COACHCARE | SERVICE LINE STRATEGY

San Diego Cardiac Center

San Diego Cardiac Center Medical Group, Inc. · Kearny Mesa, Chula Vista and El Cajon, California — an independent, physician-owned cardiology group

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

Scaling a remote-monitoring programme the practice already runs into a full Remote Care Service Line (TCM + RPM + PCM) — the operating spine for post-discharge accountability at five mandatory-TEAM hospitals, 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 San Diego Cardiac Center Medical Group, Inc. It assembles the group's public footprint, its CY2024 Medicare service record, its verified position relative to a mandatory CMS episode model, the county's Medicare enrollment and payer structure, the 2026 payment environment, and a modeled financial forecast into a single argument: this group proved the clinical model years ago and bills for it today, and the operating layer that would take it from seven physicians to the whole bench — and from one code family to the full post-discharge and monthly-management stack — has never been built.

All facts are drawn from public sources current to August 2026 and cited in the References section. All financial projections are illustrative and modeled in the CoachCare Value Analysis (MAC locality auto-resolved for ZIP 92123 — California, locality 01182-72) — verify against practice data before budgeting.

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

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Executive Summary

San Diego Cardiac Center is the trade name of **San Diego Cardiac Center Medical Group, Inc.**, an independent, physician-owned California professional medical corporation (entity 1247885, filed 1984, active) headquartered at 3131 Berger Avenue in the Kearny Mesa district of San Diego, with additional offices in Chula Vista and El Cajon. It holds its own organizational NPI and its own Medicare group enrollment, and CMS reassignment records current to July 14, 2026 show **26 clinicians reassigning benefits to the group — 23 physicians and 3 nurse practitioners**.[1] Every corporate officer and director on the state registry is one of the group's own practising cardiologists; no health system, management-services organization or private-equity sponsor appears anywhere in the governance. The group is a member practice of **Sharp Community Medical Group** — an independent physician association affiliated with Sharp HealthCare — and it simultaneously appears in Scripps Affiliated Medical Groups' own practice directory, something an employed group could not do. Sharp's public physician pages label these clinicians “Sharp Community,” not with Sharp's employed multispecialty group. It is, in the most literal sense, still its own company.

Three facts define this report, and all three come from the group's own CY2024 Medicare claims record.

1. **This practice already bills remote physiologic monitoring, and it works.** In CY2024, **seven of the group's nineteen CMS-listed physicians billed the remote monitoring code family on roughly 241 Medicare fee-for-service patients, $199,018 allowed**.[2] That is not a pilot. It is a working clinical service with device logistics, data review and monthly management time behind it. **Nothing in this report argues that the practice should start doing remote monitoring. It argues about what happens to the other two thirds of the bench, and to the rungs of the ladder above and below the ones being billed.**
2. **The add-on rung is billed by exactly one physician, and the rest of the care-management stack is at absolute zero.** 99458 — each additional 20 minutes of monthly management — was billed by **one physician, on 26 patients**, against 244 patients receiving the first-20-minute code. Setup (99453) was captured on 41 patients against 241 on device supply. And across **all 23 practitioners**, chronic care management, principal care management, transitional care management, remote physiologic data review (99091), remote therapeutic monitoring and self-measured blood pressure returned **zero services on every code**.[3]
3. **Five hospitals the group staffs entered mandatory 30-day episode accountability on January 1, 2026 — and the practice bills no transitional care at all.** CMS facility-affiliation data resolved across the group's 18 cardiology NPIs places privileges at five hospitals that are all **mandatory participants in the Transforming Episode Accountability Model** — Sharp Grossmont (CCN 050026), Sharp Chula Vista (050222), Sharp Memorial (050100), Sharp Coronado (050234) and Scripps Mercy San Diego (050077), all in CBSA 41740, all with a performance period running January 1, 2026 to December 31, 2030.[4] **The practice itself holds no CCN and is not, and**

[1] CMS Revalidation Clinic Group Practice Reassignment file, data vintage and dataset modification July 14, 2026; all rows carrying group PAC ID 8628045986 and group enrollment identifier O20040917000439. 26 reassignments: 23 physicians and 3 nurse practitioners. Officer and director information from the California Secretary of State business registry, extract dated July 27, 2025, obtained via a third-party mirror because the registry blocks automated retrieval - treat officer titles as corroborated but re-pull before contractual use.

[2] CMS Medicare Physician & Other Practitioners - by Provider and Service, CY2024 (data vintage December 1, 2024; file modified May 21, 2026), queried per NPI across all 23 practitioners on August 3, 2026. 99454: 7 physicians, 241 beneficiaries, 1,984 services, $109,974 allowed. 99457: 7 physicians, 244 beneficiaries, 1,622 services, $86,797. 99453: 3 physicians, 41 beneficiaries, $948. 99458: 1 physician, 26 beneficiaries, 31 services, $1,299. Total allowed $199,018; total paid $150,270. Traditional Medicare fee-for-service only.

[3] Same file and vintage. All 23 practitioners queried individually against 99490, 99439, 99491, 99487, 99489; 99424-99427; 99495, 99496; 99091; 98975, 98977, 98980, 98981; and 99473, 99474. Zero services on every code, for every practitioner. CMS suppresses any provider / HCPCS / place-of-service line with fewer than 11 beneficiaries, so what this establishes is the absence of a programme at meaningful scale in CY2024.

[4] CMS TEAM Participant List, hospital list as of April 15, 2026 (CMS updates it quarterly), downloaded August 3, 2026: 720 participant hospitals across 189 core-based statistical areas; CBSA 41740 San Diego-Chula Vista-Carlsbad carries 15 participant hospitals. Privileges resolved from CMS Facility Affiliation Data (dataset 27ea-46a8, updated June 26, 2026) across all 18 of the group's cardiology NPIs. CCNs independently resolved against CMS Hospital General Information (dataset xubh-q36u).

cannot be, a TEAM participant — participation attaches to a hospital CCN. Its admitting hospitals carry the episode accountability. It supplies the cardiology.

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 **$6,608,698** of net reimbursement and **$2,811,277** net to the practice over 24 months, a **42.54% 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 post-discharge window five mandatory-TEAM hospitals are now reconciled on, the scaling of the group's existing remote-monitoring programme across the whole bench, procedural throughput in structural heart and rhythm management, referral and readmission defense, and the standalone P&L. Build once, use everywhere.

The wedge, stated as precisely as the data allows. The group's CY2024 traditional-Medicare book is **$8,926,576 of allowed charges across 20 practitioners**.[5] Its remote-monitoring line inside that book is $199,018 — roughly **2.2% of its own Medicare revenue**. The programme is not failing; it is stranded. It is run as a clinical habit by a minority of the physicians rather than as an operationalised service line, it is marketed nowhere — a crawl of all 95 pages on the practice's website returns zero mentions of remote monitoring, care management, or any monitoring platform[6] — and the codes that carry most of the per-patient yield are either unharvested or unbilled. **The right reading of that is a compliment, not a criticism**: this group proved the clinical model before most cardiology practices in the country did, and then never built the machine around it.

The clinical substrate is unusually deep for a group this size, and it is the reason the modeled census is credible. Three of the nineteen CMS-listed physicians are board-certified in advanced heart failure and transplant cardiology — a bench most independent groups do not have. The practice runs a heart failure programme established in 1998 with a dedicated heart-failure nurse practitioner, a nurse-staffed anticoagulation clinic on a 15-minute recurring-visit protocol, and a device clinic billing remote interrogation on hundreds of beneficiaries a year. It was a site on a pivotal implantable pulmonary-artery-pressure trial, it is an active site on a remote-sensor insertable-cardiac-monitor study, and it publishes on hemodynamic sensor management under its own affiliation.[7] **Nurse-led, protocol-driven, between-visit chronic care is not a concept this practice needs sold to it. It has been running versions of it for nearly thirty years.**

[5] CMS Medicare Physician & Other Practitioners - by Provider, CY2024 (released May 21, 2026): total allowed $8,926,576 and total paid $6,857,996 across the 20 practitioners with CY2024 Medicare billing. Note that a widely used commercial firmographic file reports the paid figure under an allowed label; the account should be sized on the allowed amount.

[6] Full crawl of all 95 URLs in the practice's published sitemap, August 3, 2026: zero occurrences of remote patient monitoring, chronic care management, principal care management, remote therapeutic monitoring, care coordinator, care management, nurse navigator, device clinic, pacemaker clinic, home monitoring, telemonitoring, population health or heart failure clinic, and zero occurrences of CPT 99453, 99454, 99457 or 99490. This is absence of evidence about marketing, and is a weaker class of evidence than the billing negatives in note 3.

[7] ClinicalTrials.gov and PubMed, queried August 3, 2026. Pivotal implantable pulmonary-artery-pressure trial: NCT03387813, site participation March 2018 to May 2023. Active remote-sensor insertable-cardiac-monitor study: NCT04790344, active and not recruiting, completion July 2026. Home wearable atrial-fibrillation detection: NCT04074434 and NCT04546763. Home natriuretic-peptide assessment: NCT00946231. Publications carrying the practice's affiliation include PMID 37079511 (pulmonary artery pressure sensor management, June 2023), PMID 42183013 (May 2026) and PMID 41879576 and 42455094 (adult Kawasaki disease, July 2026).

The market backdrop needs correcting before it is used. San Diego is routinely described as a heavily capitated market. It is more accurate to call it a heavily *delegated* one — the distinction matters commercially. Medicare Advantage penetration in San Diego County is **53.6%**, only about 2.1 points above California and 2.4 points above the nation, and the county has been essentially flat at ~53% for four years while the national rate climbed toward it.[8] The commercially important number is the other one: **289,032 traditional fee-for-service Medicare beneficiaries in San Diego County**. Transitional care, remote monitoring and principal care management are fee-for-service benefits, and that is the pool they are billed against. What is genuinely distinctive about this market is the delegated structure — physician organizations holding professional risk under health-plan delegation — and the group's exposure to it is bounded: it contracts with HMO plans only as a downstream specialist inside the Sharp Community Medical Group network, and holds no direct capitation of its own.

And there is no shared-savings offset anywhere in the picture. The group appears in **no Medicare Shared Savings Program ACO in PY2024, PY2025 or PY2026, and in no ACO REACH provider file** — three vintages plus the REACH public use file, searched across all states.[9] Its traditional-Medicare patients are attributed to no accountable care organization. Every remote-care CPT the practice bills is clean incremental Part B revenue with no reconciliation against it and no gatekeeper above it. That is close to the best payer-side starting position a service line of this kind can have.

The timing is specific. The CY2026 Physician Fee Schedule expanded remote monitoring in exactly the direction this practice needs: **99445** pays the monthly device-supply amount for 2–15 days of data where 16 or more were previously required, which makes short post-discharge and post-procedure windows billable for the first time, and **99470** pays for the first 10 minutes of monthly management time where the floor had been 20. TEAM began January 1, 2026 — seven months before this report. A service line chartered in late 2026 is at census inside the first TEAM performance year, not after it.

