COACHCARE | SERVICE LINE STRATEGY

Acadiana Renal Physicians

Lafayette and New Iberia, Louisiana. An independent, physician-owned nephrology group at three offices, in practice for more than thirty years: 10 physicians and 7 advanced practice clinicians billing under the practice

Nephrology Service Line Performance & Optimization

2026 Strategy Report

A Remote Care Service Line (TCM + RPM + PCM) built as an extension of the monthly protocol the practice already runs for its dialysis patients, sized against its own Medicare claims and the discharges it already manages at four hospitals, and a margin-positive P&L billed under the practice's own TIN

Purpose of this document

Prepared by CoachCare, September 2026, as a discussion document for the physician owners and administrator of Acadiana Renal Physicians. It starts from the practice's own Medicare claims. In CY2024, 17 billing clinicians carried 7,509 Medicare beneficiary-lines and $2,455,788 of allowed charges. The nephrologists' patients carry an average risk score between 3.6–4.5 against a national average of 1.00, chronic kidney disease and hypertension both report at the ceiling CMS publishes to, and about 395 dialysis patients are already managed on a fixed monthly protocol.

What the same claims do not contain is any remote physiologic monitoring, chronic care management or principal care management at meaningful scale, and transitional care management on 15 patients by one clinician. The monthly discipline stops at the dialysis chair.

The forecast in section 7 sizes the gap: $1,332,100 of net reimbursement over 24 months at a 42.6% practice margin, positive from month 2, with no clinical headcount added to the practice's payroll.

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Executive Summary

Acadiana Renal Physicians is an independent, physician-owned nephrology group with two offices in Lafayette (Lafayette Parish) and one in New Iberia (Iberia Parish). CMS registry and claims data resolve **17 clinicians** to the practice's own billing organization: 10 physicians, of whom 8 are nephrologists and 2 practice internal medicine, and 7 nurse practitioners and physician assistants.[1] In CY2024 those clinicians billed **$2,455,788** of Medicare fee-for-service allowed charges across 7,509 beneficiary-lines and 31,117 services.[2] The physicians round at four hospitals and manage patients in the in-center and home dialysis units across the six-parish Acadiana market.

The panel is the argument. The practice-wide average hierarchical condition category risk score is **3.11**, and the nephrologists' own panels run between **3.6–4.5**, against a national average of 1.00. Chronic kidney disease and hypertension both report at 75%, which is the ceiling CMS publishes chronic-condition prevalence to rather than a measured rate. Diabetes runs 60–69% of each nephrologist's beneficiaries and heart failure 45–67%. 31.5% of the panel is dual-eligible for Medicare and Medicaid, and just over half is 75 or older.[3]

What is already running

The practice already runs a monthly, protocol-driven relationship with its sickest patients. In CY2024 it billed the end-stage renal disease monthly capitation codes on about 565 beneficiary-lines, $649,217 of allowed charges and roughly 28% of everything it bills to Medicare. Every in-center dialysis patient is seen on a fixed cadence, documented against a protocol and billed once a month. Six clinicians also coded the longitudinal-complexity add-on on 810 patients.[4] That is the hard part of any care-management program: a named owner, a monthly cadence, documentation that supports the claim, and the claim itself. The practice has run it for years, on capitation, for the patients already on dialysis.

What is absent

Across all 17 clinicians, every remote physiologic monitoring, chronic care management and principal care management code is absent from the same year's claims. Transitional care management appears once: the high-complexity code on 15 patients by one clinician.[5] CMS suppresses any line below eleven beneficiaries, so the exact reading is that the practice ran **no such program at meaningful scale in CY2024**. The between-visit work those codes pay for is being done for the patients not yet on dialysis. It is being done inside quarterly visits and phone calls that carry no separate payment.

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[1] Quality Payment Program eligibility interface, performance years 2025 and 2026, queried per national provider identifier and grouped by billing organization; NPPES registry; CMS Doctors & Clinicians national file; PECOS group reassignment file. All retrieved 14 September 2026. The practice website lists 9 physicians and 5 advanced practice clinicians; the difference is timing of enrollment and of the claims file.

[2] Medicare Physician & Other Practitioners — by Provider, calendar year 2024, queried per national provider identifier for the 17 clinicians whose Medicare billing resolves to the practice's organization in the Quality Payment Program eligibility interface, 14 September 2026. Beneficiary-lines are summed across clinicians and are not deduplicated; a patient seen by two clinicians is counted twice.

[3] Medicare Physician & Other Practitioners — by Provider, calendar year 2024, queried per national provider identifier for the 17 clinicians whose Medicare billing resolves to the practice's organization in the Quality Payment Program eligibility interface, 14 September 2026. Risk score, dual-eligible share, age mix and chronic-condition prevalence are read per clinician; ranges shown are the lowest and highest nephrologist values. CMS caps published prevalence at 75.0%, so chronic kidney disease and hypertension both report at that ceiling. Age mix: under 65 14.2%, 65 to 74 32.8%, 75 to 84 36.2%, 85 and over 15.2%.

[4] Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024, queried per national provider identifier and aggregated by procedure code across the same 17 clinicians, 14 September 2026. Codes 90960, 90961 and 90962 (end-stage renal disease related services, monthly, by visit count) and 90966 (home dialysis, monthly); G2211 (visit complexity inherent to a longitudinal relationship). Capitation lines are counted separately from office and hospital evaluation and management and are never summed with them.

[5] Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024, queried per national provider identifier and aggregated by procedure code across the same 17 clinicians, 14 September 2026. Codes 99453, 99454, 99457, 99458, 99091, 99490, 99439, 99491, 99424 through 99427 and 99495 were searched by exact procedure code for every clinician. None appears. 99496 reports 15 beneficiaries and 16 services for one clinician. CMS suppresses any provider and procedure line below eleven beneficiaries.

The finding in one sentence

A practice that already runs a monthly protocol on about 395 dialysis patients bills nothing for the months between visits for the roughly 1,448 established office patients whose kidney disease and blood pressure are still being managed short of dialysis, which is where progression is decided.

Why the timing is right

Three facts outside the practice's walls line up with the one inside them. About half of the practice's Medicare work is earned inside a hospital, and the transitional care codes followed 15 of those discharges in CY2024. CMS created two remote-monitoring codes for CY2026 that pay for exactly the short post-discharge windows a kidney patient needs. And the kidney payment models are being redrawn: the model that covered the Lafayette hospital referral region ended on 31 December 2025, the current one runs through 2027, and CMS has said a successor is being designed.

The practice has no mandatory CMS model exposure today, which makes the timing pure upside, and the program produces the evidence every kidney model scores on.

The forecast

The Value Analysis models a remote care service line across the practice's 1,750-patient Medicare office panel, enrolled through 11 referring clinicians. Over 24 months it produces **$1,332,100 of net reimbursement** to the practice against $765,252 of CoachCare fees, leaving **$566,848 retained, a 42.6% practice margin**.[6] Year 1 runs 40.5% and year 2 runs 43.6%. Month 1 is $5,495 negative, because implementation and integration setup post against a first-month census of 29 patients; the practice is positive from month 2 and stays there.

	Year 1	Year 2	24 months
Net reimbursement to the practice	$444,715	$887,384	$1,332,100
CoachCare program and platform fees	$264,409	$500,843	$765,252
Net to the practice	$180,306	$386,542	$566,848
Practice margin	40.5%	43.6%	42.6%
Unique patients under management	537	593	593

Value Analysis summary. Unique patients are deduplicated across programs: a patient enrolled in both monitoring and care management is one person and two enrollments, so 593 unique patients carry 906 active program enrollments at month 24.

