease programme. In a group with this procedural profile it is also a retention and throughput instrument, and the mechanism is specific: **a monitored pathway is what keeps a post-procedure or referred patient attached to the practice rather than transferring the relationship along with the referral**. For a group actively moving volume into its own ambulatory surgery centre and its own imaging suite, that retention is the same asset viewed from a different angle.

Line	What the practice's own sources establish	What the service line adds
Structural heart	**Live.** Transcatheter aortic valve replacement appears on the practice's hospital-services page, and the practice published its own structural-heart explainer in April 2026	Post-procedure blood-pressure, weight and symptom monitoring in the 2–15 day window, now billable via 99445; structured follow-up that keeps the patient in this practice's orbit rather than the implanting hospital's
Electrophysiology and device implant	Pacemaker placement, generator replacement and implantable loop recorders are all named on the hospital-services page, and the practice runs a named heart-rhythm service line	**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 and the workflow in Section 11.3)
Remote device interrogation	**Near-certain in practice, unverified in public.** A group implanting pacemakers, generators and loop recorders is almost certainly following them remotely — but **no device-clinic or remote-interrogation page exists anywhere on the site**, and this report asserts nothing about it	**Remote interrogation (93294–93298) is a separate revenue stream from physiologic monitoring (99453 onward), and the two do not substitute for each other.** If interrogation is running and under-billed, that is a finding in its own right. If it is running well, it is proof the practice already has the alert-triage habit the service line needs
Vascular and vein	Peripheral arterial disease, carotid artery disease, aortic aneurysm, renal artery stenosis, vascular surgery, carotid endarterectomy and transcarotid artery revascularization; plus a vein service	Not a remote-monitoring line in itself, but evidence of a broad procedural base the enrollment engine should be scoped to — and a reminder that the referral engine is 40 clinicians wide, not 25
Hypertension and renal denervation	**No evidence of renal denervation** on the practice's published procedure list, and this report assumes none. Renal *artery stenosis* appears on the vascular list and is a different condition entirely — the two should not be conflated	**Policy-aligned whitespace, not a current capability.** CMS national coverage determination 20.40 covers renal denervation for uncontrolled hypertension effective October 28, 2025 under Coverage with Evidence Development. Blood-pressure monitoring is intrinsic to that pathway — for candidate identification, for titration, and for the evidence the coverage condition requires. **The practice already has the blood-pressure monitoring half of it.**
Imaging and the ambulatory surgery centre	A newly opened positron-emission-tomography scanner at the Stuart headquarters and a new ambulatory surgery centre in Port St. Lucie, both framed by the practice as outpatient capability	Capital investments that pay back on throughput and on retained patients. A monitored longitudinal relationship is the cheapest retention mechanism available, and it feeds the candidate pipeline for both assets

Two honest exclusions belong in this section. First, **no procedure volume figure of any kind appears in this report** — no catheterisation count, no valve volume, no implant count. No practice-level Medicare claims analysis was performed for this account, and inventing directional volumes would be the

exact failure mode this report is written to avoid. Every capability above is named because the practice names it, and none is sized. Second, **read the renal-denervation row as an option, not a plan**. Nothing in the public record indicates this group performs the procedure. The point is narrower and more useful: a practice already running a blood-pressure monitoring programme across a large treated-hypertension population is in the natural position to build a resistant-hypertension pathway — and that pathway is the prerequisite for the procedure whenever the group chooses to look at it.

10. EMR Integration & Technology Architecture

10.1 NextGen confirmed — and a tenant that predates the rebrand

What is verified here, and what has to be confirmed in discovery

Verified: the platform is NextGen, and the evidence is direct rather than inferred. The practice's global navigation links, on every page, to a live NextGen Patient Experience Platform portal — NextGen's hosted patient portal, which is tightly coupled to NextGen Enterprise. A practice does not run that portal without running NextGen.[23]

Verified: the tenant predates the rebrand, and it has not been renamed. The portal's tenant slug encodes the **legacy Stuart cardiology professional-association name** plus an internal client identifier — meaning the NextGen relationship is older than the December 2025 rebrand and the tenant record still carries the prior legal name. A commercial firmographic file records NextGen for this practice and is correct.

