COACHCARE

Connected Cardiology:

Building a Resistant Hypertension Service Line

Prepared: January 2026

Purpose: Education and operational readiness planning for Health Systems, Medical Centers, and Ambulatory Groups whose regions have been selected for mandatory participation in the CMS Ambulatory Specialty Model (ASM).
This report is educational and does not constitute legal, billing, or regulatory advice.

Sections

1 Executive Summary

Ambulatory Blood Pressure Monitoring (ABPM) and Care Navigation for multimorbidity patients with Hypertension, paid for by Medicare via Remote Patient Monitoring (RPM) and Principal Care Management (PCM) non-Facility CPT payment pathways, can be combined into a structured renal denervation program that identifies resistant hypertension earlier, documents true treatment resistance over time, hands the cath lab a fully worked-up referral package, and provides objective outcome measures post procedure. The model turns scattered throughput into a defined pipeline: identify persistent elevation, optimize therapy and evaluate secondary causes, refer appropriate patients for RDN, then restart monitoring after the procedure to monitor and measure outcomes.

Program lens	What to know (high level)
CLINICAL PROBLEM	True resistant hypertension is underdetected, carries materially higher cardiovascular and kidney risk, and often lacks a formal escalation pathway.
RPM ENGINE	Daily BP readings, monthly trend review, and automated flagging create the objective evidence needed to spot refractory patterns and trigger physician review.
PCM ENGINE	Monthly touchpoints support medication reconciliation, secondary HTN workup, comorbidity management, and prior-authorization documentation.
CATH LAB IMPACT	A navigator submits a complete packet with RPM trends, PCM summary, workup results, and scheduling readiness, reducing friction between clinic and procedure.
POPULATION LEVEL ANALYTICS	Post procedure, ABPM and Care Navigation continues, resulting in and end to end care pathway and robust data.

2 Care Model & Referral Design

The source model centers on four connected functions. Each one produces a specific artifact that moves the patient toward RDN candidacy while reducing handoff friction for the cath lab.

Clinical Foundation
Why a structured pathway is needed

- Persistent BP elevation despite optimized therapy defines the target population.
- Many candidates remain in primary care or unidentified and without a formal escalation path.
- Monitoring and care navigation of Uncontrolled Hypertension at scale creates end to end, data driven care pathway

Remote Patient Monitoring (RPM)
Continuous BP intelligence driving referral volume

- Auto-flag patients with BP ≥130/80 on ≥2 antihypertensives for enrollment.
- Transmit daily readings and review 30-day BP trends.
- Escalate same day for SBP >180 or DBP >110; MD review for SBP >160 x3 days.
- Persistent elevation on ≥3 optimized agents triggers RDN workup.

Principal Care Management (PCM)
Optimization, workup, and coordination

- Use monthly encounters for medication reconciliation and adherence.
- Coordinate renal duplex, aldosterone/renin ratio, sleep study, and echo.
- Optimize CKD, diabetes, and OSA before referral.
- Build the record needed for prior auth and pre-op readiness.

Cardiology Clinic / Cath Lab Handoff
Single point of contact across the continuum

- Bridge PCP, nephrology, cardiology, and cath lab teams around one care plan.
- Assemble the RPM export, PCM summary, workup results, and authorization materials.
- Educate patients on logistics, scheduling, and pre-op expectations.
- Resume RPM within 48 hours and track 7/14/30-day plus 1/3/6/12-month follow-up.

Integrated referral pathway

Step	Focus	Operational output
1	Identify	RPM flags average BP ≥130/80 on ≥3 optimized agents over a 30-day trend window.
2	Screen	Navigator and PCM review secondary causes and launch aldosterone, renin, renal duplex, and sleep-study workup.
3	Optimize	Reconcile medications, address CKD/DM/OSA, and confirm that true resistance criteria are met.
4	Refer	Submit the cath lab packet with RPM export, PCM summary, workup results, and prior authorization.
5	Procedure	Perform RF or ultrasound ablation with same-day or 23-hour observation, as appropriate.
6	Monitor	Restart RPM within 48 hours and follow structured BP surveillance for up to 12 months.

~10%	3x	80-120	48h
Resistant HTN rate	Higher CV event risk	Annual RDN candidates per 1,000 enrolled in RPM for ABPM	RPM resumes post-RDN, from identification

3 Economics, Quality & Compliance

The program stacks recurring monitoring and care management revenue on top of procedure revenue, while also creating the documentation backbone needed for indication support, authorization, registry reporting, and payer conversations.

Revenue & Financial Model

Stacked value across the continuum of care

- RPM: approximately $120-$160 per enrolled patient per month (CPT 99453/99445999454/99470/99457 /99458).
- PCM: approximately $120-$180 per enrolled patient per month (CPT 99426/99427).
- 1,000 RPM/PCM enrolled hypertensive patients may yield about $100K-$120K in recurring monthly revenue while identifying 80-120 resistant hypertension patients for RDN referral.

Quality, Compliance & Outcomes

Documentation, registry, and performance support

- RPM data supplies objective evidence of uncontrolled BP for the RDN indication.
- PCM longitudinal documentation demonstrates treatment failure over time and supports prior authorization.
- Follow-up exports at 1/3/6/12 months can support outcomes registries and payer reporting.
- Key measures include BP control, medication adherence, 30-day readmission, and post-procedure complication rate.
- Target benchmark: at least 10 mmHg SBP reduction at 6 months with quarterly dashboard review.

90-day launch roadmap

Timeframe	Priority	What to complete
Days 1-30	Plan	Work with CoachCare Solutions Team to design your program and plan implementation & 12 month roadmap.
Days 31-60	Implement	The CoachCare team works with stakeholders to execute implementation plans across people, tools, and processes.
Days 61-90	Launch	Go live with patient enrollments for ambulatory hypertension monitoring and care management.
Month 4-6	Analyze	Resistant HTN Patients will be automatically flagged via RPM monitoring data for referral pathway.
Month 7-12	Scale	Move toward a 1,000+ patient panel, project 80-120 RDN cases, and use outcomes data in payer conversations.
Year 2+	Expand	Extend the regional referral network, expand RPM/PCM to additional disease states and care pathways e.g., HF, CAD, A-Fib