COACHCARE · REMOTE CARE SERVICE LINE

# Tennessee Valley Cardiovascular Center

## Cardiovascular Service Line — Performance & Optimization 2026 Strategy Report

A CoachCare Remote Care Service Line (TCM · RPM · PCM) as the operating spine — and your **ASM heart-failure chassis for January 2027.**

Florence & Sheffield, Alabama · "The Shoals" / Muscle Shoals metro

**Purpose of this report**

This report reads Tennessee Valley Cardiovascular Center's starting position and makes a single, disciplined case: a managed remote-care service line is the highest-return move available to the practice in 2026 — margin-positive on its own economics, and the operational chassis that puts TVCC in control of its heart-failure results before the CMS Ambulatory Specialty Model becomes mandatory on January 1, 2027.

Economics shown are **illustrative and modeled** from a CoachCare Value Analysis; every figure should be verified against the practice's own patient, payer, and utilization data during discovery.

**Prepared for:** Tennessee Valley Cardiovascular Center leadership
**Prepared by:** CoachCare — Remote Patient Monitoring & Care Management
**Date:** July 2026 · Confidential — prepared for TVCC leadership
**Contact: Connor Knapp, CoachCare · connor.knapp@coachcare.com**

# Table of Contents

# Executive Summary

Tennessee Valley Cardiovascular Center (TVCC) is a multi-physician cardiology group serving "The Shoals" of northwest Alabama, with offices in Florence and Sheffield and a roster of roughly eight cardiologists spanning interventional, electrophysiology and device, heart-failure, vascular, and non-invasive imaging care. Interventional and surgical work is performed at North Alabama Medical Center (NAMC) in Florence — a 263-bed tertiary cardiac hub with four catheterization labs, a hybrid suite, and open-heart capability — with the Sheffield office adjacent to Helen Keller Hospital. Public sources show no existing remote patient monitoring, care-management, or branded patient-engagement program for the practice, which makes the remote-care opportunity close to greenfield: there is no legacy program to unwind, and the practice can build a clean, reimbursement-accurate chassis from day one.[1]

**The starting position — and the 2027 payment shift.** The single most important fact in TVCC's near-term environment is that it appears on the CMS Ambulatory Specialty Model (ASM) heart-failure participant list — on the **preliminary** list dated February 2026.

**★ Time-sensitive — verify against the FINAL CMS list**

**TVCC appears on the CMS Ambulatory Specialty Model (ASM) heart-failure participant list — but this is the PRELIMINARY list (dated February 2026).**

Three TVCC cardiologists — Sean Rhuland MD (President), Therese Lango MD, and Zubair Khan MD — are listed under the group's billing/management entity "ECM TVCC LLC" in the CMS CY2027 Preliminary ASM Participants dataset, verified by National Provider Identifier. ASM is mandatory, begins January 1, 2027, covers the heart-failure cohort, and carries a first-year Part-B payment adjustment of −9% to +9%.

**The final CMS participant list is expected in summer 2026 and names could change.** Every ASM statement in this report must be confirmed against the final CMS participant list before it is treated as certain.

Either way, ASM changes the question TVCC should be asking. Today the practice manages heart-failure patients episodically, visit to visit. Under ASM, the practice is accountable for those patients' cost and quality across the full year. The organizations that do well will be the ones that already run a continuous, data-driven heart-failure operation on January 1, 2027 — not the ones scrambling to stand one up. A remote-care service line is that operation.

**The central argument — value two ways at once**

1. **Standalone value.** Recurring, subscription-like professional-fee revenue — billed by the practice at top-of-license staffing — that is margin-positive before a single value-based dollar. The stack is TCM at discharge → short-window RPM → longitudinal RPM and PCM on the principal cardiac condition. Over 24 months the model projects about $1,543,034 in net professional-fee reimbursement and roughly $658,325 in practice margin after CoachCare's fees. 24-month practice margin: 42.7% of net reimbursement (Year 1 41.2%, Year 2 43.5%).
2. **Connective tissue.** One shared engine — enrollment, connected devices, 24/7 alert-and-triage, nurse navigation, GDMT-titration support, billing capture, analytics — that simultaneously powers ASM heart-failure performance, converts avoided admissions into avoided cost, speeds safe post-procedure discharge, and defends referral relationships. Build once, reuse everywhere.

**The clinical wedge is heart failure.** Nationally, heart failure carries the highest 30-day readmission burden of any common condition — the exact patient a cardiology group is best positioned to keep out of

[1] TVCC entity, clinician, and location details verified via NPPES / NPI Registry (Florence & Sheffield) and public directory listings; roster size (~8 cardiologists) from a recruiter posting and directory cross-checks. No proprietary practice website was found — a directory-only web presence is itself a digital-maturity signal.

the hospital, and the exact cohort ASM makes TVCC accountable for. Continuous weight and blood-pressure monitoring, protocolized alerts, and pharmacist- or nurse-led guideline-directed medical therapy (GDMT) titration between visits are how remote care moves that number.