Adjacent stack, also confirmed. A patient intake and payments platform powers the practice's online bill-pay. Beyond that and the practice's own content-management host, **no third-party clinical or monitoring platform appears in any page source** across the home, patient-support, prepare-for-visit, insurance, referral or careers pages. No competing electronic-record fingerprint appears anywhere.

The integration question this raises, and it is the sharpest technical finding in the account. Both programme pages state that there is no application to download and no portal to log into. **That strongly suggests device readings and nurse contact time may not be flowing into NextGen as discrete, structured elements today** — they may live in a separate system, or in call notes. *If that is the case, it has consequences for audit defensibility, for quality reporting, and for the electronic collaborative care arrangement the specialty model requires. It is a concrete, checkable discovery question rather than an assertion.*

Why a stable, long-standing NextGen tenant is good news for this programme. It means there is no migration in flight, no competing build queue, and no tenant-ownership question — the practice controls its own record, unlike a group hosted inside a health system's instance. NextGen integration is a well-trodden path. The one caveat worth flagging is that the tenant still carries a legacy legal name, which is the same integration-debt pattern Section 1.2 describes elsewhere in the account: the brand moved faster than the underlying records did.

10.2 What the integration does

The integration pattern is well established for NextGen; only the connector, the scope and the timeline vary. What it delivers:

- **Enrollment inside the chart.** Referral to the service line is one order in the existing record, not a separate system, a separate login or a paper form — which is what makes uniform enrollment across seven sites achievable rather than aspirational.
- **Enrollment status visible in real time.** Whether a patient is enrolled, which programmes they are on, and which device they hold — visible to the clinician at the point of the next decision rather than in a monthly report.
- **Structured clinical exchange.** Health history out; vitals, evidence of care and care plans back into the chart on a monthly cadence, so the record the practice is audited on is the record it already keeps — and the record it can share with referring primary-care physicians.
- **Automated claim generation.** The monthly per-patient claim is generated by the billing engine rather than assembled by hand.

[23] The practice's global navigation links, on every page, to a live NextGen Patient Experience Platform portal on NextGen's hosted-portal domain, with a tenant slug encoding the legacy Stuart cardiology professional-association name plus an internal NextGen client identifier - meaning the NextGen relationship predates the December 2025 rebrand and the tenant has not been renamed. Retrieved August 3, 2026.

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

10.3 Why automated claim generation matters here specifically

This is not a general benefit; it is the specific difference between a programme that scales at this practice and one that does not. At a modeled census of **6,826 active programme enrollments at month 24**, across seven offices in four counties and 40 referring clinicians, the monthly billing task is thousands of per-patient, per-code, time-documented claims — each one dependent on evidence that the monitoring days and the management minutes were actually met. **The model projects 151,561 billed units over 24 months.** No back office assembles that by hand, and the failure mode is not a rejected claim; it is a programme that quietly stops billing what it delivers. **That failure mode is the exact one Section 5.2 asks about in the existing programme**, and automated generation from the monitoring record is the structural answer to it — it makes the capture rate in Section 11.5 a real operating metric rather than an aspiration.

11. Implementation Playbook: Building the Remote Care Service Line

11.1 Goals, scope, and the modeled funnel

The goal for the first twelve months is a named service line with its own P&L, a physician lead, a defined target population, uniform coverage across all seven sites, and a first billable enrollment inside 90 days. Because programmes already exist here, the first 30 days are diagnostic rather than constructive — census, code mix and per-site coverage before anything is built. The modeled funnel is deliberately conservative and bottom-up:

Model input	Value	Note
In-scope base	26,035	Discovery-stage estimate — validate against chart counts
Referring clinicians	40	25 physicians and 15 advanced practice providers, counted from the practice's own pages
Referrals per clinician per month	8	With 80% patient acceptance
On-site enrolment specialist	1 (≈80 enrollments / month)	**CoachCare's expense — embedded value, never deducted from practice margin**
RPM eligibility / acceptance	75% (19,526) / 35%	Modeled ceiling 6,834 patients; at 5,100 at month 24 and still climbing
PCM eligibility / acceptance	85% (22,130) / 30%	Modeled ceiling 6,639; at 1,725 at month 24 — the arm with the most headroom
Revenue basis	Net of a 14% realization discount	Payer mix and collection, as configured in the model
MAC locality	FL 09102-03 (ZIP 34996)	Auto-resolved in the Value Analysis; confirm per site against the Florida locality files

Target populations and clinical pathways

Population	Why it is first	Pathway
Heart failure at the Vero Beach and Sebastian sites	Both CY2027 preliminary listings sit at these two sites, both are the most recently added and geographically furthest, and the monitoring programme already names congestive heart failure as a qualifying population	Daily weight plus blood-pressure monitoring with 24/7 triage; PCM as the monthly chassis; titration against measured response
Post-discharge cardiac, across all three admitting hospitals	Continuous discharge volume from catheterisation, valve procedures, device implants and vascular surgery — and a readmission is a direct charge under two-sided risk	TCM 99495 / 99496 (not modeled) plus short-window RPM via 99445 / 99470
Heart failure across the remaining five sites	The larger population, and the one that makes the census. Extending an enrollment habit the practice already has is faster than introducing one	Weight and blood-pressure RPM plus PCM, with the same protocol at every site
Uncontrolled and resistant hypertension	The population the existing blood-pressure programme is already built for — the opportunity is depth of billing and titration cadence rather than new enrollment	Blood-pressure RPM; protocolised titration; the candidate pool for any future resistant-hypertension pathway (Section 9)

Population	Why it is first	Pathway
Post-implant and post-valve	Pacemaker, generator, loop recorder and transcatheter valve volume across three hospitals, and a new ambulatory surgery centre adding outpatient procedures	Short-window RPM (99445), kept explicitly distinct from device interrogation (Section 11.3)

A sequencing recommendation the account's own structure supports. Start at Vero Beach and Sebastian rather than at headquarters. That is counter-intuitive — the instinct is to pilot where the density and the leadership are — but the two northern sites are where the CY2027 listings sit, where programme coverage is least likely to be uniform, and where a result is most diagnostic. **If the programme runs well there, it runs anywhere in this footprint**. Headquarters follows immediately behind, with the Palm Beach sites third. This is a sequencing recommendation and not an exclusion: every site is in scope in Year 1 in the model.

11.2 Staffing: nobody has to be hired

The model delivers **67,354 care-team hours over 24 months — approximately 32.4 full-time equivalents** — supplied by the partner under the practice's protocols and clinical supervision, alongside 303,122 care-management tasks, 75,780 chart updates, 45,468 patient conversations and 2,526 hours of call time. For a group with no identifiable non-physician executive function and no population-health department, across seven sites in four counties, this is the layer that makes uniform coverage possible rather than aspirational. **The on-site enrolment specialist is funded by CoachCare: embedded value, never deducted from the practice's margin, and never a practice cost line.**

What the practice supplies is clinical direction, general supervision, and the physician lead who owns the programme's escalation protocol. What it does not supply is headcount. **One planning note specific to this footprint:** a single on-site enrolment specialist covering seven sites across seventy miles will concentrate at headquarters unless the rotation and a telephonic lane are designed deliberately. Since both arms are pace-limited rather than ceiling-limited (Section 2.2), a second enrolment pathway is the highest-leverage change available to the forecast — worth modelling explicitly before Year 2.

11.3 The device-interrogation boundary, and how to keep it clean

This practice runs an electrophysiology service and implants pacemakers, generators and implantable loop recorders. Remote device interrogation is therefore near-certain in practice, even though no public page describes it. That makes the boundary between the two remote benefits an operational design question here rather than a theoretical one.