The companion CoachCare Value Analysis sizes the opportunity on an estimated **14,837-patient in-scope Medicare base across 26 referring providers** — *a discovery-stage estimate to validate against the practice's own chart counts* — with RPM and PCM only. It projects net reimbursement of **$1,622,944** in Year 1 and **$4,985,754** in Year 2 (**$6,608,698** over 24 months — RPM $5,015,843, PCM $1,592,855); **$2,811,277** net to the practice after CoachCare fees; 473,399 physiologic readings; approximately **301 avoided hospitalizations**; and 48,901 care-team hours delivered, about **23.5 full-time equivalents** of clinical labour the practice does not have to hire. Month 1 is modeled at −$2,419 and every month from month 2 onward is net-positive. *All figures are illustrative, modeled — verify against practice data.*

2026–2027 Priority Recommendations

1. **Charter the Remote Care Service Line as a named programme with its own P&L — and give it the owner it has never had.** The single structural finding in the CY2024 data is that remote monitoring at this practice has no programme owner: seven physicians bill it, one dominates it, no vendor or platform is named anywhere in public material, and no care-management lead is published. Name a physician lead, pair them with the administrative lead, and put the existing enrolled patients under one protocol before adding a single new one.
2. **Bill the transitional-care window the group already generates.** Zero transitional care management across all 23 practitioners in CY2024, against five hospitals that entered mandatory 30-day episode accountability on January 1, 2026. TCM is the direct instrument for that window, and it is deliberately excluded from every financial figure in this report — which makes it a separate, additive decision the practice can take on its own merits (Sections 2.1 and 5).

[8] CMS Medicare Monthly Enrollment, April 2026 file (dataset modified July 23, 2026; 577,106 rows), and the CMS Medicare Advantage State/County Penetration file, July 2026, which returns 626,336 eligibles, 336,455 enrolled and 53.72% penetration for San Diego County against 51.52% for California and 51.69% nationally. The two independent files agree to within 0.1 point; the monthly-enrollment numerator is marginally broader.

[9] CMS Medicare Shared Savings Program ACO Participants, PY2024 (15,540 rows), PY2025 (15,192 rows) and PY2026 (15,370 rows), and the ACO REACH PY2024 Provider Public Use File (234,886 rows, vintage December 1, 2024, modified July 20, 2026). Searched by participant legal name and by organizational NPI across all states, not filtered to California. Zero rows returned in every file.

3. **Harvest the rungs already in front of you.** 99458 is billed by one physician on 26 patients against 244 receiving 99457; 99453 is captured on 41 patients against 241 on device supply. Neither gap is a clinical problem — both are documentation-and-capture problems, and both are solved by the same billing engine that runs the rest of the programme (Section 7.3).
4. **Extend the programme from seven physicians to the bench.** Twelve of nineteen CMS-listed physicians billed no remote monitoring at all in CY2024, including physicians carrying four-figure Medicare beneficiary counts. The clinical argument has already been won inside this practice; what is missing is a referral pathway that makes enrollment one order rather than a personal workflow.
5. **Add principal care management as the monthly chassis.** PCM (99424–99427) is written for a single high-risk condition managed by a specialist — which is precisely what a cardiology group does with heart failure, and it does not require the practice to be the patient's primary care physician. It is the highest-fit unbilled family in the file and it stacks with RPM in the same month on discrete documentation.
6. **Scope technology to what the practice actually controls.** The practice works inside Sharp HealthCare's Epic tenant and operates no portal or electronic endpoints of its own. Do not let an integration discussion become the gating item on a service line that does not depend on one. Lead on workflow and staffing; take integration scope to a joint conversation with Sharp in contracting (Section 7).
7. **Write the attribution and coordination policy before the first enrollment.** Only one practitioner may bill RPM for a given patient in any 30-day period, and Sharp Community Medical Group already supplies nurse case management to members who have one of its primary care physicians. Settle in writing which patients are the practice's to manage and which are not — before a denial or a duplicated call settles it for you (Section 2.1).

1. Footprint & Operating Model

1.1 The practice

The legal entity is **San Diego Cardiac Center Medical Group, Inc.** — a California professional medical corporation, state entity number 1247885, filed June 1, 1984 and active. The trade name “San Diego Cardiac Center” carries no separate legal registration, so contracting documents should name the corporation. The organizational NPI is 1801980446, the CMS organization PAC ID is 8628045986, and the PECOS group enrollment identifier is O20040917000439, recorded in 2004.[10] California bars lay corporations from practising medicine, so a shareholder-physician structure is legally compelled rather than distinguishing on its own; what proves independence here is the governance — every officer and director on the state registry is a practising physician in the group — and the enrollment record.

Office	Address	Status in CMS data
Kearny Mesa (corporate)	3131 Berger Ave, Suite 200, San Diego, CA 92123	Corroborated — NPPES location and mailing address; the majority of the group's CMS practice-site records resolve here. Adjacent to the CCN 050100 hospital campus
Chula Vista	750 Medical Center Ct, Suite 10, Chula Vista, CA 91911	Advertised South County office, adjacent to the CCN 050222 hospital campus. A different Chula Vista address (890 Eastlake Pkwy) appears in CMS practice-location data for three physicians — second site or stale record, worth confirming
El Cajon	300 S Pierce St, Suite 102, El Cajon, CA 92020	Corroborated — CMS practice location for three physicians. The newest of the three branded offices, serving East County
Hospital-campus sites (not branded offices)	8851 Center Dr, La Mesa · 3075 Health Center Dr, Suite 400, San Diego	Both appear as practice locations in CMS or system directory data and sit on hospital campuses (CCN 050026 and CCN 050100 respectively) — consistent with hospital-based device and advanced heart failure practice. Confirm how each is staffed and how it bills

Roster, counted from CMS rather than from the website. Three sources give three counts, and the report uses each where it is the right one. The PECOS reassignment file — the set of clinicians who reassign Medicare benefits to the group's own enrollment — shows **26 reassignments: 23 physicians and 3 nurse practitioners**, as of July 14, 2026, and that is the referring-provider count the financial model is built on. The CMS Doctors and Clinicians file, which lags enrollment, lists **19 physicians and 4 advanced practice providers**, and that 23-practitioner roster is the exact input set used for every code-level query in Section 4. The practice's own care-team page lists 17 physicians and 4 advanced practice providers.[11] Stated as a caveat rather than glossed over: reassignment records capture reassignment relationships, so they can lag a departure and will miss a hire made after the snapshot. Confirm the live roster in discovery.

Sub-specialty mix, from CMS primary-specialty coding rather than from marketing. Across the 19 CMS-listed physicians: **nine general cardiovascular disease, five interventional cardiology, three advanced heart failure and transplant cardiology, one cardiac electrophysiology**, and one internal

[10] NPPES NPI Registry (live API, retrieved August 3, 2026) for organizational NPI 1801980446 and taxonomy 207RC0000X; CMS Doctors and Clinicians National Downloadable File for organization PAC ID 8628045986; CMS Revalidation Clinic Group Practice Reassignment file for the group PECOS enrollment identifier. A wildcard NPPES search statewide returns exactly one organizational NPI for this name, and the CMS file returns exactly one organization PAC ID - everything bills under the one medical corporation.

[11] CMS Revalidation Clinic Group Practice Reassignment file (July 14, 2026): 26 reassignments. CMS Doctors and Clinicians National Downloadable File (queried August 3, 2026, org PAC ID 8628045986): 19 physicians and 4 advanced practice providers, num_org_mem 23. The practice's own care-team page (retrieved August 3, 2026): 17 physicians and 4 advanced practice providers. The D&C file lags enrollment; five clinicians appear in the reassignment file but not yet in it.

medicine with cardiology as the secondary specialty. **The three-physician advanced heart failure and transplant bench is the single most distinctive structural fact about this group** — a group of this size rarely carries one, and it is corroborated by the practice's own claim to be the only private medical group in the county covering the full range from prevention to heart transplant management. The published service range spans interventional and structural work, peripheral and vascular intervention, electrophysiology and device implantation, a heart failure programme, transplant and mechanical circulatory support co-management, enhanced external counterpulsation, pulmonary hypertension, anticoagulation management, nuclear cardiology and echocardiography, and an adult Kawasaki disease programme. *Structural, transplant and mechanical-support work is hospital-based* — performed inside the admitting hospitals, not in the practice's offices.

1.2 The operating model: independent, and inside two systems' networks

The group's admitting and referral engine runs through Sharp HealthCare's hospitals, and that shapes almost everything operational about it. CMS facility-affiliation data resolved across the group's 18 cardiology NPIs shows near-universal privileges across all four Sharp acute-care hospitals, and partial privileges at a fifth hospital owned by a competing system:

Hospital	CCN	Owner	Group cardiologists affiliated	TEAM status
Sharp Grossmont Hospital (La Mesa)	**050026**	Sharp HealthCare	**17 of 18**	**Mandatory**
Sharp Chula Vista Medical Center	050222	Sharp HealthCare	14 of 18	Mandatory
Sharp Memorial Hospital	050100	Sharp HealthCare	14 of 18	Mandatory
Sharp Coronado Hospital	050234	Sharp HealthCare	10 of 18	Mandatory
Scripps Mercy Hospital San Diego	050077	Scripps Health	6 of 18	Mandatory
UC San Diego Medical Center	050025	UC San Diego Health	2 of 18	Mandatory

CMS Facility Affiliation Data (dataset 27ea-46a8, updated June 26, 2026), resolved for all 18 of the group's cardiology NPIs; CCNs independently resolved against the CMS Hospital General Information dataset, and TEAM status against the CMS TEAM Participant List as of April 15, 2026. Privileges are not employment — they establish where the group's admitting and referral engine runs.

Two structural points follow, and they pull in opposite directions — which is why both are worth stating. First, the concentration is real: seventeen of eighteen cardiologists hold privileges at Sharp Grossmont alone, and four of the five hospitals belong to Sharp. The practice's referral flow, its inpatient consults and its call coverage all run through that relationship — and in a delegated market, so does much of its managed-care volume, because Sharp Community Medical Group is one of the plan medical groups a Medicare Advantage member must select, and referrals do not transfer between them. **Nothing in a remote care programme should be designed in a way that disturbs that**. Second, the group is not captive. It appears in Scripps Affiliated Medical Groups' practice directory in its own right — which an employed group could not do — and six of its cardiologists hold privileges at Scripps Mercy San Diego. Sharp Community Medical Group describes itself as a network of independent private practices, and Sharp's own physician directory labels these clinicians “Sharp Community,” not Sharp Rees-Stealy, its employed multispecialty group.

The administrative layer is the constraint, and it is a familiar one. The group's published administrative leadership is a chief administrative officer rather than a layered executive team, which is typical of independent California groups of this size and is consistent with the operating pattern visible in the claims data. A job-board sweep in August 2026 found the practice's own careers board carrying no open listings, and an aggregator listing a clinical research coordinator and a cardiovascular technologist — **no care coordinator, chronic-care nurse, remote-monitoring nurse, telehealth coordinator or heart failure nurse navigator posting anywhere**.[12] That evidence is deliberately weak — aggregators are unreliable and absence of a posting is not proof of absence — but it is consistent with everything else in the file, and it points at the objection to anticipate: **nobody here has the headcount to staff an expanded programme**. That is a service-delivery argument in the practice's favour rather than against it, and Section 8.2 answers it directly.