**The billing tailwind is already here.** CY2026 added short-window RPM codes — 99445 (a 2–15 day device code) and 99470 (a first-10-minute monitoring code) — that make brief, high-value monitoring windows immediately after a discharge or procedure billable for the first time. That is precisely the transitional window where a cardiology group creates the most clinical and financial value.

**The modeled economics (illustrative).** A CoachCare Value Analysis built on TVCC's Alabama locality and an estimated Medicare panel projects, over 24 months: $1,543,034 in net professional-fee reimbursement ($542,912 in Year 1, $1,000,122 in Year 2), $884,709 in CoachCare fees ($319,161 / $565,548), and $658,325 in practice margin ($223,751 / $434,574). 24-month practice margin: 42.7% of net reimbursement (Year 1 41.2%, Year 2 43.5%). Per program, 24-month net reimbursement is $888,952 for RPM ($364,015 Year 1, $524,936 Year 2) and $654,082 for PCM ($178,897 / $475,185) — exact workbook reads rounded independently, so a program row and its column total can differ by a dollar. The same program is modeled to avoid roughly 67 hospitalizations over 24 months — about $1.01M in avoided cost at $15,000 per admission — while generating 30,816 billed claims/units, 105,983 physiologic readings, and 15,361 care-team hours saved (~7.4 FTE-years). Month 1 is modeled at −$3,513 as one-time implementation and Greenway setup land against a small starting census; margin turns positive in month two (+$3,850) and stays positive thereafter — there is no negative-margin quarter. The model carries 648 unique patients in active remote care at month 24 against 989 enrolled services. All figures are illustrative, modeled — verify against practice data.

### 2026–2027 Priority Recommendations

1. **Stand up the remote-care service line now, heart-failure cohort first.** Treat the ASM heart-failure population as the launch cohort so the monitoring, titration, and documentation workflows are live and generating data well before January 1, 2027.
2. **Anchor the stack on TCM → short-window RPM → longitudinal RPM and PCM.** Capture the post-discharge transitional window with 99495/99496 and the new 99445/99470 codes, then carry patients into longitudinal monitoring with a single PCM wrapper on the principal cardiac condition.
3. **Confirm TVCC's status on the FINAL CMS ASM list (expected summer 2026) and align the go-live plan to it.** The preliminary selection is the planning basis; the final list is the commitment basis.
4. **Build on native Greenway integration from day one.** Automated claim creation, cellular-connected devices, and telephonic enrollment run inside the existing EHR; the practice is understood to run Greenway (caller-sourced; leaning Intergy) — confirm the exact product edition in contracting.
5. **Set an external-PCP collaboration model for shared heart-failure patients.** ASM anticipates a collaborative-care arrangement with primary care; because TVCC is a cardiology group, this is framed as a shared care plan and data exchange with referring PCPs — not a primary-care billing arm.
6. **Use the service line to protect procedural throughput.** Short post-procedure monitoring windows support faster, safer discharge from a busy interventional and device practice — freeing capacity for more cases.

## 1. Footprint & Operating Model

TVCC operates as a Shoals-based cardiology group across two offices — 541 W College St in Florence and 1120 S Jackson Hwy in Sheffield — with a campus presence at NAMC (1751 Veterans Dr). The

group's roster of roughly eight cardiologists covers the full ambulatory cardiovascular range: interventional cardiology (angioplasty, stenting, atherectomy), electrophysiology and device management (pacemakers and defibrillators), heart failure, vascular, and non-invasive imaging (echocardiography, nuclear, and stress testing). An active recruitment posting for an additional interventional cardiologist signals capacity growth. Hospital-based procedural and surgical work is performed at NAMC in Florence.

> **A note on structure and contracting**
> Public records show the group under more than one related entity, including a physician corporation and a separate billing/management entity ("ECM TVCC LLC," carrying a Nashville management phone line). A single recruiter posting also references hospital employment through LifePoint Health at NAMC. The practice's ownership and employment model is **not asserted here** — it should be confirmed during discovery, because it determines the contracting counterparty (an independent physician-owned PC with a Nashville management arrangement, versus a LifePoint-employed group). This report is written to hold regardless of how that resolves.

**Remote-care posture: near-greenfield.** No public evidence indicates any current RPM, PCM, patient app, or branded portal. That absence is an opportunity, not a gap to paper over: TVCC can build a clean, reimbursement-accurate service line without migrating off a legacy vendor or unwinding old workflows. (Absence of a public signal is not proof; confirm on discovery.)