	Remote cardiac device monitoring (93294–93298)	Remote physiologic monitoring (99453 onward)
What is measured	The implanted device's own telemetry — lead integrity, arrhythmia episodes, device diagnostics	Patient-generated physiologic data from a separate connected device — blood pressure, weight, pulse oximetry
Who it covers	Patients with an implanted pacemaker, defibrillator or loop recorder	Any patient with a qualifying condition — the great majority of a cardiovascular panel has no implanted device at all
What clinical question it answers	Is the device working, and has an arrhythmia occurred	Is this patient decompensating, is the blood pressure controlled, is the titration working
Status at this practice	**Unverified — no public page, but near-certain given the implant volume**	**A programme exists; its depth, census and code mix are unknown**

The two are different benefits over different data, and they answer different questions. The design rule is that the same data stream is not billed twice: a distinct device generating distinct physiologic data supports a distinct service, and the documentation has to make that distinction obvious on its face. *Confirm the specific code pairings with the payer and with billing counsel before launch.* Two notes specific to this group. If a device clinic is already running remote interrogation, the staff who triage those alerts are the natural operators of a physiologic programme — the hardest habit is already in place. And they will hold strong, well-informed opinions about alert thresholds, documentation and escalation. **Treat remote-monitoring governance here as a conversation with experts, not an education.**

11.4 Clinical workflow

1. **Audit first.** Before anything is built: enrolled census by programme and by site, code mix, and whether management-time rungs are captured. Thirty days, and it determines whether the next step is extend, replace or stop.
2. **Identify.** Heart failure, uncontrolled hypertension, post-discharge, post-implant and post-valve — built from the practice's own record, seeded at the two northern sites and by the daily discharge list.
3. **Enroll.** One order in the NextGen chart. Consent, device selection and logistics handled by the partner; the on-site enrolment specialist covers the offices in rotation, with a telephonic pathway behind it — which matters disproportionately across a footprint this geographically spread.
4. **Monitor.** Daily physiologic data with 24/7 review and alert triage against thresholds the physician lead sets — not vendor defaults. Daily weight is the primary stream for heart failure; blood pressure for hypertension.
5. **Escalate.** A defined path from alert to nurse contact to same-week outpatient intervention, with the emergency department as the exception rather than the default. This is where the 421 modeled avoided admissions actually come from, and where the downside-risk value is realised.
6. **Titrate.** Guideline-directed therapy adjusted against measured response on a schedule, with PCM as the monthly billing chassis for the work.
7. **Document and bill.** Time, readings and interventions captured as a by-product of care; claims generated automatically from the monitoring record (Section 10.3).
8. **Report back.** Structured monthly reporting to the referring primary-care physician — good practice, a referral-retention mechanism, and the substrate for the collaborative care arrangement the specialty model requires.

11.5 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	These are the measures a heart-failure cohort would be scored on from 2027, and they are the same measures that move an ENHANCED-track result today
Operational	Enrolled census by programme **and by site**; enrollment conversion rate by site; device compliance (days with data); alert-to-contact time	Census is revenue. Days-with-data is what makes 99454 and 99445 billable in the first place. Per-site reporting is non-negotiable in a seven-site group — a blended average will hide exactly the coverage gap this report is most concerned about
Financial	Time to first billable enrollment; capture rate (billed ÷ eligible); net reimbursement per patient per month; net to practice	Modeled at ~$100.59 per RPM patient-month and ~$94.01 per PCM patient-month. Capture rate is the metric that quietly decides whether the modeled P&L is realised, and it is the metric Section 5.2 suspects is the gap in the existing programme

Domain	Metric	Why it is on the dashboard
Strategic	Post-discharge reach rate within two business days; readmission delta versus the unenrolled panel; referral retention by referring practice	The numbers to take into an accountable-care or hospital conversation, and the ones that make the group's contribution measurable rather than asserted