Transitional care management is priced in section 3 and is **not in that forecast**. The dialysis monthly codes are not in it either. The forecast contains remote physiologic monitoring and principal care management only. About 42% of Medicare beneficiaries in Lafayette Parish are in Medicare Advantage, and roughly half in the surrounding parishes. Advantage plans must reimburse at least the Medicare rate for these code families. That is a floor; individual contracts set their own terms.

The enrollment specialist who drives that census, and the care team behind them, are **carried at CoachCare's expense**. They are not deducted from the margin above and they do not appear on the practice's payroll. That matters in a practice whose nurse practitioners already cover dialysis units and hospital rounding.

2026–2027 priority recommendations

1. **Bill transitional care management on the discharges already happening.** Four hospitals, physicians rounding at all of them, and 15 transitional care patients in the claims. No device, no

[6] CoachCare Value Analysis for this account, built on the CY2026 physician fee schedule at Novitas Louisiana locality 99 and recalculated 14 September 2026. Revenue is net of modeled denials, patient coinsurance and coinsurance bad debt.

new population, no consent hurdle. $205.94 and $279.41 per discharge at this locality, outside the 24-month forecast entirely.

2. **Extend the dialysis-month discipline to the months between office visits.** The cadence, the documentation habit and the billing path exist for about 395 dialysis patients. They need to reach the office patients with stage 3b to 5 kidney disease and resistant hypertension.
3. **Put blood pressure and weight on daily transmission first.** Hypertension is at the ceiling CMS publishes to and heart failure runs 45–67% of the nephrologists' panels. Blood pressure control and volume are the two signals a nephrologist acts on between visits, and both can be read from home.
4. **Layer principal care management onto the same cohort from month 2.** One dominant condition, monthly, at top-of-license staffing. It reaches its ceiling in month 21, which is the argument for starting early rather than late.
5. **Take the Medicare Advantage plan mix off the table on the first call.** With 42% of Lafayette Parish and roughly half of the surrounding parishes in Advantage, the plan mix of the practice's own panel decides how much of this forecast is fee-schedule-certain. Advantage plans must reimburse at least the Medicare rate for these code families. That is a floor; individual contracts set their own terms.
6. **Read the CY2027 final rule when it lands in early November.** The proposed rule cuts the device-supply codes by 20.6% at this locality, which flows through to −5.8% on the service line. The final rule is effective 1 January 2027.

1. The Practice Today

1.1 The panel: what the claims say

CMS publishes, per clinician, the beneficiaries seen, the allowed charges, the average risk score and the share of beneficiaries carrying each chronic condition. Read across the practice's 17 billing clinicians, the file describes one of the highest-acuity panels a specialty group can carry.

Panel measure	Value	What it means here
Beneficiary-lines, 17 clinicians	7,509	Summed across clinicians, not deduplicated; includes hospital, nursing-facility and dialysis-unit work
Established office-visit beneficiaries	1,448	Patients who return to an office of the practice (99213 to 99215): the enrollable population
Medicare allowed, CY2024	$2,455,788	Professional services across the 17 clinicians
Average risk score, practice	3.11	Three times the national 1.00 benchmark
Average risk score, nephrologists	3.6–4.5	Every nephrologist's panel sits well above the practice average
Average beneficiary age, nephrologists	72–73	Just over half the panel is 75 or older
Dual-eligible share	31.5%	Nearly one patient in three; cost-sharing is covered for them
Chronic kidney disease	75%	At the ceiling CMS publishes to
Hypertension	75%	At the ceiling CMS publishes to
Diabetes	60–69%	Two patients in three among the nephrologists
Heart failure	45–67%	Roughly one patient in two. Volume is the between-visit signal

CY2024 Medicare Physician & Other Practitioners data, by provider, for the clinicians billing under the practice. Ranges are the lowest and highest nephrologist values. CMS publishes chronic-condition prevalence to a ceiling of 75.0%, so chronic kidney disease and hypertension both report at the ceiling CMS publishes to rather than at a measured rate.

Two readings follow. First, the office panel is established rather than churning: new-patient visits number 140 beneficiaries across the practice against 1,448 established visits, and the level-five established code is almost unused.[7] A monthly care-management program enrolls from the patients who come back. Second, kidney disease and hypertension at the ceiling for every nephrologist means eligibility for a monitoring and care-management program is not a screening exercise here. It is the panel.

1.2 Where the Medicare work sits

The practice is hospital- and dialysis-heavy in Medicare fee-for-service, with a comparatively small office-visit footprint. Subsequent hospital care at moderate complexity is the single largest line in the file.

Where the CY2024 Medicare work sits	Share of allowed	What follows it today
Hospital care: initial, subsequent, discharge day, inpatient dialysis	48%	15 transitional care episodes
Dialysis monthly capitation, in-center and home	28%	A monthly protocol, already run
Office visits, new and established	13%	The next quarterly visit

CY2024 Medicare Physician & Other Practitioners file, by provider and service, for the practice's billing clinicians. Shares are of Medicare allowed amounts; the remainder is nursing-facility care, procedures and other services.

Subsequent hospital care at moderate complexity alone ran **8,503 services across 2,606 patients** and $594,129 of allowed charges in CY2024.[8] Every one of those patients leaves the building at some point. Section 3 is about what follows them home.

1.3 The monthly protocol the practice already runs

Most remote care proposals to an independent practice have to argue the concept of a monthly, protocol-driven relationship first. This one does not. The dialysis monthly codes prove the practice already runs one.

Monthly management, CY2024	Beneficiary-lines	Allowed	Clinicians
End-stage renal disease monthly services, in-center, by visit count (90960, 90961, 90962)	565	$649,217	9
Home dialysis monthly services (90966)	15	reported	1
Visit complexity add-on for a longitudinal relationship (G2211)	810	reported	6

CY2024 Medicare claims, monthly capitation and add-on codes only. Deduplicated across clinicians, the in-center capitation lines describe about 395 fee-for-service patients, or roughly 680 once the market's Medicare Advantage share is restored.

Three readings matter. The capitation lines sustain a monthly visit, a monthly note and a monthly claim on several hundred patients, which is a cadence discipline, not a pilot. The complexity add-on on 810 patients means six clinicians already code the longitudinal relationship the care-management families are built around. And the whole book sits inside the practice, so the operating model exists and has an owner.

[7] Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024, queried per national provider identifier and aggregated by procedure code across the same 17 clinicians, 14 September 2026. New-patient code 99204 reports 140 beneficiaries across five clinicians. Established codes 99213, 99214 and 99215 report 1,448 beneficiaries across the seven office nephrologists, the office-based internal medicine physician and the three advanced practice clinicians with office visits at a practice address; 99215 reports 33 beneficiaries across two clinicians.

[8] Medicare Physician & Other Practitioners — by Provider and Service, calendar year 2024, queried per national provider identifier and aggregated by procedure code across the same 17 clinicians, 14 September 2026. Code 99232 (subsequent hospital inpatient or observation care, moderate medical decision making): 2,606 beneficiaries, 8,503 services, $594,129 allowed, across 13 clinicians.

What this changes about the proposal

The hard parts of care management are the parts that need a person doing them every month: someone owns the list, works it on a schedule, documents what they found, and gets it billed. This practice solved those four problems years ago for its dialysis patients, on capitation.

What follows is the extension of that discipline, from the roughly 395 patients already on dialysis to the roughly 1,448 established office patients whose kidney disease is still being managed short of it.