### Design principles for the service line

| Principle | What it means for TVCC |
|---|---|
| **Longitudinal by default** | Heart-failure and high-risk cardiac patients are monitored continuously between visits, not managed only at episodic appointments. |
| **One scorecard** | A single view of enrolled census, alerts, titration actions, billable capture, and avoided admissions — clinical and financial on the same page. |
| **Hub-and-spoke** | Florence and Sheffield share one remote-care engine; patients are enrolled wherever they are seen and managed centrally. |
| **Top-of-license** | Nurses and pharmacists run monitoring and GDMT titration to protocol; physicians work at the top of their license on exceptions and escalations. |
| **Digital as care** | Connected devices and structured data are part of the care model — feeding both clinical decisions and ASM performance measurement. |

# 2. The Remote Care Service Line — The Spine

This is the centerpiece. The remote-care service line is not a point solution bolted onto the practice; it is the operating spine that carries recurring revenue, heart-failure performance, and procedural throughput on one shared engine.

## 2.1 What It Is: The Care-Management Stack

TVCC bills the full care-management stack on its own cardiology patients. Because a cardiology group has no primary-care panel, this is a specialty stack — there is no APCM (Advanced Primary Care Management) arm, and none is proposed. Where longitudinal wraparound is needed for a patient's primary-care conditions, it is coordinated with the patient's external PCP through a shared care plan, not billed by TVCC.

| Layer | Codes | Role in the cardiology stack |
|---|---|---|
| **TCM** | 99495 / 99496 | Transitional Care Management at discharge — the on-ramp. Two-business-day contact plus a face-to-face visit; the moment a heart-failure or post-procedure patient is most fragile and most winnable. |
| **RPM** | 99453/99454; 99445; 99457/99470; 99458 | Remote Physiologic Monitoring — weight, blood pressure, and symptoms. Short-window codes (99445/99470) cover the 2–15 day post-discharge window; 99454/99457 carry longitudinal monitoring. |
| **PCM** | 99426 / 99427 | Principal Care Management for the single, dominant high-risk condition — heart failure, coronary disease or resistant hypertension, or cardiovascular disease carried as one domain. The longitudinal wrapper the practice actually owns. |

**Why PCM, not CCM.** a specialist's care management is focused on one principal condition — resistant hypertension, coronary disease, heart failure — or on cardiovascular disease as a single domain, which is precisely what Principal Care Management is written for. Chronic Care Management assumes management of all of a patient's conditions, and it is increasingly billed by the patient's primary care practice, or absorbed into a prospective payment there. PCM fits the specialist's actual scope and does not collide with the PCP's.

> **The one coordination rule**
> Each patient gets one longitudinal care-management wrapper — PCM on the principal cardiac condition — and RPM stacks with it in the same month on discrete time and documentation. TCM is additionally billable at each qualifying discharge. Set one attribution policy at charter, with one shared care plan in Greenway; for patients co-managed with an external PCP, the primary-care wrapper stays with the PCP so the same month is never double-counted.

## 2.2 Standalone Value: Four Value Layers

Before any value-based dollar, the service line pays for itself through four layers of value.

1. **Direct professional-fee revenue.** Recurring monthly RPM and PCM billing plus TCM at each discharge — a subscription-like revenue line the practice owns.
2. **Avoided cost.** Fewer heart-failure admissions and readmissions — modeled at roughly 67 avoided hospitalizations over 24 months (≈$1.01M at $15,000/admission) — which also protects referral relationships and hospital-partner performance.
3. **Procedural throughput unlocked.** Short post-procedure monitoring windows support faster, safer discharge, freeing catheterization-lab and bed capacity for additional interventional and device cases.
4. **Strategic / model readiness.** A functioning remote-care chassis is the ASM heart-failure operating model — built and generating data before the model becomes mandatory.

### The CY2026 billing stack (illustrative local rates)

| Service / code | Type | Rate | Notes |
|---|---|---|---|
| TCM 99495 / 99496 | Per discharge | ~$200 / ~$280 | 2-business-day contact; face-to-face 14 / 7 days |
| RPM 99453 setup | One-time | $18.79 | Requires ≥2 days of data |
| RPM 99454 / 99445 | Monthly | $45.49 | 99454 = 16–30 days; 99445 = new 2–15 day short-window code |

| Service / code | Type | Rate | Notes |
|---|---|---|---|
| RPM 99457 / 99470 | Monthly | $47.43 / $23.88 | First 20 min / new first-10-min code (2026) |
| RPM 99458 | Monthly | $38.37 | Each additional 20 min |
| PCM 99426 / 99427 | Monthly | $62.78 / $49.79 | Single high-risk condition (heart failure) |

Rates shown are the local Alabama-locality magnitudes (carrier 10112, locality 00) used in the Value Analysis model — illustrative, not quotes. Actual payment is locality-adjusted and set by the regional MAC; verify current-year PFS. APCM (G0556–G0558) is intentionally excluded: it is billed by a primary-care panel, which a cardiology group does not have. TCM is billable at each qualifying discharge but is excluded from the modeled totals in this report — it is upside on top.