1.3 Design principles for the 2026 service line

Principle	What it means at this practice
Scale what already works, do not replace it	Seven physicians and roughly 241 patients are already on remote monitoring. The first job is to put those patients under one protocol, one documentation standard and one billing engine — not to migrate them for the sake of it. What the platform is today is the first discovery question (Section 7.2)
Start at the discharge, not at the office visit	The group generates its own highest-value windows through five hospitals it staffs, and bills nothing against them. Every discharge opens a 30-day transitional window; every ablation, implant and structural case opens a post-procedure window that 99445 now makes billable
Longitudinal by default	Every heart failure, uncontrolled-hypertension, post-ablation, post-implant and post-discharge patient leaves the encounter enrolled in monitoring or monthly management — not merely scheduled for a return visit a quarter later
One front door	A single enrollment, consent and device-logistics workflow. Referral to the service line is one order, with enrollment status visible to the clinician at the point of the next decision — designed to work within what the hosted record permits (Section 7)
The partner carries the load	A lean administrative layer and no dedicated care-management staff means 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. Define the boundary, the data source and the documentation for each before launch, so neither service is at risk (Section 8.3)
Consent is a design requirement, not a form	A documented, auditable consent workflow for every device and every data stream, written before the first enrollment rather than assembled afterwards. It protects the practice and it is what a hosted-record environment will be asked about first
Single scorecard	Clinical, operational and financial KPIs for the service line reviewed monthly by the physician lead and the administrative lead — including the two measures the practice cannot currently produce: capture rate, and readmission delta against the unenrolled panel (Section 8.5)

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

[12] Job-board sweep, August 2026. The practice's own applicant-tracking board showed no open listings; a major aggregator listed a clinical research coordinator and a cardiovascular technologist with no posting dates available. Aggregators are weak evidence and an absent posting is a floor rather than a ceiling.

2. The Remote Care Service Line — The Operating Spine

This section defines the service line precisely, prices its standalone economics against the practice's own Medicare base, and shows how one infrastructure serves every value lever the 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 cardiology group:

Programme	Core codes	What it does	Where it lands at this practice
TCM — Transitional Care Management *(identified, not modeled)*	99495 / 99496	The 30-day post-discharge transition: interactive contact within two business days, face-to-face visit within 14 or 7 days depending on complexity	Zero services across all 23 practitioners in CY2024, against five hospitals now carrying mandatory 30-day episode accountability. The single largest identified gap — and deliberately excluded from every financial figure in this report
RPM — Remote Physiologic Monitoring	99453; 99454 / 99445; 99457 / 99470; 99458	Cellular blood-pressure cuffs, weight scales and pulse oximeters; daily physiologic data; 24/7 review and alert triage; monthly clinical management time	Already live on roughly 241 patients across seven physicians — the base to scale from. The unbilled surface is the other twelve physicians, the 99458 add-on rung, and the short post-discharge and post-procedure windows that 99445 now makes billable
PCM — Principal Care Management	99424–99427	Monthly management of a single high-risk condition expected to last at least three months	Heart failure as the qualifying condition, on a bench with three advanced heart failure physicians. PCM does not require the practice to be the patient's primary care physician — which this group is not — and that is exactly why it fits here

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

The coordination rules that have to be settled first

RPM and PCM stack. They may be billed for the same patient in the same month with discrete time and discrete documentation — that pairing is the core of this programme. What does not stack: only one practitioner may bill RPM for a given patient in any 30-day period, so the attribution question has to be settled before enrollment rather than after a denial. That question is live at this practice today, because a programme run as seven individual clinical habits has no shared attribution rule at all.

The specific complication here, and it is worth naming. Sharp Community Medical Group already provides registered-nurse case management, disease management and transitional-care support to its members *at no cost to them* — but its published eligibility hinge is having a Sharp Community *primary care* physician. This is a specialty practice. The practical consequence is a clean split: **the traditional-Medicare fee-for-service panel is unambiguously the practice's to manage and to bill**, and the association's case-managed members are not a population to compete for. Map that boundary explicitly before launch.

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

2.2 Standalone value: a margin-positive service line

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

1. **Direct professional-fee revenue.** Recurring monthly billing on a population the practice already manages clinically, delivered at top-of-license staffing under general-supervision rules. Modeled at $6,608,698 of net reimbursement over 24 months, $2,811,277 of it net to the practice — against a CY2024 remote-monitoring line of $199,018.
2. **Avoided cost and readmission exposure.** Modeled at approximately 301 avoided hospitalizations over 24 months — on the order of $4.5 million at an illustrative $15,000 per admission. In a market where five of the hospitals the group staffs now carry 30-day episode accountability, that value is visible to the group's hospital partners as well as to the group.
3. **Procedural throughput.** A monitored discharge pathway is what converts a structural heart or ablation case from a bed-day into a same-or-next-day discharge. Freed bed-days are the constraint on procedural volume, and the hospitals now have an episode-cost reason to care about them too (Section 6).
4. **Strategic position and referral durability.** The practice keeps its own TIN, its own data and its own patient relationships while adding an infrastructure layer it would otherwise have to build, buy, or depend on a system partner to supply. In a market where the group is the larger cardiology capability inside its own system's orbit (Section 4.4), owning that layer is also a 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; billed on 41 patients in CY2024 against 241 on device supply
RPM — 99454 / 99445	Monthly	~$52	99454 = 16–30 days of data; 99445 = new 2026 short-window code (2–15 days) at the same magnitude — post-discharge and post-procedure windows now billable

Service / code	Type	~CY2026 magnitude	Notes
RPM — 99457 / 99470	Monthly	~$52 / ~$26	First 20 minutes of management time / new 2026 first-10-minute code
RPM — 99458	Monthly	~$41	**Each additional 20 minutes. Billed by one physician on 26 patients in CY2024 — the clearest single capture gap in the file**
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 California. The financial model in this report uses MAC-locality rates auto-resolved for ZIP 92123 in the CoachCare Value Analysis — California, locality 01182-72. Verify against the current CY2026 Physician Fee Schedule and the applicable California 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 local factor deserves a flag rather than an assumption. Roughly a fifth of San Diego County's Medicare beneficiaries are dual-eligible, which reduces patient-side coinsurance friction for that subset — but the county's Medicare Advantage share is 53.6%, and Medicare Advantage duals do not generate a Medicaid crossover claim. The two measures are different denominators and should not be blended. The realization discount configured in the model (6%) is the single lever that carries payer mix and collection; validate it against the practice's own remittance experience on the remote-monitoring line it already bills.

Modeled economics

The companion Value Analysis prices an RPM + PCM programme on the practice's Medicare base. The modeled population is an estimated **14,837-patient in-scope Medicare base across 26 referring providers**, all of it in scope in Year 1. *This is a discovery-stage estimate and should be validated against the practice's own chart counts before budgeting.* For reference, the sum of per-provider Medicare beneficiary counts across the 20 practitioners with CY2024 billing is 16,129 — but that figure double-counts every patient seen by more than one physician in the group and **must not be quoted as a patient count**. A unique-patient denominator cannot be derived from the public file and has to come from the practice's own record.

Enrollment builds bottom-up from **26 referring providers at eight referrals per provider per month with 80% patient acceptance**, supported by **one on-site enrollment specialist** at approximately 80 enrollments per month — **staffed at CoachCare's expense: embedded value, never deducted from the practice's margin**. Programme eligibility is modeled at 75% of the in-scope population for RPM (11,128 patients) and 85% for PCM (12,611), with acceptance of 35% and 30% respectively and 1.5% monthly attrition. Revenue is reported as **net** reimbursement — gross allowed amounts less a 6% realization discount for payer mix and collection, as configured in the model.

Modeled result	Year 1	Year 2	24-month
Net reimbursement	$1,622,944	$4,985,754	**$6,608,698**
CoachCare fees (incl. setup & integration)	$938,377	$2,859,045	$3,797,421
Net to the practice	**$684,567**	**$2,126,710**	**$2,811,277**

Modeled result	Year 1	Year 2	24-month
Practice margin	**42.18%**	**42.66%**	**42.54%**
Net reimbursement by programme	RPM $1,237,379 · PCM $385,565	RPM $3,778,465 · PCM $1,207,290	RPM $5,015,843 · PCM $1,592,855
Claims / billed units	—	—	109,461
Physiologic readings collected	—	—	473,399
Hospitalizations avoided (modeled)	—	—	~301 (≈$4.5M at an illustrative $15,000 each)
Care-team hours delivered	—	—	48,901 (≈23.5 FTE)
Active programme enrollments at month 24	—	—	4,939 (RPM 3,646 · PCM 1,293)
Unique patients (de-duplicated)	2,040 at month 12	4,034 at month 24	—

CoachCare Value Analysis, MAC locality CA 01182-72 (ZIP 92123), RPM and PCM only. Chronic care management is 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: 42.54% — net to the practice ÷ net reimbursement. Year 1 is **42.18%** and Year 2 **42.66%**, on $6,608,698 of net reimbursement and $2,811,277 net to the practice over the full 24 months.

Month 1 is modeled at **−$2,419** because one-time implementation lands there, and **every month from month 2 onward is net-positive**. By month 24 the programme is modeled at $530,844 of monthly net reimbursement and $226,477 of monthly net to the practice. The more useful way to describe the timing is this: no practice capital is at risk while the census builds, because CoachCare funds the enrollment engine, the devices and the monitoring staff.

Both arms are pace-limited, and that changes how to read month 24. RPM reaches 3,646 enrolled patients at month 24 against a modeled eligibility ceiling of 3,895, and PCM reaches 1,293 against a ceiling of 3,783. **Neither arm is constrained by the size of the eligible pool — both are constrained by how fast patients can be enrolled**. Two things follow. Year 2 is a growth year rather than a steady state, and the census at month 24 is not the programme's terminal size. And the single highest-leverage operational variable is enrollment throughput: raising referral volume across the twelve physicians who currently refer none, or adding a second enrollment pathway, moves both arms materially. That is a very different planning picture from a programme whose ceiling is already in sight.

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 ($4,985,754) is 3.1× Year 1 ($1,622,944) on the same referral engine, purely from census accumulation. Unit economics are modeled at approximately $111.25 of net reimbursement per RPM patient-month and $99.69 per PCM patient-month, across 45,086 RPM and 15,978 PCM patient-months over 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 readmission and cost results that its five admitting hospitals' TEAM episodes are reconciled on from 2026. *All figures are illustrative, modeled — verify against practice data.*

2.3 Connective tissue: one infrastructure, every lever

The same enrollment engine, connected-device logistics, 24/7 monitoring, nurse triage, billing-grade documentation 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 it is a particularly sharp argument here, because the practice has already demonstrated what the alternative looks like: a real clinical capability that reached seven physicians and stopped.