Expected impact over 24 months, as modeled: $8,352,391 of net reimbursement and $3,532,751 net to the practice at a 42.30% margin; 5,618 unique patients and 6,826 active programme enrollments at month 24; 662,476 physiologic readings; 151,561 billed units; approximately 421 avoided hospitalizations; and 67,354 care-team hours delivered. Month 1 is modeled at $1,578 of practice profit. *All figures are illustrative, modeled — verify against practice data.*

11.6 Twelve-month roadmap

Phase	Months	What happens
Diagnose	0–1	Where the decision sits established; enrolled census, code mix and per-site coverage of the existing programmes audited; the taxpayer-identification-number question at Vero Beach and Sebastian resolved; the six unresolved physician identifiers closed; MAC locality confirmed per site
Charter	1–2	Service line chartered with its own P&L; physician lead named; target populations agreed; attribution and coordination policy written before the next enrollment; the device-interrogation boundary documented
Stand up	2–4	NextGen integration built; alert thresholds and escalation protocol set by the physician lead; on-site enrolment specialist placed with a defined seven-site rotation and a telephonic lane behind it; discharge-notification process agreed with each of the three admitting hospitals
First census	3–6	Heart failure at Vero Beach and Sebastian first, then post-discharge across all three hospitals; first billable enrollment inside 90 days; the model is net-positive from month 1
Extend	6–9	Remaining five sites brought on to the same protocol; hypertension depth and post-implant pathways added; a second enrolment pathway opened, because both arms are pace-limited rather than ceiling-limited and referral throughput is the binding constraint
Institutionalise	9–12	Monthly per-site scorecard running; capture rate and readmission delta reported into the accountable care organization; transitional care management decision taken on its own merits; the final CY2027 participant list re-verified and the readiness plan in Section 7 confirmed against it

References & Data Sources

- **The practice's own website** (floridacardiovascular.com — home, about, locations, cardiologists, advanced practice providers, services, hospital-services, imaging-technology, careers, blog and sitemap, plus each location page's structured data; retrieved August 3, 2026): the seven active locations and their counties, the 25-physician and 15-advanced-practice-provider roster, the confirmed sub-specialties and hospital-based procedures, the positron-emission-tomography installation, and the absence of any cardiac rehabilitation, telehealth or device-clinic page. Provider counts were taken from individual profile pages, never from a directory aggregator.
- **The practice's two dedicated programme pages** (remote patient monitoring, and chronic care management branded “Connected Care”; retrieved August 3, 2026), quoted in Section 5.1: the complimentary condition-based blood-pressure monitor, direct home delivery, automatic transmission, the dedicated remote nurse, the preconfigured no-smartphone/no-Wi-Fi/no-application device model, the naming of congestive heart failure as a qualifying population, and the Medicare-coverage and cost-share language on both pages.
- **The practice's rebrand announcement, published December 1, 2025** (on its own blog): the 2023 partnership with the organisation it abbreviates “USHP”, the two-to-eight location and 80-to-190 employee growth, expansion into two additional counties, the new Port St. Lucie ambulatory surgery centre, and the enhanced cardiac imaging programme.
- **NPPES NPI Registry** (queried August 3, 2026 via the working CMS host): organizational National Provider Identifier 1871603332 for STUART CARDIOLOGY GROUP LLC, with “Florida Cardiovascular Partners” and “FLCVP” recorded as doing-business-as names, an internal-medicine cardiovascular-disease primary taxonomy, and a record last updated December 15, 2025; the legacy Stuart-area cardiology organization at the vacated address, last updated 2018; and 19 of the group's 25 physician identifiers with their primary taxonomies. Address-based registry search was found unreliable and was not used; all lookups were run by name, state and enumeration type and then filtered on taxonomy and city.
- **CMS Medicare Shared Savings Program — Accountable Care Organization Participants** (public-use dataset, 15,329 of 15,370 rows retrieved, queried August 3, 2026): the exact match on the practice's legal name as a participant taxpayer identification number in PBACO Holding, LLC (ACO A1001) — ENHANCED track, fourth agreement period, initial start July 1, 2012, current start January 1, 2025, low-revenue, retrospective assignment, skilled-nursing three-day-rule waiver, six-state service area, 822 participant taxpayer identification numbers. The same file establishes that the health-system-affiliated Florida organization recorded by a commercial file has exactly four participants, none of them this practice.
- **CMS Ambulatory Specialty Model Participants** (CY2027 **preliminary** participant file, all 6,637 rows retrieved and de-duplicated; dataset modified February 4, 2026; retrieved August 3, 2026): two Heart Failure cohort listings matching the group's physician identifiers, both with the CY2027 participant flag and the CY2027 small-practice flag set to Yes, both under pre-acquisition legal entities; zero rows for the group's own billing entity, its trade name, its abbreviation, the legacy Stuart cardiology entity and every plausible parent-company string, across all states. The file's state column was never used as a filter. **CY2028 through CY2031 flags are null; no final CY2027 list existed in the CMS catalog as of the retrieval date.**
- **CMS Provider Data Catalog — Hospital General Information** (retrieved August 3, 2026): CMS Certification Numbers, ownership type and CMS overall star ratings for the three hospitals in the practice's referral footprint.
- **NextGen Patient Experience Platform portal evidence** (retrieved August 3, 2026): the live portal link in the practice's global navigation, its hosted-portal hostname, and the tenant slug encoding the legacy professional-association name plus an internal client identifier. The patient intake and payments platform powering online bill-pay, and the practice's own content-management host,