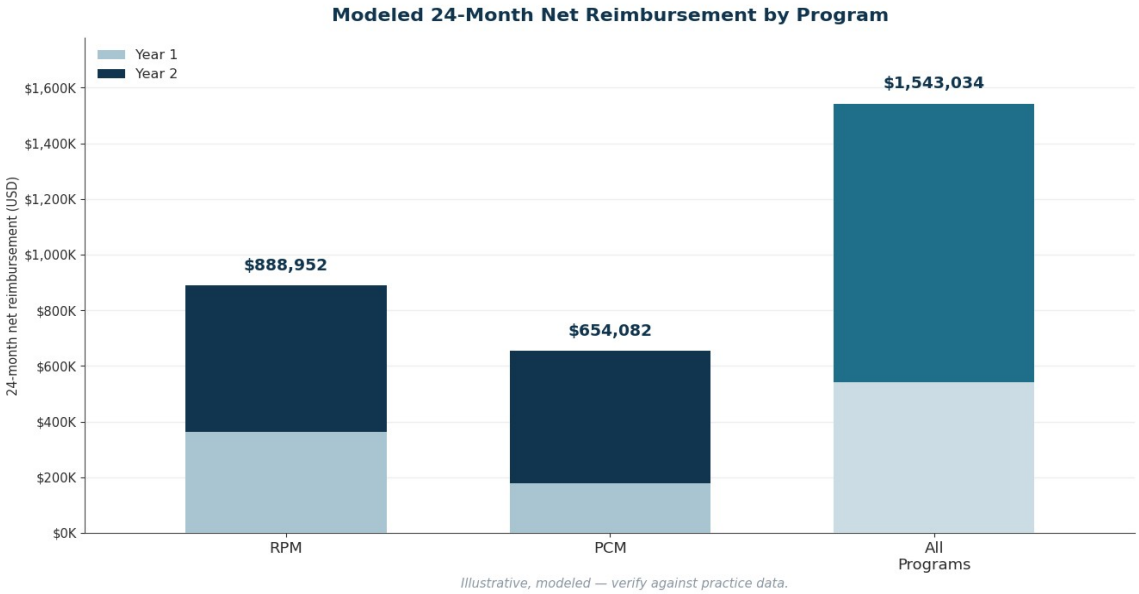


*Figure 1. Modeled 24-month net professional-fee reimbursement by program, split Year 1 / Year 2. Illustrative, modeled from a CoachCare Value Analysis on an estimated Medicare panel — verify against practice data.*

### How the recurring-revenue math works

Each enrolled heart-failure or high-risk cardiac patient generates a recurring monthly professional fee (RPM device and monitoring, plus PCM on the principal condition), on top of a TCM fee at each qualifying discharge. As the enrolled census ramps across 24 months, that recurring line compounds — which is why modeled Year 2 net reimbursement ($1,000,122) is roughly 1.8× Year 1 ($542,912). TVCC bills; CoachCare supplies the enrollment, devices, monitoring labor, and billing capture as a service.

### Modeling assumptions (read before quoting any figure)

- **Panel is an estimate.** The model uses ~1,911 total Medicare patients — modeled as the practice's traditional fee-for-service Part B population (~863) plus a Medicare Advantage population (~1,048) at the local 54.84% MA penetration (FFS ÷ (1 − MA%)), reflecting Alabama's high-MA market. It is a modeled estimate, not a practice-supplied headcount; verify against actual panel data.
- **Medicare Advantage is modeled at fee-for-service rates.** Federal rules set Medicare

Advantage payment for these services at no less than traditional Medicare, so pricing the MA population at FFS magnitudes is a conservative floor — confirm actual plan terms in contracting.

- **Enrollment mechanics.** One on-site enrollment specialist at CoachCare's expense — embedded value, never subtracted from practice margin — ~8 referrals per provider per month at an 80% patient-accept rate, and program acceptance rates of 35% (RPM) and 30% (PCM) drive the 24-month ramp — yielding active-enrollment ceilings of 502 (RPM, reached month 8) and 487 (PCM, month 17) against in-scope eligibility of 75% for RPM (1,433 patients) and 85% for PCM (1,624 patients).
- **Rates are locality magnitudes.** Alabama 2026 PFS magnitudes (carrier 10112, locality 00) — verify current-year values against the fee schedule and local MAC in contracting.
- **Avoided-admission value is directional.** Modeled at ~$15,000 per admission and an RPM-attributable reduction on an assumed baseline; a planning estimate, not a guarantee, and no facility-specific readmission rate is claimed.

## 2.3 Connective Tissue: One Engine, Every Lever

The reason to build this as a service line — rather than a series of disconnected point programs — is that one shared engine powers every lever TVCC cares about. Enroll a patient once; monitor, triage, titrate, document, and bill on the same infrastructure; and that same infrastructure simultaneously improves ASM heart-failure performance, avoids admissions, speeds procedural discharge, and defends referral relationships.

