COACHCARE | SERVICE LINE STRATEGY

Cardio Vascular Institute of Scottsdale

An independent cardiovascular practice across Scottsdale, Fountain Hills, Carefree and Wickenburg, Arizona — eight physicians, eight advanced practice providers, one Medicare enrolment

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

Extending a remote-monitoring capability the practice already operates into a full Remote Care Service Line (TCM + RPM + PCM) — a margin-positive standalone P&L billed under the practice's own enrolment, and the operating spine for post-discharge and post-procedure follow-up

What this report concludes

The practice already runs two remote programs and markets neither. In CY2024 it billed $317,532 of remote cardiac device monitoring across 7,051 services and $265,365 of chronic care management across 6,106 services on 1,139 Medicare patients.

Four code families that belong in a cardiology practice return no services. Remote physiologic monitoring, principal care management, transitional care management and the chronic-care-management add-on rung are all absent from the CY2024 file.

Modelled 24-month value: $4,265,636 of net reimbursement and **$1,816,742** retained by the practice after CoachCare fees — a **42.59% practice margin**, 41.86% in Year 1 and 42.83% in Year 2.

The constraint is enrolment throughput, not eligible patients. Both program arms are pace-limited: RPM reaches 2,674 against a 3,207 ceiling and PCM 1,002 against 3,115. Month 24 is not the program's terminal size.

Prepared by CoachCare · August 2026

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Executive Summary

Cardio Vascular Institute of Scottsdale is the trade name of an Arizona professional limited-liability company — a single-owner entity carrying its founding physician's initials, which this report does not reproduce — enumerated in 2012 and holding the practice's Medicare enrolment.[1] It operates from four published locations: the main clinical office in Scottsdale, plus Fountain Hills, Carefree and Wickenburg, with the corporate suite in a second building on the same Scottsdale block.[2] CY2024 Medicare claims place **eight physicians and eight advanced practice providers** at the practice address — notably **two more physicians than the public physician page lists**.[3]

The practice presents itself as a full-service cardiovascular group and the claims broadly agree, with one important correction. It runs a substantial in-house diagnostic footprint — nuclear cardiology, echocardiography and a non-invasive vascular lab — and **84.3% of its CY2024 Medicare payment sits in the office place of service**. Every endovascular and coronary intervention line is billed in a facility. **This is a longitudinal office practice with deep diagnostics, not a procedure-throughput office-based lab**, and the service line proposed here is designed for that.[4]

The finding

This practice does not need to be persuaded that remote monitoring works. It already runs two remote programs. In CY2024 it billed **$317,532 of remote cardiac device monitoring** across 7,051 services — including remote rhythm-monitor evaluation at 3,146 services on 365 patients, an average of 8.6 monthly reads each, and implantable hemodynamic monitoring on a further 107 patients — plus **$74,766 of ambulatory cardiac monitoring**.[5] Separately, four of the eight physicians billed **$265,365 of chronic care management** across 6,106 services on 1,139 Medicare patients.[6] Neither program appears anywhere on the practice's website.

What is absent is the ladder between them. Screened by individual national provider identifier against the full CY2024 care-management and remote-care code set, the practice shows no services at meaningful scale on remote physiologic monitoring (99453, 99454, 99457, 99458), principal care management (99424–99427), transitional care management (99495, 99496), physiologic data review (99091) or remote therapeutic monitoring.[7] And the chronic-care-management add-on rung, 99439, returns no services at all against 6,106 base services.

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[1] CMS National Plan and Provider Enumeration System, organisational record for the practice's Medicare billing entity, enumerated 26 November 2012; taxonomy 207RC0000X Internal Medicine / Cardiovascular Disease with the single-specialty group taxonomy group. The record names one physician as the authorised official with the role President/Owner. The entity is linked to the public brand three independent ways: the telephone number on the national provider record matches the number published on the practice's website exactly; an independent practice directory lists the entity at the practice's corporate suite with the same five-city footprint; and every CY2024-active physician bills from the practice's main clinical address. Retrieved 7 August 2026.

[2] Practice website, locations page, retrieved 7 August 2026. All five addresses were geocoded against the U.S. Census Bureau geocoder (Public_AR_Current benchmark); four resolved to exact matches and all five ZIPs are confirmed to sit in Maricopa County.

[3] CMS Medicare Physician & Other Practitioners — by Provider, CY2024 (released 21 May 2026), cross-referenced against the national provider enumeration system. Method: a taxonomy-targeted registry sweep at the practice ZIP filtered to the two practice street addresses, with every resulting identifier then tested for a CY2024 claims row from that address, which separates current clinicians from stale registry entries. The raw registry address search overcounts physicians by three; the practice's public physician page undercounts by two. The claims-confirmed count of eight physicians and eight advanced practice providers is the figure used throughout this report. One additional physician assistant appears on the public roster with no CY2024 claims row.

[4] CMS Medicare Physician & Other Practitioners — by Provider and Service, CY2024, summed by place-of-service indicator across all sixteen clinicians with claims rows: office $3,571,520 (84.3%) against facility $666,094 (15.7%).

[5] CMS by-Provider-and-Service PUF, CY2024. 93294 remote pacemaker system evaluation: 442 beneficiary-lines, 1,251 services, $25,663. 93295 remote implantable defibrillator evaluation: 111, 286, $7,211. 93296 remote evaluation technical support: 530, 1,526, $22,621. 93297 implantable hemodynamic monitor: 107, 842, $36,649. 93298 subcutaneous cardiac rhythm monitor: 387, 3,146, $225,388. Ambulatory monitoring 93228: 139 beneficiary-lines, $2,654; 93229: 117, $72,113. Classic Holter codes 93224–93227 return no services, which is consistent with a practice that has moved to extended-wear monitoring. Beneficiary counts are per code and contain duplication across codes and clinicians.