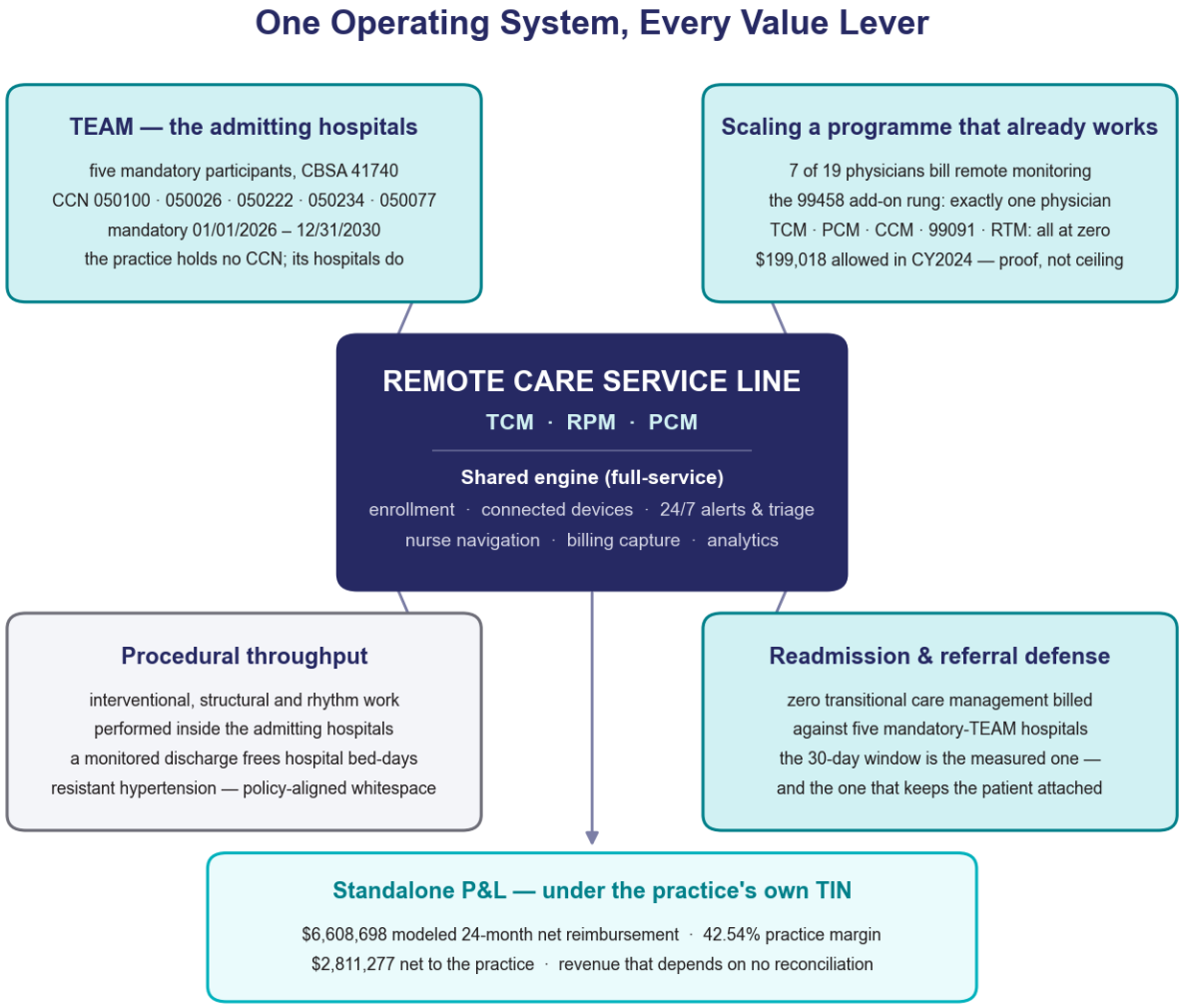

Figure 1. The Remote Care Service Line as connective tissue: one operating system powering the post-discharge window at five mandatory TEAM hospitals, the scaling of an existing remote-monitoring programme across the whole physician bench, procedural throughput in structural heart and rhythm management, readmission and referral defense, and the standalone P&L.

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
TEAM — the admitting hospitals	CCN 050026, 050222, 050100, 050234 and 050077 are all mandatory participants from January 1, 2026 through December 31, 2030, CBSA 41740 — Sharp Grossmont, Sharp Chula Vista, Sharp Memorial, Sharp Coronado and Scripps Mercy San Diego. The practice holds no CCN and is not itself a participant	TCM at discharge plus short-window RPM via 99445 covers exactly the 30 days the hospital is accountable for. The group is the instrument by which its partners defend episode performance — and that is a negotiating position, not just a clinical one

Value lever	What is at stake in 2026–2027	How the shared infrastructure powers it
Scaling the existing programme	Seven of nineteen physicians bill remote monitoring; 99458 is billed by one; 99453 is captured on 41 of 241 device-supply patients	One enrollment pathway, one documentation standard and one billing engine across the whole bench converts a personal clinical habit into a service line — and captures the rungs the current workflow does not
The empty care-management layer	Zero PCM, zero CCM, zero TCM, zero 99091, zero remote therapeutic monitoring and zero self-measured blood pressure across all 23 practitioners in CY2024	PCM is the monthly chassis for single-condition specialty management on a heart failure panel with a three-physician advanced heart failure bench. It stacks with RPM in the same month on discrete documentation
Procedural throughput	Interventional, structural and rhythm work performed inside hospitals the group does not own, in a market where those hospitals now carry episode cost	A monitored discharge pathway converts a post-procedure bed-day into a same-or-next-day discharge. Freed bed-days are capacity, and capacity is procedural volume
Readmission and referral defense	Five mandatory-TEAM admitting hospitals, and no post-discharge programme pointed at the 30-day window	Daily physiologic signal with 24/7 triage turns deterioration into a same-week outpatient intervention instead of an emergency-department visit — and keeps the patient attached to this practice rather than to whoever calls first
Standalone P&L	CY2026 code expansion (99445, 99470); revenue durability regardless of how any hospital performance year reconciles	$6,608,698 of modeled 24-month net reimbursement at a 42.54% practice margin — billed under the practice's own TIN 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**. The practice already owns the hardest inputs to that asset — a working remote-monitoring clinical model, a nurse-led protocol-driven chronic care habit running since the 1990s, and physicians who have already accepted that between-visit management is their job. What it does not yet own is the enrollment engine, the documentation standard and the billing capture that turn seven clinicians' habit into a service line.

3. 2026 Policy & Payment Environment

One mandatory CMS model bears on this practice, and it bears on it indirectly but powerfully — through the five hospitals it staffs. The rest of the payment environment is unusually clean: no accountable-care attribution, no direct capitation, and a fee-for-service pool that is large and not shrinking.

3.1 TEAM: five mandatory hospitals, and an empty post-discharge code set

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

Stated plainly, so it is not overstated

The practice holds no CCN. It is not a TEAM participant and cannot become one — participation attaches to a hospital CCN, and this is an office-based physician group. Its exposure to the model is entirely indirect.

What is direct is the leverage. **CBSA 41740 — San Diego–Chula Vista–Carlsbad — is a mandatory TEAM core-based statistical area with 15 participant hospitals**, and five of them are hospitals at which this group's cardiologists hold privileges. Every one of those five entered 30-day post-discharge episode accountability on January 1, 2026. There is effectively no hospital in this practice's service area that is not carrying mandatory episode risk.

And here is the sentence that matters most in this report. Across all 23 practitioners in CY2024, **the group billed zero transitional care management — 99495 and 99496, zero services**. The transitional-care code family is the direct billing instrument for the 30-day post-discharge window. Five hospitals are now reconciled on that window; the cardiology group that follows those patients bills nothing against it. **That is the sharpest single fact in this account, and it is entirely fixable.**

Hospital	CCN	TEAM status	Performance period	Group cardiologists
Sharp Grossmont Hospital	**050026**	**Mandatory**	01/01/2026 – 12/31/2030	**17 of 18**
Sharp Chula Vista Medical Center	050222	Mandatory	01/01/2026 – 12/31/2030	14 of 18
Sharp Memorial Hospital	050100	Mandatory	01/01/2026 – 12/31/2030	14 of 18
Sharp Coronado Hospital	050234	Mandatory	01/01/2026 – 12/31/2030	10 of 18
Scripps Mercy Hospital San Diego	050077	Mandatory	01/01/2026 – 12/31/2030	6 of 18

CMS TEAM Participant List, hospital list as of April 15, 2026 (CMS updates it quarterly), cross-referenced against CMS Facility Affiliation Data updated June 26, 2026. CBSA 41740 carries 15 mandatory participant hospitals in total. Re-check at the next quarterly update.

One market development worth knowing, because it changes who the conversation is with. In July 2026 Sharp HealthCare assumed operations of Tri-City Medical Center in Oceanside following a voter-approved measure — a hospital that is itself a mandatory TEAM participant, CCN 050128.[13] Sharp now carries mandatory episode accountability across five acute-care hospitals in a single core-based statistical area. **It makes the post-discharge conversation a system-level one rather than a hospital-by-hospital one**, and it means a cardiology group arriving with a working, measured post-discharge capability is arriving at a table that has a reason to be set.

[13] Health system public announcement and contemporaneous local news coverage, retrieved August 3, 2026: Sharp HealthCare assumed operations of Tri-City Medical Center in Oceanside in July 2026 following a voter-approved measure in June 2026, renaming it Sharp Tri-City Medical Center. CCN 050128 appears on the CMS TEAM Participant List as a mandatory participant in CBSA 41740.

3.2 The CY2026 fee schedule: remote care gets more billable

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

There is a second-order point here that applies specifically to a practice already billing the family. A group that runs 99454 and 99457 but not 99445, 99470 or 99458 is billing the middle of the ladder and neither end of it. The new short-window codes open the population the practice generates and does not currently monitor at all — post-discharge and post-procedure patients — while 99458 raises the yield on patients it is already monitoring. **Neither requires a new clinical capability. Both require a workflow and a capture mechanism.**

3.3 The market: delegated, not capitated — and the fee-for-service pool is deep

Geography	Total Medicare	Original (FFS) Medicare	MA & other	MA penetration
San Diego County	622,423	**289,032**	333,391	**53.6%**
California	7,211,841	3,498,679	3,713,162	51.5%
United States	70,330,194	34,314,772	36,015,422	51.2%

CMS Medicare Monthly Enrollment, April 2026 file (dataset modified July 23, 2026), cross-checked against the CMS Medicare Advantage State/County Penetration file, July 2026, which returns 626,336 eligibles and 53.72% penetration for the county — the two independent files agree to within 0.1 point.

Correct the framing before using it. San Diego is frequently described as a heavily capitated market. The delegated structure is genuinely distinctive — health plans delegate professional risk, utilization management and claims administration to physician organizations, and California regulates those organizations as risk-bearing entities — but **the penetration data does not support an extreme characterisation**. At 53.6%, the county runs roughly 2.1 points above California and 2.4 points above the nation, and it ranks tenth among the California counties with more than 50,000 Medicare beneficiaries. It was an early-penetration market that has plateaued at about 53% for four years while the national rate converged toward it. **A physician audience in this county will know that, and overstating it would not survive a single question.**

What the practice's own payer position actually is. The group's published insurance policy lists Medicare, most preferred-provider plans, and HMO plans *only* where they use the Sharp Community Medical Group network. Parsed carefully, that means it does not contract with HMO plans directly; it participates in HMO and Medicare Advantage business as a downstream specialist inside another organization's network. **There is no public evidence that the practice holds capitation directly or bears global risk in its own right.** The commercial consequence is straightforward: **every remote-care CPT billed on the traditional-Medicare panel is incremental Part B revenue, not an expense charged against a capitated budget**. Managed-care volume inside that network should be treated as clinical upside and quality support, never as billable revenue in a forecast.

Two caveats, stated rather than buried. First, the precise ratio of fee-for-service to Medicare Advantage to preferred-provider to Medicaid managed-care volume is not publicly disclosed for any physician group, and it is the most important number the practice can supply in discovery — the business case scales off

it. Second, the description of the delegated structure above rests partly on a regional market analysis published in 2016; the structural pattern is well established, but the specific terms should be re-confirmed rather than assumed. **Neither caveat moves the conclusion**: the county holds 289,032 traditional fee-for-service beneficiaries, and that pool has been growing in absolute terms as total Medicare enrollment in the county grew roughly 7% between 2023 and 2026.