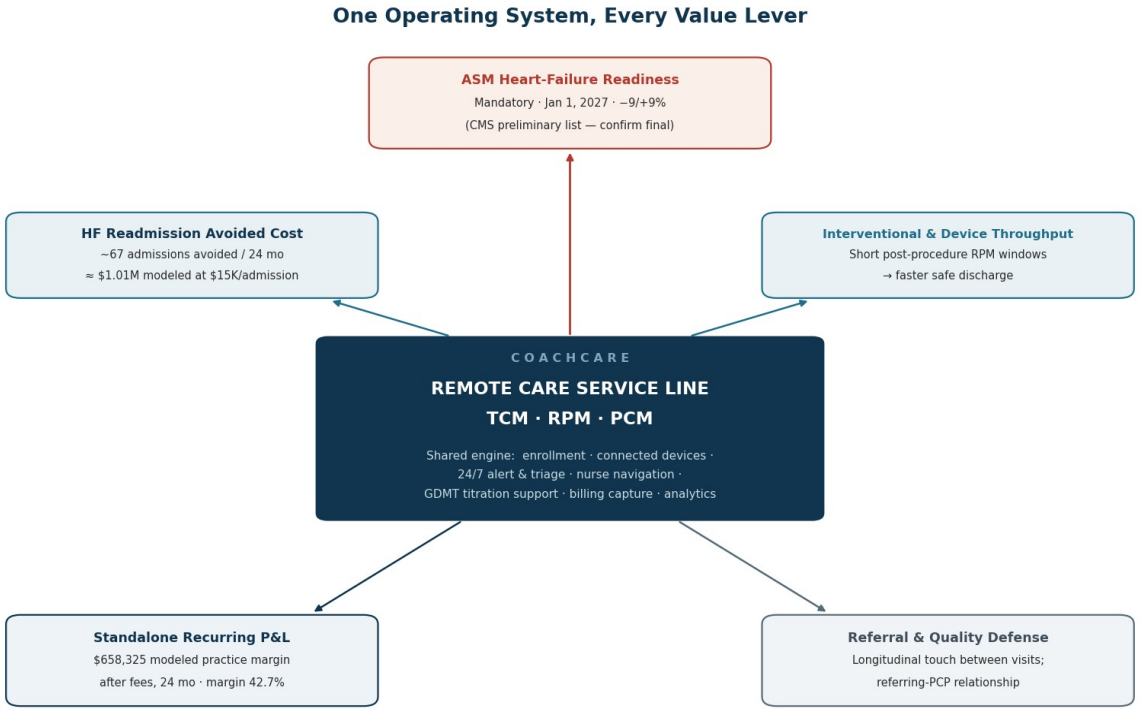


*Figure 2. One operating system, every value lever. The ASM lever reflects the CMS preliminary participant list (Feb 2026) — confirm against the final CMS list.*

### How the same infrastructure powers each lever

| Lever | What the shared engine contributes |
|---|---|
| ASM heart failure (2027) | Continuous monitoring, protocolized GDMT titration, and structured documentation — the operating model ASM rewards. Preliminary list; confirm final. |
| HF readmission avoided cost | Weight/BP trend alerts catch decompensation early; ~67 admissions avoided over 24 months (≈$1.01M modeled). |
| Interventional & device throughput | Short post-procedure RPM windows support faster safe discharge → freed cath-lab and bed capacity for more cases. |
| Referral & quality defense | A visible, continuous touch between visits strengthens referring-PCP relationships and the practice's local reputation. |
| **Standalone P&L** | Recurring RPM and PCM revenue, with TCM at discharge as upside — modeled $658,325 practice margin after fees over 24 months. 24-month practice margin: 42.7% of net reimbursement (Year 1 41.2%, Year 2 43.5%). |

## 3. The 2027 Payment Shift — Ambulatory Specialty Model

The Ambulatory Specialty Model (ASM) is the CMS Innovation Center's mandatory, specialty-focused payment model. For cardiology, the accountable condition is heart failure. ASM begins January 1, 2027, runs through 2031, and adjusts participating clinicians' Part-B payments based on cost and quality performance — a −9% to +9% adjustment in the first payment year. It holds the cardiologist accountable for a heart-failure patient's cost and quality across the year, and it anticipates an electronic collaborative-care arrangement with the patient's primary-care clinicians.

> **★ ASM verification status — PRELIMINARY**
>
> **TVCC is on the CMS preliminary ASM participant list (dated February 2026), not the final list.**
>
> Three TVCC cardiologists appear in the CMS CY2027 Preliminary ASM Participants dataset under the group's billing/management entity "ECM TVCC LLC," each confirmed by National Provider Identifier: Sean Rhuland MD (President), Therese Lango MD, and Zubair Khan MD — all in the heart-failure cohort.
>
> **The final CMS participant list is expected in summer 2026, and the roster can change.** Treat the preliminary selection as the planning basis and confirm the final list before making commitments that depend on participation.

**Why the service line is the ASM operating model.** ASM does not ask the practice to do anything philosophically new — it asks the practice to manage heart failure continuously and measurably, and then pays on the result. A remote-care service line is exactly that capability: enrollment and risk stratification, continuous weight/BP monitoring, protocolized alerting, GDMT titration between visits, and the structured data that both drives care and documents performance. Standing it up now means TVCC enters 2027 with the workflows live and a year of data in hand, rather than building the plane while flying it.

