STANISLAUS CARDIOLOGY GROUP

Independent Single-Specialty Cardiology · Modesto, California

Cardiovascular Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM, with CCM) as the operating spine

Purpose of this report

This report reads Stanislaus Cardiology Group's public profile and local market and makes a single argument: a managed **Remote Care Service Line** is the highest-return, lowest-risk optimization move available to the group in 2026 — margin-positive as a standalone service line before any value-based dollar, and built on one shared infrastructure that also defends the group's hospital referral relationships and clears the way for procedural growth.

Independent, model-free timing. Stanislaus carries no mandatory CMS-model exposure today — this is pure-upside timing, with the same remote-care infrastructure ready if the selection maps change.

Prepared by CoachCare · Remote Care Service Line Strategy · July 2026

Figures are illustrative and modeled — verify against practice data before contracting.

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Executive Summary

Stanislaus Cardiology Group is an independent, single-specialty cardiology practice in Modesto, California — five to six cardiologists operating from a recently completed, group-owned ~11,460 sq. ft. medical office. The group is heavily interventional (four of five physicians carry FSCAI), holds hospital privileges at Doctors Medical Center of Modesto (Tenet) and Memorial Medical Center (Sutter), and — importantly — does not run electrophysiology, a dedicated heart-failure service, or a structural program of its own; advanced structural and open-heart care sits with the hospital, not this group. The practice is administered by Sumintra Reddy (Office Administrator).

Starting position. The group carries zero existing remote-care footprint — no RPM, CCM/PCM, device clinic, or patient app of any kind. That is not a gap so much as clean whitespace: there is no incumbent vendor to displace, and the practice's posture is straightforward fee-for-service with no MSSP, ACO, or downside-risk entanglements, so recurring care-management revenue accrues cleanly. The single most important market fact is payer mix: Modesto runs roughly 58% Medicare Advantage penetration — well above the national average — in an aging Central Valley county with heavy interventional cardiology volume. A daily-touch, longitudinal care layer is exactly what that population needs and exactly what the group does not yet offer.

The central argument

A managed Remote Care Service Line delivers value two ways at once.

1) Standalone value. Recurring, subscription-like professional-fee revenue at top-of-license staffing — margin-positive before any value-based upside.

2) Connective tissue. One shared engine — enrollment, connected devices, 24/7 alerts and triage, nurse navigation, GDMT titration, billing capture, analytics — that simultaneously reduces avoidable readmissions at the group's hospital partners (defending downstream referrals), supports interventional and procedural throughput, and modernizes the device clinic. Build once, reuse everywhere.

The readmission wedge. Heart failure is the largest cardiac readmission burden nationally and the measure that remote monitoring moves fastest. Stanislaus does not bear a hospital's readmission penalty directly, but its referring hospital partners do — and a cardiology group that measurably reduces HF and post-procedure readmissions makes itself the indispensable partner in that relationship. GDMT titration run as a production process, between visits, is the operational core of that story.

The billing tailwind. CY2026 widened the remote-care stack in the group's favor — new short-window RPM codes (99445 for 2–15 day monitoring, 99470 for the first 10 minutes of management) make transitional and post-procedure monitoring billable, on top of the established RPM, CCM, and PCM codes. For an interventional group with a steady stream of post-PCI and post-procedure patients, that is a direct fit.

What the model shows. Applied to the group's estimated Medicare panel, an RPM + CCM + PCM service line is modeled to generate **$2,895,600 in net reimbursement over 24 months** and **$1,235,314 in practice profit after CoachCare's fees** — a practice-profit margin of roughly 42% — while avoiding roughly **77 hospitalizations** (about $1.15M in system-level cost). These are illustrative, modeled figures — they should be verified against the group's own claims and panel data — but the direction is unambiguous: each program stands on its own, margin-positive, from Year 1.