1.4 The codes that are absent

Every remote physiologic monitoring, chronic care management, principal care management and transitional care management code was searched by exact procedure code across the 17 clinicians in the CY2024 file.[9]

Code family	Codes searched	CY2024 result
Remote physiologic monitoring	99453, 99454, 99457, 99458, 99091	None present
Chronic care management	99490, 99439, 99491	None present
Principal care management	99424, 99425, 99426, 99427	None present
Transitional care management	99495, 99496	99496 on 15 patients, one clinician

CMS suppresses any provider and procedure line below eleven beneficiaries, so the defensible reading is that no such program ran at meaningful scale in CY2024.

The transitional care line is the loudest of the four. The practice's physicians round at Our Lady of Lourdes Regional Medical Center, St. Martin Hospital, Kaplan General Hospital and Abbeville General Hospital. Their patients are admitted, discharged and seen back in the office or the dialysis unit. The clinical work of a transition is being done. The payment attached to it was captured 15 times.

2. The Between-Visit Layer

A nephrology practice sees its established patients every three to four months. Kidney disease does not progress on that calendar. It progresses in the weeks between visits, when a blood pressure that never settled keeps loading the glomerulus, when a diuretic change moves the potassium, when three pounds of fluid arrive over a weekend, and when a patient who was going to be started on dialysis in a planned way with an access in place instead arrives through the emergency department with a catheter.

The service line in this report is the layer that sits in those weeks. It is built for four clinical jobs a nephrologist already does, and does better with daily data in hand.

Clinical job	What the between-visit layer adds	Who it reaches
Slowing progression in stage 3b to 5 kidney disease	Daily blood pressure from the patient's home, reviewed against the patient's own targets; a nurse call when the trend breaks; a titration prompt to the nephrologist inside the week rather than at the next visit	The bulk of the office panel: chronic kidney disease reports at the ceiling CMS publishes to for every nephrologist
Resistant hypertension	Three readings an hour apart define a trend objectively; adherence and side-effect review on a monthly call; the practice sees a month of readings, not one in the office	Hypertension at the ceiling CMS publishes to; the cohort where two or three agents are already in play

[9] As the by-Provider-and-Service source above. Sixteen codes were searched: 99453, 99454, 99457, 99458, 99091, 99490, 99439, 99491, 99424, 99425, 99426, 99427, 99495 and 99496, plus the CY2026 codes 99445 and 99470, which could not appear in a CY2024 file.

Clinical job	What the between-visit layer adds	Who it reaches
Volume	Daily weight with a three-pound-in-a-day, five-pound-in-a-week rule; diuretic plan and lab timing confirmed on the call; escalation before the emergency visit	Heart failure runs 45–67% of the nephrologists' panels
Optimal starts	A patient whose decline is watched monthly reaches dialysis with a modality chosen and an access placed rather than through the emergency department; education and modality conversations happen on the care-management call, not in a crisis	The late-stage cohort approaching a start decision

None of that is a new clinical idea to a nephrologist. What is new is that each of those jobs now has a monthly professional-fee code attached to it, that the daily data can be collected without the patient coming in, and that the work of collecting, reviewing and documenting it can be staffed by a care team the practice does not have to hire.

The wedge, stated once

The interstitial-care layer between quarterly nephrology visits is where progression actually happens. The practice already runs a monthly protocol for the patients who have reached dialysis. This is the same protocol, run earlier, for the patients who have not.

3. The Discharge Cohort and Transitional Care

About 48% of the practice's Medicare work is earned inside a hospital. Subsequent hospital care ran 8,503 services across 2,606 patients in CY2024, and the physicians round at four hospitals: Our Lady of Lourdes Regional Medical Center, St. Martin Hospital, Kaplan General Hospital and Abbeville General Hospital.[10] Each of those patients leaves the building at some point, and in CY2024 the transitional care codes followed 15 of them.

The thirty days after a kidney patient's discharge are where the next admission is decided. Fluid re-accumulates on a diuretic that was changed on the ward. A potassium drifts on a new agent. A blood pressure that was controlled on intravenous medication is not controlled on the oral regimen the patient went home with. A dialysis patient misses the first outpatient session after discharge because transport was never rebooked. None of that waits for the next quarterly visit.

Transitional care: the fastest first dollar

Transitional care management is the entry point on this account, for reasons that have nothing to do with the forecast. It requires no device, no new patient population, no consent conversation and no enrollment funnel. It requires a contact within two business days of discharge, medication reconciliation, and a face-to-face visit inside 14 days for moderate complexity or 7 days for high complexity, on patients the practice already discharges from four hospitals and already sees, in the office or in the dialysis unit.

Code	Service	CY2026 rate at this locality
99495	Transitional care management, moderate medical decision complexity, face-to-face within 14 days	$205.94
99496	Transitional care management, high medical decision complexity, face-to-face within 7 days	$279.41

[10] Quality Payment Program eligibility interface, performance year 2026: the practice's physicians carry billing reassignments to each of the four hospitals named, in addition to the practice's own organization. Hospital names are the organizations of record; no clinician is identified.

CY2026 physician fee schedule, non-facility, Novitas Louisiana locality 99 (Rest of Louisiana), resolved from ZIP 70506. All three offices bill at the same locality.

Worth saying plainly

Transitional care management is not in the 24-month forecast. The Value Analysis in section 7 contains remote physiologic monitoring and principal care management only. Every dollar of transitional care revenue sits outside those numbers, and so does every dollar of the dialysis monthly codes.

It also does more than pay. The 30-day window it covers is the window the post-discharge cadence in section 6 does its work in, and the window every kidney payment model, current or next, measures readmissions over.

4. The Service Line: TCM, RPM, PCM

4.1 The clinical and billing stack

Three programs, one infrastructure, one patient record. A patient enters wherever they are: coming out of the hospital, newly uncontrolled, or overdue for real between-visit management. They move onto a short monitoring window and settle into a longitudinal cadence that continues for as long as the condition does, which for kidney disease is indefinitely.

Stage	Program	What happens	Cadence
At discharge	Transitional care management	Contact within two business days, medications and diuretics reconciled against the discharge summary, face-to-face visit booked and confirmed	Once per discharge
Days 1–30	Remote physiologic monitoring, short window	Blood pressure and weight from the patient's home, daily review, escalation on critical values and established trends	Monthly, from 2 days of data
Month 2 onward	Remote physiologic monitoring, longitudinal	Continuous physiologic data with treatment-management time logged against it	Monthly
Month 2 onward	Principal care management	One dominant condition, chronic kidney disease or resistant hypertension, managed against a written care plan with monthly clinical staff time	Monthly

Remote monitoring and principal care management may be billed together for the same patient in the same month, on discrete documented time. That is what makes a single enrollment carry two revenue lines and one care plan. Principal care management is the right care-management family for a nephrology practice: it pays for the one serious condition the nephrologist is managing, it is billable by a specialty group without a primary-care panel, and it is separate from the dialysis monthly codes. Chronic care management, the two-or-more-condition family, is available to the practice for the many patients with kidney disease, hypertension and diabetes together; it is priced in the table below and is not in the forecast.