[6] CMS by-Provider-and-Service PUF, CY2024, CPT 99490: four physicians, 1,139 beneficiary-lines, 6,106 services, $265,365 in Medicare payment. The 5.4-months-per-patient figure is 6,106 services divided by 1,139 beneficiary-lines.

[7] CMS by-Provider-and-Service PUF, CY2024, screened code by code across every clinician identifier resolved for the practice. CMS suppresses any provider and procedure line with fewer than eleven beneficiaries, so each result reported as absent means no program at meaningful scale rather than no patients.

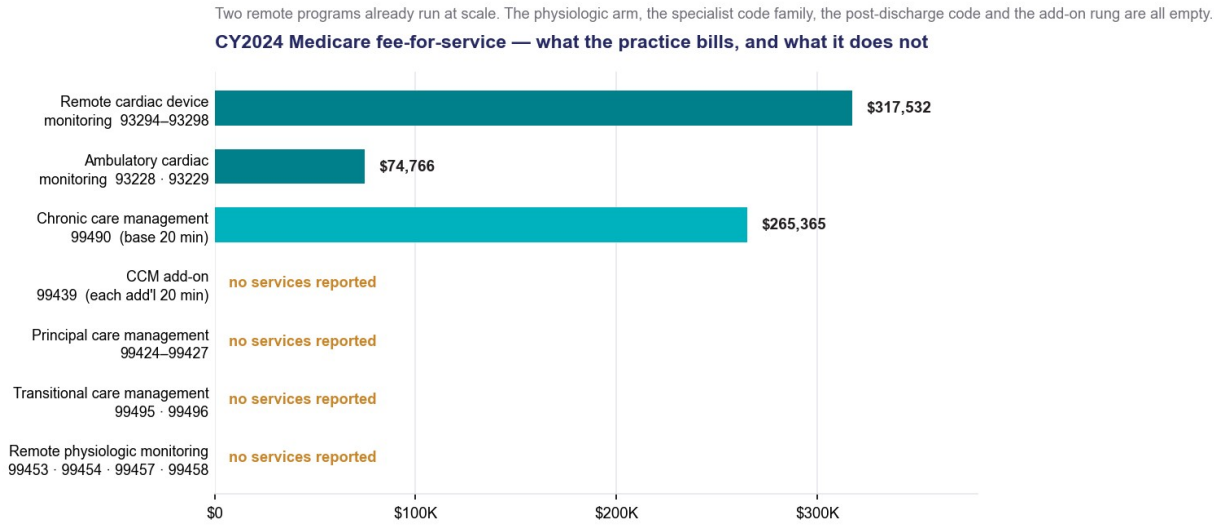

Figure 1 — CY2024 Medicare fee-for-service by code family. Two remote programs run at scale; the physiologic arm, the specialist code family, the post-discharge code and the add-on rung are empty.

The forecast

The companion Value Analysis models a two-program service line — remote physiologic monitoring and principal care management — across a Medicare panel of 12,216, sixteen referring clinicians, one CoachCare-funded on-site enrolment specialist, and CY2026 rates resolved for the Arizona payment locality.

	Year 1	Year 2	24-month
Net reimbursement	$1,046,892	$3,218,744	**$4,265,636**
CoachCare fees	$608,685	$1,840,209	$2,448,894
Practice net, after fees	**$438,207**	**$1,378,535**	**$1,816,742**
Practice margin	41.86%	42.83%	**42.59%**
Enrolled patients at year end	1,504	2,974	—

Practice margin throughout this report is net to the practice divided by net reimbursement. **The on-site enrolment specialist in the model is funded by CoachCare** — it is embedded value already reflected in the fee line above and is never a deduction from practice margin. Month-1 practice profit is **negative $4,030** because one-time implementation and integration setup post in that month; the program is margin-positive from month 2 and every month after.

Four conclusions

- **The capture gap is worth pursuing before a single new patient is enrolled.** Enrolled care-management patients are billed an average of 5.4 months out of twelve, and the add-on rung is never billed. Both are unclaimed revenue against work that is largely already being done.
- **Half the physician bench is outside the program.** Four of eight physicians account for all of the care management, and one physician holds nearly the entire remote device book. Several non-participating physicians carry four-figure Medicare panels with the same disease burden.
- **Throughput is the lever, not panel size.** Both arms are pace-limited, so the forecast responds to enrolment capacity rather than to the size of the eligible pool. A second CoachCare-funded on-site enrolment specialist raises 24-month net reimbursement by roughly 39%.

- **The electronic record is an advantage here.** The practice runs eClinicalWorks, and CoachCare is the only care management application integrated with eClinicalWorks that generates claims automatically — which is the precise failure mode visible in the CY2024 data.

1. Footprint & Operating Model

1.1 The practice

Cardio Vascular Institute of Scottsdale is a trade name. Medicare claims run through an Arizona professional limited-liability company whose national provider record names a single physician as president and owner.[8] No organisational provider identifier exists under the Cardio Vascular Institute, Cardiovascular Institute of Scottsdale, or Vascular & Limb Salvage Institute names; the brands are marketing identities over one billing entity. For contracting, that means signature authority sits with one named officer.

Location	Address	ZIP
Scottsdale — main clinical	10101 N 92nd Street, Suite 101	85258
Scottsdale — corporate suite	10117 N 92nd Street, Suite 103	85258
Fountain Hills	13430 N Saguaro Boulevard, Suite 100	85268
Carefree	36800 N Sidewinder Road, Suite A-4	85377
Wickenburg	490 Bralliar Road	85390

All five sites are in Maricopa County. **Arizona is a single statewide Medicare payment locality** — carrier 03102, locality 00 — so every office prices identically and the model needs no site-by-site rate work.[9] The Wickenburg office is roughly an hour by road from the Scottsdale campus, with Fountain Hills and Carefree between them. For a chronic cardiac patient in that catchment the practical barrier to good care is distance, and a monitoring layer is the direct answer to it.