2026–2027 Priority Recommendations

1. **Stand up the Remote Care Service Line as a standalone P&L.** Launch RPM + CCM + PCM on the existing Medicare panel with CoachCare-funded enrollment and monitoring staff, so the service line adds margin without adding practice headcount.
2. **Lead with heart failure and post-procedure monitoring.** Target the multimorbid HF and post-PCI cohorts first — the highest-acuity, highest-readmission-risk patients — and run GDMT titration as a repeatable, between-visit process.
3. **Deploy on the native Greenway integration.** Enroll and bill inside the existing EHR workflow — bidirectional enrollment, discrete vitals, automated claim generation — so patients begin services in under five days. Confirm the specific Greenway product (Intergy vs. Prime Suite) in discovery/contracting.
4. **Use the service line to defend hospital referral relationships.** Position measurable HF and readmission reductions as the group's contribution to its Tenet and Sutter partners' quality performance — turning remote care into referral-relationship insurance.
5. **Keep the whitespace levers in view.** Renal denervation and resistant-hypertension comanagement (BP RPM is intrinsic to both) is policy-aligned growth whitespace the same remote-care infrastructure unlocks with no incremental build.

1. Footprint & Operating Model

Stanislaus Cardiology Group is a physician-owned, single-specialty cardiology practice serving Modesto and the surrounding Stanislaus County / Central Valley market. The operating profile below is drawn from public sources and the account research dossier; items the dossier could not independently confirm are flagged for discovery.

Attribute	Profile (verify in discovery where flagged)
Organization	Stanislaus Cardiology Group — independent, single-specialty, physician-owned (no PE/MSO evidence)
Location	3621 Forest Glenn Dr, Modesto, CA 95355 — recently built, group-owned ~11,460 sq. ft. office; possible second location (directory-only, unverified)
Physicians	5–6 cardiologists: Kent H. Wong, Hassan Hussain, Rajesh K. Dubey, Joydev Acharya, Mutahir U. Khan (a 6th, directory-only, unverified)
Sub-specialty mix	Heavily interventional — 4 of 5 FSCAI. No EP, no dedicated HF service, no structural/vascular sub-specialist (advanced structural care sits at the hospital, not this group)
Hospital privileges	Doctors Medical Center of Modesto (Tenet, regional cardiac referral & structural program); Memorial Medical Center (Sutter)
Administration	Sumintra Reddy, Office Administrator
Payer & VBC posture	Fee-for-service; no MSSP/ACO or downside-risk contracts. Market ~58% Medicare Advantage penetration
Remote-care footprint	None today — no RPM, CCM/PCM, device clinic, or patient app. Clean whitespace; no incumbent to displace
EMR	Greenway (caller-sourced; product Intergy vs. Prime Suite unverified) — confirm in discovery/contracting

What the operating model implies. Three features of this group shape the entire strategy. First, it is interventional-heavy: a steady flow of post-PCI and post-procedure patients who need structured follow-up in the 2–30 day window — precisely the window CY2026's new short-window RPM codes were designed for. Second, it is independent and FFS: there is no hospital parent capturing the professional fees and no risk contract to complicate attribution, so a recurring care-management revenue stream lands directly on the group's P&L. Third, the advanced structural and heart-failure work lives at the hospital partners, which makes the group's referral relationships — and their defense — a first-order strategic concern rather than an afterthought.

Design principles for the service line

Principle	What it means for Stanislaus
Longitudinal by default	Chronic cardiac patients are enrolled in continuous monitoring at the point of care, not referred out — the practice owns the between-visit relationship
One shared scorecard	Enrolled census, billable-capture rate, and revenue per patient per month are tracked on the same dashboard as clinical outcomes
Top-of-license staffing	CoachCare-funded coaches and nurses run enrollment, device logistics, and monitoring; physicians and mid-levels practice at the top of their license
One front door	A single enrollment and triage pathway for RPM, CCM, and PCM — patients experience one program, not three
Digital-as-care	Connected devices and 24/7 alerting are treated as clinical infrastructure, not

Principle	What it means for Stanislaus
	IT — data drives titration and escalation

2. The Remote Care Service Line — The Spine

This section is the center of the report. A Remote Care Service Line is not a point solution bolted onto the practice; it is a managed operating line with its own P&L, its own staffing model, and its own scorecard. For an independent cardiology group, it runs as a single specialty arm — the transitional and longitudinal codes that a cardiology practice can bill on the patients it already manages.