4.2 CY2026 rates at Louisiana locality 99

Code	Service	CY2026 rate
99453	Remote monitoring setup and patient education, once per enrollment	$19.26
99454	Device supply with daily recording, 16–30 days	$46.14
99445	**Device supply with daily recording, 2–15 days, new for CY2026**	**$46.14**
99457	Treatment management, first 20 minutes	$48.26
99470	**Treatment management, first 10 minutes, new for CY2026**	**$24.30**

Code	Service	CY2026 rate
99458	Treatment management, each additional 20 minutes	$39.09
99426	Principal care management, clinical staff, first 30 minutes	$64.02
99427	Principal care management, clinical staff, each additional 30 minutes	$50.74
99424	Principal care management, physician or qualified professional, first 30 minutes	$83.28
99425	Principal care management, physician or qualified professional, each additional 30 minutes	$58.40
99490	Chronic care management, clinical staff, first 20 minutes	$62.54
99439	Chronic care management, clinical staff, each additional 20 minutes	$47.45
99491	Chronic care management, physician or qualified professional, first 30 minutes	$84.91
99495	Transitional care management, moderate complexity	$205.94
99496	Transitional care management, high complexity	$279.41

CY2026 physician fee schedule, non-facility, Novitas Louisiana locality 99, resolved from ZIP 70506 by the model's locality crosswalk. The forecast bills principal care management on the clinical-staff codes 99426 and 99427. The physician-time principal care codes, the chronic care management codes and the transitional care codes are shown for completeness and are not in the forecast.

The two codes new for CY2026 change the shape of a kidney program. 99445 pays the device-supply rate for a 2-to-15-day window instead of requiring sixteen days of data, which makes the immediate post-discharge fortnight billable on its own terms. 99470 pays for the first ten minutes of treatment management instead of requiring twenty, which makes a stable patient's month billable without inflating the time spent. Across the 24-month forecast the two together carry **$145,852** of gross remote-monitoring reimbursement, 17% of the monitoring arm's gross and about 10% of the whole service line's net reimbursement.[11]

Every rate above is the fee-for-service amount. 41.6% of Lafayette Parish's Medicare beneficiaries are in Medicare Advantage, and between 48.5% and 53.7% in the five surrounding parishes. Advantage plans must reimburse at least the Medicare rate for these code families. That is a floor; individual contracts set their own terms. The fee-for-service base, about 27,964 beneficiaries in Lafayette Parish and 65,596 across the six parishes, is where these rates are fee-schedule-certain.

4.3 Who does the work

The practice's clinicians order, review escalations that need a nephrologist, and see the patient. Everything else is done by CoachCare's care team under the practice's protocols: outreach and consent, device shipment and setup, daily reading review, monthly care-management contact, time capture, documentation into the chart, and claim generation. The on-site enrollment specialist who drives the census is CoachCare's employee and CoachCare's expense.

Function	Practice	CoachCare
Eligibility and ordering	Physician or advanced practice clinician orders by program	Screens the panel by diagnosis and flags candidates in the chart
Enrollment and consent	Introduces the program at the visit where useful	On-site enrollment specialist consents, educates and ships the cuff and scale

[11] As the Value Analysis source. 99445 carries $124,071 and 99470 carries $21,781 of gross remote-monitoring reimbursement across the 24-month horizon, against $866,955 of gross for the monitoring arm, read from the model's per-code rows on 14 September 2026.

Function	Practice	CoachCare
Daily monitoring	Receives only what needs a clinical decision	Reviews every reading against patient-specific thresholds
Escalation	Named clinical contact decides on non-critical findings	Runs the escalation engine, calls the patient, activates 911 where indicated
Monthly care management	Reviews and signs the care plan	Delivers the monthly contact, titration and lab-timing prompts, and documentation
Billing	Submits claims under its own TIN	Captures time, attaches monthly documents, creates the claim in eClinicalWorks

5. Inside eClinicalWorks

The practice already meets its patients on healow, the eClinicalWorks patient platform: the practice website offers healow Televisits as its telehealth channel.[12] CoachCare's eClinicalWorks integration is native rather than interfaced. The care team works inside the practice's chart, not beside it, at all three offices.

What the integration does	What it means in this office
Integrated ordering and enrollment	Enrollment flags and ordering by service inside the eClinicalWorks workflow; enrollment status is visible in the chart in real time, and patients begin receiving services in under five days
Exchange of health history	The care team starts from the practice's problem list, medications and allergies rather than re-collecting them, which matters on a panel where the medication list is long
Integrated vital reports	Home blood pressure and weight land in the patient's chart as structured vitals, reviewable by any clinician in the practice before the next visit
Monthly compliance documents	Evidence of care, vitals summary and the care plan are attached to the chart every month, so the record supports the claim without a second system
Automated claim generation	Claims are created by the CoachCare billing engine, which removes the manual claim step for every patient every month. CoachCare is the only care-management application integrated with eClinicalWorks that does this

CoachCare eClinicalWorks integration overview.

The last row is the one that matters most here. A billing office that already runs the monthly dialysis claims cannot absorb another 453 claim lines a month by hand. The integration means the monthly claim for every enrolled patient is created from captured time and attached documentation, and the biller reviews rather than keys.

Integration economics carried in the model are $4,000 of one-time setup, $150 per month, and $1.50 per enrolled patient per month, with the integration scope confirmed in contracting.

6. Clinical Governance and Escalation

The economics establish that the service line pays. This section establishes that it is safe and disciplined, which is the question a physician-owned group asks first. Every reading generated by the program routes through one escalation engine before it reaches the practice. The engine, the emergent pathway, the

[12] Practice website, home page, retrieved 14 September 2026, which presents healow Televisits as the practice's telehealth channel. healow is the patient-facing platform of eClinicalWorks.

routing and the post-discharge cadence below are drawn from CoachCare's Care Management Standard Operating Procedures and the SOP process maps derived from them; the appendix lists the maps.[13]

6.1 The escalation engine

- **Reading received.** Values are evaluated against the patient's own thresholds, not a generic band. A nephrologist sets a different blood-pressure target for a stage 4 patient than for a transplant candidate, and the engine holds each one.
- **Critical value.** Escalates regardless of whether the patient reports symptoms. There is no symptom gate on a critical value and no waiting for a confirmatory reading.
- **Out of range, not critical.** A retake, then a structured symptom check, before anything is routed to the practice.
- **Trend, defined objectively.** Three consecutive readings at least one hour apart for blood pressure, or a weight gain of three pounds in a day or five in a week for volume. An established trend escalates on the same footing as a single critical value.
- **Patient unreachable.** Voicemail and a scheduled callback; if the value is critical or the trend is established, the escalation proceeds regardless.
- **Documentation.** Every escalation records the vital, the findings, the contact method, who was reached, the outcome and the follow-up, written to the chart, so the record supports the clinical decision and the billing equally.

6.2 The emergent pathway

Chest pain, new shortness of breath, stroke signs, syncope, sudden swelling or a blood pressure at crisis level trigger an immediate emergency activation: the care manager calls emergency services with the patient still on the line. If the patient declines, they are directed to the clinic; if they decline that, emergency services are activated regardless.

> **The rule that makes delegation possible**
>
> **CoachCare's urgent and emergent policy supersedes any practice-specific escalation preference.** It is not a configurable setting. It is the reason a ten-physician practice whose clinicians are in dialysis units and on hospital wards for much of the day can delegate the daily watch without inheriting the risk of having done so.

6.3 Routing, so the practice sees signal rather than noise

Escalations route three ways. Emergencies go to emergency services. Non-critical findings that require a clinical decision go to a named member of the practice's team, agreed during protocol design, with the readings, the symptom check and the recommended next step attached. Stable, resolved events post to the chart as a notification and no one is paged. The volume that reaches a nephrologist is the volume that requires a nephrologist. In a practice where the physicians split their day between three offices, four hospitals and the dialysis units, that distinction is the difference between a program that gets adopted and one that gets ignored.