3.4 No shared-savings offset: every dollar is incremental Part B

This deserves its own heading because it is unusual and because it is worth a great deal. The practice was searched by legal name and by organizational NPI against the CMS Medicare Shared Savings Program participant files for **PY2024, PY2025 and PY2026** — 15,540, 15,192 and 15,370 rows respectively — and against the **ACO REACH PY2024 provider public use file** (234,886 rows), across all states rather than filtered to California. **Zero matches in every file.**[14]

What the negative actually buys

The group's traditional-Medicare patients are attributed to no accountable care organization — so there is no shared-savings reconciliation that offsets fee-for-service billing, and no ACO governance layer whose approval a new programme would need. Sharp Rees-Stealy Medical Group, Sharp's employed group, does run its own shared-savings organization, but it carries a single participant TIN — its own — so there is no route by which this practice is either included in or dragged into that accountability. Sharp Community Medical Group is absent from the shared-savings programme entirely, in all three years.

Read against the competitive set, the same fact reads differently: another independent San Diego cardiology group *is* in a shared-savings organization, and moved into a managed one for PY2026. It is being paid to reduce total cost of care — which is what remote-monitoring and care-management infrastructure is for. **The capability gap between an independent group that builds this and one that does not is about to become visible in someone's reconciliation report.**

[14] Second citation of the shared-savings and total-cost-of-care search described in note 9: CMS Medicare Shared Savings Program ACO Participants PY2024, PY2025 and PY2026, and the ACO REACH PY2024 Provider Public Use File, searched in full by participant legal name and by organizational NPI across all states. The single-participant-TIN structure of the employed group's accountable care organization is read from the same PY2026 participant file.

4. Performance Snapshot: The Starting Position

4.1 The service record: a programme that works, at a third of the bench

Every HCPCS line billed by all 23 practitioners in CY2024 was screened against the full remote-monitoring and care-management code set. The result is not the usual finding. **This practice bills remote physiologic monitoring, and has been doing it long enough for it to appear at scale in the public file**:

HCPCS	What it is	Physicians	Beneficiaries	Services	Allowed
99453	RPM setup and patient education	3	41	41	$948
99454	**RPM device supply, 30 days**	**7**	**241**	**1,984**	**$109,974**
99457	**RPM treatment management, first 20 min**	**7**	**244**	**1,622**	**$86,797**
99458	RPM management, each additional 20 min	1	26	31	$1,299
Total	**All remote physiologic monitoring, CY2024**	—	—	**3,678**	**$199,018**

CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024 (data vintage December 1, 2024; file modified May 21, 2026), queried per NPI across all 23 practitioners on August 3, 2026. Allowed amounts are services × average allowed. Traditional Medicare fee-for-service only — Medicare Advantage and commercial volume are not in this file. Beneficiary counts are per code and contain duplication across codes.

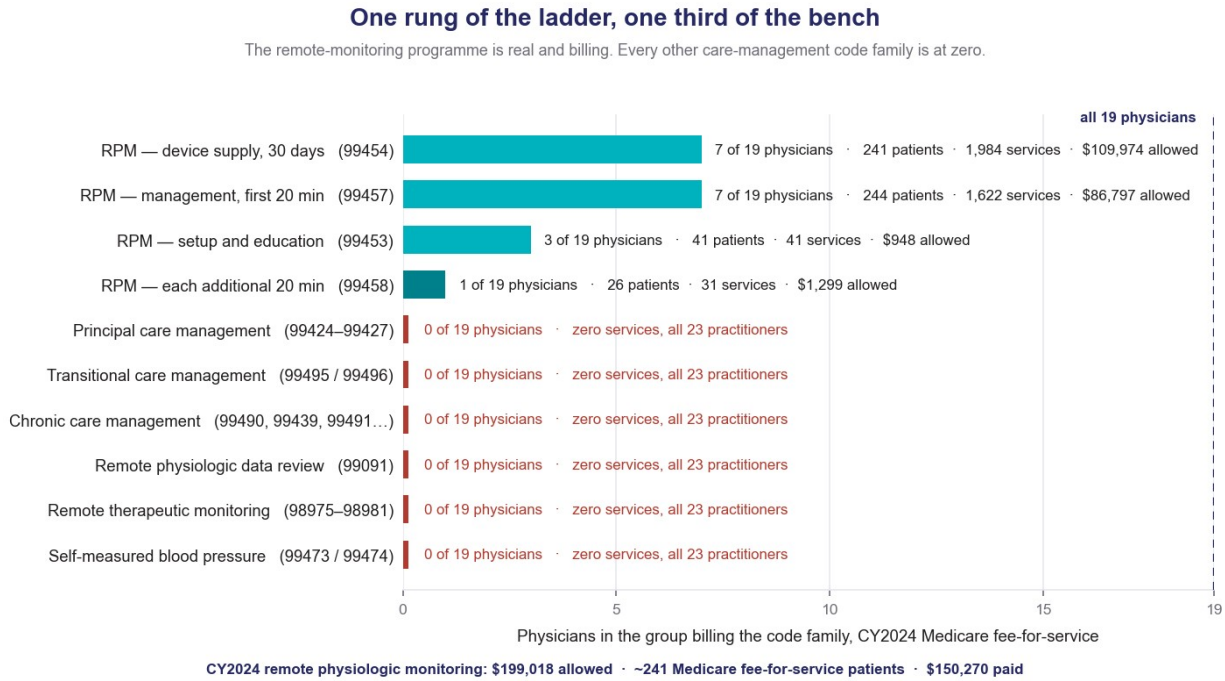

Figure 2. The group's CY2024 Medicare record, by code family. Remote physiologic monitoring is live and billing across seven of the nineteen CMS-listed physicians; the add-on rung is billed by one; every other care-management family returns zero services across all 23 practitioners. Directional snapshot of a single data year — CMS suppresses provider lines with fewer than 11 beneficiaries.

Read the distribution, not just the total. The programme is heavily concentrated: one physician accounts for roughly 45% of the remote-monitoring allowed amount and is the only physician billing the add-on code, and two of the three advanced heart failure physicians are among the seven billers. **Twelve**

of the nineteen CMS-listed physicians billed none of it — including physicians carrying four-figure Medicare beneficiary counts across general cardiology, electrophysiology and interventional practice. That is the signature of a clinical habit adopted by individuals rather than a service line adopted by a practice, and it is exactly the pattern an operating layer fixes.

A second live programme sits beside it, and it must not be confused with the first. The device side bills its own remote monitoring under the implanted-device interrogation family — roughly **$99,770 of allowed charges across 2,721 services in CY2024**, spanning pacemaker interrogation (335 beneficiaries), defibrillator interrogation (137), device technical monitoring (360), rhythm and loop-recorder monitoring (104), and **33 beneficiaries on implantable hemodynamic monitors**.[15] That last line is a pulmonary-artery-pressure sensor population — advanced heart failure patients under continuous remote hemodynamic surveillance. It is small, and it is billed by physicians outside the advanced heart failure bench, which is an odd split and a good discovery question. **The operational read is unambiguous: this practice runs a device clinic with remote follow-up staff, a triage inbox and an alert-review protocol already.**

4.2 What is at zero — and why that is the opportunity

Code family	Codes screened	CY2024 services found
Transitional care management	99495, 99496	**Zero — across all 23 practitioners**
Principal care management	99424, 99425, 99426, 99427	**Zero — across all 23 practitioners**
Chronic care management	99490, 99439, 99491, 99487, 99489	Zero — across all 23 practitioners
Remote physiologic data review	99091	Zero — across all 23 practitioners
Remote therapeutic monitoring	98975, 98977, 98980, 98981	Zero — across all 23 practitioners
Self-measured blood pressure	99473, 99474	Zero — across all 23 practitioners

Same file and vintage. This is a verified absence across the full roster, not an inference from marketing material. CMS suppresses any provider / HCPCS / place-of-service line with fewer than 11 beneficiaries, so a pilot-scale programme would not appear — what the record establishes is that no programme at meaningful scale existed in CY2024 on any of these codes.

Two of those zeros are ordinary. Two are not. Chronic care management at zero is expected and correct — it is the multi-condition instrument of primary care and this group has no primary-care panel. Remote therapeutic monitoring at zero is unremarkable for cardiology. But **principal care management at zero is a missed fit**: PCM was written for a single high-risk condition managed by a specialist, it does not require the billing practice to be the patient's primary care physician, and this group has a three-physician advanced heart failure bench and a heart failure programme running since 1998. And **transitional care management at zero, against five mandatory-TEAM hospitals, is the loudest signal in the file** (Section 5).

[15] CMS Medicare Physician & Other Practitioners - by Provider and Service, CY2024. 93294 pacemaker remote interrogation: 335 beneficiaries, 778 services, $22,991. 93295 defibrillator remote interrogation: 137, 335, $12,310. 93296 remote device technical monitoring: 360, 861, $21,357. 93297 implantable hemodynamic monitor: 33, 158, $5,585. 93298 rhythm and loop-recorder monitoring: 104, 589, $37,527. Total $99,770 across 2,721 services. Beneficiary counts are per code and contain duplication across codes and physicians.

What the CY2024 data proves, stated precisely

The file covers **Medicare fee-for-service only**. Commercial and Medicare Advantage remote monitoring would not appear in it at all, and in a county with 53.6% Medicare Advantage penetration that is a material exclusion — the practice's true remote-monitoring volume may be larger than the file shows. Equally, the file covers data year 2024; a programme launched or expanded in 2025 or 2026 would not appear, and the next CMS release covering data year 2025 is not expected until roughly mid-2027. *Confirm current-state volume, platform and staffing directly in discovery — it is the highest-value question in this account.*

What the record does establish, and establishes firmly, is the *shape* of the programme: which code families are billed and which are not, how many physicians participate, and how the rungs of the remote-monitoring ladder are captured relative to one another. Those ratios do not depend on the payer mix.

4.3 The clinical substrate is deeper than the programme it supports

It is worth being precise about what this group already has, because it changes what needs to be sold and what does not. The following are drawn from the practice's own published material and from public trial and publication records:

- **A heart failure programme established in 1998, with a dedicated heart failure nurse practitioner.** The practice's own description sets its goals as intensive patient education and monitoring and decreasing emergency department visits and hospital admissions — which is, almost word for word, the thesis of this report. *A separate self-reported outcome figure on that page is unaudited and carries no published methodology; it is deliberately not repeated or relied on anywhere in this document.*
- **A nurse-staffed anticoagulation clinic on a fifteen-minute recurring-visit protocol.** Test, result, nurse review of dose, next appointment scheduled. That is a nurse-led, protocol-driven, recurring-touchpoint chronic-care workflow already running — the precise staffing model principal care management requires.
- **A device clinic with remote follow-up.** Roughly $99,770 of implanted-device remote interrogation in CY2024, including 33 beneficiaries on implantable hemodynamic monitors. Device technicians, an alert inbox and a review protocol already exist.
- **Direct experience of remote physiologic and sensor data in research.** The practice was a site on a pivotal implantable pulmonary-artery-pressure trial (completed 2023), is an active site on a remote-sensor insertable-cardiac-monitor study, ran home wearable atrial-fibrillation detection studies, and publishes on pulmonary-artery-pressure sensor management under its own affiliation.[16] Public registries list dozens of studies with the practice as a site and several actively recruiting.
- **Consequences worth drawing out.** A practice running active trials has protocol discipline, consented-patient workflows, device-data handling and a research-coordinator function in place. That is most of the operational muscle a scaled remote-care programme needs — and it is currently pointed at sponsors rather than at the practice's own Part B revenue.