2.1 What it is: the specialty-arm stack

The service line sequences four billing motions across the cardiac patient journey — from the transition out of the hospital, through short post-procedure windows, into longitudinal chronic management:

Motion	Codes	Clinical role
TCM	99495 / 99496	Transitional Care Management: structured contact within 2 business days of discharge and a face-to-face visit within 7–14 days — the hand-off from hospital to practice
RPM	99453 · 99454 · 99445 · 99457 · 99470 · 99458	Remote Physiologic Monitoring: connected BP/weight/pulse-ox devices with monitoring time; the new 99445/99470 short-window codes fit 2–15 day post-procedure follow-up
PCM	99426 / 99427	Principal Care Management: a single high-risk condition (e.g., heart failure) managed longitudinally ≥3 months — the specialist's chronic-care wrapper
CCM	99490 / 99439	Chronic Care Management: the multimorbid majority (2+ chronic conditions ≥12 months) — the broadest cohort in an aging, MA-heavy panel

One coordination rule to set on day one

RPM stacks; CCM and PCM do not. RPM may be billed alongside either CCM or PCM (discrete time and documentation). CCM and PCM cannot both be billed for the same patient in the same calendar month — one longitudinal wrapper per patient. TCM covers the 30-day post-discharge window, then transitions the patient into RPM plus CCM or PCM.

Attribution with primary care. Because CCM can only be billed by one practice per patient per month, set a simple attribution policy with each patient's primary-care physician up front — the specialist owns TCM-at-discharge, RPM, and PCM for the cardiac condition; where the group bills CCM, it confirms the PCP is not billing it the same month. One shared care plan in the EHR keeps this clean.

2.2 Standalone value: three value layers

Before any connective-tissue benefit, the service line earns its place on the P&L. Value accrues in three layers, led — for an independent, model-free group — by the standalone economics:

1. **Direct professional-fee revenue —** Recurring, subscription-like monthly reimbursement (RPM, CCM, PCM) on patients the group already sees. Delivered at top-of-license staffing with CoachCare-funded coaches and nurses, it adds margin without adding practice headcount. This is the lead layer and the reason the service line stands on its own.
2. **Avoided cost & referral-relationship defense —** Fewer avoidable HF and post-procedure readmissions at the group's hospital partners (Tenet, Sutter). Stanislaus does not pay a readmission penalty directly, but the hospitals it refers to do — and a group that measurably

reduces those readmissions becomes the partner the hospital cannot afford to lose. Remote care converts a clinical result into referral-relationship insurance.

3. **Interventional & procedural throughput —** Structured post-PCI and post-procedure monitoring keeps the cath-lab pipeline continuous and safe, supports same/next-day discharge, and — as policy-aligned whitespace — positions the group for renal denervation and resistant-hypertension comanagement (BP RPM is intrinsic to both). Growth built on the same shared engine.

CY2026 billing stack (illustrative — CA locality)

The stack below shows the CY2026 remote-care codes and their approximate California-locality magnitudes. These are illustrative, drawn from the value-analysis model (CA carrier/locality 01112-60, Noridian) and national magnitudes where noted; actual payment is locality-adjusted and set by the regional MAC. Confirm current-year PFS values in contracting.

Service / code	Type	Approx. rate	Notes
TCM 99495 / 99496	Per discharge	~$200 / ~$280	National magnitude; 2-business-day contact + face-to-face 14 / 7 days
RPM 99453	One-time setup	~$23	Requires ≥2 days of device data
RPM 99454 / 99445	Monthly (device)	~$57	99454 = 16–30 days; 99445 = new 2–15-day short-window code (2026)
RPM 99457 / 99470	Monthly (mgmt)	~$54 / ~$27	First 20 min / new first-10-min code (2026)
RPM 99458	Monthly (add'l)	~$43	Each additional 20 minutes
PCM 99426 / 99427	Monthly (specialty)	~$70 / ~$57	Single high-risk condition (e.g., HF) ≥3 months
CCM 99490 / 99439	Monthly (chronic)	~$69 / ~$52	2+ chronic conditions ≥12 months — the multimorbid majority

> **Recurring-revenue mechanics**
>
> Each enrolled patient generates a predictable monthly professional fee for as long as they remain clinically appropriate and engaged — the economics behave like a subscription book that compounds as the enrolled census ramps. A patient enrolled in RPM plus a longitudinal wrapper (CCM or PCM) contributes multiple recurring lines per month. The model's Year-1-to-Year-2 step-up (below) is precisely this compounding: the census built in Year 1 bills for all of Year 2.