**The primary-care collaboration — framed correctly.** ASM anticipates a collaborative-care arrangement with primary care. Because TVCC is a cardiology group with no primary-care panel, this is not a CoachCare-billed primary-care arm and not APCM. It is a shared care plan and structured data exchange with each heart-failure patient's external, referring PCP — the cardiology practice owns the specialty wrapper (TCM at discharge, RPM, and PCM on the principal cardiac condition), and coordinates the primary-care wrapper with the PCP who owns it.

**A scope note**

Because TVCC is a cardiology group with no primary-care panel, the collaborative-care arrangement is coordinated with external PCPs and is never billed by TVCC as APCM. This report also makes no structural-heart or renal-denervation growth claims, as those capabilities are not established for the practice in public sources — a smaller, honest scope beats an inflated one. TEAM is not applicable either: the Florence–Muscle Shoals CBSA (22520) is not among the selected TEAM CBSAs, so TEAM is excluded from this strategy.

## 4. Operating System for Service Line Performance

Running the service line well means managing it like a service line — with a balanced scorecard that puts clinical, operational, and financial measures on one page.

| Dimension | Representative measures |
|---|---|
| **Remote-care service line** | Enrolled census (by program); time-to-first-billable-enrollment; billable-capture rate; net revenue per patient per month; alerts actioned within target. |
| **Heart-failure quality** | GDMT titration to target; 30-day HF readmissions; days at home; symptom-driven visit avoidance. |
| **Access & throughput** | Post-procedure length of stay; same/next-day discharge rate; catheterization-lab utilization; new-patient access time. |
| **Financial** | Recurring RPM and PCM revenue; TCM capture at discharge; denial rate; program contribution margin ($). |
| **ASM readiness** | HF cohort enrolled and monitored; titration protocol live; PCP collaborative-care agreements in place; performance data captured. Confirm against final CMS list. |

### ASM readiness checklist

- **Cohort defined and enrolled —** every attributed heart-failure patient on continuous weight/BP monitoring.
- **Titration as a production process —** nurse/pharmacist-led GDMT titration to protocol, with physician escalation paths.
- **PCP collaborative care —** shared care plans and data exchange with external referring PCPs (not an APCM arm).
- **Documentation & data capture —** structured monitoring and titration data feeding ASM performance measurement.
- **Final-list confirmation —** go-live plan reconciled to the final CMS ASM participant list expected summer 2026.

## 5. Performance Snapshot

TVCC has a low public digital footprint and no published practice-level quality ratings of the kind a hospital carries (a physician group does not receive a CMS Overall Hospital Star Rating). Rather than assert ratings the practice does not publish, this section frames the clinical opportunity through the national readmission picture and the heart-failure wedge — and flags what must be pulled from primary sources before any local claim.

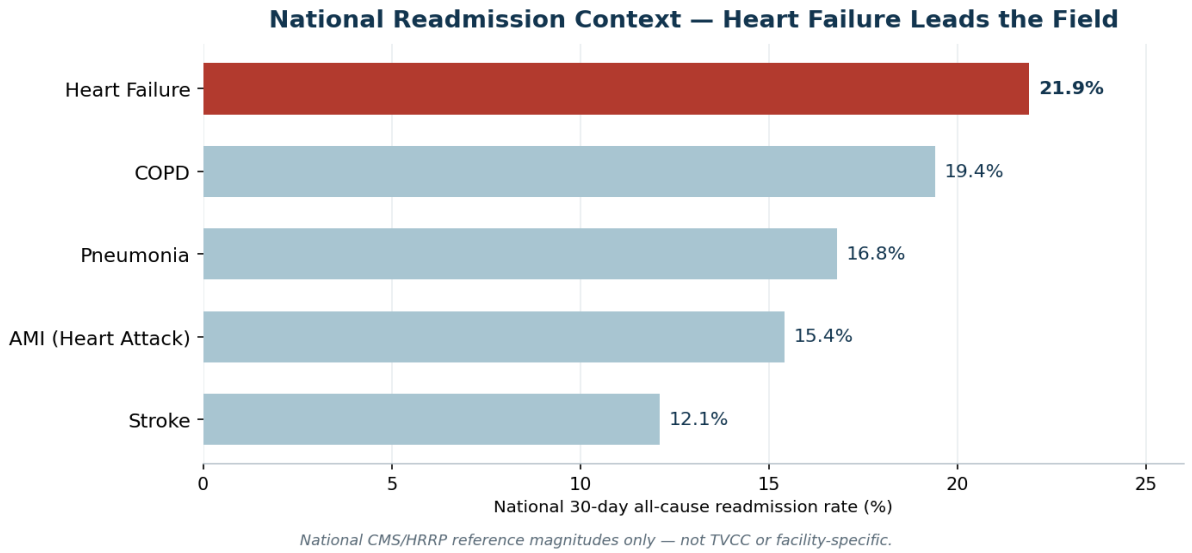


*Figure 3. National CMS/HRRP 30-day readmission reference magnitudes by condition. These are national benchmarks only — not TVCC or facility-specific — and are shown to illustrate where remote care moves the needle.*

**The heart-failure wedge.** Across the country, heart failure carries the highest 30-day readmission rate of any common inpatient condition. It is also the condition most responsive to exactly what a remote-care service line does: early detection of fluid overload through daily weights, blood-pressure trends, and symptom check-ins, paired with rapid GDMT titration. For a cardiology group that already owns these patients clinically, closing that gap is both a quality win and — under ASM — a payment one.