[16] Second citation of the trial and publication records described in note 7: ClinicalTrials.gov and PubMed, queried August 3, 2026. Public registries list dozens of studies with the practice as a site, several of them currently recruiting across heart failure, gene therapy, pulsed-field ablation and lipid-lowering programmes.

The concept needs no selling here — it needs operationalising

A crawl of all 95 pages of the practice's website in August 2026 found **zero occurrences** of remote patient monitoring, chronic care management, principal care management, care coordinator, nurse navigator, device clinic, home monitoring, telemonitoring, heart failure clinic, or any monitoring platform or vendor name — and zero occurrences of the remote-monitoring CPT codes.[17] In the same period CMS paid the practice $150,270 for remote physiologic monitoring.

The programme exists and is invisible. It is billed on roughly 241 patients and marketed nowhere: no service page, no patient-facing enrollment content, no named platform. That is the profile of a capability run as a physician-by-physician clinical habit rather than as an operationalised service line, and it is precisely why it has stalled at seven of nineteen physicians with an add-on attach rate near 11%.

Method note, because the two negatives are not equally strong. The website scan is absence of evidence about marketing. The billing zeros in Section 4.2 are a different and much stronger class of evidence — verified absences in CMS claims across the full roster.

4.4 Position in the market

This is the largest independent cardiology group in San Diego County. Counting clinicians whose CMS primary specialty is cardiovascular disease, interventional cardiology, cardiac electrophysiology or advanced heart failure and transplant cardiology, filtered to county ZIP codes and rolled up by CMS-reported organization, the group fields **18 cardiology clinicians** — more than any other independent practice in the county, and more than Sharp Rees-Stealy Medical Group, Sharp's own *employed* multispecialty group, which fields 11.[18] **That is real negotiating position, and it should inform the tone of the engagement: this practice is the larger cardiology capability inside Sharp's orbit, not a supplicant in it.**

Organization	Cardiology clinicians in the county	Read
San Diego Cardiac Center — independent	**18**	**9 general cardiovascular · 5 interventional · 3 advanced heart failure and transplant · 1 electrophysiology. The largest independent group in the county**
UC San Diego Health — employed	55	The county's largest cardiology faculty and its deepest electrophysiology and transplant bench
Scripps Health — employed groups	41 + 23 + 16	Three separate employed cardiology entities across the Scripps Clinic and Coastal arms
Sharp Rees-Stealy Medical Group — employed	11	Fewer cardiology clinicians than this practice, inside the same system's orbit
Cardiovascular Institute of San Diego — independent	16	Single-site South Bay practice at 765 Medical Center Ct — a direct geographic overlap with this group's Chula Vista office, and the nearest independent peer
Solo and micro-practices	53	A very large fragmented segment with no group reported — the county's long tail

[17] Second citation of the website crawl described in note 6: full crawl of all 95 URLs in the practice's published sitemap, August 3, 2026. Zero occurrences of any remote-monitoring, care-management, monitoring-platform or vendor term, and zero occurrences of CPT 99453, 99454, 99457 or 99490. Absence of evidence about marketing - a weaker class of evidence than the billing negatives in note 3.

[18] CMS Doctors and Clinicians National Downloadable File (updated June 26, 2026): all California clinicians whose CMS primary specialty is cardiovascular disease, interventional cardiology, cardiac electrophysiology or advanced heart failure and transplant cardiology, filtered to San Diego County ZIP codes (722 clinician-location records) and rolled up by CMS-reported organization. Two of the largest rows are hospital-based physician corporations rather than outpatient competitors, and many of their clinicians are simultaneously members of the office-based groups counted elsewhere.

Organization	Cardiology clinicians in the county	Read
Hospital-based call panels	65 + 28	**Not outpatient competitors** — these are the Sharp and Scripps Mercy hospital-based physician corporations, and many of their clinicians are simultaneously members of the office-based groups above

CMS Doctors and Clinicians National Downloadable File (updated June 26, 2026), 722 clinician-location records filtered to San Diego County ZIP codes and rolled up by CMS-reported organization. A reimbursement-grade census rather than a directory scrape.

Two competitive facts complete the picture, and both point the same way. Another independent San Diego cardiology group participates in a Medicare shared-savings organization and moved into a managed one for PY2026 — meaning it is now paid to reduce total cost of care, which is the economic case for exactly this infrastructure. And Sharp continues to expand, having assumed operations of a sixth county hospital in July 2026. **An independent group with a built, billable, hospital-facing post-discharge capability is materially harder to displace than one without**, and in a market this consolidated that is as much of the argument for building it as the revenue is.

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

The correct statement first. This practice holds no CCN. **It is not a TEAM participant and cannot become one** — participation attaches to a hospital CCN. Five hospitals at which the group's cardiologists hold privileges are mandatory participants — Sharp Grossmont (CCN 050026), Sharp Chula Vista (050222), Sharp Memorial (050100), Sharp Coronado (050234) and Scripps Mercy San Diego (050077), all CBSA 41740, January 1, 2026 through December 31, 2030 — as are the other ten hospitals in the same core-based statistical area. The group's exposure is indirect. Its *leverage* is not.

TEAM holds the hospital financially accountable for a 30-day post-discharge episode, readmissions included, reconciled against a CMS target price with a quality adjustment. The cardiac episode in the model is coronary artery bypass graft. **This group does not perform cardiac surgery** — that work is done inside the hospitals — but it is the diagnostic and referral bench that feeds those cases, it rounds on those patients, and it owns the ambulatory cardiology relationship after discharge. **The clinicians who determine what happens in the 30 days after discharge therefore sit outside the entity that carries the risk.** That is the misalignment TEAM was designed to force a resolution to, and it is the opening for this conversation.

The alignment, in one paragraph

A hospital-side financial mandate that began on January 1, 2026. Five hospitals carrying it, staffed by 6 to 17 of this group's 18 cardiologists each. A specialist group that touches those discharges, follows those patients, and holds the ambulatory relationship afterwards. And **a completely empty post-discharge code set at that group — zero transitional care management, zero short-window remote monitoring, zero principal care management**. Rare alignments like this do not stay open indefinitely, and the practice is currently on the wrong side of it by default rather than by decision.

The episode bundle, 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	**Short-window RPM: 99445 + 99470** — newly billable in CY2026 for 2–15 days of data and the first 10 minutes of management time
Days 15–30	Face-to-face visit inside the TCM window; continued monitoring; medication titration against measured response	RPM 99454 / 99457 / 99458 once the data threshold is met
Month 2 onward	The patient transitions from an episode to a managed census — heart failure, hypertension, post-procedure recovery	Longitudinal RPM + PCM (99424–99427)

The first operational problem, and it is the one that kills transitional-care programmes. Everything above depends on the practice knowing, on the day it happens, which of its patients were discharged and from which hospital. In a group that admits across five hospitals in two systems and does not control the record any of them writes in, **that daily discharge signal is the hardest single thing to build and the first thing to solve**. It is also the item most likely to require the hospitals' cooperation — which is precisely where the practice's own TEAM leverage is worth something, because the hospital carrying the episode has a direct financial interest in the group receiving that signal.

TEAM-readiness checklist

- A daily feed or process that identifies which of the practice's patients were discharged yesterday, from which hospital — the single most common point of failure in a transitional-care programme, and the one item here that benefits from the hospital's own interest.
- A standing two-business-day interactive contact protocol with named ownership and an escalation path, documented to survive audit.
- Device logistics that work at discharge rather than at the next office visit — the first 14 days are the window that matters, and 99445 now pays for them.
- A documented consent workflow for every device and data stream, executed at enrollment.
- A shared readmission dashboard with the admitting hospitals, so the group's contribution is measured rather than asserted.
- An agreed definition of the cardiac episode population with each hospital, and clarity on which post-discharge activity is the practice's and which is the hospital's.

The hospital conversation — and one condition on it

Five hospitals entered episode accountability on the same day, four of them Sharp facilities and Sharp has since taken on a fifth, and this group is the largest independent cardiology bench in Sharp's orbit. A post-discharge capability that measurably reduces 30-day readmissions is worth something specific to a hospital that is now reconciled on exactly that. It is also worth noting that the group holds privileges at Scripps Mercy San Diego — so this is a conversation it can credibly take to more than one buyer.

The condition. Any arrangement in which a hospital supports, subsidises or co-invests in physician-practice services 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.*

One last 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 TIN, whether or not any hospital ever co-invests a dollar. **The hospital conversation is what the capability makes possible — not what it depends on**, and that is the right order to build in. A group that arrives with a working post-discharge programme and measured readmission data is negotiating from a different position than one arriving with a proposal.

6. Powering Procedural Growth: Structural Heart, Rhythm and Hypertension

Remote care is usually sold as a chronic-disease programme. In a group with this procedural profile it is also a throughput multiplier, and the mechanism is specific: **a monitored discharge pathway is what lets a post-procedure patient go home on the same or next day instead of occupying a bed overnight**. Every one of this group's procedural lines is performed inside a hospital it does not own — and every one of those hospitals is now reconciled on the 30 days that follow.

Procedural line	What the public record shows	What the service line adds
Structural heart and interventional	The practice publishes transcatheter aortic valve replacement, mitral valve repair, left atrial appendage closure, chronic total occlusion work and coronary stenting, with five interventional cardiologists on the CMS roster. All of it is hospital-based	Post-procedure rhythm and blood-pressure monitoring in the 2–15 day window, now billable via 99445; earlier discharge; structured anticoagulation follow-up in a practice that already runs a nurse-staffed anticoagulation clinic
Electrophysiology and device implantation	One CMS-listed electrophysiologist, a published implant and ablation range, and a device clinic billing roughly $99,770 of remote interrogation across 2,721 services in CY2024	Post-ablation and post-implant physiologic monitoring sits alongside — not inside — device interrogation. Blood pressure, weight and symptom data are patient-generated and distinct from the device's own telemetry (see the boundary rule in Section 2.1)
Advanced heart failure, transplant and mechanical support	Three board-certified advanced heart failure and transplant physicians; transplant and mechanical circulatory support co-managed with the hospital's own coordinators; 33 beneficiaries on implantable hemodynamic monitors in CY2024	The highest-acuity population in the practice and the highest-yield population for monitoring and monthly management. Also the population where an avoided admission is worth the most to the hospital carrying the episode
Enhanced external counterpulsation	A published 35-session programme — one hour a day for seven weeks	A naturally adjacent longitudinal cohort: patients already committed to a seven-week schedule of contact, with refractory symptoms and a measurable blood-pressure and symptom profile
Hypertension and renal denervation	**No evidence of renal denervation** in the practice's published procedure range or in its CY2024 Medicare billing. This is whitespace, not a current capability	**Policy-aligned whitespace, not a plan.** CMS national coverage determination 20.40 covers renal denervation for uncontrolled hypertension effective October 28, 2025 under Coverage with Evidence Development. Blood-pressure RPM is intrinsic to that pathway — for candidate identification, for titration, and for the evidence the coverage condition requires

Read the renal-denervation row as an option, not a plan. Nothing in the public record indicates this group performs the procedure today, and this report does not assume it will. The point is narrower and more useful: a practice with five interventional cardiologists, an existing blood-pressure monitoring capability and a documented appetite for device trials 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.

One differentiator worth protecting. The practice runs an adult Kawasaki disease programme and published twice in the Journal of the American College of Cardiology family under its own affiliation in July 2026 alone.[19] It is a small population and it is not a revenue argument. It is evidence that this is a clinically

[19] PubMed, queried August 3, 2026: two Journal of the American College of Cardiology family publications on adult Kawasaki disease carrying the practice's affiliation, PMID 41879576 (July 28, 2026) and PMID 42455094 (July 15, 2026), corroborated by the practice's own

led group that behaves like an academic centre in a private-practice cost structure — which is a reason to treat it as a peer rather than as a commodity cardiology account, and a reason it will read a report like this one closely.

adult Kawasaki disease treatment page.