6.4 The post-discharge cadence

Touch	Timing	Content
First	Day 1–2	Medications and diuretics reconciled against the discharge summary; symptom and red-flag screen; confirm the follow-up appointment is booked; cuff and scale set up or re-checked

[13] CoachCare Care Management Programs Standard Operating Procedures, version March 2026, and the Care Management Process Maps derived from sections 4, 5, 7 and 11.

Touch	Timing	Content
Second	Day 5–8	Weight and blood-pressure trend read; diuretic plan and lab timing confirmed; titration questions routed to the practice; barriers surfaced: transport, cost, comprehension
Third	Day 12–14	Confirm the follow-up visit happened; reassess against the discharge plan; hand off to the longitudinal cadence; close the loop in the chart

Post-discharge follow-up sequence, triggered by any emergency-room visit or hospitalization reported in the previous 60 days. When the patient was admitted, the same window is the transitional care episode.

That sequence is where the 60 avoided hospitalizations in the forecast come from. It runs inside the same 30-day window transitional care management pays for. One cadence, two separate reasons to run it.

Discharge from the program is governed the same way. A patient who cannot be reached is escalated to the clinic and re-escalated on a fixed cadence rather than dropped, a patient who stops transmitting is worked before a billing month is lost, and the practice is notified at every decision point.

7. The Value Analysis

7.1 Model inputs and how the panel was sized

Input	Value
Medicare office panel	1,750 patients
In scope for year 1	1,750, the full office panel; dialysis patients on monthly capitation are outside it
Referring clinicians	11: the 7 office nephrologists, the office-based internal medicine physician and 3 advanced practice clinicians with office visits
On-site enrollment specialists	1, funded by CoachCare
Programs modeled	Remote physiologic monitoring and principal care management
MAC and locality	Novitas (JH), Louisiana locality 99, Rest of Louisiana, resolved from ZIP 70506; all three offices resolve to the same locality
Electronic health record	eClinicalWorks, native integration
Medicare Advantage penetration	41.6% in Lafayette Parish, where two of the three offices and six of the seven office nephrologists sit. Advantage plans must reimburse at least the Medicare rate for these code families. That is a floor; individual contracts set their own terms.
Forecast horizon	24 months

The panel figure is built from the established office-visit population rather than from total beneficiary counts. CMS reports beneficiaries per rendering clinician, and the 7,509 beneficiary-lines in the file include hospital, nursing-facility and dialysis-unit work as well as patients seen by more than one clinician. The 1,448 established office-visit beneficiaries are deduplicated across clinicians and then grossed up for the Medicare Advantage share of Lafayette Parish, because the claims file covers fee-for-service only and the practice's Advantage patients are not in it. The result is a 1,750-patient Medicare office panel. The dialysis patients on monthly capitation, about 395 in fee-for-service, are outside that panel and outside the forecast.[14]

[14] Panel derivation: 1,448 established office-visit beneficiaries (99213 to 99215) across the seven office nephrologists, the office-based internal medicine physician and the three advanced practice clinicians with office visits at a practice address, deduplicated at 70% to account for patients seen by more than one clinician, then divided by the fee-for-service share of Lafayette Parish (1 less 41.59% Advantage penetration, July 2026 CMS file) to restore the Advantage patients the claims file does not contain. The nephrologists-only anchor gives about 1,500 and the all-clinician anchor about 2,120; section 7.5 shows both.

From the panel, the model counts 1,312 patients as eligible for monitoring (75%) and 1,488 as eligible for principal care management (85%), and enrolls 35% and 30% of those respectively. That produces a monitoring ceiling of 460 patients and a care-management ceiling of 446. Principal care management is billed on the clinical-staff codes.

7.2 The 24-month forecast

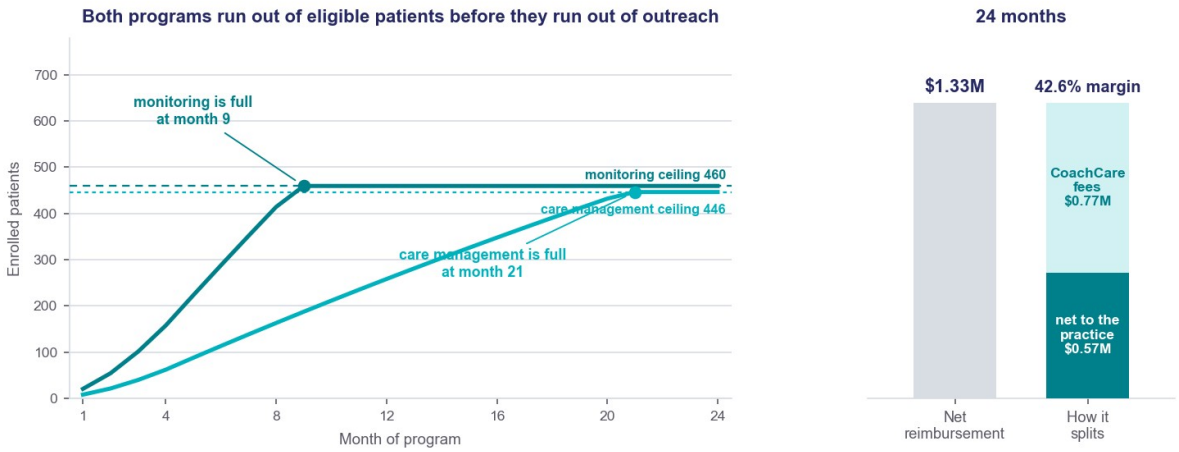


Figure 1. Enrollment against the modeled ceilings, and how 24 months of net reimbursement splits between the practice and CoachCare.

	Year 1	Year 2	24 months
Net reimbursement to the practice	$444,715	$887,384	$1,332,100
CoachCare program and platform fees	$264,409	$500,843	$765,252
Net to the practice	**$180,306**	**$386,542**	**$566,848**
Practice margin	**40.5%**	**43.6%**	**42.6% (42.55%)**

By program	Year 1 net	Year 2 net	24-month net	24-month fees	Ceiling	Ceiling reached
Remote physiologic monitoring	$313,941	$489,077	$803,018	$454,657	460	Month 9
Principal care management	$130,775	$398,307	$529,082	$273,078	446	Month 21

Per-program year splits are read from the workbook's summary, not allocated from the ramp, and reconcile to the annual totals above.

Both programs fill inside the horizon. Monitoring reaches its ceiling of 460 patients in month 9 and care management reaches 446 in month 21. After that the census is flat because the model has run out of patients it counts as eligible, not because it has run out of outreach. The binding constraint on this account is the eligibility definition, which is why the chart count and the stage mix of the office panel are the first items on the discovery agenda. Remote monitoring carries the larger share of the 24-month total,

$803,018 against $529,082, which is what a kidney and hypertension panel on daily cuffs and scales should produce.