Clinicians

CY2024 claims place **eight physicians and eight advanced practice providers** at the practice address, each confirmed by a claims row rather than by a registry registration.[10] Two of the physicians and two of the advanced practice providers do not appear on the public physician page. One of the unlisted physicians carries a full clinical load; the other shows a reduced pattern of 671 beneficiaries against $26,913 of Medicare payment, almost entirely professional-component interpretations, and bills no office evaluation-and-management services at all. Both are worth confirming, because **clinician count is the single most sensitive input in the forecast**: removing those two physicians moves 24-month net reimbursement from $4,265,636 to $3,981,524.

1.2 What the claims say this practice actually is

The public brands suggest a procedural vascular practice. The claims describe something different, and the difference matters for how the service line is designed.

Capability	What CY2024 Medicare shows
Nuclear cardiology	Myocardial perfusion imaging on 1,061 beneficiaries under one physician alone, with in-house radiopharmaceutical billed on 1,060 — an owned nuclear laboratory, and the largest single line in the practice

[8] Second citation of the entity record described in note 1. Registry searches for organisational providers in Arizona under every brand variant — Cardio Vascular Institute, Cardiovascular Institute of Scottsdale, Vascular & Limb Salvage Institute and Limb Salvage Institute — returned no results, confirming the public names are trade names over a single billing entity.

[9] The practice ZIP resolves to Medicare Administrative Contractor carrier 03102, locality 00, in the CY2026 fee-schedule locality table used by the Value Analysis workbook. All five practice ZIPs — 85258, 85268, 85377 and 85390 — resolve to the same carrier and locality, confirming Arizona as a single statewide payment locality.

[10] Practice website, cardiac services page, retrieved 7 August 2026. The page names a Heart Failure Clinic, Hypertension Clinic, Cholesterol Clinic, Arrhythmia Clinic and Coumadin Clinic, together with pacemaker and defibrillator checks and Holter and event monitoring under non-invasive testing.

Capability	What CY2024 Medicare shows
Echocardiography	Complete transthoracic echocardiography billed by seven providers
Non-invasive vascular lab	Venous and arterial duplex studies on roughly 900 beneficiaries, all billed in the office — a practice-owned vascular laboratory
Electrophysiology and devices	Pacemaker insertion, subcutaneous rhythm-monitor insertion and atrial-fibrillation ablation, plus percutaneous left-atrial-appendage closure on 103 beneficiaries
Coronary and peripheral intervention	Coronary stenting on 81 beneficiaries and peripheral atherectomy, angioplasty and stenting on roughly 50 — all billed in a facility, none in the office
Hospital inpatient work	Subsequent hospital care on 187 beneficiaries across 473 services

The load-bearing observation

84.3% of CY2024 Medicare payment — $3,571,520 — is billed in the office place of service; 15.7%, or $666,094, is billed in a facility. **Every endovascular and coronary intervention line is a facility line.** A practice-owned office-based lab billing globally would produce office-place intervention lines, and there are none.

The commercial consequence: this is a longitudinal office practice with a deep diagnostic footprint and a facility-based interventional arm. The value here is in the continuous management of a large, complex outpatient panel — which is exactly what the code families that are missing were written to pay for.

The practice's own website reinforces the reading. It names standing disease clinics — a **Heart Failure Clinic**, a **Hypertension Clinic**, plus cholesterol, arrhythmia and anticoagulation clinics — alongside pacemaker and defibrillator checks and extended-wear rhythm monitoring.[11] Very few cardiology groups commit that explicitly in public to longitudinal chronic-disease management. Nurse-led, protocol-driven, between-visit care is not a concept this practice needs sold to it; the claims show it already funds one version of it.

1.3 Design principles for the 2026 service line

- **Extend, do not introduce.** The pitch is not that the practice should start monitoring patients remotely. It is that the same operating discipline already applied to implanted devices and to care management should be applied to physiologic data, to the add-on rungs, and to the post-discharge window.
- **Bill under the practice's own enrolment.** Every code in the stack is billed by the practice, on its own physicians' orders, under its own Medicare enrolment. Nothing in the design depends on a third party's contract.
- **Solve capture, not just volume.** The existing care-management book demonstrates that this practice can deliver the care and still under-bill it. Any design that does not fix documentation and claim assembly will reproduce the same gap at larger scale.
- **Design for four offices and an hour of driving.** Device logistics, enrolment and escalation must work identically in Wickenburg and in Scottsdale.

[11] CMS mandatory-participation geography file, retrieved 7 August 2026: 235 rows covering 220 core-based statistical areas and 15 metropolitan divisions. Arizona appears exactly twice, and the practice's metropolitan area is not among them. The parser was validated against five positive controls looked up by code. Separately, the current CMS episode-model participant list — 720 hospitals as of 15 April 2026, covering 179 mandatory core-based statistical areas — contains no hospital in the practice's metropolitan area; the only eight Arizona participants sit in a different metropolitan area.

2. The Remote Care Service Line — The Operating Spine

2.1 The cardiology clinical and billing stack

Three layers, sequenced. Each bills on its own and each feeds the next.