7. Technology & Workflow: Building Inside a Hosted Epic

7.1 What is verified about the platform — and what follows from it

The platform finding, stated carefully

What is verified: the practice's electronic record is **Epic**, and it is **Sharp HealthCare's Epic instance rather than a system the practice owns**. The only patient-portal link anywhere on the practice's website is Sharp's portal; that portal resolves to an Epic MyChart deployment on Sharp's own tenant path; Sharp's portal page names Sharp Community Medical Group among the groups it serves, while noting that not every Sharp Community practice uses it; and the practice's organizational NPI registers **no Direct address and no FHIR endpoints at all** in NPPES. Even patient bill pay routes to a third-party service rather than to a practice-owned portal.[20]

What follows: interface work, application enablement, build changes and reporting configuration inside that instance are **Sharp's decisions, on Sharp's governance and timeline** — not the practice's. The most likely contractual mechanism is a community-connect style arrangement, by which a system extends its licensed instance to affiliated independent practices, but *the specific vehicle is not publicly documented and must be confirmed in discovery.*

The practical consequence, said plainly: an EMR-integration story is not this practice's to buy. A promise to integrate with the record is a promise the practice cannot accept on its own authority, and a capable administrator will say so in the first conversation. **This account is won on workflow and staffing, and integration scope is confirmed jointly with Sharp in contracting.**

7.2 What the service line runs on, without an integration decision

Everything material to the service line runs on what the practice does control: its own Medicare enrollment and TIN, its physicians' orders, its clinical protocols and supervision, its consent process, and the claims it submits. Enrollment, device logistics, monitoring, triage, documentation and claim generation are delivered by the partner. What that looks like in phases:

Phase	What it delivers	Whose decision it is
Phase 1 — launch, no dependency on Sharp	Enrollment and consent workflow; device logistics; 24/7 monitoring and triage against thresholds the physician lead sets; billing-grade documentation; automated claim generation; a structured monthly clinical summary returned in a form the practice can file to the chart; a shared worklist the care team and the practice both see	**The practice's alone**
Phase 1b — the discharge signal	A daily or near-daily process identifying which of the practice's patients were discharged, from which hospital. Achievable through practice-side processes, and materially better with hospital cooperation	The practice, with a strong hospital interest behind it (Section 5)
Phase 2 — scoped integration	Order-based referral inside the chart, enrollment status visible at the point of care, structured clinical exchange of vitals, evidence of care and care plans back into the record	**Joint — scope, feasibility and timeline confirmed with Sharp in contracting**

And one thing that is already true and should shape the plan: something already works. The practice bills 99454 today, which means physiologic data from a connected device already reaches a clinician and already supports a claim. Whatever that path is — a vendor portal, a manual review

[20] The practice's website links to exactly one patient portal - Sharp HealthCare's, at sharp.com/app. It resolves to an Epic MyChart deployment on the /sharpapp/ tenant path, with explicit Epic Systems and MyChart markers in the served page (probed August 3, 2026). Sharp's portal page names Sharp Rees-Stealy, Sharp Community and SharpCare as the medical groups it serves, and notes that not every Sharp Community practice uses it - this practice links to it exclusively, from two separate pages. NPPES record 1801980446 carries no Direct address and no FHIR endpoint entries. Patient bill pay routes to a third-party service. The community-connect style hosting mechanism is inferred from this evidence and is not publicly documented for this practice.

workflow, a scanned summary — **it is the template, and mapping it is the first technical task in discovery**. No public source names the platform, and the practice's own website names none. That question, and who owns the workflow behind it, are the two most valuable answers a first conversation can produce.

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

7.3 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 — and unusually, this account provides its own evidence. **The CY2024 record already shows what manual capture looks like**: 99453 billed on 41 patients against 241 on device supply, and 99458 billed on 26 patients against 244 receiving the first-20-minute code. Those are not clinical gaps. They are the predictable output of a workflow where the documentation and the claim are assembled by people who also have a clinic to run.

At a modeled census of **4,939 active programme enrollments at month 24**, across three offices, hospital-campus sites and 26 referring providers, the monthly billing task is thousands of per-patient, per-code, time-documented claims — each dependent on evidence that the monitoring days and the management minutes were actually met. **The model projects 109,461 billed units over 24 months.** A lean administrative layer cannot assemble that by hand, and the failure mode is not a rejected claim; it is a programme that quietly bills less than it delivers. That is, measurably, what is happening today. Automated generation from the monitoring record is what makes the capture rate in Section 8.5 a real operating metric rather than an aspiration.

8. Implementation Playbook: Building the Remote Care Service Line

8.1 Goals, scope, and the modeled funnel

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

Model input	Value	Note
In-scope Medicare base	14,837	Discovery-stage estimate — validate against chart counts
Referring providers	26	The full PECOS reassigned roster as of July 14, 2026 (23 physicians, 3 nurse practitioners)
Referrals per provider per month	8	With 80% patient acceptance
On-site enrollment specialist	1 (≈80 enrollments / month)	**CoachCare's expense — embedded value, never deducted from practice margin**
RPM eligibility / acceptance	75% (11,128) / 35%	Modeled ceiling 3,895 patients; census reaches 3,646 at month 24 and is still climbing
PCM eligibility / acceptance	85% (12,611) / 30%	Modeled ceiling 3,783; census reaches 1,293 at month 24 — enrollment-limited, not eligibility-limited
Monthly attrition	1.5%	Discharge from programme
Revenue basis	Net of a 6% realization discount	Payer mix and collection, as configured in the model

Target populations and clinical pathways

Population	Why it is first	Pathway
The ~241 patients already enrolled	They are already consented, already on devices and already billing. Consolidating them under one protocol, one documentation standard and one billing engine is the fastest value in the programme and requires no new enrollment	Audit the current capture; add 99458 where the management time supports it and 99453 where onboarding was never billed; add PCM where heart failure is the principal condition
Post-discharge cardiac	Five mandatory-TEAM hospitals, no transitional care management billed, and the exact 30 days those hospitals are now accountable for	TCM 99495 / 99496 (not modeled) + short-window RPM via 99445 / 99470
Heart failure	A three-physician advanced heart failure and transplant bench, a heart failure programme running since 1998 with a dedicated nurse practitioner, and 33 beneficiaries already on implantable hemodynamic monitors	Weight + blood-pressure RPM with 24/7 triage; PCM as the monthly chassis; titration against measured response
The twelve physicians billing nothing	Not a clinical population but the largest single source of enrollment growth in the model — and the reason both arms are enrollment-limited rather than eligibility-limited	One order in the chart, an enrollment specialist covering the offices in rotation, and a telephonic pathway for patients who cannot come in
Uncontrolled and resistant hypertension	A large treated-hypertension base across a five-interventionalist practice, and the candidate pool for any future resistant-hypertension pathway (Section 6)	Blood-pressure RPM; protocolised titration; documented response

Population	Why it is first	Pathway
Post-ablation, post-implant and post-structural-heart	Every procedural case opens a short window that is now billable, and every one of those cases is performed inside a hospital carrying episode cost	Short-window RPM (99445), kept explicitly distinct from device interrogation

8.2 Staffing: nobody has to be hired

The model delivers **48,901 care-team hours over 24 months — approximately 23.5 full-time equivalents** — supplied by the partner under the practice's protocols and clinical supervision, alongside 218,921 care-management tasks, 54,730 chart updates, 32,838 patient conversations and 1,824 hours of call time. For a group whose published administrative layer is a single chief administrative officer and whose job-board footprint shows no care-coordinator or chronic-care nurse role, this is the layer that makes the programme possible at all rather than a nice-to-have. **The on-site enrollment 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. That matters more here than the sentence usually does, because the constraint is visible in the data: a programme that seven physicians could run personally reached seven physicians and stopped.

8.3 “We already do remote monitoring” — the answer

This objection will come up in the first meeting, and at this practice it will come up twice — once about the physiologic programme and once about the device clinic. Both are true. Neither is an argument against the service line, and the answer is not to dispute them but to be precise about what is and is not already covered.

	Remote cardiac device monitoring (93294–93298)	Remote physiologic monitoring (99453 onward)
What is measured	The implanted device's own telemetry — lead integrity, arrhythmia episodes, device diagnostics	Patient-generated physiologic data from a separate connected device — blood pressure, weight, pulse oximetry
Who it covers	Patients with an implanted pacemaker, defibrillator, loop recorder or hemodynamic sensor	Any patient with a qualifying condition — the great majority of the practice's heart failure and hypertension panel has no implanted device at all
What clinical question it answers	Is the device working, and has an arrhythmia occurred	Is this patient decompensating, is the blood pressure controlled, is the titration working
Status at this practice	Running — roughly $99,770 in CY2024 across 2,721 services	Running at roughly 241 patients across 7 of 19 physicians — **with the add-on rung, the setup code and the short-window codes largely uncaptured**

The two remote programmes are different benefits over different data, and 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.* On the physiologic programme the answer is different and simpler: **the practice is right that it already does this, and the question is not whether it works but why it stopped at seven physicians, one add-on code and no post-discharge window**. That is an operating question, and it has an operating answer.

8.4 Clinical workflow

1. **Consolidate.** Before enrolling anyone new, bring the existing monitored patients under one protocol, one documentation standard and one billing engine. This is where the first month's yield comes from and it requires no new consent, no new device and no new referral.
2. **Identify.** Heart failure, uncontrolled hypertension, post-discharge, post-procedure — built from the practice's own record and from the daily discharge list.
3. **Enroll.** One order. Consent, device selection and logistics handled by the partner; the on-site enrollment specialist covers the offices in rotation, with a telephonic pathway behind it for patients who cannot come in.
4. **Monitor.** Daily physiologic data with 24/7 review and alert triage against thresholds the physician lead sets — not vendor defaults.
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 301 modeled avoided admissions actually come from.
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 7.3).
8. **Report back.** Structured monthly reporting to the referring primary care physician. In a market where specialist referral volume is routed through physician associations, this is a referral-retention mechanism as much as a clinical courtesy.