7.3 Month by month

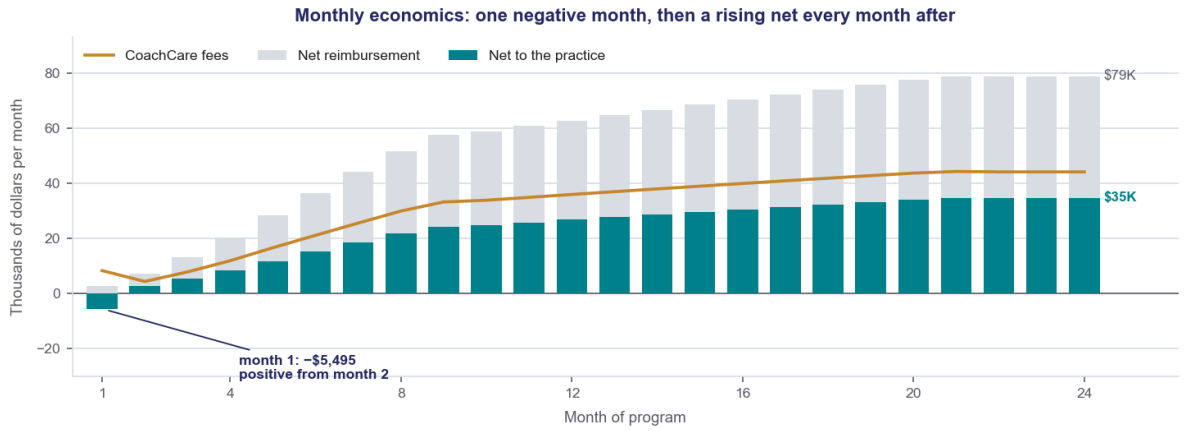


Figure 2. Net reimbursement, CoachCare fees and net to the practice by month. Month 1 is the only negative month.

Month 1 runs **$5,495 negative**. Implementation and the eClinicalWorks integration setup both post in the first month against a 29-patient census. The practice is positive from **month 2** onward and stays there. By month 12 the practice nets $26,862 a month on $62,886 of net reimbursement; by month 24, $34,783 a month on $79,016.

7.4 Patients, readings and avoided admissions

What the service line produces over 24 months	Value
Unique patients under management at month 12	537
Unique patients under management at month 24	593
Active program enrollments at month 24	906
Physiologic readings reviewed	94,116
Claims generated	26,220
Hospitalizations avoided	60
Care-team hours delivered	12,868, about 6.2 full-time equivalents

Unique patients are deduplicated across programs. A patient enrolled in both monitoring and care management is one person and two enrollments, which is why 593 unique patients carry 906 active enrollments at month 24. Care-team hours describe labor supplied by CoachCare, not headcount the practice hires.

The avoided-admission figure is built on a generic 20% annual admission rate. A stage 3b to 5 kidney cohort with heart failure in 45–67% of the nephrologists' patients admits well above that. The table below shows what the same enrolled population avoids at higher baselines, holding the model's reduction rate constant.

Annual admission rate in the enrolled cohort	Hospitalizations avoided, 24 months
20%, the modeled base	**60**
30%	90

Annual admission rate in the enrolled cohort	Hospitalizations avoided, 24 months
40%	120
50%	149

Avoided admissions scale with the cohort's baseline admission rate, holding the enrolled census and the model's reduction rate constant. None of them is in the financial forecast, which prices the fee-for-service codes only.

Those hours are the number to hold against the practice's own staffing. About 6.2 full-time equivalents of care-management labor, supplied by CoachCare, against a practice whose nurse practitioners already cover dialysis units and hospital rounding. Any version of this program that assumes existing headcount absorbs the work is a proposal that the advanced practice clinicians stop doing what they do now.

7.5 What moves the forecast

Four inputs move the 24-month answer, and each can be settled on the first call or in the first fortnight. The table holds every other input at the modeled base.

Input	Setting	24-month net	Net to the practice	Unique patients, month 24
Modeled base	**1 enrollment specialist, 1,750-patient panel, 11 clinicians**	**$1,332,100**	**$566,848**	**593**
Enrollment specialists	0	$883,518	$364,568	521
	2	$1,519,776	$653,056	593
	3	$1,606,530	$692,646	593
Panel	1,500, nephrologists only	$1,205,900	$513,771	508
	2,120, every billing clinician	$1,476,281	$626,174	710
Referring clinicians	7, the office nephrologists	$1,231,264	$521,234	591
	14	$1,387,955	$592,205	593
Upside roster	2,120-patient panel, 14 clinicians	$1,559,473	$663,698	719

Sensitivities recalculated from the same workbook, one input at a time. The panel rows rebuild the ceilings from the nephrologists-only and the all-clinician established-visit anchors; the upside roster combines the larger panel with the larger referring roster.

Read the enrollment rows carefully

Going from zero enrollment specialists to one is worth $448,581 over 24 months. That is the single largest lever in the model, and it is the answer to the staffing objection: the enrollment function is the program, and CoachCare funds it. Without one, care management never reaches its ceiling inside the horizon and the month-24 census is 521.

A second or third specialist cannot raise the ceiling. The month-24 census is 593 unique patients at one, two and three, because both programs are already pinned at their ceilings. What extra capacity buys is reaching those ceilings sooner, and the additional patient-months in between are real revenue: $187,677 more over 24 months with two specialists, $274,430 more with three.

The panel and the roster move the ceiling. The enrollment specialist count moves the speed. Both matter, and they are different conversations.

8. Market and Payer Mix

Parish	Medicare Advantage penetration	Note
Lafayette	41.6%	Two offices; six of the seven office nephrologists; the rate the model uses
Iberia	53.7%	New Iberia office
St. Landry	48.5%	
St. Martin	52.4%	One of the four hospitals
Vermilion	49.3%	Two of the four hospitals
Acadia	48.7%	

CMS State and County Medicare Advantage penetration file, July 2026. The four hospitals the practice's physicians round at sit in Lafayette, St. Martin and Vermilion parishes.

Lafayette Parish has 45,843 Medicare beneficiaries, of whom about 27,964 remain in fee-for-service. Across the six parishes the practice draws from, there are 117,411 Medicare beneficiaries, 65,596 in fee-for-service, 1,149 with end-stage renal disease, and a dual-eligible share of 26.1%.[15] The practice's claims profile in section 1 describes only the fee-for-service share of its panel. The Value Analysis grosses the panel up to include the Advantage patients, because they are enrolled in the same programs and consented the same way. Advantage plans must reimburse at least the Medicare rate for these code families. That is a floor; individual contracts set their own terms.

Lafayette Parish's poverty rate is 17.1% and its median household income $67,451; the poverty rate is 22.8% in Iberia Parish and 26.8% in St. Landry. The practice's own dual-eligible share is 31.5%, which means cost-sharing is covered for nearly one patient in three, and the enrollment conversation about coinsurance is one the specialist has in person with the rest. Louisiana Medicaid offers no general remote-monitoring or care-management benefit the practice can bill directly, so the model prices Medicare only, and dual-eligible patients bill Medicare.[16]

The dialysis geography is dense. Fifteen in-center units with 296 stations serve the six parishes and one adjoining parish, and the practice's Ambassador Caffery office shares an address with one of them. That is the physical geography the dialysis monthly protocol already runs across, and it is where the late-stage office patients this service line reaches will eventually be seen.[17]

What this means for the business case

Roughly two-fifths of the panel's reimbursement in Lafayette Parish, and about half in the surrounding parishes, is contract-dependent rather than fee-schedule-set. The practice's own Advantage plan mix, plan by plan, is therefore the single most useful piece of information it can bring to the first call.

The fee-for-service share is where the rates in section 4 apply exactly as printed. The Advantage share is where the practice's existing plan contracts decide the answer, and those contracts already exist.

[15] CMS Medicare Monthly Enrollment, calendar year 2024 annual rows for Lafayette, Iberia, St. Landry, Acadia, St. Martin and Vermilion parishes; CMS State and County Penetration, Medicare Advantage, July 2026 file.

[16] American Community Survey 2020–2024 five-year data, tables DP03 and DP05, Lafayette, Iberia and St. Landry parishes. Dual-eligible share from the by-Provider source, summed across the practice's clinicians.