2.3 Connective tissue: one engine, every lever

The reason to build this as a service line rather than a billing tactic is that one shared infrastructure powers every lever at once. The same enrollment engine, connected devices, 24/7 alert-and-triage desk, nurse navigation, titration protocols, billing capture, and analytics that produce the standalone revenue also drive readmission avoidance, procedural throughput, and the quality/experience halo. Build it once; reuse it everywhere.

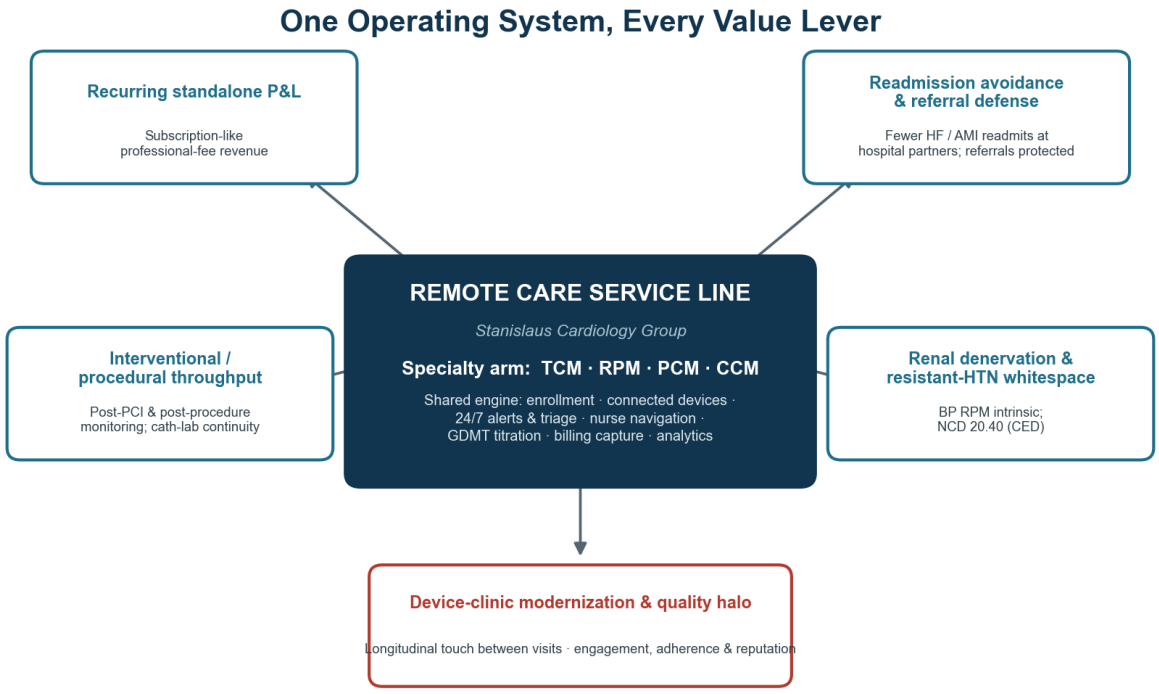

Figure 1. The Remote Care Service Line as a single operating system — one shared engine (center) driving every value lever for an independent cardiology group. Build once, reuse everywhere.

The matrix below maps how the same shared capabilities show up in each lever — the point being that the group does not staff, license, or integrate five different programs, but one:

Value lever	How the same shared engine powers it
Standalone P&L	Enrollment + devices + monitoring time → recurring RPM/CCM/PCM professional fees; billing capture ensures nothing is left on the table
Readmission avoidance & referral defense	24/7 alerts + nurse triage + GDMT titration catch decompensation early → fewer HF/post-procedure readmits at hospital partners → protected referral relationships
Interventional / procedural throughput	Post-PCI/post-procedure RPM supports safe same/next-day discharge and continuous cath-lab pipeline; short-window codes make the follow-up billable
Renal denervation & resistant-HTN whitespace	BP RPM is intrinsic to titration and to the CMS renal-denervation coverage-with-evidence pathway — the monitoring layer is a prerequisite, and the group already owns it
Device-clinic modernization & quality halo	Continuous data + engagement + adherence → a modern device clinic and a measurable patient-experience/reputation advantage