8.5 KPI dashboard and expected impact

Domain	Metric	Why it is on the dashboard
Clinical	Blood-pressure control rate; weight-alert response time; heart failure admissions and 30-day readmissions among the enrolled census	These are the measures the admitting hospitals' TEAM episodes are reconciled on, and the ones that make the group's contribution measurable rather than asserted
Operational	Enrolled census by programme; physicians referring at least one patient per month; enrollment conversion rate; device compliance (days with data); alert-to-contact time	Census is revenue, and both modeled arms are enrollment-limited. The referring-physician count is the single metric that tracks whether the programme has escaped the seven-physician pattern
Financial	Time to first billable enrollment; capture rate (billed ÷ eligible), by code rung; net reimbursement per patient per month; net to practice	Modeled at ~$111.25 per RPM patient-month and ~$99.69 per PCM patient-month. The by-rung capture rate is the metric the CY2024 data says this practice most needs
Strategic	Post-discharge reach rate within two business days; readmission delta versus the unenrolled panel; referral retention	The numbers to take into a hospital conversation — and the ones the practice currently cannot produce for its own heart failure programme

Expected impact over 24 months, as modeled: $6,608,698 of net reimbursement and $2,811,277 net to the practice at a 42.54% margin; 4,034 unique patients and 4,939 active programme enrollments at month 24; 473,399 physiologic readings; 109,461 billed units; approximately 301 avoided hospitalizations; and 48,901 care-team hours delivered. *All figures are illustrative, modeled — verify against practice data.*

8.6 Twelve-month roadmap

Phase	Months	What happens
Charter	0–1	Physician lead named; service line chartered with its own P&L; the existing remote-monitoring programme, its platform and its owner mapped; target populations agreed; attribution, coordination and consent policy written before the first enrollment
Consolidate	1–2	Existing monitored patients brought under one protocol and one billing engine; by-rung capture audited; 99453 and 99458 gaps closed where the clinical record supports them
Stand up	1–3	Alert thresholds and escalation protocol set by the physician lead; on-site enrollment specialist placed across the three offices; discharge-notification process agreed with the admitting hospitals; phase-two integration scope opened jointly with Sharp
First census	2–6	Post-discharge and heart failure cohorts enrolled first; the physicians who billed nothing in CY2024 brought into the referral pathway; month 2 is the first net-positive month in the model
Extend	6–9	Hypertension, post-ablation, post-implant and post-structural-heart pathways added; a second enrollment pathway opened, because both modeled arms are enrollment-limited rather than eligibility-limited
Institutionalise	9–12	Monthly scorecard running; by-rung capture rate and readmission delta reported; the TCM decision taken on its own merits; the readmission data taken into the hospital conversation with numbers rather than assertions

References & Data Sources

- **CMS Revalidation Clinic Group Practice Reassignment** (file modified July 14, 2026): the 26-clinician reassigned roster (23 physicians, 3 nurse practitioners), group PECOS enrollment identifier O20040917000439 and group PAC ID 8628045986.
- **CMS Doctors and Clinicians National Downloadable File** (dataset mj5m-pzi6, updated June 26, 2026, queried August 3, 2026) and the **NPPES NPI Registry** (live API, retrieved August 3, 2026): the 23-practitioner roster used for every code-level query, CMS primary and secondary specialty per clinician, practice-site addresses, organizational NPI 1801980446, and the county cardiology census.
- **CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024** (data vintage December 1, 2024; file modified May 21, 2026): the remote physiologic monitoring lines (99453, 99454, 99457, 99458), the implanted-device remote interrogation lines (93294–93298), and the negative screen across the full chronic care management, principal care management, transitional care management, remote therapeutic monitoring, 99091 and self-measured blood pressure code sets for all 23 practitioners. CMS suppresses lines with fewer than 11 beneficiaries.
- **CMS Medicare Physician & Other Practitioners — by Provider, CY2024** (same release): total Medicare allowed and paid amounts across the 20 practitioners with CY2024 billing, and per-provider beneficiary counts.
- **CMS TEAM Participant List** (published at cms.gov/team-model-participant-list; hospital list as of April 15, 2026, updated quarterly; retrieved August 3, 2026): 720 participant hospitals across 189 core-based statistical areas, including CBSA 41740 with 15 participant hospitals; CCN 050100, 050026, 050222, 050234 and 050077 all mandatory, performance period January 1, 2026 to December 31, 2030.
- **CMS Facility Affiliation Data** (dataset 27ea-46a8, updated June 26, 2026): hospital privileges resolved for all 18 of the group's cardiology NPIs, and the affiliated-clinician counts per CCN in Sections 1.2 and 3.1.
- **CMS Hospital General Information** (dataset xubh-q36u, queried August 3, 2026): independent CCN-to-facility resolution for every hospital referenced in this report.
- **CMS Medicare Shared Savings Program participants, PY2024, PY2025 and PY2026** and the **ACO REACH PY2024 Provider Public Use File** (234,886 rows; vintage December 1, 2024, modified July 20, 2026): all four files searched in full across every state by legal name and by organizational NPI. The practice does not appear in any of them.
- **CMS Medicare Monthly Enrollment** (April 2026 file, dataset modified July 23, 2026) and the **CMS Medicare Advantage State/County Penetration file, July 2026**: county, state and national Medicare, Original Medicare and Medicare Advantage enrollment, dual-eligible counts, and the penetration comparison. The two files agree to within 0.1 point.
- **County of San Diego Health and Human Services Agency demographic profiles** (published March 2026, built on US Census American Community Survey 2020–2024 five-year estimates): county population 3,288,774, aged 65+ 507,734 (15.4%). The commonly quoted 537,400 / 16.3% figure is the one-year 2024 estimate — the two vintages should never be mixed.
- **California Secretary of State business registry** (extract dated July 27, 2025, obtained via a third-party mirror because the registry's own interface blocks automated retrieval): entity number 1247885, filed June 1, 1984, active, and the officer and director set. *Every named officer independently resolves to a physician on the group's own CMS roster, which is strong corroboration — but re-pull the Statement of Information before relying on officer titles contractually.*

- **The practice's own website** (full sitemap crawl of all 95 URLs, August 3, 2026): locations, published service and procedure range, the heart failure programme, the anticoagulation clinic, the device and implantable-sensor pages, the insurance and billing policy, and the complete absence of any remote-monitoring or care-management content.
- **ClinicalTrials.gov and PubMed** (queried August 3, 2026): the pivotal implantable pulmonary-artery-pressure trial site record (completed May 2023), an active remote-sensor insertable-cardiac-monitor study, home wearable atrial-fibrillation detection studies, and publications on pulmonary-artery-pressure sensor management and adult Kawasaki disease carrying the practice's affiliation. Every trial and publication claim in this report is traceable to a registry identifier.
- **Health system and physician-association public material** (retrieved August 3, 2026): Sharp HealthCare's patient-portal page and the medical groups it names; Sharp Community Medical Group's description of itself and of its case-management, disease-management and transitional-care services and their primary-care eligibility condition; Sharp Medicare Advantage plan-medical-group and referral rules; and Sharp's July 2026 assumption of operations at Tri-City Medical Center.
- **CMS — CY2026 Medicare Physician Fee Schedule:** TCM 99495 and 99496; RPM 99453, 99454, 99445, 99457, 99470 and 99458; PCM 99424–99427; and the concurrency rules under which RPM and PCM stack. Locality-adjusted payment for this practice is set by the Medicare Administrative Contractor for California; the model resolves ZIP 92123 to locality 01182-72.
- **CMS policy references:** the Transforming Episode Accountability Model (mandatory, January 1, 2026 – December 31, 2030; five episode categories including coronary artery bypass graft; participation by hospital CCN); and national coverage determination 20.40, renal denervation for uncontrolled hypertension, effective October 28, 2025 under Coverage with Evidence Development.
- **California statutory references:** Business and Professions Code sections 2400 and 2406 (the corporate practice of medicine and the professional medical corporation), Health and Safety Code section 1206(l) (the clinic exemption), and Health and Safety Code section 1375.4 (regulation of risk-bearing organizations) — the statutory context for the group's corporate form and for the county's delegated managed-care structure.
- **California HealthCare Foundation San Diego regional market brief** (June 2016): the description of the county's delegated risk structure and the professional-risk / institutional-risk split between physician organizations and health systems. **This source is nine years old**; the structural pattern is well established but the specific terms should be re-confirmed rather than assumed.
- **CoachCare Value Analysis companion model —** all modeled economics, clinical and operational forecasts in Sections 2.2, 5, 7 and 8, including the 14,837-patient in-scope base, 75% / 85% RPM / PCM eligibility, 35% / 30% acceptance, 1.5% monthly attrition, a 6% realization discount, the 26-provider referral engine at eight referrals per provider per month with 80% acceptance, one on-site enrollment specialist at CoachCare's expense, and MAC-locality rates auto-resolved for ZIP 92123 (California, locality 01182-72).

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 runs the existing remote-monitoring programme, and on what platform.** Seven physicians bill it, one dominates it, no vendor or platform is named in any public source, and no care-management or programme lead is published. *This is the single most important question in the account* — it determines whether the service line consolidates, augments or replaces what is already running.

- **Current-state volume beyond CY2024.** The CMS file covers data year 2024 and Medicare fee-for-service only. A programme expanded in 2025 or 2026 would be invisible, and Medicare Advantage or commercial remote monitoring would not appear at all. The next release covering data year 2025 is not expected until roughly mid-2027.
- **The payer mix.** The ratio of traditional Medicare to Medicare Advantage to preferred-provider to Medicaid managed-care volume is not disclosed in any public dataset. The structural position is established — no direct capitation, HMO participation only as a downstream specialist — but the proportions are not, and the business case scales off them.
- **The electronic health record's contractual vehicle and the practice's autonomy inside it.** That the record is Sharp HealthCare's Epic instance is well evidenced. That the arrangement is a community-connect style hosting agreement is an inference. Confirm the vehicle, who administers it, what build or reporting autonomy the practice has, and how the existing remote-monitoring data reaches the chart today.
- **The practice's downstream risk share within Sharp Community Medical Group.** Whether medical-expense avoidance on managed-care members accrues to the practice or only to the association is a private contract term. It determines how much of the clinical upside outside fee-for-service is actually the practice's.
- **Whether the association's 2016-documented risk arrangements still govern.** The best available documentary source on the county's delegated structure is nine years old. Re-confirm before relying on any specific characterisation of it.
- **True unique-patient panel size.** A unique-patient denominator cannot be derived from the public CMS files, which report beneficiary instances per code per provider and contain duplication. The sum of per-provider beneficiary counts (16,129) is *not* a patient count and must not be used as one. The modeled 14,837 in-scope base is a discovery-stage estimate.
- **The live roster and the two additional CMS practice addresses.** Twenty-six reassignments as of July 14, 2026, but reassignment records lag departures and miss recent hires; one nurse practitioner enrolled as recently as June 2026. Two practice addresses appear in CMS data that are not on the practice's website, both on hospital campuses. Confirm the roster and how each site is staffed and billed.
- **The heart failure programme's own outcome data.** The practice publishes a self-reported readmission-reduction figure for its heart failure programme with no stated methodology. It is deliberately not repeated anywhere in this report. *Asking how it was measured is worthwhile for a different reason: the answer reveals what data the practice can already produce.*
- **Why the implantable hemodynamic monitoring line is billed outside the advanced heart failure bench.** Thirty-three beneficiaries on implantable hemodynamic monitors in CY2024, billed by physicians other than the three advanced heart failure and transplant specialists. An unexplained split in a programme that would normally be heart-failure-led.
- **Whether the anticoagulation clinic and the heart failure nurse practitioner role are still staffed as published.** Both appear on current practice pages, but the site's own recognition page has not been updated since 2022 and the telehealth page is still pandemic-era content — so page currency cannot be assumed.
- **Medicare Advantage and commercial contract terms.** Not publicly discoverable. Relevant because remote-monitoring coverage varies by preferred-provider contract, and because managed-care volume is clinical upside rather than billable revenue in this model.
- **Officer titles and corporate filing details.** The state corporate registry blocks automated retrieval and the officer set is mirror-derived. Re-pull the Statement of Information before any contractual use.

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 California locality files, and note that CY2027 rulemaking is in progress. The TEAM hospital list is current as of April 15, 2026 and CMS updates it quarterly; the practice itself holds no CCN and is not a TEAM participant. The electronic health record is Sharp HealthCare's Epic instance, and any integration scope must be confirmed jointly with Sharp in contracting. All Value Analysis outputs are illustrative, modeled — verify against practice data.

Prepared by CoachCare · August 2026.