were identified from the same page-source inspection — which found no monitoring-vendor script, pixel, iframe or asset of any kind.

- **CMS — CY2026 Medicare Physician Fee Schedule:** TCM 99495 and 99496; RPM 99453, 99454, 99445, 99457, 99470 and 99458; PCM 99424–99427; the concurrency rules under which RPM and PCM stack; and the 30-day single-practitioner rule for remote physiologic monitoring. Locality-adjusted payment for this practice is set by the Florida Medicare Administrative Contractor; the model resolves locality 09102-03 for ZIP 34996.
- **CMS Ambulatory Specialty Model programme documents** (model overview and participant readiness materials, retrieved August 3, 2026): the January 1, 2027 start, the five performance years 2027–2031 and payment years 2029–2033, the −9% to +9% adjustment in the first two performance years rising toward −12% to +12% by the final performance year, budget neutrality, participant identity by taxpayer identification number and National Provider Identifier, the four scored categories and their individual versus group-level assessment, and the required electronic collaborative care arrangement with primary care.
- **CMS national coverage determination 20.40,** renal denervation for uncontrolled hypertension, effective October 28, 2025 under Coverage with Evidence Development.
- **A commercial firmographic export,** caller-supplied, vintage unknown, used only as a cross-check and cited in this report solely where it disagrees with a primary source: it reports six locations against seven verifiable, a single county against four, 24 physicians against 25, an incorrect accountable care organization, an unsupported chief-executive title, and an unverified practice-level Medicare allowed amount. Its address and electronic-record fields are correct. Its admitting mix figures are undated and are the only place in this report where its numbers are quoted, labelled as directional.
- **CoachCare Value Analysis companion model —** all modeled economics, clinical and operational forecasts in Sections 2.2, 4.1, 6, 7 and 11, including the 26,035-patient in-scope base, 75% / 85% RPM / PCM eligibility, 35% / 30% acceptance, a 14% realization discount, the 40-clinician referral engine at eight referrals per clinician per month with 80% acceptance, one on-site enrolment specialist at CoachCare's expense, and MAC-locality rates auto-resolved for ZIP 34996 (Florida, locality 09102-03).

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.