[17] CMS Dialysis Facility file, Provider Data Catalog, filtered to Lafayette, Iberia, St. Landry, Acadia, St. Martin, Vermilion and Evangeline parishes, retrieved 14 September 2026: 15 units, 296 certified stations.

9. The Kidney Models, as Context

This section is context. It describes the payment models that surround a Louisiana nephrology practice in 2026, and it asserts nothing about the practice's participation in any of them.

The ESRD Treatment Choices model, which covered the Lafayette hospital referral region on a mandatory basis, ended on 31 December 2025.[18] The Kidney Care Choices model runs through 31 December 2027, and CMS has said it is designing a successor; no list of who will be in that successor exists.[19] Two independent nephrology groups in the region already sit inside a kidney care entity under that model.[20] **Acadiana Renal Physicians participates in none of these today, and nothing in this report assumes it will.**

What the models have in common is more useful than what separates them. Every one of them, current or next, asks a nephrology practice for the same four things: a consented longitudinal panel, documented monthly care management, continuous physiologic data, and a working readmission-prevention loop. This service line builds all four under fee-for-service, paid monthly under the practice's own TIN, before any deadline exists. If the practice's view of a kidney care entity changes in 2027, the evidence those entities are scored on will already be two years deep. If it does not, the service line stands on its own P&L.

What the service line produces	Where it lands
Net reimbursement on remote monitoring and care management	The practice's own P&L, section 7
Transitional care management on every discharge	The practice's own P&L, outside the forecast
Avoided admissions in the monitored cohort	Fewer hospital days for the practice's patients; the outcome every kidney model, current or next, measures
Optimal starts: modality chosen and access placed before dialysis begins	The clinical outcome the kidney models pay on, produced whether or not the practice is in one
Documented between-visit management of the stage 3b to 5 cohort	The evidence base any total-cost arrangement scores on, if the practice's position ever changes

10. Implementation Roadmap

Phase	Window	What happens
Charter	Days 1–30	Clinical protocol design with the nephrologists: blood-pressure targets by stage, weight rules, escalation routing and thresholds; eligibility definition agreed against the practice's own chart count and stage mix; billing path confirmed; eClinicalWorks integration scheduled; Advantage plan mix reviewed
First enrollments	Days 31–45	On-site enrollment specialist starts at the St. Mary office; transitional care management goes live on current discharges from all four hospitals; the first monitoring cohort is set up from the stage 4 and resistant-hypertension lists
Ramp	Months 2–9	Monitoring census climbs to its ceiling of 460 across all three offices, with the New Iberia office brought on once the two Lafayette offices are running; monthly billing cadence established; first read of readmissions in the post-discharge cohort

[18] CMS ESRD Treatment Choices model, selected hospital referral regions list (hospital referral region 213, Lafayette, Louisiana, including ZIPs 70506 and 70563); early termination finalized in the CY2026 ESRD Prospective Payment System final rule, Federal Register, 24 November 2025.

[19] CMS Innovation Center, Kidney Care Choices model: extension through performance year 2027 and design changes from performance year 2026, announced 2026; CMS statements on a kidney-specific successor model, 2026. Retrieved 14 September 2026.

[20] CMS Kidney Care Choices model participants and affiliations file, calendar year 2026, and the public transparency roster of the one kidney care entity listing Louisiana, retrieved 14 September 2026. No organization or clinician is named here.

Phase	Window	What happens
Depth	Months 10–21	Principal care management builds to its ceiling of 446 on the kidney-disease and resistant-hypertension cohort; treatment-management time capture matures; modality education moves onto the care-management call for the late-stage cohort
Steady state	Month 22 onward	Both programs at ceiling; the conversation turns to the stage mix, the roster and whether chronic care management belongs in the stack for the multi-condition patients

The dashboard the practice should hold CoachCare to

Domain	Measures
Clinical	Blood-pressure control in the monitored cohort; weight-rule escalations and outcomes; titration and lab-timing prompts completed; 30-day readmissions in the post-discharge cohort; escalations by severity and outcome; planned versus unplanned dialysis starts among enrolled patients
Operational	Enrolled census against ceiling by program and by office; time to first billable enrollment; monthly reading adherence; escalation response times; unreachable-patient resolution
Financial	Net reimbursement per enrolled patient per month; capture rate against eligible patient-months; denial rate by code and by payer; transitional care management capture against discharges at each of the four hospitals

11. The CY2027 Proposed Rule

CMS published the CY2027 physician fee schedule proposed rule on 16 July 2026. The comment period closed on 14 September 2026; the final rule is expected in early November 2026 and takes effect on 1 January 2027. None of it is final.[21] Two things in it bear directly on this forecast: the conversion factor moves from $33.4009 to $32.8409, and the remote-monitoring device-supply codes take a large cut in practice-expense value. Every code in the forecast was repriced on the practice's own billing mix at Louisiana locality 99.

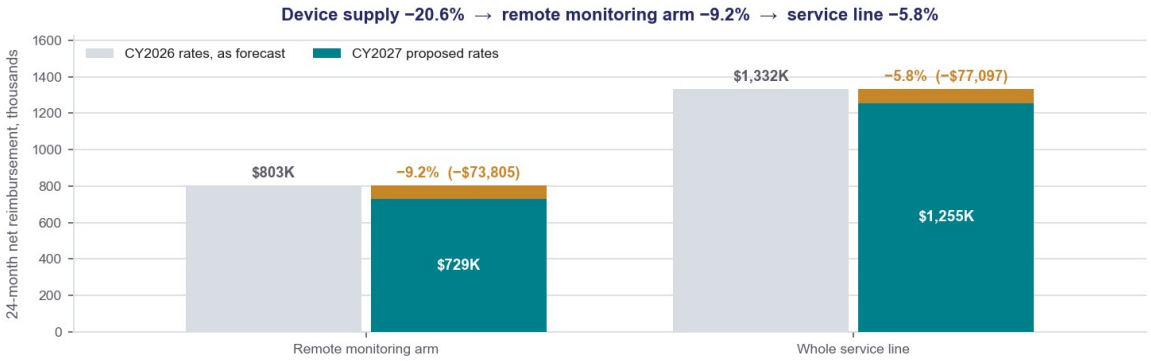


Figure 3. The CY2027 cascade on one dollar scale: the device-supply cut flows through the remote-monitoring arm to the whole service line, each percentage smaller only because its base is larger.

[21] CY2027 Physician Fee Schedule proposed rule (CMS-1848-P), published 16 July 2026, with the accompanying RVU and conversion-factor public use files. Comments closed 14 September 2026.

Device supply (99454 and 99445) falls −20.6% at this locality, from $46.14 to $36.64 per patient-month. Device supply is 31% of the remote-monitoring basket on the practice's mix, so the monitoring arm falls −9.2%, or −$73,805 over 24 months. The monitoring arm is 60% of the service line, so the whole line falls −5.8%, or −$77,097 of $1,332,100. Principal care management moves −0.6%, through the conversion factor and practice-expense churn rather than any targeted change.

Code	Service	Locality 99, CY2026	Locality 99, CY2027 proposed	Change	National, CY2026	National, CY2027 proposed
99453	Remote monitoring setup	$19.26	$17.75	−7.8%	$21.71	$20.03
99454	Device supply, 16–30 days	$46.14	$36.64	−20.6%	$52.11	$41.38
99445	Device supply, 2–15 days	$46.14	$36.64	−20.6%	$52.11	$41.38
99457	Treatment management, first 20 min	$48.26	$46.31	−4.0%	$51.77	$49.59
99470	Treatment management, first 10 min	$24.30	$19.53	−19.6%	$26.05	$20.69
99458	Treatment management, additional 20 min	$39.09	$38.17	−2.4%	$41.42	$40.39
99426	Principal care management, staff, first 30 min	$64.02	$63.21	−1.3%	$67.80	$67.00
99427	Principal care management, staff, additional 30 min	$50.74	$51.05	+0.6%	$54.11	$54.52

Locality amounts are used for the cascade and the repricing; national Addendum B amounts are shown side by side for reference. The two bases do not reconcile to the dollar, by design.