Layer	Codes	What it does	In the model?
1 · At discharge — TCM	99495 · 99496	Structured 30-day post-discharge management: interactive contact inside two business days, medication reconciliation, and a face-to-face visit inside the window. Currently at no reported services against a panel running up to 52% heart failure and 187 beneficiaries on inpatient subsequent care.	**No — upside**
2 · The first two weeks — short-window RPM	99445 · 99470	A 2–15-day device supply and first-10-minute management bundle placed on the patient at discharge or after a procedure. CY2026 is the first year this window is cleanly billable.	**Yes**
3 · Across the year — RPM	99453 · 99454 · 99457 · 99458	Device-based physiologic monitoring — weight, blood pressure, pulse — as the continuous early-warning and titration layer. The arm the practice does not run today.	**Yes**
3 · Across the year — PCM	99424–99427	Principal Care Management for a single high-risk cardiac condition. Written for a specialist managing one complex condition, and it does not require the practice to be the patient's primary care physician.	**Yes**

The forecast in this report models **remote physiologic monitoring and principal care management only**. Transitional care management, the practice's existing chronic-care-management book, its existing device-monitoring book, and all Medicare Advantage and commercial volume are excluded from the numbers and sit on top of them.

Why principal care management is the right specialist code here

Chronic care management requires two or more chronic conditions and is usually claimed by the physician who owns the patient's longitudinal primary care. Principal care management was written for the opposite situation: **a specialist managing one complex condition that requires ongoing medication adjustment and disease-specific care planning**, with no requirement that the biller be the primary care physician. For a cardiology practice managing heart failure, resistant hypertension or post-procedure recovery, it is the structurally correct family — and it returns no services in the CY2024 file.

> **One coordination rule to settle before the first enrolment**
>
> Only one practitioner may bill remote physiologic monitoring for a given patient in any 30-day period, and chronic care management and principal care management cannot both be billed for the same patient in the same month.
>
> With a care-management book already running on 1,139 patients, the first design decision is which patients move to the specialist-appropriate code and which stay where they are. That is a protocol question with a clean answer — it simply has to be answered deliberately, during protocol design, rather than discovered in a denial.

2.2 Standalone value: a margin-positive service line

The Value Analysis prices the stack at CY2026 Arizona rates and runs the practice's own enrolment engine forward 24 months.

Line	Year 1	Year 2	24-month
RPM net reimbursement	$779,599	$2,381,959	$3,161,558
PCM net reimbursement	$267,293	$836,785	$1,104,078
Total net reimbursement	**$1,046,892**	**$3,218,744**	**$4,265,636**
CoachCare fees	$608,685	$1,840,209	$2,448,894
Practice net, after fees	**$438,207**	**$1,378,535**	**$1,816,742**
Practice margin	41.86%	42.83%	**42.59%**

Unit economics sit at approximately $95.61 of net reimbursement per RPM patient-month and $89.16 per PCM patient-month, across 33,066 RPM and 12,383 PCM patient-months. **Month-1 practice profit is negative $4,030** — implementation and integration setup post in month 1 against a census that has barely started. The first profitable month is month 2, and every month from there is positive, reaching $146,938 of monthly practice margin by month 24.

The regime, and what follows from it

Both program arms are pace-limited. RPM reaches an active census of 2,674 at month 24 against an enrolment ceiling of 3,207, and PCM reaches 1,002 against 3,115. Neither ceiling binds inside the 24-month window, which means two things. First, **month 24 is not the program's terminal size** — the curve is still climbing when the forecast stops. Second, **the forecast responds to enrolment capacity rather than to panel size**. Widening the estimated panel by four hundred patients moves 24-month net reimbursement by 0.2%. Adding a second CoachCare-funded on-site enrolment specialist moves it by 38.7%, or $1,650,951, and adds $712,668 of practice profit.

2.3 One infrastructure, every lever

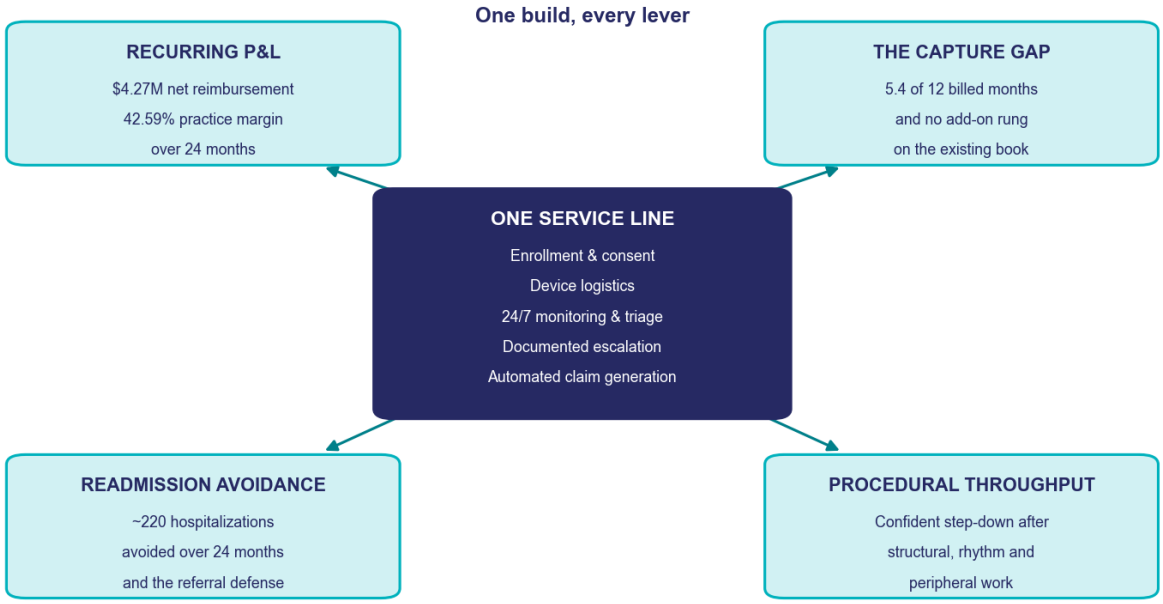

Figure 2 — One enrolment, device, triage, escalation and billing engine, amortised across every lever the practice already cares about.