- **Who selected the existing monitoring and care-management programmes, and at what level.** If they were standardised above the practice, the practice may not be the buying unit at all. *This is the single biggest qualification risk in the account.*
- **Which vendor or vendors run the two programmes.** No fingerprint of any kind was recoverable from either page — no script, pixel, iframe or asset. No vendor is named or implied anywhere in this report, and none should be assumed in any conversation.
- **Enrolled census, code mix and per-site coverage of the existing programmes.** Marketing a programme establishes nothing about penetration. Whether the management-time and add-on rungs are captured, and whether coverage is uniform across all seven sites, are unknown and are the two most valuable numbers to ask for.
- **The corporate identity behind the abbreviation the practice uses for its parent network.** The obvious domain does not resolve to a working corporate site. One frequently assumed candidate was ruled out on a decisive test — this practice is absent from that company's own published partner-practice list. **No sponsor, parent or capital source is named or implied in this report.**

- **Whether the two named physicians still bill under the legacy entities.** The CY2027 preliminary listings sit under pre-acquisition legal entities at the Vero Beach and Sebastian sites. Whether those entities remain active, and which taxpayer identification number each physician bills under today, is knowable only inside the practice.
- **Six of the 25 physicians could not be resolved to a National Provider Identifier.** The specialty-model check is complete for 19 of 25 and open for six. A surname scan of the full participant file found no plausible Florida match for any of the six, but that is weak negative evidence rather than a clean result.
- **Whether remote cardiac device interrogation is performed and billed, and by whom.** Near-certain given an electrophysiology service, pacemakers, generators and implantable loop recorders — but no device-clinic or remote-interrogation page exists and nothing is asserted here. It is a distinct revenue stream from physiologic monitoring.
- **County demographics, senior share and Medicare Advantage penetration.** Not retrieved during research, and material: Shared Savings Program participation and the specialty model both cover Original Medicare only, so Medicare Advantage share directly sizes the population sitting outside them. *No demographic or penetration figure is asserted anywhere in this report.*
- **Practice-level Medicare claims history.** No per-provider service record, risk-score profile, condition-prevalence read or code-level utilization screen was performed for this account. No procedure volume, panel acuity figure or current-billing claim appears anywhere in this report as a result.
- **True unique-patient panel size and payer mix.** The 26,035-patient in-scope base is a discovery-stage modelling estimate rather than a counted chart population, and a commercial file's practice-level Medicare allowed amount was not independently verified. Every figure in Section 2.2 scales with this input.
- **MAC locality across the full footprint.** The model prices off the Stuart headquarters ZIP. Seven sites across four counties and three statistical areas should be confirmed site by site against the current Florida locality files before budgeting.
- **Entity form — professional association versus limited liability company.** The patient-portal tenant and a state corporate-registry result reference one form; CMS files carry the other. The state registry was gated behind an automated-access challenge that was not bypassed. A conversion or parallel entities is likely but unverified.
- **Whether the legacy Stuart-area cardiology entity at the vacated address was formally acquired, and when.** The address match and the timing are strong circumstantial evidence; the transaction itself is not documented in any public source found.
- **Whether the practice holds Medicare Advantage or commercial value-based contracts directly.** No payer or risk page appears on the site and no evidence was found either way.
- **The active location count.** The site claims eight, exposes seven location pages, and still links a site it says it vacated in July 2026. Seven is treated as the verifiable active count throughout.
- **Third-party news, litigation and quality awards.** Not retrievable during research — the session's search budget was exhausted. The practice's own news feed carries seven posts, only one of them corporate. Treat coverage here as weak rather than as searched-and-empty.

Global verification caveat

Facts in this report reflect public sources current to August 2026 and are cited above. Items flagged “CoachCare-provided,” “stated assumption,” “estimate,” “probable” 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. The Ambulatory Specialty Model finding rests on the **preliminary** CY2027 participant list, is attributed to pre-acquisition legal entities rather than to the group's own billing entity, is complete for 19 of 25 physicians, and must be re-checked against the final file. No practice-level Medicare claims analysis was performed for this account, so no procedure volume, panel acuity figure or current-billing claim appears anywhere in this report. All Value Analysis outputs are illustrative, modeled — verify against practice data.

Prepared by CoachCare · August 2026.