The proposal does not change the case. The service line at CY2027 proposed rates still produces $1,255,003 of net reimbursement over 24 months on the same census. It does change what the practice should expect from the device-supply line, and it is one more reason to start in 2026 rather than wait for the final rule.

12. Open Items for the First Call

Eight questions decide how much of this report's forecast survives contact with the practice's own data, and all eight can be answered on the first call.

1. **The chart count and the stage mix.** The 1,750-patient Medicare office panel is built from established-visit beneficiaries in the CMS file, grossed up for the Advantage share. A unique-patient count from eClinicalWorks, with the stage 3b to 5 share and the home-versus-in-center split, replaces the figure outright, and section 7.5 shows what it moves.
2. **The electronic health record.** The practice meets patients on healow, which is the eClinicalWorks patient platform; confirming eClinicalWorks as the chart, and whether any hospital-extended system is used for rounding, fixes the integration scope.
3. **Who owns the office panel day to day.** Whether the referring roster is the 7 office nephrologists, the 11 clinicians modeled, or the larger roster in section 7.5, and which advanced practice clinicians are purely dialysis-unit and hospital rounding.
4. **The two roster additions.** The practice website lists a nephrologist who does not yet appear in CMS claims or registry data, and an advanced practice clinician at the Ambassador Caffery office whose Medicare billing resolves to a hospital system. Whether either is in the practice's roster decides between the base case and the upside roster.
5. **The Medicare Advantage plan mix.** 42% of Lafayette Parish and roughly half of the surrounding parishes are in Advantage, and the panel is priced at the fee schedule. Advantage plans must

reimburse at least the Medicare rate for these code families. That is a floor; individual contracts set their own terms. Which plans, and in what proportion, is the question.

6. **Hospital attribution of office patients.** The physicians carry billing reassignments to four hospitals. Whether any of those hospitals' value-based arrangements attribute the practice's office patients, and whether that changes the practice's view of care-management attribution, is not publicly registered.
7. **Dialysis-unit roles and time.** Medical director roles at the area's dialysis units, and how much physician time sits in-center against the office, shape who can order and who can review escalations on which days.
8. **Discharges today.** 15 transitional care patients were billed in CY2024. Who touches a discharge today, at which of the four hospitals, and how the practice learns a patient has gone home, decides how fast the fastest first dollar arrives.

The case in three sentences

A remote care service line built on the office panel this practice already manages produces $1,332,100 of net reimbursement and $566,848 of retained margin over 24 months, at a 42.6% practice margin, billed under the practice's own TIN.

It does that while producing the between-visit layer where kidney disease progression is decided, on a panel where chronic kidney disease and hypertension both report at the ceiling CMS publishes to and roughly half the patients have heart failure.

The operating model is already running for the dialysis patients. What is missing is its reach.

To take any of this further, the next step is a working session with the practice's physician owners and administrator to walk the chart count, the roster and the plan mix against this model. Connor Knapp · Head of Sales · CoachCare · connor.k@coachcare.com.

References & Data Sources

Every figure in this report traces to one of the sources below. CMS files were queried directly rather than through an aggregator, and each query date is recorded in the numbered notes throughout.

Source	Used for	Vintage
Medicare Physician & Other Practitioners — by Provider	Allowed charges, beneficiary-lines, risk score, age mix, dual-eligible share, chronic-condition prevalence for the practice's billing clinicians	CY2024, queried 14 September 2026
Medicare Physician & Other Practitioners — by Provider and Service	Procedure-level claims: hospital care, dialysis monthly codes, office visits, the complexity add-on, and the absent remote-care and care-management families	CY2024, queried 14 September 2026
Quality Payment Program eligibility interface; NPPES registry; CMS Doctors & Clinicians national file; PECOS group reassignment file	Clinician roster, group identifier, billing-organization attribution, hospital reassignments	PY2025 and PY2026 / current, retrieved 14 September 2026
CMS Dialysis Facility file, Provider Data Catalog	In-center units and certified stations in the seven-parish area	Current, retrieved 14 September 2026
CMS ESRD Treatment Choices model, selected hospital referral regions; CY2026 ESRD Prospective Payment System final rule	Section 9: model coverage of the Lafayette region and its end date	Federal Register, 24 November 2025
CMS Kidney Care Choices model, participants and affiliations file; CMS Innovation Center announcements	Section 9: model term, design changes and successor status	CY2026 file; announcements through 2026
CMS State and County Medicare Advantage penetration file	Parish Advantage penetration	July 2026
CMS Medicare Monthly Enrollment	Parish Medicare, fee-for-service, end-stage renal disease and dual-eligible counts	CY2024
American Community Survey five-year data, Acadiana parishes, Louisiana	Income and poverty	2020–2024
CY2026 physician fee schedule, Novitas Louisiana locality 99	Every CY2026 rate quoted in sections 3 and 4	CY2026, conversion factor $33.4009
CY2027 physician fee schedule proposed rule (CMS-1848-P) and public use files	Repricing in section 11, locality and national	Published 16 July 2026
Practice website	Offices, services, telehealth platform, clinician roster count	Retrieved 14 September 2026
CoachCare eClinicalWorks integration overview	Section 5	Current
CoachCare Care Management Standard Operating Procedures and SOP process maps	Section 6: escalation engine, emergent pathway, routing, post-discharge cadence, discharge flow	Version March 2026
CoachCare Value Analysis for this account	The 24-month forecast, per-program detail, sensitivities and clinical outputs	Recalculated 14 September 2026

Appendix. SOP process maps

Section 6 is drawn from seven workflow maps derived from CoachCare's Care Management Programs Standard Operating Procedures, version March 2026. The maps cover the full patient journey from population screening through monitoring, escalation and discharge, and are walked with the practice's clinical lead during the charter phase.

Map	SOP section	What it governs
01 Patient qualification and device assignment	Section 13, exhibits A and B	How the practice's population is screened by diagnosis and routed to the right device and program; device selection follows an ordered hierarchy, and the highest-priority qualifying diagnosis wins
02 Remote monitoring patient lifecycle	Section 6	Referral through consent, device setup, and the two loops that run every month: the clinical escalation loop and the billing-threshold loop
03 Care management lifecycle and escalation	Section 7	Non-face-to-face coordination against a comprehensive care plan, monthly outreach, and the three-way escalation split: emergency, non-critical routing, and record-only
04 Clinical alert and escalation decision logic	Section 4	The shared escalation engine every monitoring program routes through; critical values escalate regardless of symptoms, out-of-range readings go through retake and symptom check first
05 Emergent and urgent communication protocol	Section 5	The 911 pathway for active emergent symptoms reported during outreach; CoachCare's policy supersedes any practice-specific escalation preference
06 Post-discharge follow-up sequence	Section 7.6.1	Triggered by an emergency visit or hospitalization in the previous 60 days; a fixed three-touch cadence inside two weeks, each touch documented and escalated per protocol
07 Patient discharge decision flow	Section 11	Discharge criteria and the unreachable-patient escalation timelines; the clinic is notified in every case, and discharges process in the first week of the following month