Lever	What the service line does for it
Recurring P&L	$4,265,636 of net reimbursement and $1,816,742 retained over 24 months, at a 42.59% practice margin, on top of the existing procedural, imaging, device and care-management book
The capture gap	Fixes the 5.4-of-twelve billed-month pattern and the never-billed add-on rung on the cohort the practice already manages
Readmission avoidance	Roughly 220 hospitalisations avoided over 24 months, and the referral-relationship value that comes with a patient who does not come back
Procedural throughput	Confident step-down after structural, rhythm-management and peripheral work, with someone watching between the table and the follow-up visit
Capacity without hiring	36,562 care-team hours over 24 months, about 17.6 full-time equivalents, delivered rather than recruited
Geography	Daily physiologic data instead of windshield time across a catchment that reaches an hour north-west of the main campus

3. The 2026 Payment Environment

3.1 The CY2026 fee schedule: two new rungs on the ladder

Until CY2026 the remote-monitoring device-supply code required sixteen days of readings inside a thirty-day window before anything was billable. A patient discharged on a Friday, stabilised over two weeks and stepped down never qualified — which is to say the highest-risk window in cardiology was the one window the code set did not reach.

- **99445 — device supply, 2 to 15 days.** Makes the short post-discharge and post-procedure window billable in its own right. Post-discharge weight, blood pressure and pulse are where a readmission is either caught or missed.
- **99470 — first 10 minutes of treatment management.** A shorter increment beneath the twenty-minute code, matching the real shape of post-procedure follow-up, where clinical work is frequent and brief rather than monthly and long.

Together they change the arithmetic of a post-discharge program: the practice can now be paid for the fortnight in which most of the clinical risk actually sits, rather than waiting for a thirty-day cycle to complete.

3.2 No mandatory-model exposure in this market

The practice's metropolitan area does not appear on the current CMS mandatory-participation selection files, and no hospital in the area carries mandatory episode accountability.[12] The practice is also absent from the PY2026 Medicare Shared Savings Program participant file, searched by every legal and brand name across all states against a working control.[13] **Nothing in this report is compliance-driven**: the timing is pure upside, and the infrastructure a service line builds is the same infrastructure any future selection map would require.

3.3 A 51.7% Medicare Advantage county, and an affluent panel inside it

Maricopa County runs **51.70% Medicare Advantage penetration** — 817,504 eligible beneficiaries, 422,645 of them enrolled in a plan.[14] Roughly half the county's Medicare population therefore sits outside fee-for-service care-management billing. The panel figure used in this report is grossed up for that, and the fee-for-service portion should be read as a floor: the Medicare Advantage and commercial books are invisible in public claims data and are not counted anywhere in the forecast.

Within that county, this practice's patients are unusual, and favourably so. **The practice's Medicare panel is 2.4% dual-eligible against 14.5% countywide**.[15] Scottsdale's median household income is $110,886 against $89,300 for Maricopa County, its poverty rate is 7.3% against 11.0%, and its uninsured rate is 5.1% against 10.6%.[16] Coinsurance tolerance is the most common objection to enrolling patients in monthly care-management programs, and on this panel it is a smaller obstacle than almost anywhere.

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[12] CMS Medicare Shared Savings Program PY2026 participant file, downloaded in full: 15,370 participant rows across 511 accountable care organisations. The participant legal business name field was searched across all states for every legal and brand variant associated with the practice, returning no matches. A known-positive control search returned a single expected row, confirming the query works. Participation in other total-cost-of-care arrangements is not publicly documented at participant level and is not asserted either way in this report.

[13] CMS Medicare Advantage State/County Penetration file, July 2026: Maricopa County, Arizona — 817,504 eligible beneficiaries, 422,645 enrolled in a Medicare Advantage plan, 51.70% penetration. The CMS Medicare Monthly Enrollment file independently returns 51.2% on a slightly different denominator; the penetration file is the figure cited.

[14] CMS by-Provider PUF, CY2024: dual-eligible beneficiaries as a share of the practice's total beneficiary count across all clinicians with claims rows. The county comparison is from the CMS Medicare Monthly Enrollment file, April 2026, where dual-eligible beneficiaries are 117,675 of 812,942.

[15] U.S. Census Bureau, American Community Survey 2020–2024 five-year estimates, tables DP03 and DP05, retrieved 7 August 2026 for Maricopa County and for Scottsdale city. Median household income is DP03_0062E; the separately reported median family income figure is a different measure and is not used here.

[16] Second citation of the CY2024 by-Provider and by-Provider-and-Service files described in notes 3 and 5. All queries were run by individual national provider identifier rather than by provider or organisation name, which avoids both the false negatives and the false positives that name matching produces in these files.

4. Performance Snapshot: The Starting Position

4.1 Two remote programs already running

Every figure in this section is drawn from the practice's own CY2024 Medicare fee-for-service claims, queried by individual national provider identifier rather than by name.[17]

Program	Beneficiary-lines	Services	Medicare paid
Remote cardiac device monitoring (93294–93298)	1,577	7,051	**$317,532**
Remote rhythm-monitor evaluation (93298)	387	3,146	$225,388
Remote pacemaker and defibrillator evaluation (93294–93296)	1,083	3,063	$55,495
Implantable hemodynamic monitor (93297)	107	842	$36,649
Ambulatory cardiac monitoring (93228 · 93229)	256	257	**$74,766**
Chronic care management (99490)	1,139	6,106	**$265,365**

The device book is mature rather than incidental. Remote rhythm-monitor evaluation alone runs 3,146 services across 365 beneficiaries — **an average of 8.6 monthly reads per patient**, which is what a disciplined recurring service looks like in claims. It carries device logistics, scheduled data review, documented interpretation and monthly billing behind it. The practice has already built that machine once.