> **What to confirm before citing local numbers**
>
> Facility-specific 30-day heart-failure readmission rates for TVCC's hospital partners — North Alabama Medical Center (CCN 010006) and Helen Keller Hospital — were **not retrieved for this report and are deliberately not cited.** Pull them from CMS Care Compare (and note the data vintage) before making any local readmission claim. County-level Medicare Advantage penetration should likewise be confirmed from the CMS county file; Alabama's statewide MA mix is among the nation's highest, which increases utilization pressure and strengthens the remote-care case.

## 6. Powering ASM: Heart Failure + PCP Collaboration

This section makes the ASM connection concrete. The remote-care service line is not adjacent to ASM readiness — it is the ASM operating model, expressed as day-to-day workflow. (ASM participation reflects the CMS preliminary list of February 2026; confirm against the final CMS list expected summer 2026.)

**The heart-failure operation, as a production process:**

- **Identify & enroll —** every attributed heart-failure patient is risk-stratified and enrolled onto connected weight and blood-pressure monitoring, most efficiently at a TCM touch after discharge.
- **Monitor & alert —** daily physiologic data flows into a 24/7 alert-and-triage layer; weight and BP trends surface decompensation days before a symptomatic crash.
- **Titrate to target —** nurse- and pharmacist-led GDMT titration runs to protocol between visits, turning guideline-directed therapy into a repeatable process instead of an every-few-months office event.
- **Document & measure —** structured monitoring and titration data both drive care and produce the performance record ASM is scored on.

**The collaborative-care arrangement, done right.** ASM anticipates an electronic collaborative-care arrangement with primary care. For TVCC this is a coordination relationship, not a billing arm: a shared heart-failure care plan in the EHR and structured data exchange with each patient's external referring PCP. TVCC owns the cardiology wrapper (TCM, RPM, and PCM on the principal cardiac condition); the PCP owns the primary-care wrapper. This keeps attribution clean and avoids any double-counting of the same patient-month.

**Design decisions to lock before go-live**

- **Attribution:** one longitudinal wrapper per patient — PCM on the principal cardiac condition; RPM stacks alongside it; the PCP owns primary-care management for shared patients.
- **Targeting:** launch with the attributed ASM heart-failure cohort, then widen to the broader high-risk cardiac panel.
- **Shared care plan:** one plan of record in Greenway; agreed data exchange with referring PCPs.
- **Readiness:** workflows live and generating data in 2026; go-live reconciled to the final CMS ASM list (summer 2026).

# 7. Powering Procedural Growth: Interventional & Device Throughput

The same engine that manages heart failure also protects the procedural economics of a busy interventional and device practice. TVCC's cardiologists perform catheterization-based interventional work (angioplasty, stenting, atherectomy) and electrophysiology/device procedures at NAMC, a hub with four catheterization labs and a hybrid suite. Remote care is a throughput multiplier for that work.

**How the throughput math works.** The 2026 short-window RPM codes (99445 for a 2–15 day device window, 99470 for the first 10 minutes of monitoring) make it billable — and clinically defensible — to monitor a patient closely for the first two weeks after a procedure. That short, structured window supports faster, safer same- or next-day discharge: the patient goes home sooner with a monitoring safety net, which frees catheterization-lab and inpatient-bed capacity for additional cases. Build the monitoring chassis once for heart failure, and the post-procedure window is a reuse, not a new build.

**Scope discipline**

This lever is deliberately limited to interventional and device throughput, which public sources support. No structural-heart program (TAVR, TEER/MitraClip, WATCHMAN) and no renal-denervation growth claim is made here, because those capabilities are not established for the practice in public sources. If discovery confirms additional procedural lines, the same short-window monitoring model extends to them.

# 8. Implementation Playbook

### Goals & scope

Stand up a managed remote-care service line that is margin-positive on its own economics and ASM-ready before January 1, 2027. Scope: TCM + RPM + PCM, billed by TVCC, on the heart-failure and high-risk cardiac panel across Florence and Sheffield.

### Target populations (in launch order)

- **Attributed ASM heart-failure cohort (launch first) —** the patients TVCC will be measured on in 2027.

- **Post-discharge and post-procedure patients —** captured at the TCM / short-window RPM on-ramp.
- **Broader high-risk cardiac panel** — coronary disease, resistant hypertension and post-procedure patients, each carrying one PCM wrapper on their principal cardiac condition with RPM alongside it.