3. The 24-Month Value Model

The figures below come from the CoachCare Value Analysis built for Stanislaus Cardiology Group, applied to an estimated total-Medicare panel of ~4,146 patients. The panel is modeled as **total Medicare = FFS Part B ÷ (1 − MA %)** (≈1,711 FFS ÷ (1 − 58.73%) ≈ 4,146), with Medicare Advantage modeled at Medicare (FFS) rates because MA allowables are federally set at ≥100% of Medicare — cardiology-specific program eligibility is RPM 60%, CCM 70%, PCM 70% of the panel. Enrollment is driven by a referral engine (below), ramping through Year 1 to a steady-state active census that bills for all of Year 2. The panel size is an estimate, the figures are illustrative and modeled — verify against the group's own claims and panel data before contracting — and every rate and assumption is user-editable. No discount or margin percentage is implied; the numbers below are the group's net reimbursement and its profit after CoachCare's fees.

How enrollment is modeled

A referral-driven engine, not cold outreach: **one CoachCare-funded on-site enrollment specialist** (embedded in the practice, an included-value pathway) plus **eight physician referrals per provider per month** across the group's ~6 providers at an **80% patient-accept rate**, converting to programs at **30% RPM, 25% CCM, and 25% PCM**. The census builds gradually through Year 1 and holds through Year 2 — which is why Year 2 bills roughly 2.9× Year 1.

Financial value

Program	Year 1 net	Year 2 net	24-month net	24-mo practice profit
RPM	$321,245	$870,074	$1,191,319	$487,713
CCM	$304,868	$902,101	$1,206,969	$558,849
PCM	$120,261	$377,050	$497,311	$216,526
Total	**$746,375**	**$2,149,226**	**$2,895,600**	**$1,235,314**

Program rows show profit before shared ancillary costs; the Total profit ($1,235,314) is net of one-time implementation, EMR-integration, and telephonic-enrollment fees, so it is slightly below the sum of the program rows.

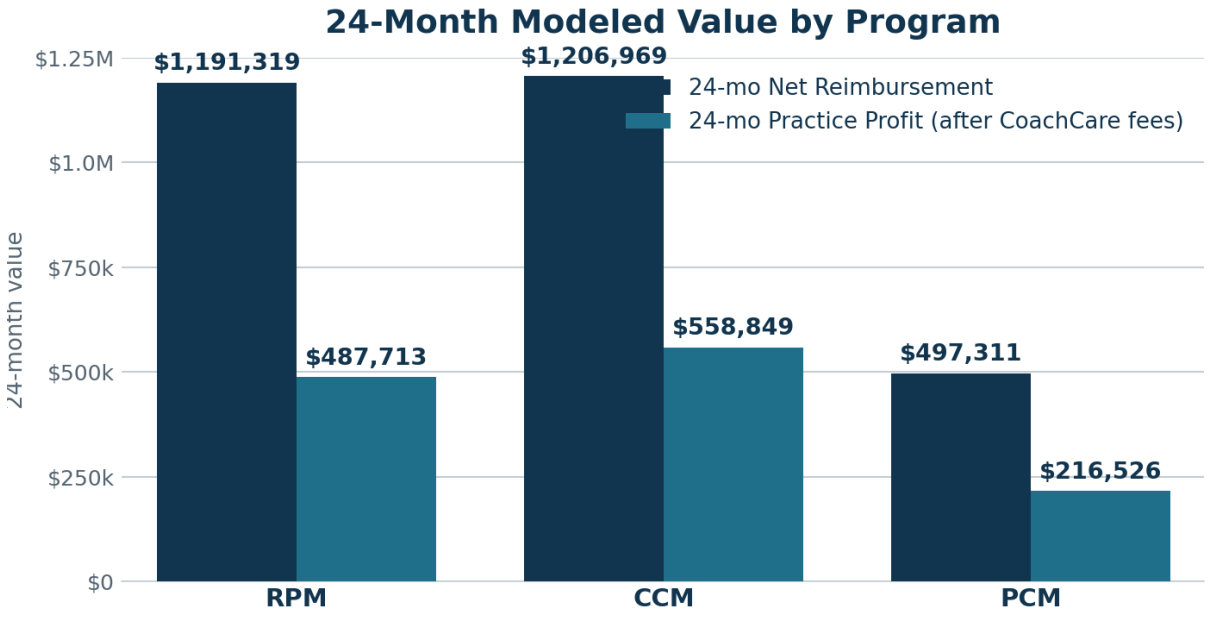

Figure 2. 24-month modeled net reimbursement and practice profit by program. Each program is individually margin-positive. Illustrative, modeled — verify against practice data.