Implant and insertion procedures are reported separately and are not part of any monitoring total in this report. Subcutaneous rhythm-monitor insertion and pacemaker insertion together came to $20,820 in CY2024. They are procedures, not monitoring, and folding them into a monitoring figure would overstate the recurring book.

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

Code family	CY2024 status
Remote physiologic monitoring — 99453 · 99454 · 99457 · 99458	No reported services
Physiologic data collection and interpretation — 99091	No reported services
Remote therapeutic monitoring — 98975–98981	No reported services
Principal care management — 99424 · 99425 · 99426 · 99427	No reported services
Transitional care management — 99495 · 99496	No reported services
Chronic care management add-on — 99439	No reported services, against 6,106 base services

CMS suppresses any provider and procedure line with fewer than eleven beneficiaries, so the accurate statement is that **there is no program at meaningful scale on any of these families in CY2024** — not that no patient received the service. Across sixteen clinicians the hidden volume cannot be large, and it does not change the conclusion.

[17] Two independent artifacts, both retrieved 7 August 2026. First, the patient portal linked from the practice's own website and help-desk page is hosted on eClinicalWorks' portal domain under a practice-specific portal identifier, with a second link to the vendor's patient-engagement service under a tenant path carrying the practice's name. Second, three of the practice's physicians publish eClinicalWorks Direct secure-messaging endpoints on their national provider records. A patient portal alone does not establish an electronic-record vendor, because several portals are deliberately vendor-agnostic; a Direct endpoint published on the provider record is an electronic-record-layer artifact and does.

4.3 The panel: complex, high-acuity, and seen a few times a year

Measure	Value	Read
Beneficiary-weighted HCC risk score	**1.334**	33.4% above the national 1.00 reference; nine of sixteen clinicians exceed 1.30
Heart failure prevalence	18% – 52%	Range across clinician panels; highest in the electrophysiology and hospital-facing practices
Chronic kidney disease	22% – 34%	Consistent across the whole bench
Diabetes	17% – 31%	—
Chronic obstructive pulmonary disease	12% – 26%	—
Ischemic heart disease	22% – 70%	—
Hypertension and hyperlipidemia	at the reporting ceiling	CMS caps published chronic-condition prevalence at 75.0%; both families sit at the cap for every clinician, so 75% is a ceiling rather than a measurement
Established outpatient visit beneficiaries	8,429	Provider-summed count on 99213 and 99214 — the basis for the modelled panel

This is a sick, complex, longitudinal panel that is seen a handful of times a year. **The thirty days after a discharge, and the eleven months between visits, are where the outcomes are actually decided** — and today nothing structured happens in either interval.

5. The Capture Gap Inside the Book You Already Have

Before any new patient is enrolled, there are two recoverable gaps inside the care-management program the practice already runs. Neither is clinical.

Gap one — 5.4 billed months out of twelve

6,106 chronic-care-management services across 1,139 beneficiary-lines is an average of **5.4 billed months per enrolled patient per year**. A patient enrolled in a monthly care-management program and managed continuously generates twelve. The gap is some mix of mid-year enrolment and months where the work was done and the claim was not assembled — and both are addressable by the same fix.

Gap two — the add-on rung is never billed

The add-on code captures each additional twenty minutes of clinical staff time in a month beyond the first twenty. Across 6,106 base services in CY2024 it was billed **no times at all**. For a panel with this acuity — a third above national risk, with heart failure at up to 52% — the proposition that no patient in the program ever required a second twenty minutes in a month is not plausible. What is plausible is that the second twenty minutes happened and was never documented in a way that produced a claim.

Gap three — half the bench

Four of the eight physicians billing from this practice account for all of the chronic care management, and one physician holds nearly the entire remote device book. Several of the non-participating physicians carry four-figure Medicare panels with the same heart-failure and kidney-disease burden. **That is not a clinical failure — it is the predictable result of running a service as a personal workflow rather than as a service line**. A referral pathway that makes enrolment one order, rather than a habit one physician built, is what moves those panels, and it requires no new hire.

> **What the three gaps have in common**
>
> Each one is a documentation-and-capture problem, not a care problem. They are the predictable output of a workflow where the clinical note, the time log and the claim are assembled by people who also have a clinic to run.
>
> **An engine that generates the claim as a by-product of the care fixes all three without changing what anyone does at the bedside.**

6. Powering Procedural and Referral Throughput

The interventional and rhythm-management arms of this practice all produce the same patient: stable enough to go home, fragile enough to bounce, and unobserved between the table and the follow-up visit. In CY2024 that included coronary stenting on 81 beneficiaries, percutaneous left-atrial-appendage closure on 103, atrial-fibrillation ablation on 82, pacemaker insertion on 39, and peripheral atherectomy, angioplasty and stenting on roughly 50 more.

Procedure family	What remote care adds
Structural heart and left-atrial-appendage closure	Post-procedure blood-pressure and rhythm surveillance during the anticoagulation transition, when the decisions are frequent and the patient is at home
Rhythm management and device implant	The physiologic layer beside the device telemetry the practice already reviews — weight and blood pressure alongside rhythm, which is what distinguishes a heart-failure decompensation from an arrhythmia
Peripheral intervention and limb salvage	Structured post-procedure follow-up in a population where wound healing, blood-pressure control and glycaemic control determine whether the intervention holds
Referral relationships	A patient who is monitored, escalated and kept out of hospital is the strongest possible argument to the physician who sent them — and the practice currently has no structured way to demonstrate it

The forecast in this report does not include any procedural revenue and does not assume any increase in case volume. The point is narrower and more defensible: **confident step-down protects throughput, and structured follow-up protects the referral that produced the case**.