### Staffing, technology & billing architecture

- **Top-of-license clinical model —** nurses and pharmacists run monitoring and GDMT titration; CoachCare supplies the enrollment (including a funded on-site enrollment specialist), connected-device logistics, monitoring labor, and billing capture as a service, so the practice adds program capacity without adding headcount it must hire and manage. The model projects roughly 15,361 care-team hours saved over 24 months (~7.4 FTE-years) that the practice reallocates rather than hires against.
- **Native Greenway integration, day one —** CoachCare integrates with the practice's Greenway EHR, with telephonic patient enrollment, cellular-connected devices with real-time vitals, and automatic claim creation running inside the existing system.

> **Greenway integration — confirm in contracting**
> The integration is built for the Greenway platform (Intergy is the assumed product edition for a multi-provider specialty group; Prime Suite is the fallback). The Greenway product is caller-sourced and should be confirmed. Integration setup follows catalog pricing (setup fee on the order of $2,500, with no separate monthly or per-patient integration fee for Greenway in the current catalog). Confirm the exact Greenway product edition and integration pricing in contracting.

### Clinical workflow (steady state)

Enroll at a TCM touch or clinic visit → ship and activate connected devices → daily physiologic data into 24/7 alert-and-triage → protocolized GDMT titration between visits → structured documentation → monthly billable capture (RPM + PCM) and TCM at each qualifying discharge.

### KPI dashboard

| Clinical | Operational | Financial |
|---|---|---|
| GDMT titration to target; 30-day HF readmissions; days at home | Enrolled census; time-to-first-billable-enrollment; alerts actioned on time | Net revenue / patient / month; billable-capture rate; denial rate; contribution margin ($) |

### Expected impact & 12-month roadmap

**Modeled 24-month impact (illustrative; verify against practice data):** $1,543,034 net professional-fee reimbursement, $658,325 practice margin after fees, ~67 avoided hospitalizations (≈$1.01M avoided cost), 30,816 billed claims/units, 105,983 physiologic readings, and 15,361 care-team hours saved. 24-month practice margin: 42.7% of net reimbursement (Year 1 41.2%, Year 2 43.5%).

1. **Months 1–2 — Stand up.** Contract and confirm Greenway product; integrate; define the HF cohort; set attribution and PCP-collaboration model; train staff.
2. **Months 3–6 — Enroll & ramp.** Enroll the ASM heart-failure cohort first via TCM on-ramps and clinic referral; go live on monitoring, titration, and billing capture.
3. **Months 7–12 — Scale & prove.** Widen to the broader high-risk panel; stand up the balanced scorecard; accumulate the ASM performance-data record and reconcile the plan to the final CMS list.
4. **Into 2027 — ASM go-live.** Enter January 1, 2027 with a live heart-failure operation and a year of data, not a standing start.

# References & Data Sources


1. CMS Innovation Center — Ambulatory Specialty Model (ASM) Participants dataset, data.cms.gov (CY2027 Preliminary, updated Feb 2026); NPI-verified selection of TVCC cardiologists under “ECM TVCC LLC.”
2. CMS — Ambulatory Specialty Model program design (mandatory; heart-failure cohort; PY2027–2031; first-year Part-B adjustment −9% to +9%).
3. NPPES / NPI Registry — TVCC entity and clinician records (Florence & Sheffield).
4. CMS Care Compare / HRRP — national 30-day readmission reference magnitudes (Figure 3); facility-specific rates for NAMC (CCN 010006) and Helen Keller Hospital to be pulled and dated on discovery.
5. CMS CY2026 Physician Fee Schedule — remote-care billing codes (TCM, RPM incl. new 99445/99470, PCM); local Alabama-locality magnitudes (carrier 10112, locality 00) used in the model.
6. CoachCare Value Analysis (2026) — modeled economics for TVCC on an estimated ~1,911 total-Medicare panel (FFS + MA); source of all illustrative financial, clinical, and operational figures.
7. CoachCare / Greenway Care Coordination Services — native Greenway integration overview (telephonic enrollment, connected devices, automatic claim creation).
8. CoachCare — program scale references (managed conditions, providers, implementations, claims, and vitals recorded).


**Verification & validation caveat**

This report is a planning artifact, not an audited financial or legal document. Every present-day fact should be re-verified before it is relied upon. In particular: (1) TVCC’s ASM participation reflects the CMS **preliminary** list (Feb 2026) — confirm against the final list expected summer 2026; (2) all economics are illustrative and modeled on an estimated panel (~1,911 total Medicare, FFS + MA, with MA priced at fee-for-service magnitudes) — re-run against actual practice data; (3) the ownership/employment model (physician-owned PC with a Nashville “ECM” management arrangement versus LifePoint employment), the Greenway product edition and integration pricing, the contracting entity, and any facility-specific readmission and MA-penetration figures must be confirmed on discovery.

Contact: Connor Knapp, CoachCare · connor.knapp@coachcare.com.