Reading the ramp. Year 1 net reimbursement of $746,375 grows to $2,149,226 in Year 2 — roughly a 2.9× step-up — because the enrolled census built gradually through Year 1 bills for all twelve months of Year 2. The 24-month totals are **$2,895,600 in net reimbursement** and **$1,235,314 in practice profit after CoachCare's fees** (a practice-profit margin of roughly 42%), with RPM and CCM as the two largest contributors and PCM adding a focused heart-failure line.

Clinical & operational value

Beyond the professional fees, the model quantifies the clinical and workload effects of continuous monitoring on the enrolled panel over 24 months:

Metric	24-month modeled value	What it represents
~77	hospitalizations avoided	≈ $1.15M in system-level cost avoided at ~$15,000 per admission — the readmission-defense story, quantified
51,349	billed claims / units	Total reimbursable claim lines generated across RPM, CCM, and PCM
120,591	physiologic readings	Connected-device data points feeding titration and early-warning alerts
24,590	care-team hours saved	≈ 11.8 FTE-years of clinical/administrative time absorbed by CoachCare staff, not practice headcount

How to read these numbers

Every figure in this section is illustrative and modeled from the CoachCare Value Analysis, not a guarantee of results. The inputs — panel size (~4,146 is an estimate), eligibility percentages, the referral-based enrollment engine, avoided-admission rate, and the ~$15,000-per-admission cost basis — are all user-editable, and the totals recalculate live. The right next step is a discovery session to replace the estimated panel and eligibility inputs with the group's actual claims data.

4. Performance Snapshot & the Readmission Wedge

An independent cardiology group is not scored on a CMS hospital star rating, but its clinical value is anchored in the same place a hospital's is: the readmission burden of its cardiac patients. Heart failure is the largest cardiac readmission burden nationally, and the condition remote monitoring moves fastest — which is exactly why it is the wedge for this service line.

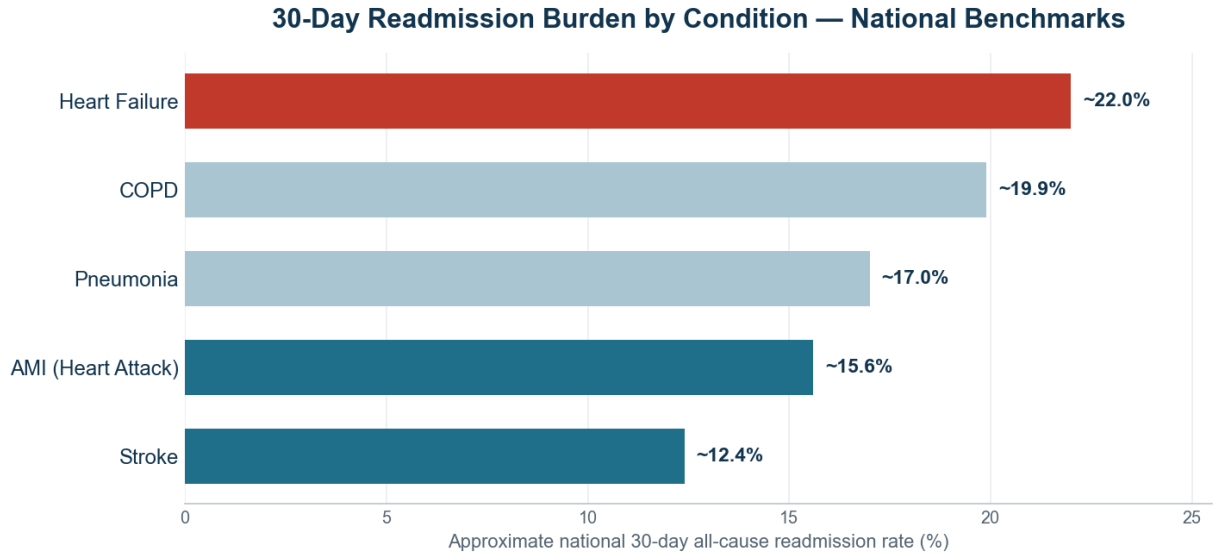

Figure 3. Approximate national 30-day all-cause readmission rates by condition. Heart failure carries the largest cardiac burden and is the measure continuous monitoring moves fastest. Illustrative national benchmarks — lower is better; refresh against current CMS data.