7. Technology & Workflow: Building Inside eClinicalWorks

7.1 What is verified about the platform

The practice runs **eClinicalWorks**, confirmed two independent ways.[18] The patient portal linked from the practice's own site is hosted on eClinicalWorks' portal domain under a practice-specific portal identifier, and three of the practice's physicians publish eClinicalWorks Direct secure-messaging endpoints on their national provider records. A portal alone would leave the vendor unsettled, because portals are frequently vendor-agnostic. A Direct endpoint is an electronic-record-layer artifact, and it settles it.

Three things remain to be scoped: the eClinicalWorks version, whether the deployment is cloud or self-hosted, and which modules are licensed — particularly the care-management module. Those determine the build sequence and the timeline. They are the first questions in a scoping call.

7.2 What the integration does

Capability	What it means in the workflow
Integrated enrolment	CoachCare care teams enrol qualified Medicare patients on the practice's behalf, prompted by enrolment flags and order triggers inside the existing workflow, with enrolment status visible in real time. Nobody learns a second system.
Ordering by service and device	The order for a service and the device that supports it are one action, not two systems reconciled afterwards.
Exchange of health history	Problem list, medications and history flow in, so the care plan starts from the chart rather than from a phone call.
Integrated vital reports	Readings land in the chart where the physician already looks, not in a separate vendor portal.
Compliance documentation	Evidence of care, vitals and care plans attach to the patient's chart monthly. The audit trail assembles itself.
Automated claim generation	The CoachCare billing engine creates the claim, removing the manual per-patient, per-month claim step entirely.

Under the integrated workflow, enrolled patients begin receiving services in under five days.[19]

7.3 Why automated claim generation matters here specifically

This is usually a feature slide. For this practice it is the central argument, because **the practice supplies its own evidence for it**. Enrolled care-management patients are billed 5.4 months of twelve, and the add-on rung is never billed against 6,106 base services. Those are capture losses on care that was delivered.

The volume is the reason the gap exists and the reason it will widen. At the modelled census of **3,675 active enrolments at month 24** across four offices and sixteen clinicians, the monthly billing task is thousands of per-patient, per-code, time-documented claims — **81,325 billed units over 24 months**. A lean administrative layer cannot assemble that by hand. The failure mode is not a rejected claim; it is a program that quietly bills less than it delivers, which is precisely the pattern already visible in the CY2024 data.

[18] CoachCare eClinicalWorks integration documentation. The integration covers enrolment by service and device, exchange of health history, integrated vital reports, monthly compliance documentation attached to the patient chart, and automated claim creation through the CoachCare billing engine.

[19] Second citation of the clinician-roster method described in note 3. The two physicians and two advanced practice providers absent from the public physician page each carry a CY2024 claims row from the practice's main clinical address, which is a stronger test of current practice than either a registry registration or a website listing. Removing the two unlisted physicians from the referral engine moves the 24-month net reimbursement forecast from $4,265,636 to $3,981,524.

8. Implementation Playbook

8.1 Goals, scope, and the modelled funnel

Model input	Value
Medicare panel, in scope	12,216
Referring clinicians	16 — eight physicians and eight advanced practice providers
Programs	Remote physiologic monitoring and principal care management
Eligibility applied to the in-scope panel	RPM 75% · PCM 85%
Enrolment acceptance	RPM 35% · PCM 30%
Referral engine	8 referrals per clinician per month at 80% acceptance
On-site enrolment specialists	1, funded by CoachCare, at 80 enrolments per month
Monthly attrition	1.5%
Payment locality	Arizona — carrier 03102, locality 00; one rate set for all sites
Electronic record	eClinicalWorks

Milestone	Enrolled patients	Enrolled services	Monthly net reimbursement
Month 1	48	60	$6,359
Month 6	633	819	$78,477
Month 12	1,504	1,859	$174,664
Month 24	**2,974**	**3,675**	**$342,744**

Enrolled services and enrolled patients are different measures and both are shown deliberately. Enrolled services counts active program enrolments, so a patient in both programs counts twice. Enrolled patients is the deduplicated unique count. At month 24 the model's 3,675 enrolled services correspond to 2,974 unique patients.

8.2 Staffing: nobody has to be hired

CoachCare operates the engine — enrolment outreach, device logistics, 24/7 monitoring, escalation and billing-ready documentation — while the practice's physicians govern the protocols and make every clinical decision. Launch requires no new practice headcount.

The forecast carries **36,562 care-team hours over 24 months, about 17.6 full-time equivalents**, delivered by CoachCare rather than recruited by the practice. The on-site enrolment specialist in the model is funded by CoachCare: it is embedded value already reflected in the fee line, and it is never deducted from practice margin. **Because both arms are pace-limited, enrolment capacity is the strongest lever in the model** — a second on-site specialist raises 24-month net reimbursement by 38.7% and practice profit by $712,668.

8.3 “We already do remote monitoring” — the answer

It is the right objection and it deserves a direct answer, because it is true.

- **Yes — and it is well run.** The device book is a mature recurring service with 8.6 monthly reads per patient on the largest code. Nothing here suggests otherwise.

- **It is a different data stream and a different code family.** Device telemetry reports rhythm and device function. Physiologic monitoring reports weight, blood pressure and pulse — the signals that predict a heart-failure decompensation before a rhythm change does. They are complementary, they bill on separate families, and the practice bills only one of them.
- **It is concentrated in one physician.** A capability held by one clinician is a capability, not a service line. The whole argument of this report is about the difference.
- **The operating muscle transfers directly.** Enrolment, consent, a device that transmits, someone watching the feed, a defined escalation path, a monthly documented claim — the practice has built all of it once already. Extending it is a smaller change than starting it.