Data-vintage note

The rates above are approximate national benchmarks used to illustrate relative burden, not facility-specific figures. Stanislaus Cardiology Group's hospital partners — Doctors Medical Center of Modesto (CCN 050464) and Memorial Medical Center — have their own condition-level readmission rates that should be pulled from current CMS Care Compare / HRRP data before any figure is cited to the practice.

Why the wedge matters to this group specifically

The referral relationship is the asset. Because the group's advanced structural and heart-failure work is delivered at the hospital, its economic engine depends on referral relationships with Tenet's Doctors Medical Center and Sutter's Memorial Medical Center. Those hospitals carry HRRP readmission penalties on exactly the conditions — heart failure above all — that a well-run remote-care program reduces. A cardiology group that can show measurable HF and post-procedure readmission reductions is no longer just a source of volume; it is a partner in the hospital's quality performance. That is the most durable form of referral defense available.

GDMT titration as a production process. Guideline-directed medical therapy for heart failure works only when it is actually titrated to target — a task that fails in the gaps between quarterly visits. Running titration as a structured, between-visit process on the remote-care engine (protocol-driven up-titration, nurse-led follow-up, connected weight and BP data, pharmacist support where available) is how the group converts a guideline into an outcome. It is also the single highest-ROI clinical workflow the service line enables.

Device-clinic modernization. For an interventional group, the remote-care engine is also the natural substrate for a modern device and post-procedure clinic — continuous data, structured follow-up, and early-warning alerts replacing episodic phone tag. This is where the standalone revenue and the clinical mission reinforce each other most directly.

5. Building the Remote Care Service Line

The service line is a build, not a purchase — but a light one, because CoachCare supplies the enrollment labor, devices, monitoring staff, and billing capture. The playbook below sequences the first twelve months.

Goals, scope & target populations

- **Scope.** RPM + CCM + PCM (with TCM at every discharge) on the group's Medicare panel, run as a single enrollment and triage pathway.
- **Lead cohorts.** Heart-failure and multimorbid patients (PCM/CCM + RPM) and post-PCI / post-procedure patients (short-window RPM), targeted first for highest acuity and readmission risk.
- **Panel.** An estimated ~4,146 total-Medicare patients (modeled as FFS Part B ÷ (1 − MA %): ≈1,711 FFS ÷ (1 − 58.73%) ≈ 4,146), with cardiology eligibility of roughly 60% for RPM and 70% for CCM/PCM — to be replaced with the group's actual claims data in discovery.

Staffing, technology & billing architecture

- **Top-of-license staffing + embedded enrollment.** CoachCare-funded health coaches and nurses run telephonic enrollment, device logistics, and 24/7 monitoring and triage, and a CoachCare-funded on-site enrollment specialist works the group's referral flow (eight referrals per provider per month at an 80% accept rate); the group's physicians and mid-levels own clinical decisions and titration.
- **Native Greenway integration, day one.** Enrollment, discrete vitals, compliance documentation, and claim generation live inside the existing Greenway EHR workflow — bidirectional enrollment by service, integrated vitals, and automated claim creation, so patients begin RPM/CCM services in under five days.

> **EMR confirmation flag**
>
> **Confirm the Greenway product in contracting.** The native Greenway integration is available day one and is catalog-priced. The specific product — Greenway Intergy vs. Prime Suite — is caller-sourced and not yet independently confirmed; the build assumes Intergy as primary. Verify the exact product (and the integration line items) in discovery/contracting before finalizing.

- **Connected devices.** Cellular-connected BP cuffs, scales, and pulse-oximeters with real-time data — no patient Wi-Fi or app friction — shipped and supported by CoachCare.
- **Billing capture.** Automated claim generation and code-completion tracking ensure each eligible encounter is captured — the difference between a program that breaks even and one that compounds.