8.4 Clinical governance and escalation

The economics show the service line pays. Governance is what shows it is safe, and it is the half most likely to be assumed rather than designed. Every reading routes through one shared escalation engine, so the practice receives signal rather than noise.

- **Critical values escalate immediately**, regardless of whether the patient reports symptoms. There is no wait-and-see branch on a critical value, and no client preference can suppress it.
- **Out-of-range readings are worked, not forwarded** — confirm technique, retake, run a structured symptom check. Most resolve there, which is why the practice's inbox stays clean.
- **Trend is defined objectively**: three consecutive readings at least one hour apart for blood pressure or glucose, or three readings within seven days for heart rate. A confirmed trend escalates on the same footing as a threshold breach.
- **Unreachable is not a dead end**. The attempt is documented and a callback requested, and if the reading was critical or a confirmed trend the escalation proceeds anyway.
- **Every escalation is documented the same six ways** — vital, findings, method, contact, outcome, follow-up — so any episode can be reconstructed end to end.
- **The emergent floor is non-negotiable**. Chest pain, new shortness of breath, stroke signs, syncope, worst-ever headache or sudden swelling trigger a 911 call with the patient still on the line. CoachCare's urgent and emergent policy supersedes any client-specific escalation preference.

Post-discharge, the program runs a three-touch cadence triggered by any emergency-room visit or hospitalisation in the previous sixty days: **day 1–2 to stabilise** (home safely, medications reconciled, follow-up booked, device transmitting), **day 5–8 to detect** (the window where decompensation declares itself, reviewed against readings already flowing in), and **day 12–14 to secure** (follow-up confirmed, open issues closed, patient handed into the longitudinal panel). That cadence is the mechanism behind the avoided-hospitalisation figure below.

8.5 KPI dashboard and expected impact

Measure	24-month modelled value
Net reimbursement	**$4,265,636**
Practice net, after CoachCare fees	**$1,816,742**
Practice margin	**42.59%**
Billed claims and units	81,325
Physiologic readings	347,193
Hospitalisations avoided	220 — roughly $3.3M of avoided acute cost at $15,000 each
Care-team hours delivered by CoachCare	36,562 (17.6 full-time equivalents)
Enrolled patients at month 24	2,974

Measure	24-month modelled value
Enrolled services at month 24	3,675
First profitable month	Month 2

8.6 Twelve-month roadmap

Window	What happens
Days 1–30 · Charter and protocol design	Agree escalation thresholds, the routing matrix and after-hours cover. Settle which patients move to the specialist-appropriate code family and which stay in the existing care-management book. Confirm the eClinicalWorks version, deployment and licensed modules, and scope the integration build.
Days 30–60 · Build and connect	Stand up the integration — enrolment flags, order triggers, vital reports into the chart, monthly evidence-of-care attachments and automated claim generation. Configure device logistics for all four catchments.
Days 60–90 · Pilot on the heart-failure cohort	Start where the clinical case is strongest and a clinic already exists. Enrol from one or two physicians' panels, prove the escalation loop and the claim, then open the referral pathway to the rest of the bench.
Months 4–6 · Extend across the bench	Bring the physicians outside the current care-management program into the referral pathway. Take the capture gap on the existing cohort — the 5.4 billed months and the never-billed add-on rung — as the first tranche of recovered revenue.
Months 7–12 · Add the post-discharge and post-procedure funnels	Establish the daily discharge signal, layer transitional care management and the short-window codes onto the existing enrolment engine, and review whether a second on-site enrolment specialist is warranted by the referral supply.

The decision in front of the practice

This practice has already proven, twice, that it can run a recurring remote service and bill it every month. What it has not done is build the machine around that capability — the referral pathway that reaches every physician, the physiologic layer beside the device layer, the post-discharge window, and the claim that assembles itself.

The modelled result of building it is $4,265,636 of net reimbursement and $1,816,742 retained over 24 months, with no new practice headcount.

References & Data Sources

Every figure in this report traces to one of the sources below. Claims figures are CY2024 Medicare fee-for-service, queried by individual national provider identifier. Modelled figures come from the companion CoachCare Value Analysis workbook, recalculated for this report.

Source	Vintage	Used for
CMS Medicare Physician & Other Practitioners — by Provider	CY2024, released May 2026	Beneficiary counts, Medicare payment, HCC risk scores, chronic-condition prevalence
CMS Medicare Physician & Other Practitioners — by Provider and Service	CY2024, released May 2026	The code-level screen: device monitoring, care management, the absent families, place of service, procedure volumes
CMS National Plan and Provider Enumeration System	Retrieved August 2026	Entity resolution, clinician roster, Direct secure-messaging endpoints
CMS mandatory-participation selection files	Current published files, August 2026	Model-participation gates
CMS Medicare Shared Savings Program participant file	PY2026	Shared-savings participation gate
CMS Medicare Advantage State/County Penetration	July 2026	Maricopa County Medicare Advantage penetration and the panel gross-up
CMS Medicare Physician Fee Schedule	CY2026	Rates, resolved by carrier and locality from the practice ZIP
U.S. Census Bureau, American Community Survey 5-year estimates	2020–2024	Scottsdale and Maricopa County income, poverty and coverage
CoachCare Value Analysis workbook	Built August 2026	All modelled financial, clinical and operational figures
The practice's own published website	Retrieved August 2026	Locations, service lines, standing disease clinics, patient portal

*A companion document, **CVI_Scottsdale_Microsite_Disclosures_and_Assumptions.md**, records every modelling assumption, estimation method, sensitivity, source vintage and open item behind the figures in this report.*