KPI dashboard

The service line runs on a single scorecard blending clinical, operational, and financial measures:

Category	Metrics tracked
Clinical	Enrolled census; HF cohort on titrated GDMT; readings reviewed; alerts actioned; readmissions among enrolled patients
Operational	Time-to-first-billable-enrollment; device-deployment cycle time; monitoring-time compliance; care-team hours absorbed
Financial	Billable-capture rate; revenue per patient per month; net reimbursement vs. model; practice profit after fees

Expected impact & 12-month roadmap

Phase	Window	Focus	Milestone
1 Launch	Months 1–2	Greenway integration live; staff trained; HF + post-PCI cohorts identified	First billable enrollments
2 Ramp	Months 3–6	Enrollment ramp across RPM/CCM/PCM; titration protocols in production	Census & capture rate climbing to plan
3 Scale	Months 7–12	Full panel penetration; device clinic modernized; referral-defense reporting to hospital partners	Year-1 net reimbursement (~$746,375 modeled)
4 Compound	Year 2	Enrolled book bills for the full year; whitespace levers (RDN/HTN) evaluated	Year-2 step-up (~$2,149,226 modeled)

The bottom line for Stanislaus

An independent, interventional-heavy cardiology group in a 58%-Medicare-Advantage market, with zero remote-care footprint and no value-based-care risk, is close to an ideal setting for a partner-built Remote Care Service Line. The model shows it is margin-positive before any value-based dollar — **$1,235,314 in modeled 24-month practice profit at roughly a 42% margin** — while defending the hospital referral relationships the group's procedural engine depends on. The right next step is a discovery session to validate the panel and eligibility inputs against the group's own claims data.

References & Data Sources

This report combines the CoachCare Value Analysis built for Stanislaus Cardiology Group with the account research dossier and public sources. Present-day facts are sourced below; items the dossier could not independently confirm are flagged in-text for discovery.

1. CoachCare Value Analysis — Stanislaus Cardiology Group (2026). Practice-specific model of net reimbursement, practice profit, and clinical/operational value across RPM, CCM, and PCM; CA carrier/locality 01112-60 (Noridian). All rates and inputs user-editable; figures illustrative and modeled.
2. Account research dossier — Stanislaus Cardiology Group (Modesto, CA), July 2026. Practice profile, physician roster, sub-specialty mix, administration, EMR, market, and payer-posture verification. Group NPI 1902828841.
3. CMS 30-day readmission measures (HRRP / Care Compare). National condition-level benchmarks used illustratively; facility-specific rates for Doctors Medical Center of Modesto (CCN 050464) and Memorial Medical Center to be pulled from current data before citation.
4. CMS NCD 20.40 — Renal Denervation for uncontrolled hypertension (effective Oct 28, 2025). Coverage with Evidence Development; BP remote monitoring intrinsic to titration and evidence capture.
5. Greenway Health — Care Coordination Services / CoachCare native Intergy integration. Bidirectional enrollment by service, integrated discrete vitals, compliance documentation, and automated claim generation; patients begin CCM/RPM services in under five days. Confirm product (Intergy vs. Prime Suite) in contracting.
6. Medicare Advantage penetration — Modesto / Stanislaus County (2025–2026). ~58% MA penetration, above the ~54% national average; verify current-year figure and the group's plan contracts in discovery.
7. CY2026 Medicare Physician Fee Schedule — remote-care code set. TCM, RPM (incl. new 99445 / 99470), PCM, and CCM code magnitudes; locality-adjusted by the regional MAC. Confirm current-year PFS values before contracting.

Global verification & validation caveat

All financial, clinical, and operational figures in this report are illustrative and modeled from the CoachCare Value Analysis, not guarantees of outcomes. Panel size (~4,146 is an estimate; modeled as FFS Part B ÷ (1 − MA %), with Medicare Advantage modeled at Medicare rates), program eligibility, the referral-based enrollment engine, avoided-admission rate, reimbursement rates, and the per-admission cost basis are all user-editable assumptions that should be replaced with Stanislaus Cardiology Group's actual claims and panel data in discovery. CMS billing rates are locality-adjusted and set by the regional MAC; confirm current-year Physician Fee Schedule values before contracting. EMR product, physician roster, and second-location details are flagged in-text for confirmation.